



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

**THURSDAY, APRIL 7, 2016
2:00 P.M.**

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

BOARD OF DIRECTORS

Mark Refowitz, Chair	Lee Penrose, Vice Chair
Supervisor Lisa Bartlett	Supervisor Andrew Do
Peter Agarwal	Ellen Ahn
Theresa Boyd	Samara Cardenas, M.D.
Viet Van Dang, M.D.	Tricia Nguyen
Mike Ryan	(Vacant)
Supervisor Todd Spitzer, Alternate	

CHIEF EXECUTIVE OFFICER
Michael Schrader

CHIEF COUNSEL
Gary Crockett

CLERK OF THE BOARD
Suzanne Turf

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

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

The Board Meeting Agenda and supporting documentation is available for review 8:00 a.m. – 5:00 p.m., Monday-Friday, at CalOptima, 505 City Parkway West, Orange, CA 92868 and online at www.caloptima.org.

CALL TO ORDER

Pledge of Allegiance
Establish Quorum

PRESENTATIONS/INTRODUCTIONS

None

MANAGEMENT REPORTS

1. [Chief Executive Officer Report](#)
 - a. Chief Operating Officer (COO) Appointment
 - b. Medi-Cal Expansion Rate Reduction
 - c. California Children's Services Transition
 - d. OneCare Connect
 - e. CalOptima Community Network Anniversary
 - f. Regulatory Audits
 - g. Intergovernmental Transfer (IGT) 5
 - h. CalOptima 20th Anniversary
 - i. Key Meetings
 - j. Community Engagement

PUBLIC COMMENTS

At this time, members of the public may address the Board of Directors on matters not appearing on the agenda, but within the subject matter jurisdiction of the Board of Directors. Speakers will be limited to three (3) minutes.

CONSENT CALENDAR

2. [Minutes](#)
 - a. Approve Minutes of the March 3, 2016 Regular Meeting of the CalOptima Board of Directors
 - b. Receive and File Minutes of the November 18, 2015 Regular Meeting of the CalOptima Board of Directors' Quality Assurance Committee; the December 22, 2015 and February 25, 2016 Meetings of the CalOptima Board of Directors' OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan); and the February 11, 2016 Meeting of the CalOptima Board of Directors' Provider Advisory Committee
3. [Approve CalOptima 2016 Quality Improvement Program and 2016 Work Plan](#)
4. [Approve CalOptima 2016 Utilization Management Program and 2016 Work Plan](#)
5. [Approve CalOptima 2016 Program of All-Inclusive Care for the Elderly \(PACE\) Quality Assessment and Performance Improvement Plan](#)
6. [Approve and Reinstate Updated Policy GG.1643 Minimum Physician Standards](#)
7. [Approve Measurement Year CY 2016 Pay for Value Programs for Medi-Cal and OneCare Connect](#)
8. [Authorize a Mock Audit of the OneCare Connect Program; Authorize a Budget Reallocation to Fund This Mock Audit](#)
9. [Ratify Amendment A-06 to the Secondary Agreement with the California Department of Health Care Services](#)

REPORTS

10. Consider Selection of Taxi Vendor and Authorize Contract for Taxi Services Effective July 1, 2016
11. Consider Selection of Vision Vendor and Authorize Contract for Vision Services Effective July 1, 2016
12. Consider Recommended Expenditure Categories for Intergovernmental Transfer (IGT) 5 and Recommended Expenditure Plan for IGT 4
13. Adopt Resolution Approving CalOptima's Updated Human Resources Policies and Employee Handbook
14. Consider Adoption of Position on Senate Bill (SB) 1273, Legislation that Clarifies Counties' Ability to use Mental Health Services Act (MHSA) Funds to Provide Crisis Stabilization Services, and on SB 1308, that Imposes New Restrictions on County Organized Health System (COHS) Plans Including CalOptima

ADVISORY COMMITTEE UPDATES

15. Member Advisory Committee Update
16. Provider Advisory Committee Update
17. OneCare Connect Cal MediConnect (Medicare and Medicaid Plan) Member Advisory Committee Update

INFORMATION ITEMS

18. February 2016 Financial Summary
19. Compliance Report
20. Federal and State Legislative Advocates Reports
21. CalOptima Community Outreach and Program Summary

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

ADJOURN TO CLOSED SESSION

- CS 1 Pursuant to Government Code Section 54956.9, subdivision (d)(2), CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION (one case)

ADJOURNMENT

NEXT REGULAR MEETING: Thursday, May 5, 2016 at 2:00 p.m.

MEMORANDUM

DATE: April 7, 2016
TO: CalOptima Board of Directors
FROM: Michael Schrader, CEO
SUBJECT: CEO Report
COPY: Suzanne Turf, Clerk of the Board; Member Advisory Committee; Provider Advisory Committee; OneCare Connect Member Advisory Committee

COO Appointment

I am pleased to announce that Ladan Khamseh has been appointed CalOptima Chief Operating Officer, effective April 4. At CalOptima since our founding in 1995, Ladan has held increasing positions of responsibility in Operations and Customer Service departments, including most recently as Executive Director of Operations and, since October 2015, Interim COO. Her commitment to CalOptima's mission and members is unparalleled, and I look forward to her continued contributions to the agency.

Medi-Cal Expansion (MCE) Rate Reduction

In a March 28 meeting with the Department of Health Care Services (DHCS) rate team, CalOptima learned more regarding the upcoming reduction in Fiscal Year 2016–17 rates for MCE members. We now have some indication that the cuts will not be as deep as initially suggested. MCE rates will decrease from \$475 per member per month (PMPM) currently, but not all the way down to the \$275 PMPM paid for Medi-Cal Classic Temporary Aid for Needy Families (TANF) members. Draft rates should be released to health plans in April. However, CalOptima is working now to prevent last year's situation from recurring, whereby we were informed about MCE cuts only three weeks before implementation and had to then quickly notify providers. In March, CalOptima launched a communications plan, sending letters to contracted specialists, health networks and hospitals, and addressing the topic at meetings with provider and hospital associations as well as our Provider and Member Advisory Committees. Raising awareness will help our partners understand and budget for the change that will occur in July. Still, because the information from the state is not final, our approach to implementing the rate reduction is yet to be determined and will, of course, be subject to your Board's approval.

California Children's Services (CCS) Transition

On March 25, CalOptima welcomed DHCS Director Jennifer Kent as the featured speaker at a stakeholder meeting regarding the upcoming CCS transition to Medi-Cal managed care. Nearly 100 attendees representing hospitals, providers, health networks and member advocacy groups filled the room. CalOptima Board of Directors Chair Mark Refowitz provided opening remarks reflecting his dual role with CalOptima and the Orange County Health Care Agency, which oversees the current CCS program. I spoke about CalOptima's guiding principles in approaching this transition for a complex group of vulnerable children. Ms. Kent summarized why DHCS is pursuing the CCS transition. She said that change is needed for two primary reasons: 1) to put

the CCS program on more stable and sustainable financial footing under Medi-Cal managed care, and 2) to integrate CCS services with a child's other medical and social needs, thereby delivering a streamlined, quality health care experience. She expressed support for CalOptima and the other county organized health systems, which have been purposely selected to implement the CCS transition based on their track record of quality care. Overall, it was a positive kickoff to what will be a series of stakeholder meetings to engage interested parties in helping CalOptima plan a smooth transition that is responsive to Orange County and the needs of CCS children.

OneCare Connect (OCC)

OCC continues to be dynamic, with every month bringing updates and changes to strengthen the program that lower costs and improves care for seniors and people with disabilities. See below for news about annual passive enrollment, long-term care (LTC) passive enrollment, increased funding and a new advocacy campaign:

- **Annual Passive Enrollment:** CalOptima's one-year passive enrollment process by birth month and by long-term care facility concludes in July. But in late March, health plans offering Medicare-Medicaid programs won an extension of the method that automatically enrolls members. The Centers for Medicare & Medicaid Services (CMS) and DHCS agreed in concept to allow an annual passive enrollment process for seniors who age into Medicare. Operational details are being developed, and I will share more about how this will work in the future.
- **LTC Passive Enrollment:** On March 31, CalOptima hosted representatives from 40 LTC facilities that will have residents passively enrolled into OCC in June and July. At the event, CalOptima clinical, claims and provider relations staff presented an overview of OCC and its advantages for providers and LTC facilities. CalOptima will hold a similar event on April 27. These meetings are part of efforts to reduce the OCC opt-out rate of LTC residents. Statewide, the opt-out rate for LTC residents is nearly 100 percent, but CalOptima's unique approach has reduced this to less than 60 percent in Orange County.
- **Increased Funding:** CalOptima advocated alongside the Association for Community Affiliated Plans (ACAP) to support a change in the risk-adjustment model for dual eligible members, including those in OCC. On April 1, CalOptima received a \$3.8 million retroactive increase in 2016 OCC rates for January to March. All rates from April to December will increase by 7.4 percent. This increase, however, is not assured in the future. Currently, commercial plans are lobbying for CMS to kill the adjustment for 2017, because it reduces their payment on traditional Medicare Advantage plans, which largely do not serve dual eligibles. In response, CalOptima is working with our local delegation to send letters to CMS requesting the change be upheld. CMS will make a decision about 2017 rate methodology this month.
- **New Advocacy Campaign:** Launched in 2015, the Coordinated Care Initiative (CCI) Sustainability Workgroup brings together health plans, state associations and other consumer groups interested in the continuation of the CCI. In March, the group moved to the next phase of advocacy by branding itself as "Californians for Coordinated Care" and implementing a communications plan. The group issued a [press release](#) about its formation and authored an [op-ed piece](#) that ran in the Sacramento Bee. Californians for Coordinated Care also launched a Twitter account, @CA_CCI. As a participant in Californians for Coordinated Care, CalOptima is retweeting this material.

CalOptima Community Network Anniversary

March marked the one-year anniversary of the launch of CalOptima Community Network, which was specifically designed to expand access to care and offer a direct contracting option for providers. Data show that Community Network is successfully meeting those goals. Providers have responded, creating a robust network of 622 primary care providers and 2,492 specialists. In the first year, membership has more than doubled, increasing from nearly 26,000 members at the launch in 2015 to more than 55,000 in March 2016. Thanks to your Board for guiding the network's development and supporting its mission of strengthening Orange County's safety net.

Regulatory Audits

- **Medi-Cal:** From February 8–17, up to 13 DHCS auditors were on-site to complete the annual medical audit of our Medi-Cal plan. Auditors noted that they saw significant improvement compared with the prior year, and the overall tone of the audit was positive. CalOptima's draft Medi-Cal audit report will arrive on or before April 5 and the exit conference will be April 7. Several auditors will attend in person with additional DHCS staff participating via teleconference. CalOptima will have until April 22 to provide information or rebuttals to the draft audit report. Then, DHCS has 30 days from the exit conference to issue the final audit report, which will be May 7.
- **OneCare:** CMS performed a validation audit for OneCare from March 29–30, 2016, to ensure that the findings issued in the March 2015 final audit report are fully remediated. The validation audit was conducted in six sessions via webinar. Additional documentation was submitted on March 31, and auditors left open the date for CMS' response.

Intergovernmental Transfer (IGT) 5

To maximize the opportunity with our fifth IGT transaction, CalOptima has secured multiple funding partners, including UCI, the Orange County Health Care Agency, the Children and Families Commission of Orange County, and the cities of Newport Beach and Orange. Consistent with your Board's approval, CalOptima submitted to DHCS on March 29 an application and non-binding interest letters from our proposed funding partners. DHCS will soon determine if CalOptima is approved to move forward with the transaction. At your April meeting, staff will present the general categories of spending for CalOptima's share of IGT 5.

CalOptima 20th Anniversary

- **Legacy Awards:** Coming soon on Thursday, April 21, CalOptima will honor our providers and community partners at a special event, the Legacy Awards. Held at Bowers Museum in Santa Ana, this event will recognize key leaders who were essential contributors to the launch of CalOptima. The program will also celebrate the ongoing collaboration between CalOptima and local providers, which has resulted in our status as a model health plan in California. Legacy Award recipients are:
 - Mary Dewane, *founding CalOptima Chief Executive Officer*
 - Kenneth E. Bell, M.D., *former CalOptima Chief Medical Officer*
 - Jean Forbath, *former CalOptima Board member and founder of Share Our Selves*
 - Hon. Harriett Wieder (*posthumous award*), *former Orange County Supervisor and founding Board member*

- *And founding CalOptima Board members:* John R. Cochran III (Chairman); Peter Anderson, M.D.; Arthur Birtcher; Richard Frankenstein, M.D.; Claire Heaney and Joyce Munsell

I look forward to your Board attending to honor CalOptima's contribution to the health of Orange County along with our other invited guests, including hospital CEOs, health network executives and community-based organization leaders.

- **Employee Activities Committee Scholarship Essay Contest:** CalOptima employees' commitment to serving members is reflected in a new opportunity developed by our Employee Activities Committee (EAC). The committee voted to recognize the agency's 20th anniversary with a Scholarship Essay Contest for members pursuing a career in health care or social services. Money for the awards will come from EAC fundraising activities; no public dollars will be used. Each entry is to cover three topics: how CalOptima has helped them, why they are working toward a career in health care or social services, and why they would make a good candidate for the award. Applications are available on CalOptima's [website](#).

Key Meetings

Below are brief summaries of five key meetings during the past month:

- **Coalition of Orange County Community Health Centers:** Held at CalOptima, the coalition's quarterly meeting on March 4 addressed Federally Qualified Health Center issues, alternative payment programs, quality incentives and other topics.
- **Local Health Plans of California CEO Brianna Lierman:** CalOptima is conducting an initial exploration of Knox-Keene licensure, and Ms. Lierman met with the executive team on March 9 to share her expertise regarding this form of health plan licensure. There may be advantages to CalOptima voluntarily obtaining a Knox-Keene license, as opposed to it being mandated by legislation, as last year's defeated S.B. 260 intended. At this time, 22 Medi-Cal managed care plans in the state have a Knox-Keene license, while five county organized health systems, including CalOptima, do not. There continues to be a perception that Knox-Keene licensure offers better protections for members.
- **ACAP Medicare Meeting:** On March 17, I presented at ACAP's Medicare Meeting, which was attended by about 50 CEOs from Medicaid plans nationwide. The topic was value-based purchasing, and I shared details about our proposed OCC LTC Value-Based Program, which is currently under review by regulators. Subject to the regulatory response and with authorization by your Board, CalOptima would share savings with primary care providers and LTC facilities for quality performance that keeps OCC members in LTC healthier and prevents unnecessary hospitalizations.
- **Orange County Employees Association (OCEA):** On March 18, I met with Jennifer Muir, OCEA general manager, regarding the CCS transition to CalOptima from Orange County Health Care Agency, whose employees are represented by OCEA. I shared with her that CalOptima is in the early stages of working with the state, county and stakeholders to exchange information and collaborate on a transition plan in the best interest of the CCS program and children. One approach to the transition may be to contract back with county employees for the care coordination function of CCS.
- **Service Employees International Union (SEIU) and County Health Executives Association of California (CHEAC):** On March 29, I traveled to Sacramento for a meeting about CCS arranged by CalOptima's state advocate, Edelstein Gilbert Robson & Smith, and

state association, Local Health Plans of California. SEIU and CHEAC representatives were interested in meeting the health plans involved in the CCS transition to share their concerns and learn how health plans provide care to members with complex needs. Overall, the meeting was positive, and I had the opportunity to share examples of CalOptima's commitment to providing quality health care. We will work through our advocate and association to continue the conversation with SEIU and CHEAC during the CCS transition.

Community Engagement

As a community-based health plan, CalOptima is dedicated to active involvement in Orange County. Here is an example of recent engagement:

- **Community Alliances Forum:** CalOptima held our quarterly Community Alliances Forum on March 9, focusing on the Orange County Women's Health Project. I provided opening remarks that reflected CalOptima's ongoing commitment to women's health issues. The featured speakers detailed the project's efforts to improve women's health and address the problem of domestic violence. As always, the room was filled to capacity with staff from community-based organizations, and their feedback was positive. They appreciate CalOptima's role as the convener of these forums.



CalOptima
Better. Together.

CEO Report

Board of Directors Meeting
April 7, 2016

Michael Schrader
Chief Executive Officer

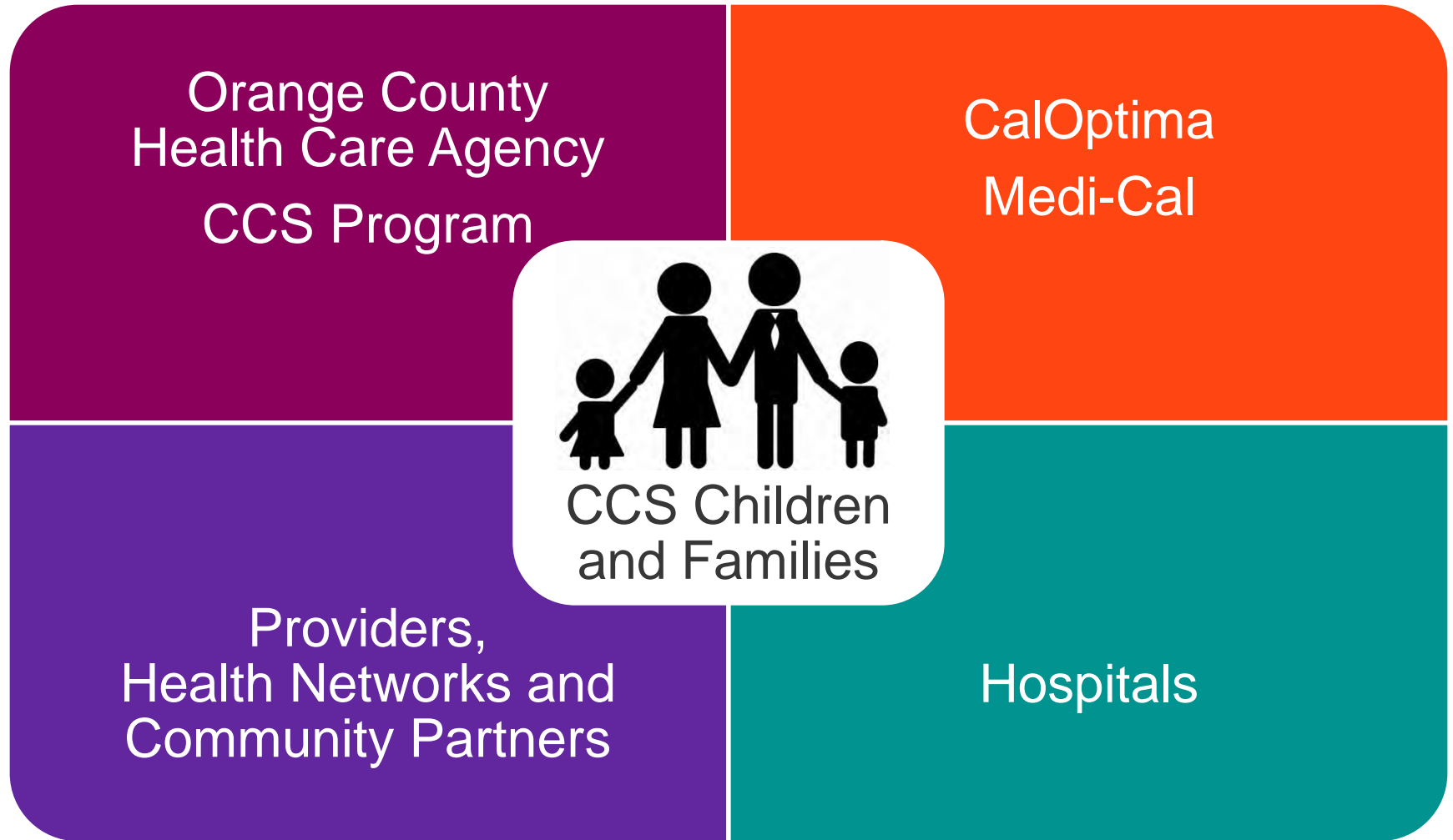
COO Appointment

- Effective April 4, Ladan Khamseh is CalOptima Chief Operating Officer
- At CalOptima since 1995, Ladan has held increasing positions of responsibility in Operations and Customer Service

Medi-Cal Expansion Rate Reduction

- CalOptima had a March 28 meeting with Department of Health Care Services rate team
- Cuts for Medi-Cal Expansion rates for Fiscal Year 2016–17 will move down toward the Temporary Aid for Needy Families rate, but will not match it
- CalOptima has implemented a communications plan to inform contracted partners about the upcoming change
- Draft rates should be released this month

CCS: A Partnership in Orange County



Guiding Principles: CCS Children

- Continuity of care
 - Members continue seeing the same providers they currently see
 - Existing CCS children and families maintain relationships with their current CCS care coordinators
- Integration of services
 - Members have “one stop” for CCS and non-CCS-related services
- Member choice
 - Members access a broad and diverse network of providers that covers the entire county and beyond when necessary
- Timely access
 - Children receive timely authorizations and appointments with specialists

Guiding Principles: CCS Providers

- Broad participation
 - All existing CCS-paneled providers participate in the new Whole-Child Model
- Administrative simplification
 - Fewer agencies and policies means less fragmentation
- Stable payments
 - Providers receive 140 percent for CCS specialty care

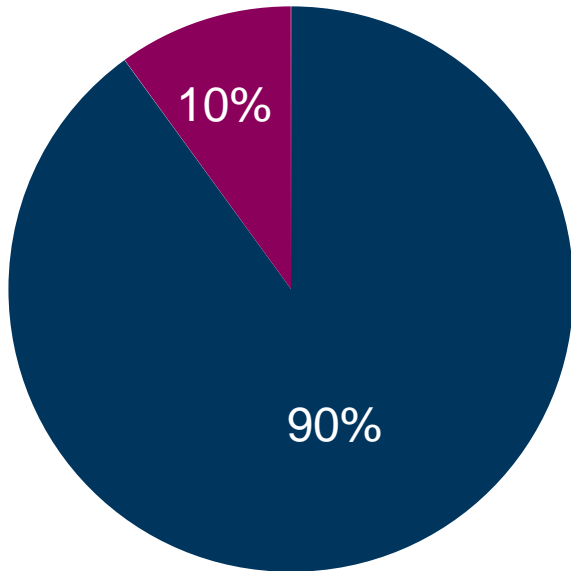
Guiding Principles: CCS Community

- Thoughtful approach
 - CalOptima shows careful consideration and ample planning to minimize disruption of any future transition in CCS community
- Collaboration
 - CCS families, providers, consumer advocates, CCS program staff and others work together at local stakeholder meetings

CCS Children in Orange County

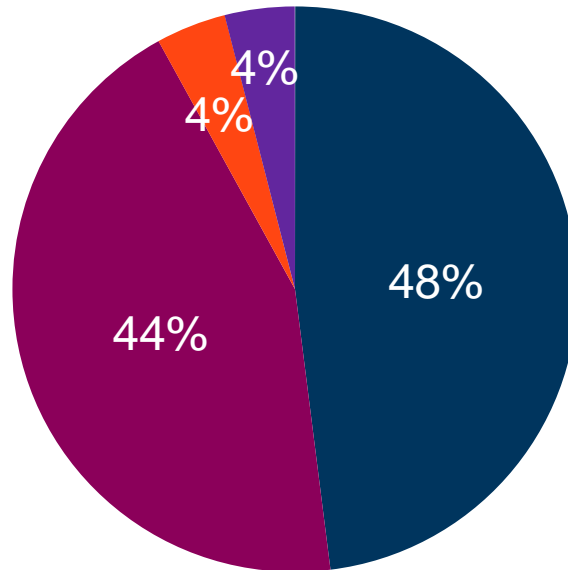
- Approximately 13,000 children

Insurance



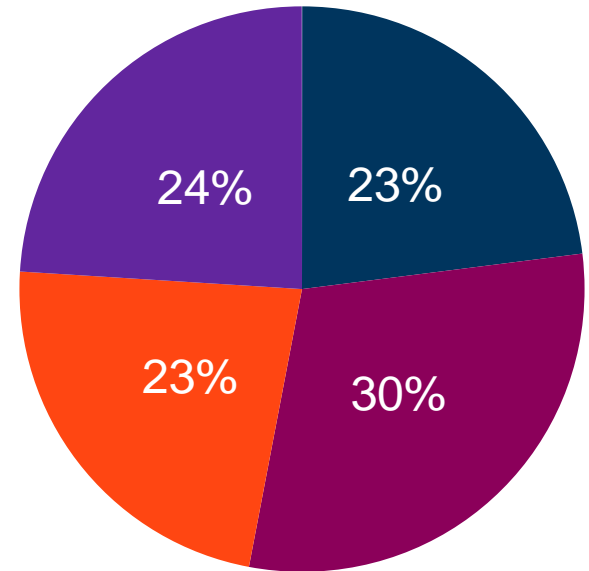
■ Medi-Cal
■ Non-Medi-Cal

Language



■ Spanish ■ English
■ Vietnamese ■ Other

Age



■ 0-5 ■ 6-10
■ 11-15 ■ 16-20

CCS Children by Health Network

Health Network	% of CCS Population
CHOC Health Alliance	53%
Arta Western	9%
Monarch	7%
Kaiser	6%
CalOptima Community Network	6%
Family Choice	4%
AltaMed	3%
Noble	3%
United Care Medical Group	3%
AMVI	2%
Prospect	2%
Talbert	2%

Source: Membership Data, March 18, 2016

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CalOptima's Prior Transitions

Healthy Families Program

- January 2013
- 6 months of advance planning
- 74,000 children in HFP plans moved to CalOptima Medi-Cal

Medical Services Initiative

- January 2014
- 24 months of advance planning
- 40,000 adults in county MSI program moved to CalOptima Medi-Cal

OneCare

- January 2016
- 12 months of advance planning
- 9,800 seniors in OneCare moved to OneCare Connect

CalOptima's Current Transitions

Behavioral Health Treatment

- February 2016
- 17 months of advance planning
- ~1,200 children from the Regional Center of Orange County to Medi-Cal

California Children's Services

- July 2017
- 17 months of advance planning
- ~13,000 children in the county CCS program to CalOptima

CCS Transition Summary

- Some uncertainty exists at the state level
- CalOptima intends to start planning now
 - Best course of action to shape policy and determine what's best for Orange County's CCS children
- Additional stakeholder meetings will be held for at least the next 16 months

20th Anniversary Legacy Awards

- Recognize those who laid the foundation for the agency
- Honor our current provider and community partners
- Thursday, April 21, 6 p.m., Bowers Museum, Santa Ana



MINUTES
REGULAR MEETING
OF THE
CALOPTIMA BOARD OF DIRECTORS

March 3, 2016

A Regular Meeting of the CalOptima Board of Directors was held on March 3, 2016, at CalOptima, 505 City Parkway West, Orange, California. Chair Mark Refowitz called the meeting to order at 2:10 p.m., and led the Pledge of Allegiance.

ROLL CALL

Members Present: Mark Refowitz, Chair; Lee Penrose, Vice Chair; Peter Agarwal; Ellen Ahn; Supervisor Lisa Bartlett; Theresa Boyd (at 2:45 p.m.); Samara Cardenas, M.D.; Viet Van Dang, M.D.; Supervisor Andrew Do; Tricia Nguyen; Mike Ryan (non-voting; at 2:28 p.m.)

Members Absent: All members present

Others Present: Michael Schrader, Chief Executive Officer; Gary Crockett, Chief Counsel; Richard Helmer, Chief Medical Officer; Ladan Khamseh, Interim Chief Operating Officer; Len Rosignoli, Chief Information Officer; Javier Sanchez, Chief Network Officer; Chet Uma, Chief Financial Officer; Suzanne Turf, Clerk of the Board

MANAGEMENT REPORTS

1. CEO Report

Chief Executive Officer Michael Schrader reported on the state's estimated 35-40% reduction in the FY 2016-17 Medi-Cal Expansion rates effective July 1, 2016, subject to approval by the Centers for Medicare & Medicaid Services. The new rate for Medi-Cal Expansion members is expected to be similar to the Medi-Cal Classic rate for adult Temporary Assistance for Needy Family (TANF) members. It was noted that while the rate information from the state is not yet final, CalOptima is implementing a communication plan to ensure full awareness in the provider community of the impending cuts to CalOptima by the state, and the likelihood that the full reduction will be passed along to providers. Staff will keep the Board informed on the progress of this significant financial development. Vice Chair Penrose commented on the need to strengthen our advocacy at the state level regarding the inadequacy of the Medi-Cal provider rates.

Mr. Schrader provided an update on the transition of California Children's Services (CCS) to managed care effective no sooner than July 2017. This transition is being driven by the Department of Health Care Services with the goal to reduce fragmentation and to better coordinate care for children with complex, chronic medical conditions. CalOptima continues to plan for this transition with weekly calls and monthly meetings with the Orange County Health Care Agency CCS, and will host a kickoff meeting for stakeholders to share background information and the anticipated transition process.

PUBLIC COMMENT

There were no requests for public comment.

CONSENT CALENDAR

Chair Refowitz announced the following change to the Consent Calendar: Item 11, Ratify and Authorize Extensions of CalOptima Medi-Cal Health Network Contracts, was continued to the April 7, 2016 Board of Directors Meeting.

2. Minutes

- a. Approve Minutes of the February 4, 2016 Regular Meeting of the CalOptima Board of Directors; and
- b. Receive and File Minutes of the November 19, 2015 Regular Meeting of the CalOptima Board of Directors' Finance and Audit Committee, and the Minutes of the December 10, 2015 Meeting of the CalOptima Board of Directors' Provider Advisory Committee

3. Authorize Extension of Expenditures of Fiscal Year 2010-11 Intergovernmental Transfer Funds for OneCare Personal Care Coordinators (PCC) through December 31, 2016, and Authorize the Reallocation of OneCare Connect PCC Funding to Cover the Cost of the OneCare PCC Program through Calendar Year 2016

4. Approve Proposed Budget Allocation Changes in the CalOptima Fiscal Year 2015-16 Operating Budget for Medecision (CalOptima Link Provider Portal) Annual Licensing Fees

5. Consider Adoption of Resolution Approving Updated CalOptima Policy GA.8058, Salary Schedule

6. Authorize Extension of the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Clinic Contracts that Expire During Fiscal Year 2016-17

7. Authorize Extension of the CalOptima Medi-Cal, OneCare, OneCare Connect, and PACE Fee-for-Service Primary Care Physician Contracts that Expire During Fiscal Year 2016-17

8. Authorize Extension of the CalOptima Medi-Cal, OneCare, OneCare Connect, and PACE Fee-for-Service Specialist Physician Contracts that Expire During Fiscal Year 2016-17

9. Authorize Extension of the CalOptima Medi-Cal, OneCare, OneCare Connect, and PACE Hospital Provider Contracts that Expire During Fiscal Year 2016-17

10. Authorize Extension of the CalOptima Medi-Cal, OneCare, OneCare Connect, and PACE Ancillary Contracts that Expire During Fiscal Year 2016-17

12. Authorize Budget Reallocations in the CalOptima Fiscal Year 2015-16 Operating Budget from OneCare to OneCare Connect

Due to their provider affiliations, Vice Chair Penrose recused himself on Consent Calendar items 6, 7, 8 and 9; Director Ahn recused on item 6; Director Cardenas recused on item 7; and Director Dang recused on item 8. Supervisor Bartlett did not participate on Consent Calendar items 6, 7, 8, and 9. Supervisor Do did not participate on Consent Calendar items 7, 8, 9, and 10. Director Boyd abstained on item 7.

Action: On motion of Chair Refowitz, seconded and carried, the Board of Directors approved the Consent Calendar as presented.

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REPORTS

13. Authorize Staff to Negotiate a Lease Agreement for Office Space, Expend Funds on Furnishings and Evaluate and Pursue Other Space Planning Options

Chet Uma, Chief Financial Officer, presented the following recommended actions: authorize the Chief Executive Officer, with the assistance of legal counsel, to negotiate and execute a lease of up to 66 months for up to 20,000 square feet of office space at a price per square foot not to exceed \$2.55 per month with City Plaza located at 1 City Boulevard West, Orange, California; and authorize a supplemental budget of up to \$2.8 million for expenditures for associated furnishings.

Vice Chair Penrose reported that the proposed recommendations were reviewed at the Board of Directors' Finance and Audit Committee meeting held on February 18, 2016. Mr. Penrose commended staff for reevaluating the space plan, which resulted in additional cost savings. After considerable discussion of the matter, the Board took the following action.

Action: On motion of Vice Chair Penrose, seconded and carried, the Board of Directors authorized the Chief Executive Officer, with the assistance of legal counsel, to negotiate and execute a lease of up to 66 months for up to 20,000 square feet of office space at a price per square foot not to exceed \$2.55 per month with City Plaza located at 1 City Boulevard West, Orange, California, and authorized a supplemental budget of up to \$2.8 million for expenditures for associated furnishings. (Motion carried 8-1-0; Director Agarwal voting no; Director Boyd absent)

14. Consider Authorization of Expenditures in Support of CalOptima's Participation in Community Events

Action: On motion of Chair Refowitz, seconded and carried, the Board of Directors: 1) Authorized expenditures for CalOptima's participation in the following events: up to \$1,000 and staff participation at the Anekant Community Center, the City of Anaheim and GBS Linens, Inc., 10th Annual Free Anaheim Health Fair on April 2-3, 2016 in Anaheim; and up to \$10,000 and staff participation at the Age Well Senior Services' 2016 South County Senior Summit on May 20, 2016 in Laguna Woods Village; 2) Made a finding that such expenditures are for a public purpose and in furtherance of CalOptima's mission and statutory purpose; and 3) Authorized the Chief Executive Officer to execute agreements as necessary for the expenditures and participation in the events. (Motion carried 9-0-1; Supervisor Bartlett recused herself from the discussion and vote)

15. Authorize Agreements with the University of California-Irvine, the Children & Families Commission of Orange County, the County of Orange, the City of Orange, the City of Newport Beach, and the California Department of Health Care Services to Secure Medi-Cal Funds through the Rate Year 2014-15 Voluntary Intergovernmental Transfer (IGT) Rate Range Program

Based on his affiliations with the Orange County Health Care Agency and the Children & Families Commission, Chair Refowitz did not participate in the discussion and vote on this item.

Cheryl Meronk, Strategic Development Director, presented the following recommended actions: 1) Authorize IGT funding partnerships with the University of California-Irvine, the Children & Families

Commission, the County of Orange, the City of Orange, the City of Newport Beach, and the California Department of Health Care Services (DHCS) to participate in the upcoming Rate Year 2014-15 Voluntary Intergovernmental Transfer Rate Range Program (IGT 5); and 2) Authorize the Chair and/or Vice Chair to execute agreements with these entities as necessary to seek the IGT 5 funds.

Ms. Meronk reported that in addition to UCI, the following new eligible units of government have submitted letters of interest regarding IGT partnerships: Children & Families Commission, County of Orange, City of Orange, and City of Newport Beach. As proposed, the partnerships may result in an increase in net revenue to CalOptima of approximately \$15.6 million in one-time IGT revenue, with net proceeds split evenly between the respective funding entities and CalOptima. The funds received by CalOptima are to be invested in Board-approved programs/initiatives that support CalOptima's mission and benefit Medi-Cal beneficiaries. It was noted that DHCS notification of the availability of the Rate Year 2014-15 IGT Rate Range Program is anticipated in early March 2016. An expenditure plan for IGT 5 funds will be presented for Board consideration at a future meeting.

Action: On motion of Director Ahn, seconded and carried, the Board of Directors: 1) Authorized IGT funding partnerships with the University of California-Irvine, the Children & Families Commission, the County of Orange, the City of Orange, the City of Newport Beach, and the California DHCS to participate in the upcoming Rate Year 2014-15 Voluntary IGT Rate Range Program (IGT 5); and 2) Authorized the Chair and/or Vice Chair to execute agreements with these entities as necessary to seek the IGT 5 funds. (Motion carried 8-0-0; Chair Refowitz did not participate in the discussion and vote; Director Nguyen absent)

ADVISORY COMMITTEE UPDATES

16. Provider Advisory Committee (PAC) Update

Jenna Jensen, PAC Chair, reported on activities at the February 11, 2016 PAC meeting that included a presentation on CalOptima's Childhood Obesity Program, Shape Your Life, to help educate and prevent obesity in children. PAC members recommended partnering with schools, working with existing advocacy programs, and supporting legislation to promote a positive environment for physical activity and nutrition.

17. Member Advisory Committee (MAC) Update

MAC Chair Mallory Vega reported on the recruitment process for seven MAC seats expiring on June 30, 2016. The recruitment period is February 29, 2016 to April 1, 2016 for seats representing Children, Consumer, Foster Children, Long-Term Care, Medically Indigent Persons, Persons with Mental Illness, and Persons with Special Needs.

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

Patty Mouton, OCC MAC Chair, reported that the Committee is recruiting for the following seats expiring on June 30, 2016: Community-Based Adult Services Provider representative, Home and Community-Based Services Representative Serving Seniors, Long-Term Care Facility representative, Member Advocate representative, and OneCare Connect Member or Family Member of a OneCare Connect member. The recruitment period is February 29, 2016 to April 1, 2016.

INFORMATION ITEMS

The following Information Items were accepted as presented:

19. January 2016 Financial Statements
20. Compliance Report
21. Federal and State Legislative Advocates Report
22. CalOptima Community Outreach and Program Summary

BOARD MEMBER COMMENTS

Supervisor Do announced that the Board of Supervisors approved revisions to CalOptima's ordinance that include changing the membership of the Board to nine voting members and one non-voting member. The revised ordinance will be operative as of August 4, 2016. The Orange County Health Care Agency is conducting the recruitment, and current Board members were encouraged to reapply. Supervisor Do also commented on the need to examine the County's ethnic communities and demographics as it relates to the community assessment.

Supervisor Bartlett reported that she attended a press conference with Supervisor Do on February 26, 2016, regarding SB1273, a bill authored by State Senator John Moorlach that will give the County greater flexibility over the use of Mental Health Services Act funds to provide crisis stabilization services, and suggested adding this as a support item in CalOptima's legislative platform.

Director Ryan announced that March is National Professional Social Work Month, which celebrates the contributions and dedication of social workers.

Vice Chair Penrose thanked CalOptima's Intergovernmental Transfer (IGT) funding partners for their participation in the process to maximize Orange County's allocation of available IGT funds.

Chair Refowitz reported that, as the Board liaison, he attended the recent CalOptima Compliance Committee meeting, and complimented staff and our provider partners for their work in preparing for the various completed audits.

ADJOURNMENT

Hearing no further business, Chair Refowitz adjourned the meeting at 3:44 p.m.

/s/ Suzanne Turf
Suzanne Turf
Clerk of the Board

Approved: April 7, 2016

MINUTES
REGULAR MEETING
OF THE
CALOPTIMA BOARD OF DIRECTORS’
QUALITY ASSURANCE COMMITTEE

CALOPTIMA
505 CITY PARKWAY WEST
ORANGE, CALIFORNIA

November 18, 2015

CALL TO ORDER

Chair Viet Van Dang called the meeting to order at 5:40 p.m., and led the Pledge of Allegiance.

Members Present: Viet Van Dang, M.D., Chair; Theresa Boyd (at 5:53 p.m.); Samara Cardenas, M.D.; Tricia Nguyen

Members Absent: Ellen Ahn

Others Present: Michael Schrader, Chief Executive Officer; Gary Crockett, Chief Counsel; Richard Helmer, Chief Medical Officer; Richard Bock, M.D., Deputy Chief Medical Officer; Ladan Khamseh, Interim Chief Operating Officer; Javier Sanchez, Chief Network Officer; Suzanne Turf, Clerk of the Board

CONSENT CALENDAR

1. Approve the Minutes of the August 19, 2015 Regular Meeting of the CalOptima Board of Directors Quality Assurance Committee

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

PUBLIC COMMENTS

There were no requests for public comment.

INFORMATION ITEMS

2. PACE Member Advisory Committee Update

Mallory Vega, PACE Member Advisory Committee (PMAC) Community Representative, provided an update on PMAC activities. The next meeting is scheduled in December 2015.

3. OneCare Connect Risk Stratification and Health Risk Assessment Process

Tracy Hitzeman, RN, CCM, Case Management Director, provided an overview of the OneCare Connect Risk Stratification and Health Risk Assessment Process. A Health Risk Stratification is performed upon member enrollment in OneCare Connect that is based on historical claims data, and

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identifies members with complex health needs. A review of the health risk stratification results for the period July 2015 through September 2015 was provided to the Committee.

It was reported that CalOptima is responsible for conducting health risk assessments (HRA) for all OneCare Connect members. The HRA reflects the member's health concerns, scheduled appointments and treatments, and serves as the platform for the member's Individualized Care Plan. A reassessment is performed annually or if the member's health condition changes.

4. Member Experience Strategy Update

Caryn Ireland, Executive Director of Quality and Analytics, provided an update on the Member Experience Work Group. The goal of the work group is to identify focus areas and implement strategies to raise member experience scores in the Consumer Assessment of Healthcare Providers and Systems (CAHPS), which impacts NCQA accreditation and national ratings. Workgroup activities include the following: launch a supplemental survey to members; customer service post-call survey; evaluation of member pain points; develop a toolkit or decision tools for PCPs; implement member education on referral and authorization process; and develop provider and office staff in-service on customer service. Health network-specific member satisfaction reports will be distributed in November.

5. Update on CalOptima Childhood Obesity Program – “Shape Your Life”

Chief Medical Officer Richard Helmer, M.D., provided an overview of past disease management activities for the Childhood Obesity Prevention and Treatment Program (COPTP). An assessment of COPTP found that there is limited provider understanding of evidence-based recommendations, providers and members are unaware of community resources and what is offered through CalOptima, and access is an issue for members due to limited intervention sites. It was noted that evidence is not yet conclusive on the long-term benefits of intensive short-term interventions; however, evidence-based recommendations on the prevention and treatment of childhood obesity have been made and endorsed by the Centers for Disease Control and Prevention, and the American Medical Association.

Dr. Helmer reviewed the first phase of the obesity program redesign including rebranding, adopting guidelines, developing tools and training, and program content modification. During Phase 2, a Request for Information was submitted to evaluate the existing program, the development of clinical and operational components for program revision, program expansion, and program implementation and ongoing evaluation. Phase 3 will address the ongoing operation of the program with the goal to be self sufficient, and program evaluation and modification based on lessons learned or changes in guidelines or industry practices. Staff will present program updates and recommendations to the Board of Directors' Quality Assurance Committee for consideration at future meetings.

6. 2015 Quality Improvement Work Plan Update

Ms. Ireland provided an update on the Quality Improvement Work Plan for the third quarter of 2015. A review of the activities during this quarter included credentialing, grievances and appeals, audit and oversight, disease management, customer service, pharmacy, provider access and availability, prenatal/postpartum care, behavioral health, osteoporosis management, immunizations rates, and member satisfaction.

7. Quarterly Reports to the Quality Assurance Committee

The Committee accepted the Member Trend Report as presented.

MANAGEMENT REPORT

Medical Director Miles Masatsugu, M.D., provided a brief update on the recent PACE audit conducted by the Department of Health Care Services and the Centers for Medicare & Medicaid Services on November 2-5, 2015. Overall, the audit was positive, and staff will present an update to the Committee upon receipt of the final audit report.

COMMITTEE MEMBER COMMENTS

Dr. Cardenas thanked staff for their work on the Childhood Obesity and Depression Programs.

Director Nguyen offered her assistance with the Breath Mobile, Childhood Obesity and Depression programs, which may be funded through Intergovernmental Transfer (IGT) funds.

ADJOURNMENT

Hearing no further business, Chair Dang adjourned the meeting at 6:54 p.m.

/s/ Suzanne Turf
Suzanne Turf
Clerk of the Board

Approved: March 23, 2016

MINUTES

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

December 22, 2015

The Regular Meeting of the CalOptima Board of Directors' OneCare Connect Member Advisory Committee (OCC MAC) held on December 22, 2015, at CalOptima, 505 City Parkway West, Orange, California.

CALL TO ORDER

Chair Patty Mouton called the meeting to order at 3:02 p.m. Chair Mouton led the Pledge of Allegiance.

ESTABLISH QUORUM

Members Present: Ted Chigaros, Christine Chow, Gio Corzo, Sandy Finestone, Sara Lee, Patty Mouton, Jorge Sole (non-voting)

Members Absent: Donta Harrison, Lena Berlove (non-voting), George Crits, M.D. (non-voting), Erin Ulibarri (non-voting)

Others Present: Michael Schrader, Chief Executive Officer; Javier Sanchez, Chief Network Officer; Ladan Khamseh, Interim Chief Operating Officer; Candice Gomez, Executive Director, Program Implementation; Richard Bock, M.D., Deputy Chief Medical Officer; Terrie Stanley, Executive Director, Clinical Operations; Belinda Abeyta, Director, Customer Service; Becki Melli, Program Specialist, Customer Service; Caryn Ireland, Executive Director, Quality Analytics; Phil Tsunoda, Executive Director, Public Policy and Public Affairs

MINUTES

Approve the Minutes of the September 24, 2015 Regular Meeting of the CalOptima Board of Directors' OneCare Connect Member Advisory Committee

Action: On motion of Ted Chigaros, seconded and carried, the Committee approved the minutes of the September 24, 2015 meeting as presented.

PUBLIC COMMENT

No requests for public comment were received.

REPORTS

Consider Recommendation of FY 2015-2016 OneCare Connect MAC Member/Family Member Seats

Member Chigaros reported that the OneCare Connect MAC Nominations Ad Hoc Subcommittee, composed of Members' Chigaros, Gio Corzo and Chair Mouton, evaluated the applications received for the family member seats. Member Chigaros reported that the recommended slate of candidates includes OneCare Connect family members Destiny Le, Susie Gordee and Josephina Diaz.

Action: On motion of Sandy Finestone, seconded and carried, the OCC MAC approved the OneCare Connect slate of candidates as submitted.

Consider Approval of FY 2015-2016 OCC MAC Goals and Objectives

Chair Mouton reported that the OCC MAC Goals & Objectives (G&O) Ad Hoc Subcommittee, composed of Chair Mouton and Members' Chigaros and Christine Chow, recommended the approval of the FY 2015-16 G&O, which were developed based on the state's Cal MediConnect goals and CalOptima's strategic plan.

Action: On motion of Sandy Finestone, seconded and carried, the OCC MAC approved the FY 2015-2016 Goals and Objectives as submitted.

CEO AND MANAGEMENT TEAM DISCUSSION

Marie Connell, Senior Technical Writer, Communications, announced that the new OneCare Connect promotional marketing materials and other promotional materials were available for OCC MAC members to share with their organizations.

Chief Executive Officer (CEO) Update

Michael Schrader, Chief Executive Officer, provided an update on the proposed CalOptima Strategic Plan for FY 2016-2019. Mr. Schrader reported that the strategic plan includes the core themes of partnerships and engagement, innovation and value, while the building blocks essential to success include workforce performance and financial stability. Mr. Schrader noted that the OCC MAC, MAC and Provider Advisory Committees convened an ad hoc on December 7, 2015 to provide additional feedback. He added that CalOptima staff will bring the strategic plan to the January 21, 2016 Joint MAC and PAC meeting before presenting to the Board for consideration in February 2016.

Member Chigaros attended the MAC/OCC MAC/PAC Ad Hoc Subcommittee meeting where ad hoc members recommended the following: 1) collaborate directly with providers, including considering direct pay for performance initiatives; 2) ensure CalOptima is a thought partner in the evaluation of community-based or provider pilots by sharing data to support evaluation and impact analysis; 3) ensure the role of the PAC is explicitly referenced in the objectives on provider collaboration; 4) ensure that the word "expanding access" is incorporated into objectives for provider/plan collaboration; 5) continue to see direct member engagement and

input into proposed pilots, programs and services; and 6) collaborate with community based organizations on advocacy issues impacting members, providers, and the community.

CMO Update

Richard Bock, Deputy Chief Medical Officer, announced that the new Pharmacy Benefit Manager (PBM), MedImpact, is still on track to go live January 1, 2016. CalOptima expects it to be a seamless transition for members. Dr. Bock added that CalOptima is monitoring the transition for OneCare members that are moving into OneCare Connect to ensure there will be no issues.

Dr. Bock reported that CalOptima has several audits to prepare for in 2016. The Centers for Medicare & Medicaid Services (CMS) will audit CalOptima's PBM transition in March 2016. In addition, the CMS Risk Adjustment Data Validation (RADV) audit will review the Hierarchical Condition Category (HCC) coding and how payment is made by CMS for Medicare recipients.

Dr. Bock reported that CalOptima is working on improving the member experience. Dr. Bock explained that members rate their experience through the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys. CalOptima will convene focus groups and conduct additional surveys. Dr. Bock reported that CalOptima would analyze the data and findings to determine how and where improvement is needed.

INFORMATION ITEMS

Member Enrollment and OneCare Connect Update

Candice Gomez, Executive Director of Program Implementation, and Belinda Abeyta, Director, Customer Service, provided an update on OneCare Connect, member enrollment and Long Term Care (LTC) passive enrollment. The networks with the majority of members are Monarch, CalOptima Community Network (CCN) and Prospect Medical Group. The opt-out rate for December is 64.22%, while the opt-out rate for members transitioning from OneCare to OneCare Connect is currently 3.78%. The highest percentage of opt-outs by language continues to be Vietnamese followed by Korean. The main reason given by members for opting out is that members want to remain in fee-for-service. The LTC passive enrollment opt-out rate for November was 57.9% and for December was 72%. Due to the percentage increase in December, Chief Network Officer Javier Sanchez and his team worked with some of the LTC facilities to identify any concerns or issues needing to be addressed.

OneCare Connect Health Risk Assessment

Terrie Stanley, Executive Director, Clinical Operations, provided an update on OneCare Connect Health Risk Assessments (HRA). From July through November 2015, CalOptima identified 4,872 members that needed to complete a HRA. Ms. Stanley explained that HRA's could be completed over the phone, by mail or in person. CalOptima mailed 4,649 HRAs and made 10,389 calls to complete the assessments. Ms. Stanley added that it could take as long as three months to complete a HRA.

Ombudsman Update

Sara Lee, Supervising Attorney, Health Consumer Action Center (HCAC) at the Legal Aid Society of Orange County, presented the Ombudsman update. The HCAC provides outreach, education and advocacy to health consumers accessing health care coverage. In addition, the HCAC provides legal advocacy to obtain appropriate coverage and services to Orange County consumers. Ms. Lee explained that as the Ombudsman for Cal MediConnect/OneCare Connect, the HCAC resolves issues with the OneCare Connect plan, ensures access to care and continuity of care, assists with enrollment or disenrollment/retroactive disenrollment and provides assistance with complaints and appeals. The HCAC provided edits on the opt-out notice to the Department of Health Care Services (DHCS) through the statewide Ombudsman meeting to address confusing language. Ms. Lee reported on the types of calls that the HCAC receives regarding the OneCare Connect program.

Committee Member Updates

Chair Mouton announced that the Alzheimer's Association of Orange County Chapter was recently restructured and is now Alzheimer's Orange County, an independent community based organization that is no longer affiliated with the National Alzheimer's Association.

Chair Mouton announced that beginning January 2016, a committee member would present spotlight presentations at each OCC MAC meeting. These presentations will ensure that committee members understand the OneCare Connect community. Member Christine Chow volunteered to present at the January 2016 meeting. Member Jorge Sole agreed to present at the February 2016 meeting, and Member Gio Corzo agreed to present at the March 2016 meeting. Chair Mouton announced that the CalOptima Board of Directors would not be meeting in January.

Member Sole reported that the Social Services Agency (SSA) is educating approximately 27,000 In Home Supportive Services (IHSS) recipients and approximately 19,000 IHSS providers about a Fair Labor Standards Act (FLSA) ruling for homecare workers scheduled to become effective February 1, 2016. This ruling ensures that homecare providers receive additional benefits, such as over time, travel time and wait time. Mr. Sole announced that the toll free number is (844) 825-3002 and contains in-depth information for the homecare providers.

The next OneCare Connect Member Advisory Committee meeting is January 28, 2016 at 3:00 p.m.

ADJOURNMENT

Hearing no further business, Chair Mouton adjourned the meeting at 4:30 p.m.

/s/ Cindi Reichert
Cindi Reichert
Program Assistant

Approved: February 25, 2016

MINUTES

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

February 25, 2016

The Regular Meeting of the CalOptima Board of Directors' OneCare Connect Member Advisory Committee (OCC MAC) held on February 25, 2016, at CalOptima, 505 City Parkway West, Orange, California.

CALL TO ORDER

Chair Patty Mouton called the meeting to order at 3:05 p.m. Chair Mouton led the Pledge of Allegiance.

ESTABLISH QUORUM

Members Present: Ted Chigaros, Christine Chow, Josefina Diaz, Sandy Finestone, Susie Gordee, Donta Harrison, Sara Lee, Patty Mouton, Lena Berlove (non-voting), Erin Ulibarri (non-voting)

Members Absent: Gio Corzo, George Crits, M.D. (non-voting), Jorge Sole (non-voting)

Others Present: Michael Schrader, Chief Executive Officer; Javier Sanchez, Chief Network Officer; Ladan Khamseh, Interim Chief Operating Officer; Candice Gomez, Executive Director, Program Implementation; Richard Bock, M.D., Deputy Chief Medical Officer; Terrie Stanley, Executive Director, Clinical Operations; Belinda Abeyta, Director, Customer Service; Becki Melli, Customer Service; Caryn Ireland, Executive Director, Quality Analytics; Phil Tsunoda, Executive Director, Public Policy and Public Affairs

MINUTES

Approve the Minutes of the December 22, 2015 Regular Meeting of the CalOptima Board of Directors' OneCare Connect Member Advisory Committee

Action: On motion of member Sandra Finestone, seconded and carried, the OCC MAC approved the minutes as submitted.

PUBLIC COMMENT

No requests for public comment were received.

Chair Patty Mouton welcomed the two new OCC MAC family members of a OneCare Connect member Josefina Diaz and Susie Gordee.

CEO AND MANAGEMENT TEAM DISCUSSION

Chief Executive Officer (CEO) Update

Michael Schrader, Chief Executive Officer, reported that approximately 10,000 OneCare members transitioned to OneCare Connect on January 1, 2016, resulting in an enrollment of 16,390 OneCare Connect members, as of January 29. He noted that the addition of former OneCare members changed the opt-out rate in the new program considerably. Mr. Schrader added that based on passive enrollment notices sent from August 2015 to January 2016, only 45 percent of potential eligible members have opted out of OneCare Connect. Mr. Schrader reported the successful transition of the new Pharmacy Benefit Manager (PBM) to MedImpact occurred January 1, 2016, for all programs.

Mr. Schrader announced that continuation of the OneCare Connect program is dependent on state funding. Governor Brown released his draft state budget on January 7, 2016, which preserves the Coordinated Care Initiative (CCI) until January 2018.

Mr. Schrader reported that the Orange County Board of Supervisors is considering revisions to CalOptima's Ordinance to restructure the CalOptima Board of Directors. Proposed changes include nine voting members, removing the seat for the Social Services Agency, changing the seat for the Health Care Agency to a non-voting position, and changing the definition of some of the other seats so that a broader pool of candidates may be eligible. Upon approval, the Orange County Health Care Agency will begin the recruitment process immediately for the new CalOptima Board with new Board members being seated for the August 2016 Board meeting.

CMO Update

Richard Bock, M.D., Deputy Chief Medical Officer, announced that ample preparation paid off for a relatively smooth transition of the Pharmacy Benefit Manager (PBM) to MedImpact. He added that the Centers for Medicare & Medicaid Services (CMS) would audit the PBM transition. Dr. Bock reported that the Department of Health Care Services (DHCS) completed the annual medical audit of our Medi-Cal plan and noted that the auditors saw significant improvement compared with the prior year. The preliminary report will be ready in April with the full report due in May. Dr. Bock also reported on the upcoming Risk Adjustment Data Validation Audit (RADV) where CMS auditors will review chart documentation to support risk-adjusted diagnoses, under which CalOptima receives payment for OneCare and OneCare Connect programs.

INFORMATION ITEMS

Federal and State Budget and Legislative Update

Phil Tsunoda, Executive Director, Public Affairs, presented an update on the FY 2016-17 State Budget, which proposes \$122.6 billion General Fund, representing a 5.6% increase over this current fiscal year. The budget proposes an expenditure of \$19.6 billion for the Medi-Cal program, an increase of 8% over FY 2015-16. Mr. Tsunoda explained that the two main factors for the increase in Medi-Cal funding include the State's anticipated increase in Medi-Cal enrollment and the State's financial obligation for the 3.5 million Medi-Cal Expansion (MCE)

members, adding that beginning January 1, 2017, the State will begin paying a portion of the cost obligation for the MCE population. In accordance with the Affordable Care Act, the federal government fully funded the MCE cost obligation for the first three years of implementation and the state begins to incur a portion of this obligation in 2017.

Mr. Tsunoda reported that the current managed care organization (MCO) tax expires on June 30, 2016. In response, the Governor called a special session of the Legislature to establish and stabilize funding sources for Medi-Cal, most notably to modify the MCO tax to conform to federal guidelines. Mr. Tsunoda added that the State Assembly and Senate introduced legislation delineating a new MCO tax structure. The modified MCO tax requires two-thirds vote in the Legislature and if approved, will take effect July 1, 2016.

Member Enrollment

Belinda Abeyta, Director, Customer Service, reported that the OneCare Connect member enrollment for January finished at 15,623 with 1,277 passive enrollments in February. She added that the top three health networks for enrollment are Monarch Family Physician Group, Prospect Medical Group and Family Choice Physician Group. Ms. Abeyta reported that the opt-out rate for Long-Term Care (LTC) passive enrollment for January was 50.9 percent.

OneCare Connect Update

Candice Gomez, Executive Director, Program Implementation, announced that CalOptima has conducted family nights at Long-Term Care (LTC) facilities so families could learn more about the OneCare Connect program and passive enrollment. Outreach to facilities will continue.

OneCare to OneCare Connect Transition

Terrie Stanley, Executive Director, Clinical Operations, reported that CalOptima was required to administer a Health Risk Assessment (HRA) on every member that transitioned from OneCare to OneCare Connect. She explained that members are stratified into risk categories based on utilization data, which determines the timeline for completion of the HRA. Members placed in the high-risk category must complete an HRA within 45 days of enrollment and members in the low-risk category must complete an HRA within 90 days of enrollment. Ms. Stanley stated that completed HRAs are used for scheduling of Interdisciplinary Care Team meetings and the creation of an Individualized Care Plan.

Member Ted Chigaros commented that there has been provider confusion about member eligibility when a Long-Term Care member transitions to OneCare Connect. Candice Gomez, Executive Director, Program Implementation, will follow up on this issue.

Ombudsman Update

Member Sara Lee, Supervising Attorney, Health Consumer Action Center (HCAC) at the Legal Aid Society of Orange County, presented the Ombudsman update and a profile of the organization. She stated that the role of their agency is to assist OneCare Connect clients navigate the health care system, resolve eligibility issues and assist with any service barriers. Legal Aid is part of a statewide health consumer alliance and serves as the Ombudsman for Orange County's OneCare Connect program. Ms. Lee confirmed that DHCS determined that Aid

Paid Pending (APP) would not trigger the deeming period. If deeming starts before APP, APP trumps deeming and the individual would no longer be in the deeming period.

Committee Member Updates

Chair Mouton reminded the Committee that when OCC MAC was established, five of the ten voting seats were set up for a one-year term and the other five were set up for a two-year term in order to stagger reappointments. Therefore, five seats are due to expire on June 30, 2016, including Seniors, Community-Based Adult Services (CBAS), Long-Term Care Facilities provider (LTC), Member Advocate, as well as the open seat for the OneCare Connect Member/Family Member of a OneCare Connect member. She noted that recruitment for these seats begins February 29, 2016 through April 1, 2016.

Chair Mouton announced that six volunteers are needed to serve on two ad hoc subcommittees: three volunteers for the Nomination Ad Hoc Subcommittee and three volunteers for the Goals and Objectives Ad Hoc Subcommittee. She added that any OCC MAC member being considered for reappointment is not eligible to participate in the Nomination Ad Hoc Subcommittee. Members Sandy Finestone, Erin Ulibarri and Lena Berlove volunteered for the Nomination Ad Hoc while Chair Mouton and Members Sandy Finestone and Josefina Diaz volunteered for the Goals and Objectives Ad Hoc Subcommittee.

Chair Mouton asked the OCC MAC to suggest agenda items for upcoming meetings. In response, Member Berlove suggested a presentation on the homeless population, Member Chigaros suggested a presentation on mental health and substance abuse among OneCare Connect members, and Chair Mouton requested a presentation on the progress of the palliative care program for OneCare Connect members.

The next OneCare Connect MAC meeting is March 24, 2016 at 3:00 p.m.

ADJOURNMENT

Hearing no further business, Chair Mouton adjourned the meeting at 4:33 p.m.

/s/ Cindi Reichert

Cindi Reichert
Program Assistant

Approved: March 24, 2016

MINUTES

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

February 11, 2016

A Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee (PAC) was held on Thursday, February 11, 2016 at the CalOptima offices located at 505 City Parkway West, Orange, California.

Absent a quorum of the PAC, Acting PAC Chair Ross reordered the agenda to hear Agenda Item VI.A, Chief Executive Officer Report, until a quorum was reached.

Chief Executive Officer (CEO) Report

Chet Uma, Chief Financial Officer, presented highlights from the CEO Report to the Board, including the transition of 10,000 OneCare (OC) members to OneCare Connect (OCC) on January 1, 2016, resulting in a total enrollment of 16,390 in OCC. He added that the successful transition of the Pharmacy Benefit Manager (PBM) to MedImpact occurred on January 1, 2016.

Member Pham thanked staff for a smooth transition and noted that the only issue was the volume of prior authorizations, but those have decreased significantly.

Mr. Uma also reported that the six-month Applied Behavior Analysis (ABA) transition to CalOptima of approximately 1,100 Medi-Cal members from the Regional Center of Orange County (RCOC) started on February 1, 2016. Mr. Uma reported that the 1115 Waiver renewal, approved on December 30, 2015, includes \$6.2 billion in federal funding to support Medi-Cal programs. The majority of the funding is for new payment methodologies and policies for public hospitals, but \$1.5 billion is slated for the waiver's creation of the county-based Whole-Person Care (WPC) pilots that will target high-risk Medi-Cal populations. The Department of Health Care Services (DHCS) implementation to provide full-scope Medi-Cal coverage to all children under the age of 19 years regardless of immigration status continues. Approximately 9,000 children will be affected in Orange County by the restricted-scope Medi-Cal. These children will automatically transition to full scope coverage no earlier than May 2016. CalOptima met with California Children's Services (CCS) to discuss the DHCS proposal to transition children in CCS to a new Whole-Child Model, which would transfer responsibility for most CCS functions from the county to CalOptima no sooner than July 2017.

Acting Chair Ross requested information on the possible restructuring of the CalOptima Board by the Board of Supervisors. Mr. Tsunoda responded that the Board of Supervisors will consider an ordinance change related to the restructuring of the composition of the CalOptima Board. If the amended ordinance is approved, the recruitment process will begin with new Board members seated for the August 2016 Board meeting.

CALL TO ORDER

Barry Ross, Acting PAC Chair, called the meeting to order at 8:25 a.m., and Member *Pham* lead the *Pledge of Allegiance*.

ESTABLISH QUORUM

Members Present: Theodore Caliendo, M.D.; Alan Edwards, M.D.; Camille Fitzpatrick, MSN, ANP-BC, GNP-BC; Stephen N. Flood; Pamela Kahn, R.N.; Teri Miranti; Cheryl Petterson; Mary Pham, Pharm.D, CHC; Pamela Pimentel, R.N.; Barry Ross, R.N., MPH, MBA

Members Absent: Jena Jensen; George Orras, Ph.D.; Suzanne Richards, RN, MBA, FACHE; Joseph M. Ruggio, M.D., FACP, FACC, FSCAI Jacob Sweidan, M.D., FAAP

Others Present: Chet Uma, Chief Financial Officer; Richard Bock, M.D., Deputy Chief Medical Officer; Javier Sanchez, Chief Network Officer; Ladan Khamseh, Interim Chief Operating Officer; Phil Tsunoda, Executive Director, Public Affairs; Donald Sharps, M.D., Medical Director; Behavioral Health Integration; Miles Masatsugu, M.D., Medical Director, Maria Wahab, Member Outreach and Education Manager , Cheryl Simmons, Executive Assistant

MINUTES

Approve the Minutes of the December 10, 2015 Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee

Action: On motion of Member Miranti seconded and carried, the Committee approved the minutes of the December 10, 2015 meeting as presented. (Motion carried 10-0; Members Jensen, Orras, Richards, Ruggio and Sweidan absent)

Approve the Minutes of the January 21, 2016 Special Meeting of the CalOptima Board of Directors' Provider Advisory Committee and the CalOptima Board of Directors' Member Advisory Committee

Action: On motion of Member Flood seconded and carried, the Committee approved the minutes of the January 21, 2016 meeting as presented. (Motion carried 10-0; Members Jensen, Orras, Richards, Ruggio and Sweidan absent)

PUBLIC COMMENTS

No requests for public comments were received.

CEO AND MANAGEMENT REPORTS

Chief Financial Officer Update

Mr. Uma presented CalOptima's financial summary for December 2015. Mr. Uma noted that actual consolidated enrollment for December was 796,331. He noted that the majority of the growth came from the Medi-Cal Expansion Program (MCE), while the Temporary Assistance for Needy Families (TANF) population decreased, which may be indicative of the economy improving. Enrollment for OneCare Connect (OCC) for the month of December was 4,037 members, compared to a budget of 9,024 members. The lower enrollment is attributable to the high opt out rate during the passive enrollment period. Mr. Uma reminded the PAC that the January OCC enrollment will show the transition of 10,000 OneCare members to OCC. Mr. Uma reviewed CalOptima's balance sheet, reporting total assets at approximately \$2 billion, total liabilities of roughly \$1.5 billion, resulting in net assets of \$635.1 million. He noted that CalOptima continues to exercise good judgment in the hiring process because enrollment levels are not projecting what was anticipated.

Member Miranti requested information on the enrollment swing for the month of January and noted it was affecting everyone. Mr. Uma noted that there had been a decrease in actual enrollment in January and that February was also trending towards a decrease and Finance was actively looking at the root cause of this decrease with the State. Mr. Uma reviewed the Health Network Enrollment Summary slides for Medi-Cal, OneCare and OneCare Connect as requested by the PAC at a previous meeting. Acting Chair Ross noted that the new networks had low numbers and questioned when they came on board. Javier Sanchez responded that OC Advantage started in September and that Heritage Provider Network started in December. He noted that one of the problems being encountered with these new networks was they were not eligible for auto assignment for the first year or they receive a very basic percentage because CalOptima's algorithms are largely based on quality performance and performance is reported after their first year. Mr. Sanchez noted that it is a concern that has been identified because CalOptima has a policy that networks must maintain enrollment of 5,000 members. Member Miranti recommended that CalOptima staff review this policy and offer something more balanced and determine if there is an opportunity to waive the quality requirement for a year.

Chief Medical Officer Update

Richard Bock, M.D., Deputy Chief Medical Officer, reported that DHCS auditors are currently on-site until February 19, 2016 and will be interviewing physicians and network providers. Preliminary findings indicate that the auditors are impressed with improvements on processes, such as turnaround times for authorizations. Dr. Bock added that improvement is still needed on providing initial health assessments to new members within 120 days of enrollment. Dr. Bock also reported on the Risk Adjustment Data Validation Audit (RADV) CMS auditors will be reviewing chart documentation to support risk-adjusted diagnoses by which CalOptima is paid for OneCare and the OneCare Connect programs. CMS plans to review 200 members' charts dating back to dates of service in 2011 to determine whether the risk adjusted, diagnostic codes submitted for claims to CMS are validated by a chart audit. Dr. Bock noted that CMS has also chosen to audit the PBM transition on January 1, 2016 from PerformRx to MedImpact.

Dr. Bock provided an update on the pay for performance measures, noting that the 2016 Medi-Cal measures will be similar to those of 2015 with the addition of adult and child access measures, the retirement of provider satisfaction measures and a change in weighting of member experience. For OneCare Connect, CalOptima continues to work for mandated CMS approvals. Dr. Bock will provide more information when it becomes available.

Donald Sharps, M.D., Medical Director of Behavioral Health, updated the PAC on the transition of members from the Regional Center of Orange County (RCOC) to CalOptima. Dr. Sharps confirmed that all but four of the members who transitioned were able to stay with their preferred vendor who had already been providing them services through the RCOC. These four members were assisted in finding new vendors, so there was minimal impact on the transition. Dr. Sharps noted that the transitioning members had January/February birthdates and that two months of birthdates will be transitioned every month over the next 5 months until it is complete.

At the request of Acting Chair Ross, Dr. Sharps gave a brief follow-up from the January 21, 2016 Joint MAC/PAC meeting. Dr. Sharps discussed the need for Primary Care Physicians (PCPs) and mental health providers to communicate with each other on a regular basis. Although the Health Insurance Portability and Accountability Act (HIPAA) and the more restrictive consent laws in California do allow for communication by providers without a release of information, a universal release of information form has been developed that meets county guidelines for consent given by the member so that the two entities can communicate.

Member Miranti asked for clarification on the form as to whether or not members are required to do this or is it just to make sure the members have knowledge or awareness that the PCP and the mental health provider are talking and if so what was the reason behind it. Dr. Sharps reiterated that the release of information form is to ensure that providers on the behavioral health side will feel that they can answer questions and participate in Inter-disciplinary Care Teams (ICTs). It is not a regulatory requirement that they have the form to talk as a treating provider, but because of past years and how HIPAA was introduced, this has become a belief that we are trying to overcome.

Acting Chair Ross suggested that one of the things that might be monitored is how fast they will credential new providers. Mr. Ross noted having received feedback from providers who have experienced delays in credentialing behavioral health providers and the providers themselves have reported that they do not receive feedback in a timely manner on their credentialing applications. Mr. Ross also noted that when speaking to Beacon, they have stated that they have a communication form in their physician manual, but upon inspection of the manual, the form was not included. Mr. Ross stressed the importance of the form and what could be done to overcome this barrier. Dr. Sharps will return to the PAC with an update on the status of the necessary forms for PCPs to obtain information on behavioral health for their patients at the next meeting.

Chief Network Officer Update

Javier Sanchez, Chief Network Officer, reported that CalOptima has contracted with a vendor, Optum, to assist with the upcoming RADV Audit. Optum will be contacting providers directly.

CalOptima is offering an incentive to providers to cover the cost of copying, scanning and retracting records from 2011. Member Miranti noted that Optum already contacted several networks, asking for help in outreaching to non-contracted and contracted providers. She added that this is a very difficult and laborious process to try to get as many HCC codes as possible.

Mr. Sanchez noted that there was some confusion related to OneCare Connect and the payment and authorization of skilled services. CalOptima has been working with skilled nursing facilities to clarify that concern, especially in the shared risk model. Helpful tools will become available March 2016 and will be presented at the next California Association of Health Facilities (CAHF) meeting. Mr. Sanchez noted that CalOptima is in the process of passing down rate adjustments from DHCS to long-term care facilities. Mr. Sanchez also notified the PAC that provider hospitals have requested a workgroup to study and identify policy options for maintaining equitable and sustainable Medi-Cal rates.

Mr. Sanchez discussed the CalOptima Provider Directory, noting that a process had been developed to validate the information found in the directory. In response to Member Caliendo's question whether the provider directory could be found on-line, Mr. Sanchez noted that it is located on the CalOptima web site and updated daily. Member Pham questioned whether an organization/group's profile was limited to only one language. Mr. Sanchez responded that he would get back to Member Pham and the PAC with the answer. Member Miranti questioned the sustainability of getting away from a paper model and making the directory electronic. Mr. Sanchez responded that the goal was to create an electronic data exchange for reconciliation of these directories.

INFORMATION ITEMS

Federal State and Budget Update

Phil Tsunoda, Executive Director, Public Policy and Public Affairs, reported on the Governor's FY 2016-17 State Budget, which proposes a \$122.6 billion General Fund, representing a 5.6% increase over the 2015-2016 General Fund. The budget proposes a \$19.6 billion expenditure for the Medi-Cal program, representing an 8% increase over the current fiscal year. The two main factors contributing to the increase in Medi-Cal funding include the State's anticipated increase in Medi-Cal enrollment and the State's obligation for the 3.5 million Medi-Cal Expansion (MCE) members. Mr. Tsunoda noted that beginning January 1, 2017, the State would begin paying a portion of the cost obligation for the MCE population. He added that in accordance with the Affordable Care Act, in which the Federal government fully funded the MCE cost obligation for the first three years of implementation, the State would incur this obligation beginning in 2017. The budget proposal states that beginning January 2017, the state estimates its cost share burden at \$740 million.

Mr. Tsunoda provided an update on the managed care organization (MCO) tax, noting that the current MCO tax expires on June 30, 2016. The Governor has called a special session of the Legislature to establish and stabilize funding sources for Medi-Cal, including the passage of a new MCO tax. The new MCO tax is expected to be modified to conform to federal guidelines. Two new bills, SB2x 15 by Senate Health Chair Hernandez and AB2x 20 by Assembly Health Chair Bonta, memorializes the Governor's new MCO tax proposal. It appears that most managed

care plans are in support of the proposal. The modified MCO tax will require a supermajority of two-thirds vote in the Legislature and it is assumed that the MCO tax will be extended for an additional three years.

CalOptima Childhood Obesity Program: “Shape Your Life”

Dr. Miles Masatsugu, Medical Director, presented CalOptima’s plan to expand the Shape Your Life program across Orange County, utilizing the allocated Inter-Governmental Transfer (IGT) funds. PAC members noted that 90% of the parents with Medi-Cal children who fit the guidelines for obesity do not follow up on the necessary treatment for their children. Dr. Masatsugu discussed how the Shape Your Life program recently implemented a readiness to change assessment to help determine which members are ready for a more intensive integration. Dr. Masatsugu described the current intervention and treatment available which are partly based on the child’s age, risk factors and their body mass index (BMI). Dr. Masatsugu discussed the evidenced-based treatment recommendations that have been supported by the Center for Disease Control (CDC), the American Medical Association (AMA) and the American Academy of Pediatrics (AAP). These recommendations suggest a tiered approach to treatment with the first and second intervention occurring in the PCP’s office. The IGT funds will allow CalOptima to expand its intervention, which corresponds to the third intervention in the evidenced-based treatment model. After a robust discussion among the members, PAC provided suggestions to staff on ways to reach out to this vulnerable population. Member Pimentel noted that babies who are breastfed have a lower instance of childhood obesity. PAC members will continue to advise staff at future meetings on ways to help reduce the stigma of this disease and help by supporting legislation to promote a positive environment for physical activity and nutrition.

ADJOURNMENT

There being no further business before the Committee, the meeting adjourned at 9:50 a.m.

/s/ Cheryl Simmons

Cheryl Simmons
Interim Staff to the PAC

Approved: March 10, 2016

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to Be Taken April 7, 2016

Regular Meeting of the CalOptima Board of Directors

Consent Calendar

3. Approve the 2016 CalOptima Quality Improvement Program and 2016 Work Plan

Contact

Richard Bock, M.D., Deputy Chief Medical Officer, (714) 246-8400

Recommended Action

Approve the recommended revisions to the 2016 Quality Improvement Program and 2016 Work Plan.

Background

As part of existing regulatory and accreditation mandated oversight processes, CalOptima's Quality Improvement Program ("the QI Program") and Quality Improvement Work Plan ("the QI Work Plan") must be reviewed, evaluated, and approved annually by the Board of Directors.

The QI Program defines the structure within which quality improvement activities are conducted, and establishes objective methods for systematically evaluating and improving the quality of care for all CalOptima Members. It is designed to identify and analyze significant opportunities for improvement in care and service, to develop improvement strategies, and to assess whether adopted strategies achieve defined benchmarks. The QI Program guides the development and implementation of the annual QI Work Plan.

The QI Work Plan is the operational and functional component of the QI Program and outlines the key activities for the upcoming year. The QI Work Plan provides the detail objectives, scope, timeline, monitoring and accountable persons for each activity. Progress against the QI Work Plan is monitored throughout the year.

CalOptima staff has updated the 2016 Program Description & related Work Plan with revisions to ensure that it is aligned to reflect the changes for the health networks/physician medical groups and with strategic organizational changes to ensure that all regulatory requirements are met in a consistent manner across the Medi-Cal and OneCare programs and NCQA accreditation standards.

Discussion

The 2016 Quality Improvement Program is based on the Board-approved 2015 Quality Improvement Program and describes: (i) the scope of services provided; (ii) the population served; (iii) key business processes; and (iv) important aspects of care and service for all programs to ensure they are consistent with regulatory requirements, NCQA standards, and CalOptima's own Success Factors.

The revisions are summarized as follows:

1. Updated the introductory pages to align better with CalOptima's Vision, Mission & Values; the plans we offer and who we work with – including and updated list of our Health Networks;
2. Updated Behavioral Health network information and the Behavioral Health Quality Improvement Committee responsibilities;
3. Updated the list of CalOptima Officers and staff (DCMO, Executive Director, Public Affairs); and included Health Education & Disease Management under the Quality areas supporting the QI Program;
4. Reflects the adoption of the annual UM Work Plan which complements the QI Program and Work Plan;
5. Updated the voting members for QIC (included CMO/DeputyCMO) and officially added CalOptima Medical Director, Quality as Chair, QIC;
6. Added the goals and responsibilities of the Credentialing Peer Review Committee and linked sentinel event monitoring activities to this committee;
7. Added CMS STARS as additional measures for standard quality indicators;
8. Updated the information related to Duals Special Needs Plan (OneCare/OneCare Connect);
9. Updated the QI Committee structure.

The recommended changes are necessary to meet the requirements specified by the Centers for Medicare and Medicaid Services, California Department of Health Care Services, and NCQA accreditation standards.

Fiscal Impact

There is no fiscal impact for the recommended changes/revisions to the 2016 Quality Improvement Program and 2016 Work Plan.

Concurrence

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

Attachments

PowerPoint Presentation – 2016 Quality Improvement Program Description and Work Plan
Proposed 2016 Quality Improvement Program – Executive Summary
Proposed 2016 Quality Improvement Program

/s/ Michael Schrader
Authorized Signature

04/01/2016
Date



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2016 Quality Improvement Program Description and Work Plan

**Board of Directors Meeting
April 7, 2016**

Dr. Richard Bock, Deputy Chief Medical Officer

2016 Program Description

- Our program description:
 - Encompasses all clinical care, clinical services and organizational services provided to our members
 - Uses evidence-based guidelines, data and best practices tailored to our populations
 - Utilizes support systems for our members with vulnerabilities, disabilities and chronic illnesses

2016 Program Description Revisions

- Updated our Health Network and Behavioral Health information
- Reflects the adoption of the annual UM Program Description and UM Work Plan
- Added the goals and responsibilities for our Credentialing/Peer Review Committee
- Incorporates our Delegation and Oversight grid (Attachment B), identifying the function and responsibility of our various delegated organizations

2016 Work Plan Enhancements

- Expanded Quality initiatives for LTSS, Behavioral Health
- Shape Your Life Implementation
- Continuous quality improvement projects for DHCS and CMA
- Evaluating technology solutions for population health management
- PACE QI Work Plan Information Sharing
- Continued focus on Member Experience
- Implementation of our Value Based Pay-for-Performance Program

Quality Improvement (QI) Program 2016

Executive Summary of Revisions

1. Updated the NCQA Seal on the face page;
2. Updated the first 19 pages with CalOptima's Vision, Mission & Values; re-ordered this section starting with plans we offer and who we work with – including and updated list of Health Networks;
3. Updated the introduction of the Quality Improvement Program;
4. Updated list of CalOptima Officers and staff (DCMO, COO, Executive Director Quality and Analytics, Executive Director Public Affairs, Executive Director Compliance); included Health Education & Disease Management under the Quality areas supporting the QI Program;
5. Updated Behavioral Health quality improvement information and the Behavioral Health Quality Improvement Committee responsibilities;
6. Included the adoption of the annual UM Work Plan which complements the QI Work Plan; updated the components of the QI Work Plan;
7. Updated voting members for QIC (included CMO/DCMO) and added CalOptima Medical Director, Quality as Chair, QIC;
8. Added goals, responsibilities of CPRC and linked sentinel event monitoring activities to this committee;
9. Included handling of sentinel events under CPRC responsibilities;
10. Updated the Complex Care Management section with further information on segmentation of the population and responsibilities of the ICT;
11. Added STARS as additional measures for standard indicators;
12. Updated the information related to Duals Special Needs Plan (OneCare/OneCare Connect);
13. Updated the functions of the Clinical Data Warehouse;
14. Updated the Cultural & Linguistic Services responsibilities;
15. Updated the Corrective Action Plans section to include the roles and responsibilities of the Quality Improvement and Audit & Oversight Departments;
16. Updated the Annual Program Evaluation requirements;
17. Updated the QI Committee structure diagrams;
18. Kept in mind that practitioners are people and providers are places, “practitioner” has replaced “provider” within the program description;
19. Assured NCQA & DHCS requirements are included in the program description and related work plans.



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20165

QUALITY IMPROVEMENT PROGRAM





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20156 QUALITY IMPROVEMENT PROGRAM SIGNATURE PAGE

Quality Improvement Committee Chairperson:

Richard Helmer, M.D.
Chief Medical Officer

Date

Board of Directors' Quality Assurance Committee Chairperson:

Viet Van Dang, M.D.

Date

Board of Directors Chairperson:

Mark Refowitz

Date

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CALOPTIMA OVERVIEW **WE ARE CALOPTIMA**

Caring for the people of Orange County has been CalOptima's privilege over 20 years since 1995. -We believe that each our Medicaid (Medi-Cal) and Medicare members deserves the highest best quality care and service throughout the health care continuum. CalOptima works in collaboration with providers, community stakeholders and government agencies to achieve our mission and ~~and~~ vision while upholding our values.

One of our greatest opportunities is working together with providers, facilities and community organizations in serving the Medicaid and Medicare population, often with very complicated health issues. -We believe that each member deserves best quality care and service throughout the healthcare continuum.

CalOptima **Our Mission**

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

The Mission of CalOptima is the foundation of everything we do. ~~-It permeates throughout every level of the organization. -Our M~~ission is ~~our~~ focused on our members, and our members are the sole reason why ~~we~~ CalOptima exists.

Our Vision

~~Our vision is -~~To be a model public agency and community health plan that provides an integrated and well-coordinated system of care to ensure optimal health outcomes for all of our members.

Our Values — CalOptima CARES

Collaboration: We seek regular input and act upon it. We believe outcomes are better through teamwork and effective communication with our members, providers, community health centers and community stakeholders.

Accountability: We were created by the community, for the community, and are accountable to the community. Our Board of Directors, Member Advisory Committee and Provider Advisory Committee meetings are open to the public.

Respect: We respect and care about our members. We listen attentively, assess our members' health care needs, identify issues and options, access resources, and resolve problems.

- We treat members with dignity in our words and actions
- We respect the privacy rights of our members
- We speak to our members in their languages
- We respect the cultural traditions of our members

We respect and care about our partners. We develop supportive working relationships with providers, community health centers and community stakeholders.

Excellence: We base our decisions and actions on evidence, data analysis and industry-recognized standards so our providers and community stakeholders deliver quality programs and services that meet our members' health needs. We embrace innovation and welcome differences of opinion and individual initiative. We take risks and seek new and practical solutions to meet health needs or solve challenges for our members.

Stewardship: We recognize that public funds are limited, so we use our time, talent and funding wisely, and maintain historically low administrative costs. We continually strive for efficiency.

We are "Better. Together."

We cannot achieve our mission and our vision alone. We must work together with providers, community health centers, county agencies, ~~S~~State and ~~F~~Federal agencies, and other community stakeholders. Together, we develop innovative solutions and meet our diverse members' health care needs. We are "Better. Together."

ORGANIZATION ~~W~~H~~Θ~~A~~T~~ IS CALOPTIMA?

Background ~~who we are~~

Our ~~u~~Unique ~~D~~dual ~~R~~role

CalOptima is unique in that we must exhibit being the best of both a public agency upholding public trust, and a health plan seeking efficiency and member satisfaction.

As both, CalOptima must:

- Make the best use of our resources, funding and expertise
- Solicit stakeholder input
- Ensure transparency in our governance procedures
- Be accountable for the decisions we make

How ~~w~~We ~~B~~became CalOptima

Orange County is unique in that it does not have county-run hospitals or clinics. By the mid-1990s, there was a coalescing crisis since not enough providers accepted Medi-Cal. This resulted in overcrowding in emergency rooms and delayed care, due to Medi-Cal recipients using emergency rooms across the county not only for acute care, but for primary care as well.

~~CalOptima was created in the mid-1990s by a unique and~~ A dedicated coalition of local elected officials, hospitals, physicians, and community advocates rallied and created a solution. The answer in 1995 was to create CalOptima as. It is a ~~C~~county ~~O~~rganized ~~H~~health ~~S~~ystem (COHS) authorized by ~~State~~SState and ~~F~~Federal Federal law to administer Medi-Cal (~~Medicaid~~) benefits in Orange County. CalOptima began serving members in 1995. Today, CalOptima is the largest of six COHS in the United States.

CalOptima is a public agency and has, as a ~~a~~ COHS:

- [Single-plan responsibility for providing Medi-Cal in the county](#)
- [Mandatory enrollment of all full-scope Medi-Cal beneficiaries, including dual eligibles](#)
- [Responsibility for almost all medical acute services and ~~many~~ Long-Term Services and Supports \(LTSS\), including custodial long-term care.](#)

~~CalOptima contracts with the State~~[State of California Department of Health Care Services \(DHCS\)](#) to arrange and pay for covered services to Medi-Cal members.

~~In 1998, CalOptima became licensed under the Knox-Keene Health Care Service Plan Act (Knox-Keene Act) to provide health insurance coverage under the Healthy Families Program through a contract with the Managed Risk Medical Insurance Board (MRMIB). The Program will sunset in incremental stages with members transitioning to Medi-Cal beginning January, 2013.~~

In 2005, CalOptima became licensed to furnish a Medicare Advantage Special Needs Plan (MA SNP) through a competitive, risk-based contract with the Centers for Medicare and Medicaid Services (CMS), ~~which~~[This plan, called OneCare \(HMO SNP\),](#) allows CalOptima to offer Medicare and Medi-Cal benefits under one umbrella to dual eligible individuals.

[OneCare is also a Medicare Advantage Prescription Drug plan. OneCare operates exclusively as a “Zero Cost Share, Medicaid Subset Dual Special Needs Plan.” OneCare only enrolls beneficiaries who qualify as a zero cost sharing Medicaid subset. To identify dual-eligible members, OneCare imports daily member eligibility files from the SState and FFederal government with Medicaid and Medicare eligibility segments.](#)

~~In July, 2015, CalOptima launched its OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan). Program -This is a three-year demonstration project in an effort by California and the federalFFederal government to begin the process, — through a single organized health care delivery system, — of integrating the delivery of medical, behavioral health, long-term~~[long-term care services and supports, and community-based services for dual eligible beneficiaries. The program’s goal is to help members stay in their homes for as long as possible and shift services out of institutional settings and into the home and community. A key feature of CalOptima is identifying high-risk enrollees who need comprehensive care coordination, and assembling an appropriate care team to develop and track an individualized care plan.](#)

~~*Should there be a paragraph here explaining how we became licensed for OneCare Connect, etc.?*~~

[CalOptima was created as a public agency, operates like a private sector health plan and is accountable to stakeholders to build public trust.](#)

~~Because it is based within the community it serves, CalOptima is especially sensitive to, and its operations reflect, the unique health care environment and needs of Orange County’s Medi-Cal and dual-eligible beneficiaries.~~

~~Cal Optima's mission is to provide members with access to high-quality health services delivered in a cost-effective and compassionate manner.~~

WHO WHAT WE SERVE OFFER:

Medi-Cal

~~In California, Medicaid is known as Medi-Cal. For over more than 20 years, CalOptima has been serving Orange County's Medi-Cal population. Due to the implementation of the Affordable Care Act and the State of California created "Covered California," membership in CalOptima from between 2012-2014-16 grew by 49 percent. More low-income children and adults with limited income and resources qualified for Medi-Cal.~~

~~Medi-Cal covers low-income adults, families with children, seniors, persons people with disabilities, children in foster care as well as former foster youth up to age 26, pregnant women, and low-income people with specific diseases, such as tuberculosis, breast cancer or HIV/AIDS. A member must live in Orange County and be enrolled in Medi-Cal.~~

OneCare (HMO SNP)

~~& OneCare Connect~~ **Background**

~~OneCare (HMO SNP) means total care. All Our members' with Medicare and Medi-Cal benefits are covered in one single plan, making it easier for our members to get the health care they need.~~

~~For more than a decade, CalOptima has been offering OneCare to low-income seniors and people with disabilities who qualify for both Medicare and Medi-Cal. We have extensive experience serving the complex needs of the frail, disabled, dual -eligible members in Orange County.~~

~~To be a member of OneCare, a member person must live in Orange County and be enrolled in Medi-Cal and Medicare Parts A and B, and not be eligible for OneCare Connect.~~

~~In 2005, CalOptima became licensed to provide a Medicare Advantage Special Needs Plan (MA SNP) through a competitive, risk-based contract with the Centers for Medicare and Medicaid Services (CMS). This allowed CalOptima to offer Medicare and Medicaid benefits to dual-eligible individuals under one program called OneCare. CalOptima is based in the community it serves and has extensive experience in serving the complex needs of the frail/disabled, dual-eligible members in Orange County. Cal Optima's mission is to provide members with access to quality healthcare services delivered in a cost-effective and compassionate manner.~~

~~OneCare is a Medicare Advantage Prescription Drug plan. OneCare operates exclusively as a "Zero-Cost Share, Medicaid Subset Dual Special Needs Plan." OneCare only enrolls beneficiaries who qualify as a zero-cost sharing Medicaid subset. To identify dual-~~

~~eligible members, OneCare imports daily member eligibility files from the State and Federal government with Medicaid and Medicare eligibility segments.~~

~~CalOptima is based in the community it serves and has extensive experience in serving the complex needs of the frail/disabled, dual-eligible members in Orange County.~~

OneCare Connect-Cal MediConnect Plan

OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) is a new plan that launched in 2015 for people who qualify for both Medicare and Medi-Cal.

~~It provides integration~~OneCare Connect also integrates with the ~~M~~ultipurpose ~~S~~enior ~~S~~ervices ~~P~~rogram (MSSP), ~~and~~ In-Home Supportive Services (IHSS) and Long-Term Care (LTC).

~~At no extra cost, our members also get vision care, and taxi rides to medical appointments and enhanced dental benefits.~~ Plus, our members get support so they can receive the services they need, when they need them. A Personal Care Coordinator works with our members and their doctors to create an individualized health care plan that fits our members' needs.

~~To join~~~~be a member of~~ OneCare Connect, a member must live in Orange County, have both Medicare Parts A and B and Medi-Cal, ~~and be 21 years or older.~~ Members cannot be receiving services from a regional center ~~and not be~~ enrolled in certain waiver programs. Other exceptions apply.

Medi-Cal

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

In 2013, CalOptima launched the first PACE program in Orange County. PACE is a community-based Medicare and Medi-Cal program that provides coordinated and integrated health care services to frail elders to help them continue living independently in the community.

PACE provides all the ~~a~~cute and long-term care services covered by Medicare and Medi-Cal through an Interdisciplinary Team (IDT). The IDT is made up of physicians, nurses, social workers, dietitians, physical therapists, occupational therapists, home-care staff, activity staff and transportation staff who are committed to planning, coordinating and delivering the most fitting and personalized health care to our participants.

To be a PACE participant, members must be at least 55 years old, live in our Orange County service area, be determined as eligible for nursing facility services by the State of California, and be able to live safely at home or in a community setting with proper support.

PACE participants must receive all needed services, other than emergency care, from CalOptima PACE providers and are personally responsible for any unauthorized or out-of-network services.

WHO WE WORK WITH....:

Contracted Health Networks/Contracted Network Providers

Providers have several options for participating in CalOptima's programs to provide health care to Orange County's Medi-Cal members. Providers can contract with a CalOptima health network, and/or participate through CalOptima Direct, and/or the CalOptima Community Network.

CalOptima members can choose one of 12154 health networks, representing over more than 7,500 practitioners.

CalOptima contracts with Practitioners and Health Networks to provide care to Orange County's Medi-Cal beneficiaries. Our network now encompasses XXX CCN providers and XX Health Networks, representing over 7500 practitioners.

CalOptima CareCommunity Network (CCN)

The CalOptima CareCommunity Network provides doctors with an alternate path to contract directly with CalOptima to serve our members. Currently, CalOptima contracts with 11143 private health networks for Medi-Cal. CCN is administered internally by CalOptima and is the 12154th network available for members to select, supplementing the existing health network delivery model, and creating additional capacity for growth.

CCN PCPs are reimbursed on a fee-for-service basis.

Members enrolled in CCN include foster children, members with qualifying conditions such as end-stage renal disease, seniors and persons with disabilities, University of California Irvine Federally Qualified Health Center members, transplant patients, breast and cervical cancer patients, and long-term care patients.

CalOptima Care Network (CCN) is designed to ensure that all members in this network have a primary care physician who is accountable for coordinating all aspects of the member's care, including making referrals to contracted specialists. CCN members have the opportunity to select a contracted PCP of their choice, or are assigned to a PCP if they do not select one. CCN PCPs are reimbursed on a fee-for-service basis. Members enrolled in CCN include Foster Kids, members with qualifying conditions such as End Stage Renal Disease, Seniors and Persons with Disabilities, UCI FQHC members, transplant patients, breast and cervical cancer patients, and long-term care patients.

CalOptima Direct (COD)

CalOptima Direct is a self-directed program administered by CalOptima to serve Medi-Cal members in special situations, including foster children, dual-eligibles (those with both Medicare and Medi-Cal who elect not to participate in CalOptima's MA

SNP), members in skilled nursing facilities, and share of cost members. COD also currently includes the following categories of vulnerable and complex/catastrophic care members: transplant, hemophilia, HIV, end-stage renal disease (ESRD), and sSeniors and pPersons with dDisabilities.

Not all CalOptima members are health network eligible. Members who are not eligible for enrollment in a health network may be assigned to CalOptima Direct based on the below criteria:

- Transitional members waiting to be assigned to a delegated health network
- Medi-Cal/Medicare members (Medi-Medi)
- Members who reside outside of Orange County
- Medi-Cal share-of-cost members
- Members residing in Fairview Developmental Center

~~Need paragraph on Health Networks (HN):~~

~~Our Health Networks assist CalOptima in rounding out our large practitioner community across Orange County. Upon successful completion of audits, the Health Networks may be delegated for clinical and administrative functions which may include:~~

- ~~• Utilization Management~~
- ~~• Case and Complex Case Management~~
- ~~• Claims (professional only)~~
- ~~• Contracting~~
- ~~• Credentialing of practitioners (credentialing of Healthcare Delivery Organizations (HDO) is not delegated)~~
- ~~• Customer Services activities~~
- ~~• Cultural and Linguistic Services~~

CalOptima Health Networks

As stated earlier, we cannot achieve our mission and our vision alone, and, as such CalOptima contracts with a variety of Hhealth nNetworks to provide care to Orange County's beneficiariesmembers. Since 2008, CalOptima has also included Health Maintenance Organizations (HMOs), Physician/Hospital Consortia (PHCs), Physician Medical Groups (PMGs), and Shared Risk Medical Groups (SRGs).

CalOptima's HMOs, PHCs, PMGs and SRGs include more than over 3,500 Primary Care Providers (PCPs) and 30 hospitals and clinics. New networks that demonstrate the ability to comply with CalOptima's delegated requirements are added as needed.

October 2013

<u>Health Network/Delegate No.</u>	<u>Medi-Cal</u>	<u>OneCare</u>	<u>OneCare Connect</u>
<u>AltaMed Health Services</u>	<u>SRG</u>	<u>PMG</u>	<u>SRG</u>
<u>AMVI Care Health Network</u>	<u>PHC</u>	<u>PMG</u>	<u>PHC</u>
<u>Arta Western Health Network</u>	<u>SRG</u>	<u>PMG</u>	<u>SRG</u>

CHOC Health Alliance	PHC		
Family Choice Health Network	SRG	PMG	SRG
Heritage — ADOC Medical Group	HMO		HMO
Heritage — Regal Medical Group	HMO		HMO
Kaiser Permanente	HMO		
Monarch Family HealthCare	SRG	PMG	SRG
Noble Mid-Orange County	SRG	PMG	SRG
OC Advantage Medical Group	PHC		PHC
Prospect Medical Group	SRG		SRG
Talbert Medical Group	SRG	PMG	SRG
United Care Medical Group	SRG	PMG	SRG

Upon successful completion of audits, the ~~H~~health ~~n~~Networks may be delegated for clinical and administrative functions, which may include:

- [Utilization Management](#)
- [Case and Complex Case Management](#)
- [Claims \(professional ~~only~~ and institutional\)](#)
- [Contracting](#)
- [Credentialing of practitioners \(~~credentialing of Healthcare Delivery Organizations \(HDOs\) is not delegated~~\)](#)
- [Customer Services activities](#)

~~CalOptima Direct (COD)~~

~~CalOptima Direct is a self-directed program administered by CalOptima to serve Medi-Cal members in special situations, including foster children, dual eligibles (those with both Medicare and Medi-Cal who elect not to participate in Cal Optima's MA SNP), members in skilled nursing facilities, and share of cost members. COD also currently includes the following categories of vulnerable and complex/catastrophic care members: transplant, hemophilia, HIV, end-stage renal disease (ESRD), and Seniors and Persons with Disabilities.~~

~~BEHAVIORAL HEALTH COLLEGE HEALTH IPA AND HEALTH SERVICES, TO BEHAVIORAL~~

BEHAVIORAL HEALTH SERVICES

Medi-Cal Ambulatory Behavioral Health Services:

CalOptima delegates to College Health Independent Practice Association (CHIPA) for utilization Management of the Provider Network. CHIPA sub-contracts and delegates to Beacon Health Strategies, LLC (Beacon) other functions that include credentialing the provider network, the Access Line, and several quality improvement functions.

CalOptima is responsible for providing outpatient mental health services to members with mild to moderate impairment of mental, emotional, or behavioral functioning, resulting from a mental health disorder, as defined in the current dDiagnostic and Sstatistical Mmanual of Mmental Ddisorders. Mental hHealth services include but are not limited to: individual and group psychotherapy psychology, psychiatric consultation, medication management, and psychological testing when clinically indicated to evaluate a mental health condition.

CalOptima delegates to College Health Independent Practice Association (CHIPA) for utilization Mmanagement of the Pprovider nNetwork. CHIPA sub-contracts and delegates to Beacon Health Strategies, LLC (Beacon) other functions that include credentialing the provider network, the Access Line, and several quality improvement functions.

-In addition, CalOptima covers behavioral health treatment (BHT) for members 20 years of age and younger with a diagnosis of Autism Spectrum Disorder (ASD).

Behavioral health services are also within the scope of practice for PCPs, including offering screening, brief intervention, and referral to treatment (SBIRT) services to members 18 yrsyears of age and older who misuse alcohol.- Providers in primary care settings also screen for alcohol misuse and provide personspeople engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse and/or referral to mental health and/or alcohol use disorder services as medically necessary.

OneCare and OneCare Connect Behavioral Health Services

CalOptima has contracted with Windstone Behavioral Health for the behavioral health services portion of care for the of OneCare and OneCare Connectline of business. CalOptima delegates uUtilization mManagement (UM) to Windstone. Evidence--based MCG guidelines are usedtilized in the UM decision--making process.

OUR LINES OF BUSINESS:

THE MEDI-CAL PROGRAM — NEED TO CHECK THESE DESCRIPTIONS

Scope of Services

Under ~~its~~ our Medi-Cal ~~Program~~ program, CalOptima provides a comprehensive scope of acute and preventive care services for Orange County's Medi-Cal and dual eligible population.

These services include, but are not limited to, the following:

Adult preventive services	Hospital/inpatient care	Pediatric preventive services
Community-based adult services	Immunizations	Child health and disability prevention (CHDP)
Doctor office visits	Laboratory services	Physical therapy
Durable mMedical eEquipment	Limited allied health services	Prenatal care
Emergency cCare	Medical supplies	Specialty care services
Emergency tTransportation	Medications	Speech therapy
Non-emergency medical transportation (NEMT)	Newborn care	Substance use disorder preventive services — limited
Hearing aid(s)	Nursing facility services	Vision care
Home Hhealth cCare	Occupational therapy	
Hospice care	Outpatient mental health services — limited	

- ~~Preventive Services for children and adults~~
- ~~Perinatal Care~~
- ~~Primary Care~~
- ~~Specialty Care~~
- ~~Emergency Services~~
- ~~Minor Consent/Sensitive Services~~
- ~~Inpatient Services~~
- ~~Ancillary Services~~
- ~~Behavioral Health~~

Certain services are not covered by CalOptima, or may be provided by a different agency, including those indicated below:-

- Specialty mental health services are administered by ~~the~~ Orange County Health Care Agency ([OC](#) HCA).
- Substance ~~Use-use d~~Disorder services are administered by ~~the Orange County~~[OC](#) HCA.
- Dental services are provided through California's Denti-Cal program.

ASO Services for the Orange County Mental Health Plan

~~On July 1, 2010, the County of Orange Health Care Agency (HCA) changed the Administrative Services Organization (ASO) responsible for administering Medi-Cal specialty mental health services from Pacificare Behavioral Health (PBH) to CalOptima. Under this contract with HCA, CalOptima is responsible for:~~

- ~~• Developing a network of specialty mental health services providers;~~
- ~~• Paying claims for specialty mental health services;~~
- ~~• Providing a 24-hour clinical telephone line to triage member calls, conduct brief clinical assessments, and authorize services;~~
- ~~• Coordinating services between specialty mental health and physician health providers;~~
- ~~• Handling complaints about specialty mental health services; and~~
- ~~• Providing quality improvement services.~~

~~CalOptima has contracted with Beacon Health Strategies to carry out many of the administrative functions required under the contract with HCA.~~

Behavioral Health- Medi-Cal

~~CalOptima's program for Medi-Cal includes expanded Behavioral Health benefits effective January 1, 2014. Services include:~~

- ~~• Individual/group mental health evaluation and treatment (psychotherapy-excluding Serious and Persistent Mental Illness/Serious Mental Illness)~~
- ~~• Psychological testing, when clinically indicated, to evaluate a mental health condition~~
- ~~• Psychiatric consultation for medication management~~
- ~~• Outpatient laboratory, supplies, and supplements~~
- ~~• Screening and Brief Intervention (SBI) for Substance Use Conditions~~
- ~~• Drugs, excluding anti-psychotic drugs (covered by Medi-Cal FFS)~~

California Children's Services

Services for children with certain physical limitations, ~~and~~ chronic health conditions or diseases are provided through California Children's Services (CCS), which is a ~~state~~[state](#)wide program. [Currently](#), CCS authorizes and pays for specific medical services and equipment provided by CCS-approved specialists for ~~CCS-CCS~~-eligible conditions. DHCS [manages](#) the CCS program [and the County of Orange County Health Care Agency](#)

~~division of Maternal-Child Health operates the program. CalOptima is responsible for~~
~~coordinating care and services for all non-CCS related conditions. There is work~~
~~underway at CCS for it to operate integrate CCS services as a benefit of CalOptima.~~
~~Planning is in place for this. This transition is planned for to take place sometime in 2017.~~

~~Larger counties operate their own CCS programs, while smaller counties share the~~
~~operation of their program with State CCS regional offices in Sacramento, San Francisco,~~
~~and Los Angeles. The program is funded with Federal, State, and county tax monies,~~
~~along with some fees paid by parents or guardians.~~

Members ~~w~~With Special Health Care Needs

To ensure that clinical services as described above are accessible and available to
members with special health care needs, ~~—~~ such ~~as as members that are S~~seniors, ~~and~~
~~Persons persons people~~ with ~~D~~disabilities and ~~persons people~~ with chronic conditions, ~~—~~
CalOptima has developed specialized case management services. ~~—~~These case
management services are designed to ensure coordination and continuity of care, and are
described in the Utilization Management Program.

~~In a~~Additionally, CalOptima works with community programs to ensure that members
with special health care needs, ~~(or with high risk or complex medical and developmental~~
~~conditions)~~ receive additional services that enhance their Medi-Cal benefits. These
partnerships are established through special programs, such as the CalOptima
Community Member Liaison program, and specific Memoranda of Understanding
(MOU) with certain community agencies, ~~—, including~~ HCA, CCS, and the Regional
Center of Orange County (RCOC).

Medi-Cal Managed Long-Term Services and Supports

Beginning July 1, 2015, Long-Term Services and Supports (LTSS) became a CalOptima
benefit for all Medi-Cal enrollees members. CalOptima ensures LTSS services are
available to members who have health care needs and meet the program eligibility
criteria and guidelines.

~~The LTSS p~~Program offers includes four programs:

- Community-Based Adult Services (CBAS)
- Nursing Facility ~~Series~~Services for Long-Term Care Services
- Multipurpose Senior Services Program (MPSS)
- In-Home Supportive Services (IHSS)
-

ONECARE PROGRAM(HMO SNP)

~~The CalOptima OneCare program provides health care services to dual eligible seniors and persons with disabilities (SPDs) who enroll in the program.~~

Scope of Services

OneCare ([HMO SNP](#)) provides a comprehensive scope of services for the dual eligible members ~~who are not eligible for OneCare Connect—~~.

These services include, but are not limited to the following:

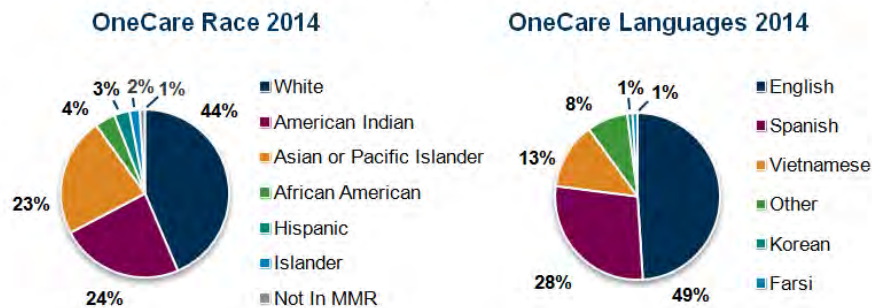
Acupuncture and other alternative therapies	Foot care	Outpatient surgery
Ambulance	Hearing services	Prescription drugs
Chiropractic care	Home health care	Preventative care
Dental Sservices — limited	Hospice	Prosthetic devices
Diabetes supplies and services	Inpatient hospital care	Renal dialysis
Diagnostic tests, lab and radiology services, -and X-rays	Inpatient mental health care	Skilled nursing facility
Doctor's office visits	Mental health care	Transportation — limited
Durable medical equipment	Outpatient rehabilitation	Urgently needed services
Emergency Ccare	Outpatient substance abuse	Vision services

- ~~Preventive Services~~
- ~~Behavioral Health~~
- ~~Dental Services~~
- ~~Long Term Supportive Services~~
- ~~Primary Care~~
- ~~Specialty Care~~
- ~~Complex Case Management~~
- ~~Emergency Services~~
- ~~Inpatient Services~~
- ~~Ancillary Services~~

~~Certain services are not covered by CalOptima, or may be provided by a different agency including those indicated below:~~

- ~~Dental Services~~
- ~~Vision~~
- ~~Meals~~
- ~~Taxi~~

OneCare 2014 Member Demographics 2014



ONECARE CONNECT ~~CAL~~ MEDICONNECT PLAN

Scope of Services

Launched on July 1, 2015, OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) is a health plan offered by CalOptima to simplify and improve health care for low-income seniors and people with disabilities. OneCare Connect combines our members' Medicare and Medi-Cal benefits, adds supplemental benefits, and offers personalized support — all to ensure each member receives the right care in the right setting.

OneCare Connect is part of Cal MediConnect, a demonstration program operating in seven counties throughout California. The demonstration aims to transform the health care delivery system for people eligible for Medicare and Medi-Cal. These people often have several chronic health conditions and multiple providers, yet their separate insurance plans often create confusion and fragmented care. By ~~combining~~ combining all benefits into one plan, OneCare Connect delivers coordinated care. Care coordination eliminates duplicated services and shifts services from more expensive institutions to home- and community-based settings.

OneCare Connect achieves these advancements via CalOptima's innovative Model of Care. Each member has a Personal Care Coordinator whose role is to help the member navigate the health care system and receive integrated medical, behavioral and supportive services. Addressing individual needs results in a better, more efficient health care experience for the member.

~~OneCare Connect scope of~~ These ~~These~~ services include, but are not limited to, the following:

<u>Acupuncture (pregnant women)</u>	<u>Hearing screenings</u>	<u>Over-the-counter drugs — (limited)</u>
<u>Ambulance Sservices</u>	<u>Incontinence supplies — limited</u>	<u>Radiology</u>

Case management	In-Home Supportive Services (IHSS)	Rehabilitation services
Chiropractic care services	Inpatient hospital care	Renal dialysis
Diabetes supplies and services	Inpatient mental health care	Screening tests
Disease self--management	Institutional care	Skilled nursing care
Doctor visits	Lab tests	Specialist care
Durable medical equipment	Medical equipment for home care	Substance abuse services
Emergency Ccare	Mental or behavioral health services	Supplemental dental services
Eye exams	Multipurpose -Senior Services Program (MSSP)	Transgender services
Foot care	Prescription drugs	Transportation to a doctor's office
Glasses or contacts --- limited	Preventive care	Occupational, physical or speech therapy
Health education	Prosthetic devices	Urgent Ccare
Hearing aids – limited	Outpatient care	“Welcome to Medicare” preventive visit

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY

Scope of Services

[Launched by CalOptima on August 1, 2013, CalOptima PACE is the only PACE center in Orange County. It is a community-based Medicare and Medi-Cal program that provides coordinated and integrated health care services to frail elders to help them continue living independently in the community.](#)

[PACE provides all the acute and long-term care services covered by Medicare and Medi-Cal. The services are arranged for our participants, based on their needs as indicated by our Interdisciplinary Team.](#)

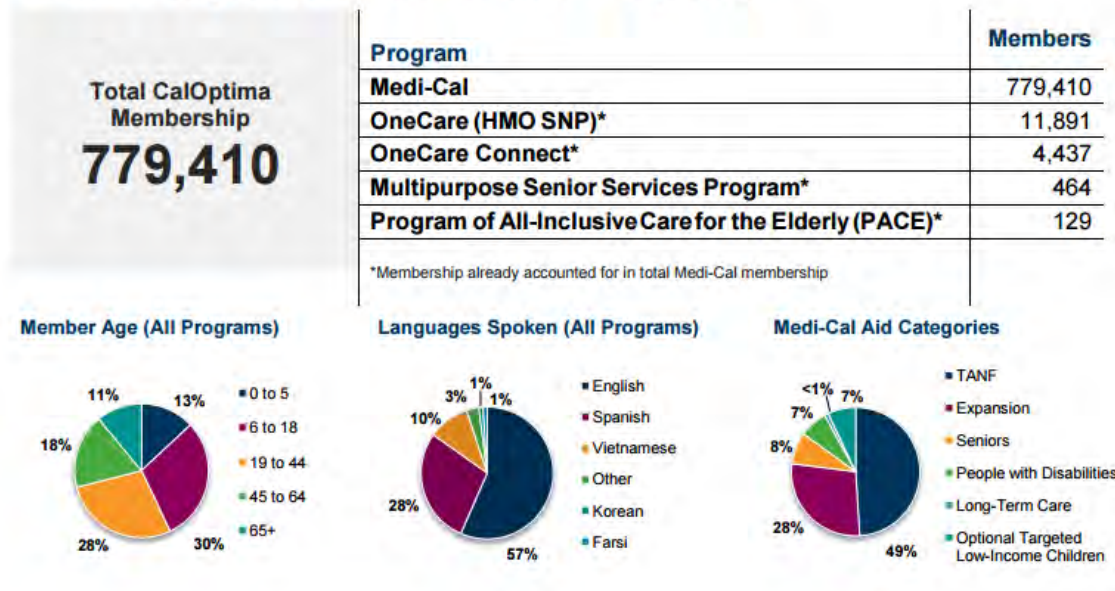
Membership Demographics



Fast Facts: February 2016

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

Membership Data as of December 31, 2015

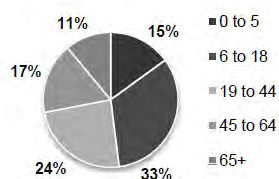


Mission: To provide members with access to quality health care services delivered in a cost-effective and compassionate manner

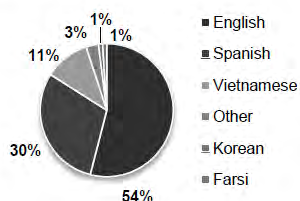
Membership Data as of November 30, 2014

<div> <p>Total CalOptima Membership</p> <p>691,737</p> </div>	Program	Members
	Medi-Cal	691,737
	OneCare (HMO SNP)*	13,646
	Multipurpose Senior Services Program*	442
	Program of All-Inclusive Care for the Elderly (PACE)*	64
*Membership already accounted for in total Medi-Cal membership		

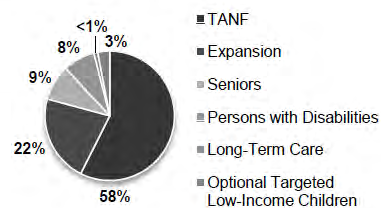
Member Age (All Programs)



Languages Spoken (All Programs)



Medi-Cal Aid Categories



Quality Improvement Program

CalOptima Mission

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

~~The Mission of CalOptima is the foundation of everything we do. It permeates throughout every level of the organization. Our Mission is our members and our members are the sole reason why we exist.~~

CalOptima's Quality Improvement (QI) Program encompasses all clinical care, clinical services and organizational services provided to our members, which aligns with our vision to provide an integrated and well-coordinated system of care to ensure optimal health outcomes for all of our members.

CalOptima has developed programs using evidence-based guidelines that incorporates data and best practices tailored to our populations. Our focus ~~expand~~extends across the health care continuum, from preventive care, closing gaps in care, care management, disease management, and complex care management. Our approach ~~utilizes~~uses support systems for our members with vulnerabilities, disabilities and chronic illnesses.

AUTHORITY, ACCOUNTABILITY AND RESPONSIBILITY

Board of Directors

The CalOptima Board of Directors has ultimate accountability and responsibility for the quality of care and services provided to CalOptima members. The responsibility to oversee the program is delegated by the Board of Directors to the Board's Quality Assurance Committee, ~~which~~ ~~performs~~oversees the functions of the Quality Improvement Committee described in Cal-Optima's State and Federal Contracts, ~~and~~ and to Cal-Optima's Chief Executive Officer (CEO), as discussed below.

The Board holds the ~~Chief Executive Officer~~CEO and Chief Medical Officer (CMO) accountable and responsible for the quality of care and services provided to members. The Board of Directors ~~promote~~promotes the separation of medical services from fiscal and administrative management to ~~assure~~ensure that medical decisions will not be unduly influenced by financial considerations. The Board of Directors approves and evaluates the QI Program annually.

The Quality ImprovementQI Program is based on on-going data analysis to identify the clinical needs, risk levels and appropriate interventions to ~~make~~ certain that the program meets the specific needs of ~~its~~ members. The CMO is charged with identifying appropriate interventions and resources necessary to implement the QI Program. Such

recommendations shall be aligned with ~~federal~~^{Federal} and ~~state~~^{State} regulations, contractual obligations, and fiscal parameters.

Quality Improvement Program, Role of CalOptima Officers

~~The~~ **Chief Executive Officer (CEO)** allocates financial and employee resources to fulfill program objectives. - The CEO delegates authority, when appropriate, to the Chief Medical Officer (CMO), the Chief Financial Officer (CFO) and the Chief Operating Officer (COO). - The CEO ~~makes~~ certain that the Quality Improvement Committee (QIC) satisfies all remaining requirements of the Quality Management & Improvement (QI) Plan~~Program~~, as specified in the State~~State~~ and Federal~~Federal~~ Contracts.

~~The~~ **Chief Medical Officer (CMO)**, ~~or~~ or physician designee, ~~—~~ chairs the QIC, which oversees and provides direction to Cal-Optima's QI activities, and supports efforts so that the QI Program objectives are coordinated, integrated, and accomplished. - At least quarterly, the CMO presents reports on QI activities to the Board of Directors' Quality Assurance Committee.

Deputy Chief Medical Officer (DCMO), along with the CMO, oversees strategies, programs, policies and procedures as ~~it~~^{they} relates to CalOptima's medical care delivery system. The DCMO and CMO oversees Quality Analytics, Quality Management, Utilization Management, Case Management, Health Education & Disease Management, Pharmacy Management, and Long-Term ~~Care~~ Services and Supports.

~~The Chief of Strategy & Executive Director of Public Affairs serves as the State Liaison; oversees the development and amendment of CalOptima's policies and procedures to oversee adherence to State and Federal requirements; and the management, development, and implementation of CalOptima's Communication plan, Issues Management, and Legislative Advocacy. This position also oversees the integration of activities for the Community Relations Program. The QI Department collaborates with the Department of Public Affairs to address specific developments or changes to policies and procedures that impact areas within the purview of QI.~~

Chief Network Officer (CNO) is responsible ~~for the development and expansion~~^{for developing and expanding} of CalOptima's ~~State Programs~~^{programs}, and is responsible ~~for~~^{by} implementing strategies that achieve the established program objectives; ~~leverage~~^{leveraging} the core competencies of CalOptima's existing administrative infrastructure to build an effective and efficient operational unit to serve CalOptima's ~~networks~~^{Direct}; and ~~making~~^{ing} sure the delivery of accessible, ~~cost~~^{cost}-effective, quality health care services throughout the service delivery network. - The CNO leads and directs the integrated operations of the ~~State P~~^{programs}-networks, and must coordinate organizational efforts internally, as well as externally, with ~~State P~~^{program}-members, providers, and community stakeholders.

Chief Operating~~ons~~ **Officer (COO)** is responsible for oversight and day-to-day operations of several departments including Operations, Information Services, Claims

Administration, Customer Service, Grievance and Appeals Resolution Services, Coding Initiatives and Electronic Business.

Executive Director, of Quality & Improvement Analytics (ED of QA) ~~Improvement~~ is responsible for facilitating the company-wide ~~Quality Improvement~~ Program, driving improvements with Healthcare Effectiveness Data and Information Set (HEDIS), DHCS, CMS and Star measures and ratings, and ~~facilitation~~ facilitating of compliance with NCQA. -The ED of QA serves as a member of the executive team and with the CMO supports efforts to promote adherence to established quality improvement strategies and programs throughout the company. -Reporting to the ED of QA is the Director of Quality Analytics, the Director of Health Education & Disease Management, and the Manager for Quality Improvement (QI).

Executive Director ~~(ED)~~ **of Clinical Operations** (ED of CO) is responsible for oversight of all operational aspects of key Medical Affairs functions, including: Utilization, Case Management, Health Education & Disease Management, Long-Term Services and Supports, and MSSP Services, along with new program implementation related to initiatives in these areas. The ED of Clinical Operations CO serves as a member of the executive team, and, with the CMO, - makes certain that Medical Affairs is aligned with CalOptima's strategic and operational priorities.

The Executive Director of Public Affairs (ED of PA) serves as the State Liaison; oversees the development and amendment of CalOptima's policies and procedures to ensure adherence to State and Federal requirements; and the management, development and implementation of CalOptima's Communication plan, Issues Management and Legislative Advocacy. This position also oversees the integration of activities for the Community Relations Program. The QI Department collaborates with Public Affairs to address specific developments or changes to policies and procedures that impact areas within the purview of QI.

Executive Director of Compliance (ED of C) is responsible to monitor and drive interventions so that CalOptima and its HMOs, PHCs, SRGs, MBHO, and PMGs meet the requirements set forth by DHCS, CMS, and DMHC. -The Compliance staff works in collaboration with the CalOptima -Audit and Oversight ~~d~~Department to refer any potential sustained noncompliance issues or trends encountered during audits of health networks, provider medical groups, and other functional areas. ~~EDC~~ The Executive Director, Compliance ED of C, also oversees CalOptima's regulatory and compliance functions, including the development and amendment of CalOptima's policies and procedures to ensure adherence to State and Federal requirements.

QUALITY IMPROVEMENT PROGRAM PURPOSE

The purpose of the CalOptima ~~Quality Improvement (QI)~~ Program is to establish objective methods for systematically evaluating and improving the quality of care

provided to CalOptima members through CalOptima CCN and COD-Direct, as well as ~~the-our~~ contracted provider networks. Through the QI Program, and in collaboration with its ~~contracted providers, -networks,~~ CalOptima strives to continuously improve the structure, processes, and outcomes of its health care delivery system.

The CalOptima QI Program incorporates continuous QI methodology of Plan-Do-Study-Act (PDSA) that focuses on the specific needs of ~~Cal-Optima~~CalOptima's multiple customers (members, health care providers, ~~and community-agencies-based organizations and government agencies~~):

- It is organized to identify and analyze significant opportunities for improvement in care and service.
- It ~~will~~ foster the development of improvement strategies, along with systematic tracking, to determine whether these strategies result in progress towards established benchmarks or goals.
- It is focused on QI activities carried out on an ongoing basis to ~~promote efforts which-that~~ support the identification and correction of quality of care issues.
- **Quality Improvement Department**

Quality Improvement, Quality Analytics, Disease Management & Health Education & Disease Management departments, ~~-in conjunction with multiple Medical Directors~~ The ~~Departments~~ support ~~and~~ the organization's mission and strategic goals, and oversees the processes to monitor, evaluate and act on the quality of care and services that members receive.

~~The QI and Quality Analytics Departments functions include:~~

- ~~Monitor, evaluate and act to improve clinical outcomes for members.~~
- ~~Design, manage and improve work processes, clinical, service, access, member safety, and quality related activities~~
 - ~~Drive improvement of quality of care received~~
 - ~~Minimize rework and costs~~
 - ~~Minimize the time involved in delivering patient care and service~~
 - ~~Empower staff to be more effective~~
 - ~~Coordinate and communicate organizational information, both division and department specific, and system-wide~~
- ~~Support the maintenance of quality standards across the continuum of care and all lines of business~~
- ~~Maintain company-wide practices that support accreditation by the National Commission for Quality Assurance (NCQA)~~
- ~~Coordinate and drive improvements with HEDIS compliance and access to preventive care and management of chronic conditions to HEDIS® standards~~

~~All CalOptima members have timely access to health care that is delivered by qualified practitioners and delivery systems, which meets or exceeds standards determined by CalOptima, the Centers for Medicare and Medicaid Services (CMS), the California Department of Managed Health Care (DMHC), the California Department of Health~~

Care Services (DHCS), California Department of Aging (CDA) and the National Committee for Quality Assurance (NCQA).

QUALITY IMPROVEMENT DEPARTMENT

The Quality Improvement Department supports the specific focus of monitoring quality of care issues and assuring the credentialing standards, policies and procedures are implemented to provide a qualified provider network for our members. -QI fully aligns with the QI team to support the organizational mission, strategic goals, and processes to monitor and drive improvements to the quality of care and services, and that care and services are rendered appropriately and safely to all CalOptima members.

Quality Improvement Department activities include:

- Monitor, evaluate and act to improve clinical outcomes for members.
- Design, manage and improve work processes, clinical, service, access, member safety, and quality related activities
 - Drive improvement of quality of care received
 - Minimize rework and unnecessary costs
 - Measure the member experience of accessing and getting needed care
 - Empower staff to be more effective
 - Coordinate and communicate organizational information, both division and department-specific, as well as agency-wide
- Support the maintenance of quality standards across the continuum of care and all lines of business
- Maintain company-wide practices that support accreditation by the National Commission for Quality Assurance (NCQA)

QUALITY ANALYTICS DEPARTMENT

The Quality Analytics Department works fully aligned-aligns with the Quality Improvement QI team Department and QI team to support the organizational mission, strategic goals, and processes to monitor and drive improvements to the quality of care and services, and ensure that care and services are rendered appropriately and safely to all CalOptima members.

The Quality Analytics Department activities include design, implementation and evaluation of initiatives to:

- Monitor outcomes
- Drive solutions and interventions to improve quality of care, access to preventive care, and management of chronic conditions to clinical guidelines

● ~~received~~

- Support efforts to improve internal and external customer satisfaction
- Improve organizational quality improvement functions and processes to both internal and external customers
- Collect clear, accurate and appropriate data used to analyze problems and measure improvement
- Coordinate and communicate organizational information, both division and department specific, and ~~system~~-agencywide
- Participate in various reviews through the QI Program such as the All Cause Readmission monitoring, access to care, availability of practitioners and other reviews
- Facilitate satisfaction surveys for members and practitioners
- Evaluate and monitor provider credentials
- Provide ~~organization~~-agencywide oversight of monitoring activities that are:
 - Balanced: ~~————~~ Measures clinical quality of care and customer service
 - Comprehensive: Monitors all aspects of the delivery system
 - Positive: ~~————~~ Provides incentive to continuously improve

In addition to working directly with the contracted health networks, data sources available for identification, monitoring and evaluating of opportunities for improvement and effectiveness of interventions include, but are not limited to:

- Claims information/activity
- Encounter data
- Utilization data
- Case Management reports
- Pharmacy ~~D~~data
- STARS and HCC data
- Group Needs Assessments
- Results of Risk Stratification
- HEDIS Performance
- Member and Provider ~~Satisfaction~~satisfaction
- Quality Improvement Projects (QIPs, ~~PIPs~~, and ~~CCIPs~~)
- Health Risk Assessment data

HEALTH EDUCATION & DISEASE MANAGEMENT DEPARTMENT

The Health Education ~~and~~ Disease Management department is the third area in Quality which that provides program development and implementation for the ~~organization~~-agencywide chronic condition improvement programs. -Health Education & Disease Management (HE & DM) Programs provides for the identification, assessment, stratification, and implementation of appropriate interventions for members with chronic diseases. -Programs and materials use educational strategies and methods appropriate for member and designed to achieve behavioral change for improved health and are reviewed

on an annual basis. Program topics covered include Asthma, -Congestive Heart Failure, Diabetes, Exercise, Nutrition, Hyperlipidemia, Hypertension, Pediatric Weight Management, and Tobacco Cessation.

Primary goals of the department ~~are~~^{is} to achieve members' wellness and autonomy through advocacy, communication, education-, identification of services, resources and service facilitation throughout the continuum of care. Materials are written at the sixth grade reading level and are culturally and linguistically appropriate for our members.

~~Disease Management & Health Education~~ & Disease Management supports CalOptima members with customized ~~interventions which~~ interventions, which may include:

- Healthy lifestyle management techniques and health education programs and services at no charge to members
- Medication education to ensure adherence to appropriate pharmacotherapy treatment plans
- Informational booklets for key conditions
- Referrals to community or external resources
- -Execute and coordinate programs with Case Management, Utilization Management, Quality Analytics and our Health Network Providers.

RESOURCES TO ~~DIRECTLY~~ DIRECTLY SUPPORT SUPPORT THE QUALITY IMPROVEMENT QUALITY IMPROVEMENT PROGRAM AND QUALITY IMPROVEMENT COMMITTEE

~~Cal Optima~~CalOptima's budgeting process includes personnel, IT resources, and other administrative costs projected for the QI Program. -The resources are revisited on a regular basis to promote adequate support for ~~Cal Optima~~CalOptima's QI Program.

The QI ~~S~~staff directly impacts and influences the QI Committee and related committees through monitoring, evaluation and interventions, -providing the various committees with outcomes and effectiveness of corrective actions.

The following staff positions provide direct support for organizational/ and operational QI ~~p~~Program functions and activities:

Medical Director, Quality ~~and Analytics~~

~~Designated If a~~Appointed by the CMO, the Medical Director of Quality ~~and Analytics~~ is responsible for the direction of the QI Program objectives to drive the organization's mission, strategic goals, and processes to monitor, evaluate and act on the quality of care and services delivered to members.

- ~~The following positions report to the Medical Director of Quality and Analytics~~
 - ~~Manager Quality Improvement~~
 - ~~Director of Quality and Analytics~~

Manager, Quality Improvement

Responsibilities include assigned ~~day-day~~ to day operations of the QI ~~D~~department, including Credentialing, Facility Site Reviews, Facility Physical Access Compliance and

working with the ED of ~~QI~~Quality. ~~This p~~osition is also responsible for QI Program and Work Plan implementation.

- The following positions report to the QI Manager:
 - QI Nurse Specialists, ~~7-FTEs~~
 - Data Analyst
 - Credentialing Coordinators, ~~6-FTEs~~
 - Credentialing Program Assistant
 - Facility Site Review Master Trainer
 - Facility Site Review Nurse Reviewers, ~~3.5-FTEs~~

Director, Quality Analytics ~~Director~~

Provides administrative and analytical direction to support quality measurement activities for the ~~organization~~-agencywide ~~Quality Improvement~~QI Program by managing, executing and coordinating QI activities and projects, aligned with the QI ~~D~~epartment supporting clinical operational aspects of quality management and improvement. Provides coordination and support to the QIC and other committees to support compliance with regulatory, ~~controlling~~ and accreditation agencies.

- The following positions report to the Director of Quality Analytics:
 - Quality Analytics HEDIS Manager
 - Quality Analytics Medical Data Manager
 - Quality Analytics QI Initiatives Manager
 - Quality Analytics Analysts (~~7.0-FTE~~)
 - Quality ~~Analysties~~Analytics Project Managers (~~5-FTEs~~)
 - Quality Analytics Program Coordinators (~~2-FTEs~~)
 - Quality Analytics Program Specialists (~~5-FTEs~~)

Director, Health Education- & Disease Management

Provides direction for program development and implementation for the ~~organization~~-agencywide ~~disease management and health education~~ and disease management initiatives.- Aenssures linkages supporting a whole--person perspective to health and health care with ~~the~~ Case Management, Care Management, and Utilization Management, supporting a whole person perspective to health and health care. Also, s-Supports the Model of Care implementation for ~~the~~ membership. -Reports program progress and effectiveness to QIC and other committees to support compliance with regulatory and accreditation agencies.

- The following positions report to the Director, ~~of~~ Health Education & Disease Management:
 - Disease Management Manager (Program Design)
 - Disease Management Manager (Operations)
 - Health Education Manager
 - Health Education Supervisor
 - Disease Management Health Coaches
 - Sr.enior Health Educator
 - Health Educators
 - Registered Dieticians

- Program Specialists
- Program Assistant

QUALITY IMPROVEMENT (QUALITY IMPROVEMENT) (QI) **STRATEGIC GOALS**

The purpose of the Quality Improvement (QI) Program is to establish objective methods for systematically evaluating and improving the quality of care provided to CalOptima members. Through the QI Program, CalOptima strives to continuously improve the structure, processes, and outcomes of its health care delivery system.

The QI Program incorporates continuous QI methodology that focuses on the specific needs of multiple stakeholders (members, health care providers, and community &and government agencies):

- It is organized to identify and analyze significant opportunities for improvement in care and service
- It ~~will~~ fosters the development of quality improvement strategies, along with systematic tracking, to determine whether these strategies result in progress towards established benchmarks or goals
- It is focused on QI activities and projects carried out on an ongoing basis to monitor that quality of care issues are identified and corrected as needed

QI Goals and Objectives

Quality improvement QI goals and objectives are to monitor, evaluate and improve:

- The quality of clinical care and services provided by the health care delivery system in all settings, especially as it pertains to the unique needs of the population
- The important clinical and service issues facing the Medi-Cal population relevant to its demographics, high-risks, ~~and~~ disease profiles for both acute and chronic illnesses, and preventive care
- The continuity and coordination of care between specialists and primary care practitioners, and between medical and behavioral health practitioners by annually acting on at least three identified opportunities
- The accessibility and availability of appropriate clinical care and to a network of providers with experience in providing care to the population
- The qualifications and practice patterns of all individual providers in the network to deliver quality care and service
- Member and provider satisfaction, including the timely resolution of complaints and grievances
- Risk prevention and risk management processes
- Compliance with regulatory agencies and accreditation standards
- Annual review and acceptance of the UM Program Description and Work Plan

- The effectiveness and efficiency of internal operations
- The effectiveness and efficiency of operations associated with functions delegated to the contracted medical groups
- The effectiveness of aligning ongoing quality initiatives and performance measurements with ~~the organization's~~ [CalOptima's](#) strategic direction in support of its mission, vision, and values
- Compliance with Clinical Practice Guidelines and evidence-based medicine
- Compliance with regulatory agencies and accreditation standards (NCQA)
- Support of the ~~organization's~~ [agency's](#) strategic quality and business goals by utilizing resources appropriately, effectively, and efficiently
- Set expectations to develop plans to design, measure, assess, and improve the quality of the organization's governance, management, and support processes
- Support the provision of a consistent level of high quality of care and service for members throughout the contracted network, as well as monitor utilization practice patterns of practitioners, contracted hospitals, contracted services, ancillary services, and specialty providers
- Provide oversight of quality monitors from the contracted facilities to continuously assess that the care and service provided satisfactorily meet quality goals
- ~~Make certain contracted facilities report outbreaks of conditions and/or diseases to the public health authority — or Orange County Health Department Agency; — which may include; but are not limited to Methicillin resistant staphylococcus aureus (MRSA), staphylococcus aureus infections, scabies, Tuberculosis, etc. as reported by the Health health nNetworks.~~
- ~~Promote patient safety and minimize risk through the implementation of patient safety programs and early identification of issues that require intervention and/or education and work with appropriate committees, departments, staff, practitioners, provider medical groups, and other related health care delivery organizations (HDOs) to assure that steps are taken to resolve and prevent recurrences~~

QI Measureable Goals from the Model of Care

The Model of Care (MOC) is member-centric by design, and -monitors, evaluates, and acts upon the coordinated provisions of seamless access to individualized, quality health care. ~~The~~ MOC meets the needs of the special member populations through strategic activities and goals. -Measureable goals are established and reported annually.

The MOC goals are:

- Improving ~~Access-access~~ to ~~Essential-essential Services~~ [services](#)

- Improving ~~Access~~ access to ~~Affordable~~ affordable ~~Care~~ care
- Improving ~~Coordination~~ coordination of ~~Care~~ care ~~Through~~ through an ~~Identified~~ identified ~~Point~~ point of ~~Contact~~ contact
- Improving ~~Seamless~~ seamless ~~Transitions~~ transitions of ~~Care~~ care ~~Across~~ across ~~Healthcare~~ health care settings, ~~Providers~~ providers; and ~~Health~~ health ~~Services~~ services
- Improving ~~Access~~ access to ~~Preventive~~ preventive ~~Health~~ health ~~Services~~ services
- Assuring ~~Appropriate~~ appropriate ~~Utilization~~ utilization of ~~Services~~ services
- Improving integration of ~~Medical~~ medical and ~~Behavioral~~ behavioral ~~Health~~ health ~~Services~~ services
- Improving ~~Beneficiary~~ beneficiary ~~Health~~ health ~~Outcomes~~ outcomes

A formal annual performance evaluation is conducted and strategies for continuous improvement for the coming year are established. These are reported to the QI Committee.

WORK PLAN

(SEE ATTACHMENT A — 2016 QI WORK PLAN)

The ~~Quality Improvement~~ QI Work Plan outlines key activities for the upcoming year. -It is reviewed and approved by the QIC. -The QI Work Plan indicates objectives, scope, timeline, planned monitoring and accountable persons for each activity. -Progress against the QI Work Plan is monitored throughout the year. QI Work Plan addendums may be established to address the unique needs of members in ~~Special~~ ~~Needs~~ ~~Plans~~ or other health plan products as needed to capture the specific scope of the plan.

The QI Work Plan is the operational and functional component of the ~~Quality Improvement~~ QI Program and is based on the most recent and trended HEDIS scores, physician quality measures, and other measures identified for attention, including any specific requirements mandated by the ~~state~~ ~~State~~ ~~in which the health plan is licensed~~, or accreditation standards where these apply.

The QI Program- guides the development and implementation of an annual QI Work Plan and a separate Utilization Management (UM) Work Plan that includes:

- Case Management
- Client Revisions ~~Behavioral Health~~
- LTSS
- Health Education & Disease Management, Health Assessments, Health Education ~~and related CCIP, QIP, PIPs~~
- Access & Availability to Care
- Member Experience & Satisfaction with Care & Service
- Patient Safety & Pharmacy Initiatives
- HEDIS/STARS Improvement
- Delegation Oversight
- Organizational Quality Projects

• ~~Quality of clinical care~~

• ~~Quality of Service~~

• ~~Safety of clinical care~~

- QI Program scope
- Yearly objectives
- Yearly planned activities
- Time frame for each activity's completion
- Staff member responsible for each activity
- Monitoring of previously identified issues
- Annual evaluation of the QI Program
- Priorities for QI activities based on the specific needs of Cal Optima's organizational needs and specific needs of Cal Optima's populations for key areas or issues identified as opportunities for improvement
- Priorities for QI activities based on the specific needs of Cal Optima's populations, and on areas identified as key opportunities for improvement
- Ongoing review and evaluation of the quality of individual patient care to aid in the development of QI studies based on quality of care trends identified

The [QI](#) Work Plan supports the comprehensive annual evaluation and planning process that includes review and revision of the QI Program and applicable policies and procedures.

UTILIZATION MANAGEMENT

Coverage for health care services, treatment and supplies in all lines of business is based on the terms of the plan and subject to medical necessity. -Contracts specify that medically necessary services are those which are established as safe and effective, consistent with symptoms and diagnosis and furnished in accordance with generally accepted professional standards to treat an illness, disease, or injury; consistent with CalOptima medical policy, and not furnished primarily for the convenience of the patient, attending physician or other provider.

Use of evidence-based, industry-recognized criteria promotes efforts that medical decisions are not influenced by fiscal and administrative management considerations. As described in the [2015-2016](#) Utilization Management (UM) Program all review staff are trained and audited in these principles. ~~All medical necessity decisions are made by clinical staff~~ [Clinical staff makes all medical necessity decisions](#) and any denial is made only by a physician reviewer, including those decisions made by delegated health networks. Medical ~~directors~~ [Directors](#) actively engage subspecialty physicians as peer

review consultants to assist in medical necessity determinations. Adherence to standards and evidence-based clinical criteria is obtained by cooperative educational efforts, personal contact with providers and monitoring through clinical studies.

BEHAVIORAL HEALTH

~~CalOptima~~ CalOptima focuses on the continuum of care for both medical and behavioral health services. -Focusing on continuity and coordination of care, CalOptima ~~will monitor~~ monitors and ~~works to~~ improve the quality of behavioral health care and services provided ~~based on applicable contract requirements to our members~~. The QI ~~P~~ program includes services for behavioral health and review of the quality and outcomes of those services delivered to the members within our network of practitioners and providers.

The quality of Behavioral Health services may be determined through, but not limited to the following:

- Access to care
- Availability of practitioners
- Coordination of care
- Medical record and treatment record documentation
- Complaints and grievances
- Appeals
- Compliance with evidence-based clinical guidelines
- Language assistance
- HEDIS and STAR measurements

The Medical Director responsible for Behavioral Health services ~~shall be~~ is involved in the behavioral aspects of the QI Program. The BH Medical Director ~~shall be~~ is available for assistance with member behavioral health complaints, development of behavioral health guidelines, recommendations on service and safety, provide behavioral health QI statistical data, and follow-up on identified issues. - The BH Medical Director shall serve as the chairperson of the BH QI Committee which is a sub-committee of the CalOptima QI Committee. - The BH Medical Director also serves as a voting member of CalOptima's the Plan's QI Committee.

CONFIDENTIALITY

CalOptima has policies and procedures to protect and -promote proper handling of confidential and privileged medical record information. -Upon employment, all CalOptima employees, — including contracted professionals who have access to

confidential or member information. ~~—~~ sign a written ~~state~~statement delineating responsibility for maintaining confidentiality.

In addition, all Committee members of each entity are required to sign a Confidentiality Agreement on an annual basis. -Invited guests must sign a Confidentiality Agreement at the time of Committee attendance.

All records and proceedings of the ~~Quality Improvement~~QI Committee and the subcommittees, related to member- or practitioner-specific information are confidential, and are subject to applicable laws regarding confidentiality of medical and peer review information, including Welfare and Institutions Code section 14087.58, which exempts the records of QI proceedings from the California Public Records Act. -All information is maintained in confidential files. -The HMOs, PHCs, SRGs, MBHOs, and PMGs hold all information in the strictest confidence. Members of the ~~Quality Improvement~~QI Committee and the subcommittees sign a “Confidentiality Agreement.” -This Agreement requires the member to maintain confidentiality of any and all information discussed during the meeting. -The CEO, in accordance with applicable laws regarding confidentiality, issues any Quality Improvement reports required by law or by the ~~State~~State Contract.

CONFLICT OF INTEREST

CalOptima maintains a Conflict of Interest policy to ~~make~~ certain potential conflicts are avoided by staff and members of Committees. -This policy precludes using proprietary or confidential CalOptima information for personal gain or the gain of others, as well as direct or indirect financial interests in, or relationships with, current or potential providers, suppliers, or members, except when it is determined that the financial interest does not create a conflict.

All employees sign a Conflict of Interest ~~state~~statement on an annual basis.

Fiscal and clinical interests are separated. -CalOptima and its delegates do not ~~specifically~~ reward practitioners or other individuals conducting utilization review for issuing denials of coverage, services, or care. -There are no financial incentives for UM decision-makers that could encourage decisions that result in under-utilization.

STAFF ORIENTATION~~/~~, TRAINING AND EDUCATION

CalOptima seeks to recruit ~~highly-qualified~~highly qualified individuals with extensive experience and expertise in ~~Health~~health sServices for staff positions. -Qualifications and educational requirements are delineated in the position descriptions of the respective positions.

Each new employee is provided an intensive, hands-on training and orientation program with a staff preceptor. -The following topics are covered during the program, as applicable to specific job description:

- CalOptima New Employee Orientation
- HIPAA and Privacy/Corporate Compliance
- Use of technical equipment (phones, computers, printers, facsimile machines, etc.)
- Applicable Department Program, ~~p~~Policies & ~~p~~P Procedures, etc.
- Appeals Process
- Seniors and Persons with Disabilities Awareness Training

CalOptima encourages and supports continuing education and training for employees, which increases competency in their present jobs and/or prepares them for career advancement within CalOptima. -Each year, a specific budget is set for continuing education for each licensed ~~Health Services~~ employee.

MOC-related employees and contracted providers and practitioners network are trained at least annually on the Model of Care (MOC). -The MOC training is a part of the comprehensive orientation process, and includes ~~face face-to-to~~ face, interactive, and web-web-based platforms; ~~and as well as~~ paper format.

SAFETY PROGRAM

Program Objective/ and Purpose

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Member (Patient) safety is very important to CalOptima; it aligns with Cal-Optima's mission ~~state~~statement: *"To provide members with access to quality health care services delivered in a ~~cost~~ cost-effective and compassionate manner."* By encouraging members and families to play an active role in making their care safe, medical errors will be reduced. Active, involved and informed patients and families are vital members of the health care team.

Member safety is integrated into all components of member enrollment and health care delivery organization continuum oversight and is a significant part of our quality and risk management functions. -Our member- safety endeavors -are clearly articulated both internally and externally, and include -strategic efforts specific to member safety.

This plan is based on a needs assessment; and includes the following areas:

- Identification and prioritization of patient safety-related risks for all CalOptima members, regardless of line of business and contracted health care delivery organizations
- Operational objectives, roles and responsibilities, and targets based on the risk assessment

- Plans to ~~conduct~~ appropriate patient safety training and education are available to members, families, and health care personnel/physicians
- Patient safety program and its outcomes, to be reviewed annually
- Health ~~Education~~education and ~~Promotion~~promotion
- Group Needs Assessment
- Over/Under ~~Utilization~~utilization monitoring
- Medication Management
- Case Management/Disease Management
- ~~Operational Aspects of Care and Service~~
-

Member Safety prevention, monitoring and evaluation include:

- Providing education and communication through the Group Needs Assessment to assess the ~~Member's~~member's comprehension through their language, cultural, and diverse needs
- Distributing member information that improves their knowledge about clinical safety in their own care; ~~for example, (such as~~ member brochures, which outline member concerns or questions that they should address with their practitioners for their care)
- Collaborating with Health Networks and practitioners in performing the following activities: improving medical record documentation and legibility, establishing timely follow-up for lab results; addressing and distributing data on adverse outcomes or polypharmacy issues by the Pharmacy ~~and &~~ Therapeutics (P&T) Committee, and maintaining continuous quality improvement with pharmaceutical management practices to require safeguards to enhance patient safety
- Alerting the pharmacy to potential drug interactions and/or duplicate therapies, and discussing these potential problems with the prescribing physician(s), allows the opportunity for the practitioner to correct the amount of the appropriate drug is being delivered
- Improving continuity and coordination between sites of care, such as hospitals and skilled nursing facilities, to assure timely and accurate communication
- Utilizing facility site review, Physical Accessibility Review Survey (PARS), and medical record review results from practitioner and health care delivery organization at the time of credentialing to improve safe practices, and incorporating ADA (Americans with Disabilities Act), and SPD (Seniors and Persons with Disabilities) site review audits into the general facility site review process
- Tracking and trending of adverse event reporting to identify system issues that contribute to poor safety

Elements of the safety program address the environment of care and the safety of members, staff, and others in a variety of settings. ~~The focus of the program is to~~ identify

and remediate potential and actual safety issues, and to ~~monitor ongoing staff education and training, including:-~~

- Ambulatory setting
 - Adherence to ADA standards, including provisions for access and assistance in procuring appropriate equipment, such as electric exam tables
 - Annual blood-borne pathogen and hazardous material training
 - Preventative maintenance contracts to promote that equipment is kept in good working order
 - Fire, disaster, and evacuation plan, testing, and annual training
- Institutional settings including ~~Long-Long-Term Care (LTC), and Home and Community Based Services (HCBS), (including CBAS and MSSP)~~ settings and ~~Long-Long-Term Support and Services~~ Services and Supports (LTSS) settings
 - Falls and other prevention programs
 - Identification and corrective action implemented to address post operative complications
 - Sentinel events identification and appropriate investigation and remedial action
 - Administration of ~~f~~Flu/~~P~~pneumonia vaccine
- Administrative offices
 - ~~Fire, disaster, and evacuation plan, testing, and annual training~~

COMMITTEE AND KEY GROUP STRUCTURES

(SEE ~~APPENDIX A~~ PAGE 424252 ~~—FOR~~ COMMITTEE ORGANIZATION STRUCTURE DIAGRAM)

Board of Directors' Quality Assurance Committee

The Board of Directors appoints the Quality Assurance Committee (QAC) to review and accept the overall QI Program and annual evaluation, and routinely receives progress reports from the QIC describing improvement actions taken, progress in meeting objectives, and improvements achieved. The QAC shall also make recommendations for annual modifications of the QI program and actions to be taken when objectives are not met. CalOptima is required under California's open meeting law, the Ralph M. Brown Act, Government Code §54950 *et seq.*, to hold public meetings except under specific circumstances described in the Act. CalOptima's QAC meetings are open to the public.

Member Advisory Committee

The Member Advisory Committee (MAC) is composed of representatives of the population CalOptima serves. ~~The~~ Committee ~~MAC acts to support ensures~~ that CalOptima members' values and needs are integrated into the design, implementation, operation, and evaluation of the overall CalOptima QI program. ~~The~~ members of the Committee ~~MAC~~ provides advice and recommendations on community outreach, cultural and linguistic needs and needs assessment, member survey results, access to health care, preventative services, and contracting. The Committee ~~MAC~~ meets on a bi-monthly basis

and reports directly to the CalOptima Board of Directors. MAC meetings are open to the public.

The MAC membership is composed of representatives from the following constituencies:~~includes the following representatives:~~

- Adult beneficiaries representative
- Children representative
- Consumer representative
- Family Support representative
- Foster Children representative
- Long-Long-Term Care representatives
- Medi-Cal beneficiaries representative
- Medically indigent persons representative
- Orange County Health Care Agency representative
- Orange County Social Services Agency representative
- Persons with disabilities representative
- Persons with mental illnesses representative
- Persons with Special Needs representative
- Recipients~~Recipients~~ of CalWORKs representative
- Seniors representative

Provider Advisory Committee

The Provider Advisory Committee (PAC) is composed of representatives from the following constituencies:

- Health Networks
- Hospitals
- Physicians
- Nurses
- Allied Health Services
- Community Clinics
- The Orange County Health Care Agency (HCA)
- Long-Long-Term Services and Supports including (LTC Facilities and CBAS)
- Mid-Level Practitioners
- Behavioral/mental health

Quality Improvement Committee (QIC)

The QIC is the foundation of the QI program. -The QIC assists the CMO in overseeing, maintaining, and supporting the QI Program and QI Work Plan activities.

The purpose of the QIC is to assure that all QI activities are performed, integrated, and communicated internally and to the contracted HMOs, PHCs, SRGs, MBHO, and PMGs to achieve the end result of improved care and services for members. -The QIC oversees the performance of delegated functions by its HMOs, PHCs, SRGs, MBHO, and PMGs and contracted provider and practitioner partners. -The composition of the QIC includes a participating Behavioral Health Practitioner to specifically address integration of

behavioral and physical health, appropriate utilization of recognized criteria, development of policies and procedures, and case review as needed, and identification of opportunities to improve care.

The QIC provides overall direction for the continuous improvement process and ~~s~~ evaluates ~~that-whether~~ activities are consistent with CalOptima's strategic goals and priorities. ~~It s~~ supports efforts that an interdisciplinary and interdepartmental approach is taken and adequate resources are committed to the program. It ~~monitors~~ compliance with regulatory and accrediting body standards relating to Quality Improvement Projects (QIP), activities, and initiatives. In addition, and most importantly, it ~~makes~~ certain that members are provided optimal quality of care. HEDIS activities and interventions are reviewed, approved, processed, monitored, and reported through the QIC.

Responsibilities of the QI Committee include the following:

- Recommends policy decisions
- Analyzes and evaluates policy decisions
- Makes certain that there is practitioner participation in the QI ~~p~~Program through planning, design, implementation and review
- Identifies needed actions and interventions
- Makes certain that there is follow-up as necessary

~~Providers', practitioners', and HMOs', PHCs', SRGs', MBHO, and PMGs' P~~practice patterns ~~of providers, practitioners, HMOs, PHCs, SRGs, MBHO, and PMGs~~ are evaluated, and recommendations are made to ~~promote~~ practices that all members receive medical care that meets CalOptima standards.

The QIC ~~shall develop,~~ oversee, and coordinate ~~s~~ member outcome-related quality improvement actions. Member outcome-related QI actions consist of well-defined, planned QI Projects by which the plan addresses and achieves improvement in major focus areas of clinical and non-clinical services.

The QIC also recommends strategies for dissemination of all study results to CalOptima-contracted providers and practitioners, HMOs, PHCs, SRGs, MBHO, and PMGs.

The QI Projects themselves consist of four (4) cycles:

- **Plan**— — detailed description and goals
- **Do**— — Implementation of the plan
- **Study**— — data and collection
- **Act**— — analyze data and develop conclusions

The goal of the QI Program is to improve the health outcomes of members through systematic and ongoing monitoring of specific focus areas and development and implementation of QI Projects and interventions designed to improve provider and practitioner and system performance.

The QIC provides overall direction for the continuous improvement process and monitors that activities are consistent with Cal-Optima's strategic goals and priorities. -It promotes efforts that an interdisciplinary and interdepartmental approach is taken, and adequate resources are committed to the program and drives actions when opportunities for improvement are identified.

The composition of the QIC is defined in the QIC Charter and includes, but may not be limited to the following:

Voting Members:

- Four (4) participating physicians or practitioners, with no more than two (2) administrative medical directors
- CalOptima CMO/DCMO
- CalOptima Medical Director, Quality (Chair)
- CalOptima Medical Director also representing the UM Committee
- CalOptima Medical Director, Behavioral Health also representing the BH QI Committee
- Executive Director Clinical Operations
- Director of Network Management
- Director Business Integration

The QIC is supported by:

Executive Director, Quality Improvement
Manager, Quality Improvement
Director, Quality Analytics
Director, Health Education & Disease Management
Committee Recording Secretary as assigned

Quorum

A quorum consists of a majority of the voting members (at least six) of which at least four are physicians or practitioners. fifty percent (50%) plus one (1) of voting member participation and of the six; the minimum quorum must include four (4) physicians or practitioners. -Once a quorum is attained, the meeting may proceed and any vote will be considered official, even if the quorum is not maintained. -Participation is defined as attendance in person or participation by telephone.

The QIC meets no less than eight (8) times per year, and reports to the Board QAC no less than quarterly.

QIC and all quality improvement subcommittee reports and proceedings are covered under California Welfare & Institution Code § 14087.58(b), Health and Safety Code § 1370, and California Evidence Code §1157. -Section 14087.58(b) renders records of QI proceedings, including peer review and quality assessment records, exempt from disclosure under the Public Records Act.

Minutes of the Quality Improvement Committee (QIC)

Contemporaneous minutes reflect all Committee decisions and actions. -These minutes are dated and signed by the Committee Chair to -demonstrate that they are representative of the official findings of the committee.

Minutes of the QIC meeting include, but are not limited to goals and objectives outlined in the QI Charter and which include but are not limited to:

- Active discussion and analysis of quality issues Aanalysis-~~of~~
- Credentialing or re-credentialing issues, as appropriate
- Establishment or approval of clinical practice guidelines
- Reports from various committees and subcommittees
- Recommendations, actions, and follow-up actions
- Plans to disseminate Quality Management/Improvement information to network providers and practitioners
- Tracking of work plan activities

All agendas, minutes, reports, and documents presented to the QIC are maintained in a confidential manner. -Minutes are maintained in an electronic format and not reproduced (except for Quality Profile documentation) in order to maintain confidentiality, privilege, and protection.

The following ~~committees~~ are committees and subcommittees of the QIC:

Credentialing and Peer Review Committee (CPRC)

The CPRC provides guidance and peer input into the CalOptima practitioner and provider selection process, and determines corrective actions as necessary to support that all practitioners and providers that serve CalOptima members meet generally accepted standards for their profession or industry. - The CPRC reviews, investigates, and evaluates the credentials of all internal CalOptima medical staff for membership, and maintains a continuing review of the qualifications and performance of all external medical staff. The CPRC's review and findings are reported to the QIC, with recommendations for approval/denial of credentialing. -All approved providers and practitioners are presented to QAC on a quarterly basis as part of the CMO's report.

The ~~G~~goals of the CPRC include:

1. Maintain a peer review and credentialing program that aligns with regulatory (DHCS, DMHCS, CMS) and accreditation (NCQA) standards.
2. Promote continuous improvement of the quality of health care provided by providers in CalOptima Direct/CalOptima Community Network and its delegated health networks.
3. Conduct peer-level review and evaluation of provider performance and credentialing information against CalOptima requirements and appropriate clinical standards.
4. Investigate patient care outcomes that raise quality and safety concerns for corrective actions, as appropriate.

CPRC primary responsibilities include:

1. Provide peer review and credentialing functions for CalOptima.
2. Review reports submitted by internal departments including but not limited to Audit ~~and~~ Oversight, Quality Improvement (PQI issues), GARS (complaints) and take action on credentialing or quality issues, as appropriate.
3. Provide guidance and peer participation in the CalOptima credentialing/ and recredentialing processes to ensure that all providers that serve CalOptima members meet generally accepted standards for their profession or industry.
4. Make final determinations regarding the eligibility of providers to participate in the CalOptima program based on CalOptima policies and applicable standards.
5. Review, investigate, and evaluate the credentials of CalOptima Direct/-CalOptima Community Network practitioners and internal CalOptima medical staff.
6. Review facility site review results and oversee all related actions.
- 4.7. Investigate, review and evaluate quality of care matters referred by CalOptima's functional departments (including, without limitation, Customer Service, Grievance and Appeals Resolution Services, Utilization Management, Case Management, and Pharmacy) and/or the ~~Chief Medical Officer~~ CMO or his/her physician designee related to CalOptima Direct/CalOptima Care Network or its delegated Health Networks.

2.8. Initiate and monitor imposed provider corrective actions and make adverse action recommendations, as necessary and appropriate.

In addition, as a part of CalOptima's Patient Safety Program, and utilizing the full range of methods and tools of that program, **SENTINEL EVENT MONITORING**
As part of the CalOptima Patient Safety Program, and utilizing the full range of methods and tools of that program, CalOptima conducts Sentinel Event monitoring. A sSentinel eEvent is defined as "an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof."- The phrase "or risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.

Sentinel eEvent monitoring includes patient safety monitoring across the entire continuum of Cal-Optima's contracted providers: HMOs, PHCs, SRGs, MBHO, PMGs, and health care delivery organizations.- The presence of a Sentinel eEvent is an indication of possible quality issues, and the monitoring of such events will increase the likelihood of early detection of developing quality issues so that they can be addressed as early as possible. Sentinel eEvent monitoring serves as an independent source of information on possible quality problems, supplementing the existing Patient Safety Program's consumer-complaint-oriented system.

All medically related cases are reviewed by the CPRC to determine the appropriate course of action and/or evaluate the actions recommended by an HMO, PHC, SRG, MBHO, or PMG delegate. -Board certified peer-matched specialists are available to review complex cases as needed. -Results of peer review are used at the reappointment cycle, or upon need, to review the results of peer review and determine the competency of the provider. -This is accomplished through routine reporting of peer review activity to HMOs, PHCs, SRGs, MBHO, -and PMGs for incorporation in their re-credentialing process.

The CPRC shall consist of a minimum of five (5) physicians selected on a basis that will provide representation of active physicians from the CalOptima Direct network and/or the Health Networks. -Physician participants shall represent various specialties including but not limited to general surgery, OB/ GYN, and primary care. -In addition, the Chairperson and CalOptima's Chief Medical Officer CMO or DCMO are considered part of the Committee and, as such, are voting members. -The CPRC provides reports to CalOptima Quality Improvement QI Committee at least quarterly.

Grievance and Appeals Resolution Services Subcommittee (GARS)

The Grievance and Appeals Resolution Services subcommittee serves to protect the rights of our members, and to promote the provision of quality health care services and enforces that the policies of CalOptima are consistently applied to resolve member complaints in an equitable and compassionate manner through oversight and monitoring.

The GARS Subcommittee serves to provide a mechanism to resolve provider and practitioner complaints and appeals expeditiously. —It protects the rights of practitioners and providers by providing a multilevel process that is fair and progressive in nature, leading to the resolution of provider complaints. —The GARS Subcommittee meets at least quarterly, and reports to the QIC.

Pharmacy and Therapeutics Subcommittee

The Pharmacy and Therapeutics (P&T) Subcommittee is a forum for an evidence-based formulary review process. - The P&T promotes clinically sound and cost effective pharmaceutical care for all CalOptima members and reviews anticipated and actual drug utilization trends, parameters, and results on the basis of specific categories of drugs and formulary initiatives, as well as the overall program. - In addition, the P&T Committee reviews and evaluates current pharmacy-related issues that are interdisciplinary, involving interface between medicine, pharmacy and other practitioners involved in the delivery of health care to CalOptima's members. - The P&T Committee includes practicing physicians and the contracted provider networks. - A majority of the members of the P&T Committee are physicians (including both CalOptima employee physicians and participating provider physicians), and the membership represents a cross section of clinical specialties and clinical pharmacists in order to adequately represent the needs and interests of all plan members. The P&T Committee provides written decisions regarding all formulary development and revisions. The P&T Committee meets at least quarterly, and reports to the UMC subcommittee.

Utilization Management Committee Subcommittee

The Utilization Management subcommittee promotes the optimum utilization of health care services, while protecting and acknowledging member rights and responsibilities, including their right to appeal denials of service. The UM Subcommittee is multidisciplinary, and provides a comprehensive approach to support the Utilization Management Program in the management of resource allocation through systematic monitoring of medical necessity and quality, while maximizing the cost effectiveness of the care and services provided to members.

The UM sub-committee monitors the utilization of health care services by CalOptima Direct, Medi-Cal and through the delegated HMOs, PHCs, SRGs, MBHO, and PMGs to identify areas of under or over utilization that may adversely impact member care. -The UM Subcommittee oversees Inter-rater Reliability testing to support consistency of application in criteria for making determinations, as well as development of Evidence Based Clinical Practice Guidelines and completes an annual review and updates the clinical practice guidelines to make certain they are in accordance with recognized clinical organizations, are evidence-based, and comply with regulatory and other agency standards. The UM Subcommittee meets quarterly and reports to the QIC.

The UM Subcommittee includes a minimum of four (4) practicing physician representatives, reflecting CalOptima's HMO, PHC, SRG, MBHO, and PMG composition, and is appointed by the CMO. -The composition includes a participating Behavioral Health Practitioner* to specifically address integration of behavioral and physical health, appropriate utilization of recognized criteria, development of policies and procedures, and case review, as needed.

The UM subcommittee is supported by:
Medical Director, Concurrent Review

Director, ~~of~~ Utilization Management
Director, ~~of~~ Pharmacy
Director, ~~of~~ Enterprise Analytics
Manager, Referral/Prior Authorization
Manager, ~~of~~ Concurrent Review

Quorum:

A quorum consists of fifty percent (50%) plus one ~~(1)~~ of voting member participation and of the eleven ~~(11)~~, the minimum quorum must include three ~~(3)~~ committee participants from the community. Once a quorum is attained, the meeting may proceed and any vote will be considered official, even if the quorum is not maintained. Participation is defined ~~as~~ attendance in person or participation by telephone.

** ~~(Behavioral Health~~ ~~P~~practitioner is defined as medical director, clinical director or participating practitioner from the organization.)*

Long-Long-Term Services and Supports -SubCcommittee (LTSS)

The LTSS ~~S~~subcommittee is composed of representatives from the ~~Long-Long~~-Term Care (LTC), ~~Community~~-Community-Based Adult Services (CBAS), ~~and~~ Multipurpose Senior Services Program (MSSP); ~~c~~-Communityies, which may include administrators, directors of nursing, facility Medical Directors, and pharmacy consultants, along with appropriate CalOptima staff. ~~Previously,~~ the CBAS Quality Advisory Subcommittee was integrated into the LTSS Quality Subcommittee. The LTSS subcommittee members serve as specialists to assist CalOptima in the development, implementation, and evaluation of establishing criteria and methodologies to measure and report quality standards with Home and Community Based Services (HCBS) and in LTC facilities where CalOptima members reside. ~~The~~ LTSS subcommittee also serves to identify “best practices” and partner with facilities to share the information as it is identified. ~~Theis~~ LTSS subcommittee meets quarterly and reports to the QIC.

Benefit Management Subcommittee (BMSC)

The purpose of the Benefit Management Subcommittee is to oversee, coordinate, and maintain a consistent benefit system as it relates to Cal-Optima’s responsibilities for administration of all its program lines of business benefits, prior authorization, and financial responsibility requirements for the administration of benefits. ~~The~~ subcommittee shall also- see to it that benefit updates are implemented, and communicated accordingly, to internal CalOptima staff, and that updates are provided to contracted HMOs, PHCs, SRGs, MBHO, and PMGs. ~~The~~ Government Affairs ~~D~~department ~~will~~ provides the technical support to the subcommittee, which includes, but is not limited to, analyzing regulations and guidance that impacts the benefit sets and Cal Optima’s authorization rules.

Behavioral Health Quality Improvement SubCCcommittee (BHQIC)

The Behavioral Health Quality Improvement ~~Subcommittee~~ Committee was established in 2011 ~~with the intended purpose of to~~ ensur~~ing~~ members receive timely and satisfactory behavioral health care services, enhancing continuity and coordination between physical health and behavioral health care providers, monitoring key areas of services to members and providers, identifying areas of improvement and guiding CalOptima towards the vision of bi-directional behavioral health care integration.

The BHQIC responsibilities are to:

- Ensure adequate provider availability and accessibility to effectively serve the membership
- Oversee the functions of delegated activities
- Monitor that care rendered is based on established clinical criteria, clinical practice guidelines, and complies with regulatory and accrediting agency standards
- Ensure that Member benefits and services are not underutilized and that assessment and appropriate interventions are taken to identify inappropriate over utilization
- Utilize Member and Network Provider satisfaction study results when implementing quality activities
- Maintain compliance with evolving National Committee for Quality Assurance (NCQA) accreditation standards
- Communicate results of clinical and service measures to Network Providers
- Document and report all monitoring activities to appropriate committees

~~The BHQI is responsible for monitoring key areas of service to members and providers through review of reports and presentations, identifying quality concerns, trends or systemic issues and opportunities for improvement, and communicating to QIC its findings and recommendations.~~

The designated Chairman of the BHQI subcommittee is the Medical Director, Behavioral Health, who is responsible for chairing the subcommittee as well as reporting findings and recommendations to QIC.

The composition of the BHQI Committee is defined in the BHQI Charter and includes, but may not be limited to the following:

- Medical Director, Behavioral Health Integration (Chair)
- Chief Medical Officer/Deputy Medical Officer
- Medical Director, Quality and Analytics
- Executive Director, ~~Medical Management~~ Clinical Operations
- Executive Director, Quality Analytics
- Medical Director, Utilization Management
- Director, Behavioral Health Integration

- Clinical Pharmacist
- Medical Director, Orange County Health Care Agency
- Medical Director, Medi-Cal MBHO
- Chief Clinical Officer, Medi-Medi MBHO
- Medical Director, Health Network
- Medical Director, Regional Center of Orange County
- Contracting Behavioral Health Care Practitioners

The BHQI shall meet, at a minimum, on a quarterly basis, or more often as needed.

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METHODOLOGY

QI Project Selections and Focus Areas

Performance and outcome improvement projects will be selected from the following areas:

- Areas for improvement identified through continuous HMO, PHC, SRG, PMG, and internal monitoring activities, including, but not limited to, (a) potential quality concern (PQI) review processes, (b) provider and facility reviews, (c) preventive care audits, (d) access to care studies, (e) satisfaction surveys, (f) HEDIS results, and (g) other subcommittee unfavorable outcomes
- Measures required by regulators such as DHCS and CMS

The QI Project methodology described below will be used to continuously review, evaluate, and improve the following aspects of clinical care: preventive services, perinatal care, primary care, specialty care, emergency services, inpatient services, ~~long~~ long-term care, and ancillary care services

- Access to and availability of services, including appointment availability, as described in the Utilization Management Program and in policy and procedure
- ~~Case Management~~
- Coordination and continuity of care for sSeniors and Persons with Disabilities
- Provisions of chronic, ~~and~~ complex care management and case management services
- Access to and provision of preventive services

Improvements in work processes, quality of care, and service are derived from all levels of the organization.

- Staff, administration, and physicians provide vital information necessary to support continuous performance is occurring at all levels of the organization
- Individuals and administrators initiate improvement projects within their area of authority, which support the strategic goals of the organization
- Other prioritization criteria include the expected impact on performance, (if the performance gap or potential of risk for non-performance is so great as to make it a priority), and items deemed to be high risk, high volume, or problem-prone processes
- Project coordination occurs through the various leadership structures: Board of Directors, Management, QI and UM Committees, etc., based upon the scope of work and impact of the effort
- These improvement efforts are often cross functional, and require dedicated resources to assist in data collection, analysis, and implementation. -Improvement activity outcomes are shared through communication that occurs within the previously identified groups

QI Project Quality Indicators

Each QI Project will have at least one (and frequently more) quality indicator(s).- While at least one quality indicator must be identified at the start of a project, more may be

identified after analysis of baseline measurement or re-measurement.- Quality indicators will measure changes in health status, functional status, member satisfaction, and provider/staff, HMO, PHC, SRG, MBHO, PMG, or system performance.- Quality indicators will be clearly defined and objectively measurable.- Standard indicators from HEDIS & STARS measures are acceptable.

Quality indicators may be either outcome measures or process measures where there is strong clinical evidence of the correlation between the process and member outcome. This evidence must be cited in the project description.

QI Project Measurement Methodology

Methods for identification of target populations will be clearly defined.-Data sources may include encounter data, authorization/claims data, or pharmacy data.-To prevent exclusion of specific member populations, data from the-Clinical Data Warehouse will be utilized. See explanation of Clinical Data Warehouse; below.*

For studies/measures that require data from sources other than administrative data (e.g., medical records), sample sizes will be a minimum of 411 (with 5 to 10% over sampling), so as to allow performance of statistically significant tests on any changes. Exceptions are studies for which the target population total is less than 411, and for certain HEDIS studies whose sample size is reduced from 411 based on Cal-Optima's previous year's score.- Measures that rely exclusively on administrative data utilize the entire target population as a denominator.

CalOptima also uses a variety of QI methodologies dependent on the type of opportunity for improvement identified.-The Plan/Do/Study/Act model is the overall framework for continuous process improvement.- This includes:

Plan 1) Identify opportunities for improvement

2) Define baseline

3) Describe root cause(s)

4) Develop an action plan

Do 5) Communicate change/plan

6) Implement change plan

Study 7) Review and evaluate result of change

8) Communicate progress

Act 9) Reflect and act on learning

10) Standardize process and celebrate success

CARE OF MEMBERS WITH COMPLEX NEEDS

CalOptima is committed to serving the needs of all members assigned, and places additional emphasis on the management and coordination of care of the most vulnerable populations and members with complex health needs. - Our goal is promotion of the delivery of effective, quality health care to members with special health care needs, including, but not limited to, physical and developmental disabilities, multiple chronic conditions, and complex behavioral health and social issues through:

- Standardized mechanisms for member identification through use of data
- Documented process to assess the needs of member population
- Multiple avenues for referral to case management and disease management programs
- Management of transitions of care across the continuum of health care from outpatient or ambulatory to inpatient or institutionalized care, and back to ambulatory
- Ability of member to ~~opt~~-opt-out
- Targeted promotion of the use of recommended preventive health care services for members with chronic conditions (e.g. diabetes, asthma) through health education and member incentive programs
- Use of evidenced based guidelines distributed to members and practitioners that are relevant to chronic conditions prevalent in the member population (e.g. COPD, asthma, diabetes, ADHD)
- Development of individualized care plans that include input from member, care giver, primary care provider, specialists, social worker, and providers involved in care management, as necessary
- Coordinating services for members for appropriate levels of care and resources
- Documenting all findings
- Monitoring, reassessing, and modifying the plan of care to ~~drive~~ appropriate quality, timeliness, and effectiveness of services
- Ongoing assessment of outcomes

-CalOptima's case management program includes three (3) care management levels that reflect the health risk status of members. -All members are stratified using a plan-developed stratification tool that utilizes information from data sources such as acute hospital/emergency department utilization, severe and chronic conditions, and pharmacy. The members are stratified into complex, care coordination, and basic care management levels.

The ~~Interdisciplinary~~Interdisciplinary Care Team (ICT) -for low risk members — is -basic — -and occurs at the PCP level. Moderate and high risk members are managed by an ICT at the Medical Group level for delegated groups or at the plan level in the instance of the Community Network.

The members of the ICT always includes the member (and care-givers or an authorized representative with member approval or appropriate authorization to act on behalf of a member) and PCP. -For members with more needs, other disciplines are included, but not limited to a Medical Director, Sspecialist(s), cCase mManagement tTeam, bBehavioral hHealth Sspecialist, Ppharmacist, Ssocial Wworker, Ddietician, and/or Llong--Term

Care Manager. The teams are designed to see that members' needs are identified and managed by an appropriately composed team.

The Interdisciplinary Care Teams process includes:

- Basic ICT for ~~Low-Low~~-Risk Members ~~—~~ Basic Team at PCP level
 - Team Composition: ~~M~~member, ~~c~~Caregiver, ~~or~~ ~~A~~uthorized ~~R~~epresentative, PCP, PCP support staff (~~N~~nurse, etc.), ~~and~~ ~~S~~pecialist(s)
 - Roles and responsibilities of this team:
 - Basic case management, including advanced care planning
 - Medication reconciliation
 - Identification of member at risk of planned and unplanned transitions
 - Referral and coordination with specialists
 - Development and implementation of an ICP
 - Communication with members or their representatives, vendors, and medical group
 - Review and update the ICP at least annually, and when there is a change in the members health status
 - Referral to the primary ICT, as needed
- Primary ICT for Moderate to ~~High-High~~-Risk Members ~~—~~ ICT at the Physician Medical Group (PMG) level or the Health Plan for Community Network
 - ICT Composition (appropriate to identified needs): ~~—~~ ~~M~~member, ~~c~~Caregiver, or ~~A~~uthorized ~~R~~epresentative, PMG Medical Director, PCP and/or ~~S~~pecialist, ~~A~~mbulatory ~~c~~ase ~~M~~anager (CM), ~~H~~ospitalist, ~~H~~ospital CM and/or ~~d~~Discharge ~~P~~lanners, PMG Utilization Management staff, ~~B~~ehavioral ~~H~~health ~~S~~pecialist, and ~~S~~ocial ~~W~~orker
 - Roles and responsibilities of this team:
 - Identification and management of planned transitions
 - Case management of high risk members
 - Coordination of ICPs for high risk members
 - Facilitating member, PCP and specialists, and vendor communication
 - Meets as frequent as is necessary to coordinate and care and stabilize member's medical condition
- Complex ICT for High-Risk Members ~~—~~ ~~OneCare Clinical Level~~ ICT at the Physician Medical Group (PMG) level or Health Plan for Community Network
 - Team Composition (As appropriate for identified needs): ~~M~~member, ~~c~~Caregiver, or ~~A~~uthorized ~~R~~epresentative, PMG Medical Director, CalOptima ~~c~~linical/PMG ~~c~~ase ~~M~~anager, PCP and/or ~~S~~pecialist, ~~S~~ocial ~~W~~orker, and ~~B~~ehavioral ~~H~~health ~~s~~Specialist
 - Roles and responsibilities of this team:
 - Consultative for the PCP and PMG teams

- -Encourages member engagement and participation in the IDT process
- Coordinating the management of members with complex transition needs and development of ICP
- Providing support for implementation of the ICP by the PMG
- Tracks and trends the activities of the IDTs
- Analyze data from different data sources in the plan to evaluate the management of transitions and the activities of the IDTs to identify areas for improvement
- Oversight of the activities of all transition activities at all levels of the delivery system
- Meets as often as needed until member's condition is stabilized-

Dual Eligibles Special Needs Plan (SNP)/OneCare and OneCare Connect

The goal of D-SNPs is to provide health care and services to those who can benefit the most from the special expertise of CalOptima providers and focused care management. Care management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet the comprehensive medical, behavioral health, and psychosocial needs of an individual and the individual's family, while promoting quality and cost-effective outcomes. The goal of care management is to help patients regain optimum health or improved functional capability, cost-effectively and in the right setting. It involves comprehensive assessment of the patient's condition, determining benefits and resources, and developing and implementing a care management plan that includes performance goals, monitoring and follow-up.

CalOptima's D-SNP care management program includes, but is not limited to:

- Complex case management program aimed at a subset of patients whose critical event or diagnosis requires extensive use of resources, and who need help navigating the system to facilitate appropriate delivery of care and services
- Transitional case management program focused on evaluating and coordinating transition needs for patients who may be at risk of rehospitalization
- High-risk and high-utilization program aimed at patients who frequently use emergency department (ED) services or have frequent hospitalizations, and at high-risk individuals (e.g., patients dually eligible for Medicare and Medicaid or patients who are institutionalized)
- Hospital case management program designed to coordinate care for patients during an inpatient admission and discharge planning
- Care management program focused on patient-specific activities and the coordination of services identified in members' care plans. Care Mmanagement performs these activities and coordinates services for members to optimize their health status and quality of life

Objectives

CalOptima's goals for 2016~~5~~ are:

- Continue with the comprehensive assessment strategy
- Measure and assess the quality of care CalOptima provides
- Evaluate how CalOptima addresses the special needs of our beneficiaries
- Drive interventions and actions when opportunities for improvement are identified

Please reference the 2016 Case Management Program Description for further details and program plans.

DISEASE MANAGEMENT PROGRAM

The Disease Management (DM) Program is a targeted program for the management, coordination, and interventions for a highly vulnerable patient population. CalOptima assumes responsibility for the Disease Management program for all of its lines of business, therefore the management for Disease Management is non-delegated to the PHCs, SRGs, and PMGs; ~~however, the~~ The contracted PHCs, SRGs, and PMGs must participate collaboratively with interventions necessary to produce compliant quality outcomes. The DM program is a comprehensive system of caring for members with chronic illnesses. A system-wide, multidisciplinary approach is utilized that entails the formation of a partnership between the patient, the healthcare practitioner, and CalOptima. The DM program coordinates care for members across time, locates and provides services and resources, and supports the members as they learn to care for themselves.

A detailed description of the Disease Management Program is contained in ~~the the Case Management/~~ Disease Management Program Description document. The DM Program is evaluated on an annual basis.

CLINICAL DATA WAREHOUSE

The Clinical Data Warehouse aggregates data from CalOptima's core business systems and processes, such as member eligibility, provider, encounters, claims, and pharmacy. The clinical data warehouse allows staff to apply evidence-based clinical practice guidelines to analyze data for quality purposes, such as disease management population identification, risk stratification, process measures and outcomes measures. CalOptima staff creates and maintains the data base with quarterly data updates.

Based upon evidence-based practice guidelines built into the system, the clinical data warehouse can assess the following:

- Identify and stratify members with certain disease states

- Identify over/under utilization of services
- Identify missing preventive care services
- Identify members for targeted interventions

Identification/Stratification of Members

Using clinical business rules, the database identifies members with a specific chronic disease condition, such as Asthma, Diabetes, or Congestive Heart Failure. It then categorizes the degree of certainty the member has the condition as being probable or definitive. Once the member has been identified with a specific disease condition, the database is designed to detect treatment failure, complications and co-morbidities, noncompliance, or exacerbation of illness to determine if the member requires medical care, and recommends an appropriate level of intervention.

Identify Over/Under Utilization of Services

Using clinical business rules, the database can identify if a member or provider is over or under utilizing medical services. In analyzing claims and pharmacy data, the data warehouse can identify if a member did not refill their prescription for maintenance medication, such as high blood pressure medicines. The database can also identify over utilization or poor management by providers. For example, the system can list all members who have exceeded the specified timeframe for using a certain medication, such as persistent use of antibiotics greater than 61 days.

Identify Missing Preventive Care Services

The data warehouse can identify members who are missing preventative care services, such as an annual exam, an influenza vaccination for members over 65, a mammogram for women for over 50 or a retinal eye exam for a diabetic.

Identify Members for Targeted Interventions

The rules for identifying members and initiating the intervention are customizable to CalOptima to fit our unique needs. By using the standard clinical rules and customizing CalOptima specific rules, the database is the primary conduit for targeting and prioritizing health education, disease management and HEDIS-related interventions.

By analyzing data that CalOptima currently receives (i.e. claims data, pharmacy data, and encounter data) the data warehouse can identify the members for quality improvement and access to care interventions, which will allow us to improve our HEDIS measures. This information will guide CalOptima in not only targeting the members, but also the HMOs, PHCs, SRGs, MBHO, PMGs, and providers who need additional assistance.

Medical Record Review

Wherever possible, administrative data is utilized to obtain measurement for some or all project quality indicators. Medical record review may be utilized as appropriate to augment administrative data findings. In cases where medical record abstraction is used, appropriately trained and qualified individuals are utilized. Training for each data element (quality indicator) is accompanied by clear guidelines for interpretation.

Validation will be done through a minimum 10% sampling of abstracted data for rate to standard reliability, and will be conducted by the Director, Quality Analytics or designee. If validation is not achieved on all records samples, a further 25% sample will be reviewed. If validation is not achieved, all records completed by the individual will be re-abstracted by another staff member.

Where medical record review is utilized, the abstractor will obtain copies of the relevant section of the record. Medical record copies, as well as completed data abstraction tools, are maintained for a minimum period, in accordance with applicable law and contractual requirements.

Interventions

For each QI Project, specific interventions to achieve stated goals and objectives are developed and implemented. Interventions for each project must:

- Be clearly defined and outlined
- Have specific objectives and timelines
- Specify responsible departments and individuals
- Be evaluated for effectiveness
- Be tracked by QIC

For each project, there are specific system interventions that have a reasonable expectation of effecting long-term or permanent performance improvement. System interventions include education efforts, policy changes, development of practice guidelines (with appropriate dissemination and monitoring) and other plan-wide initiatives. In addition, provider and member specific interventions, such as reminder notices and informational communication, are developed and implemented.

Improvement Standards

A. Demonstrated Improvement

Each project is expected to demonstrate improvement over baseline measurement on the specific quality indicators selected. In subsequent measurements, evidence of significant improvement over the initial performance to the indicator(s) must be sustained over time.

B. Sustained Improvement

Sustained improvement is documented through the continued re-measurement of quality indicators for at least one year after the improved performance has been achieved.

Once the requirement has been met for both significant and sustained improvement on any given project; there is no other regulatory reporting requirement related to that project. CalOptima may internally choose to continue the project or to go on to another topic.

Documentation of QI Projects

Documentation of all aspects of each QI Project is required. Documentation includes (but is not necessarily limited to):

- Project description, including relevance, literature review (as appropriate), source and overall project goal.
- Description of target population
- Description of data sources and evaluation of their accuracy and completeness
- Description of sampling methodology and methods for obtaining data
- List of data elements (quality indicators). Where data elements are process indicators, there must be documentation that the process indication is a valid proxy for the desired clinical outcome
- Baseline data collection and analysis timelines
- Data abstraction tools and guidelines
- Documentation of training for chart abstraction
- Rater to standard validation review results
- Measurable objectives for each quality indicator
- Description of all interventions including timelines and responsibility
- Description of benchmarks
- Re-measurement sampling, data sources, data collection, and analysis timelines

— Evaluation of re-measurement performance on each quality indicator~~The Clinical Data Warehouse aggregates data from Cal Optima's core business systems and processes, such as member eligibility, provider, encounters, claims, and pharmacy. The clinical data warehouse allows staff to apply evidence-based clinical practice guidelines to analyze data for quality purposes, such as disease management population identification, risk stratification, process measures, and outcomes measures. CalOptima staff creates and maintains the data base with quarterly data updates.~~

— ~~Based upon evidence-based practice guidelines built into the system, the clinical data warehouse can assess the following:~~

- ~~Identify and stratify members with certain disease states~~
- ~~Identify over/under utilization of services~~
- ~~Identify missing preventive care services~~
- ~~Identify members for targeted interventions~~

— **Identification/Stratification of Members**

— ~~Using clinical business rules, the database can identify members with a specific chronic disease condition, such as Asthma, Diabetes, or Congestive Heart Failure. It then categorizes the degree of certainty the member has the condition as being probable or definitive. Once the member has been identified with a specific disease condition, the database is designed to detect treatment failure, complications and co-morbidities, noncompliance, or exacerbation of illness to determine if the member requires medical care, and recommends an appropriate level of intervention.~~

— **Identify Over/Under Utilization of Services**

- Using clinical business rules, the database can identify if a member or provider is over or under utilizing medical services. In analyzing claims and pharmacy data, the data warehouse can identify if a member did not refill their prescription for maintenance medication, such as high blood pressure medicines. The database can also identify over utilization or poor management by providers. For example, the system can list all members who have exceeded the specified timeframe for using a certain medication, such as persistent use of antibiotics greater than 61 days.

— **Identify Missing Preventive Care Services**

- The data warehouse can identify members who are missing preventative care services, such as an annual exam, an influenza vaccination for members over 65, a mammogram for women for over 50, or a retinal eye exam for a diabetic.

— **Identify Members for Targeted Interventions**

- The rules for identifying members and initiating the intervention are customizable to CalOptima to fit our unique needs. By using the standard clinical rules and customizing CalOptima specific rules, the database will be the primary conduit for targeting and prioritizing health education, disease management, and HEDIS-related interventions.

- By analyzing data that CalOptima currently receives (i.e. claims data, pharmacy data, and encounter data), the data warehouse will can identify the members for quality improvement and access to care interventions, which will allow us to improve our HEDIS measures. This information will guide CalOptima in not only targeting the members, but also the HMOs, PHCs, SRGs, MBHO, PMGs, and providers who need additional assistance.

— **Medical Record Review**

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—

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- ~~List of data elements (quality indicators). Where data elements are process indicators, there must be documentation that the process indication is a valid proxy for the desired clinical outcome~~
- ~~Baseline data collection and analysis timelines~~
- ~~Data abstraction tools and guidelines~~
- ~~Documentation of training for chart abstraction~~
- ~~Rater to standard validation review results~~
- ~~Measurable objectives for each quality indicator~~
- ~~Description of all interventions including timelines and responsibility~~
- ~~Description of benchmarks~~
- ~~Re-measurement sampling, data sources, data collection, and analysis timelines~~
- ~~Evaluation of re-measurement performance on each quality indicator~~
-

KEY BUSINESS PROCESSES, FUNCTIONS, IMPORTANT ASPECTS OF CARE AND SERVICE

CalOptima provides comprehensive acute and preventive care services, which are ~~are~~ based on the philosophy of a medical “home” for each member. -The primary care practitioner is this medical “home” for members who previously found it difficult to access services within their community. -The Institute of Medicine describes the concepts of primary care and community oriented primary care, which apply to the CalOptima model:

- Primary Care, by definition, is accessible, comprehensive, coordinated, and continual care delivered by accountable providers of personal health services.
- Community Oriented Primary Care is the provision of primary care to a defined community, coupled with systematic efforts to identify and address the major health problems of that community.

The important aspects of care and service around which key business processes are designed include:

Clinical Care and Service:

- Access and Aavailability
- Continuity and Coordination of Care
- Preventive care, including:
 - Initial Health ~~Risk~~ Assessment
 - Initial Health Education
 - Behavioral Assessment
- Patient Dagnosis, Care, and Treatment of acute and chronic conditions

- Complex Case Management: CalOptima coordinates services for members with multiple and/or complex conditions to obtain access to care and services via the Utilization and Case Management Department, which details this process in its UM/CM Program and other related policies and procedures.
- Drug Utilization
- Health Education and Promotion
- Over/Under Utilization
- Disease Management

Administrative Oversight:

- Delegation Oversight
- Member Rights and Responsibilities
- Organizational Ethics
- Effective Utilization of Resources
- Management of Information
- Financial Management
- Management of Human Resources
- Regulatory and Contract Compliance
- Customer Satisfaction
- Fraud and Abuse* as it relates to quality of care

* CalOptima has adopted a zero tolerance policy for fraud and abuse, as required by applicable laws and its regulatory contracts. The detection of fraud and abuse is a key function of the CalOptima Program.

DELEGATED AND NON-DELEGATED ACTIVITIES

CalOptima delegates certain functions and/or processes to HMO, PHC, SRG, MBHO, and PMG Contractors who are required to meet all contractual, statutory, and regulatory requirements, accreditation standards, CalOptima policies, and other guidelines applicable to the delegated functions.

Delegation Oversight

Participating entities are required to meet Cal-Optima's QI standards and to participate in Cal-Optima's QI Program.

CalOptima has a comprehensive interdisciplinary team that is assembled for evaluating any new potential delegate for ability to perform its contractual scope of responsibilities. ~~Delegation oversight~~ Predelegation review is conducted through the Audit and Oversight Department and overseen by the Delegation Oversight Committee reporting to the Compliance Committee. -(See Attachment B for the 2016 Delegation Grid.)

Non-Delegated Activities

The following activities are not delegated, and remain the responsibility of CalOptima:

- Quality Improvement, as delineated in the Contract for Health Care Services
- QI Program for all lines of business, HMOs, PHCs, SRGs, MBHO, and PMGs must comply with all quality related operational, regulatory, and accreditation standards
- Disease Management Program, may otherwise be referred to as Chronic Care Improvement Program
- Health Education (as applicable)
- Grievance and Appeals process for all lines of business, peer review process on specific, referred cases
- Development of system-wide indicators, thresholds and standards
- Satisfaction ~~S~~urveys of members, practitioners and providers
- Survey for Annual Access and Availability
- Access and availability oversight and monitoring
- Second level review of provider grievances
- Development of credentialing and re-credentialing standards for both practitioners and healthcare delivery organizations (HDOs)
- Credentialing and re-credentialing of ~~Healthcare Delivery Organizations (HDOs)~~
- Development of Utilization Management and Case Management standards
- Development of QI standards
- Management of Perinatal Support Services (PSS)
- Risk management
- Pharmacy and drug utilization review as it relates to quality of care
- Interfacing with ~~State~~State and ~~Federal~~Federal agencies, medical boards, insurance companies, and other managed care entities and health care organizations

PEER REVIEW PROCESS

Peer Review is coordinated through the QI Department. Medical staff triage potential quality of care issues and conduct reviews of suspected physician and ancillary quality of care issues. All closed cases ~~will be~~are presented to CPRC to ~~assess if~~ documentation is complete, and no further action is required. - The QI ~~D~~department also ~~tracks~~, monitors, and trends, service and access issues to determine if there is an opportunity to improve care and service. -Results of Quality of Care reviews and tracking and trending of service and access issues are reported to the CPRC at time of re-credentialing. -Quality of care case referral to the QI ~~d~~Department ~~is~~are based on referrals to the QI ~~d~~Department originated from multiple areas, which include, but are not limited to, the following: ~~P~~prior ~~A~~authorization, ~~C~~oncurrent ~~R~~review, ~~C~~ase ~~M~~management, ~~L~~egal, ~~C~~ompliance, ~~C~~ustomer ~~s~~Service, ~~P~~pharmacy, or ~~G~~rievances and ~~a~~Appeals ~~R~~resolution.

~~SENTINEL EVENT MONITORING~~

~~AS PART OF THE CALOPTIMA PATIENT SAFETY PROGRAM, AND UTILIZING THE FULL RANGE OF METHODS AND TOOLS OF THAT PROGRAM, CALOPTIMA CONDUCTS SENTINEL EVENT MONITORING. A SENTINEL EVENT IS DEFINED AS “AN UNEXPECTED OCCURRENCE INVOLVING DEATH OR SERIOUS PHYSICAL OR PSYCHOLOGICAL INJURY, OR THE RISK THEREOF.” THE PHRASE “OR RISK THEREOF” INCLUDES ANY PROCESS VARIATION FOR WHICH A RECURRENCE WOULD CARRY A SIGNIFICANT CHANCE OF A SERIOUS ADVERSE OUTCOME.~~

~~SENTINEL EVENT MONITORING INCLUDES PATIENT SAFETY MONITORING ACROSS THE ENTIRE CONTINUUM OF CAL OPTIMA’S CONTRACTED PROVIDERS: HMOs, PHCs, SRGs, MBHO, PMGs, AND HEALTH CARE DELIVERY ORGANIZATIONS. THE PRESENCE OF A SENTINEL EVENT IS AN INDICATION OF POSSIBLE QUALITY ISSUES, AND THE MONITORING OF SUCH EVENTS WILL INCREASE THE LIKELIHOOD OF EARLY DETECTION OF DEVELOPING QUALITY ISSUES SO THAT THEY CAN BE ADDRESSED AS EARLY AS POSSIBLE. SENTINEL EVENT MONITORING SERVES AS AN INDEPENDENT SOURCE OF INFORMATION ON POSSIBLE QUALITY PROBLEMS, SUPPLEMENTING THE EXISTING PATIENT SAFETY PROGRAM’S CONSUMER COMPLAINT-ORIENTED SYSTEM.~~

~~ALL MEDICALLY RELATED CASES ARE REVIEWED BY THE CPRC TO DETERMINE THE APPROPRIATE COURSE OF ACTION~~

~~AND/OR EVALUATE THE ACTIONS RECOMMENDED BY AN HMO, PHC, SRG, MBHO, OR PMG DELEGATE. BOARD CERTIFIED PEER MATCHED SPECIALISTS ARE AVAILABLE TO REVIEW COMPLEX CASES AS NEEDED. RESULTS OF PEER REVIEW ARE USED AT THE REAPPOINTMENT CYCLE, OR UPON NEED, TO REVIEW THE RESULTS OF PEER REVIEW AND DETERMINE THE COMPETENCY OF THE PROVIDER. THIS IS ACCOMPLISHED THROUGH ROUTINE REPORTING OF PEER REVIEW ACTIVITY TO HMOs, PHCs, SRGs, MBHO, AND PMGs FOR INCORPORATION IN THEIR RE-CREDENTIALING PROCESS.~~

CULTURAL AND & DISEASE MANAGEMENT PROGRAM **LINGUISTICS SERVICES LINGUISTIC SERVICES**

CalOptima serves a large and culturally diverse population. The five most common languages spoken ~~in the~~for all CalOptima ~~Medi-Cal population~~programs are: English ~~at (46.57 percent%)~~, Spanish ~~at (37.28%)~~ percent, Vietnamese ~~at (14.0 %)~~percent, Farsi ~~at (1%)~~,one percent, ~~and~~ Korean ~~at one percent~~, Chinese ~~at one percent~~, Arabic ~~at one percent (1%)~~and all others ~~at three percent, combined~~. -CalOptima provides member materials in:

- ~~Medi-Cal member materials are provided in seven languages: English, Spanish, Vietnamese, Korean, and Farsi, Chinese and Arabic~~
- ~~OneCare member materials are provided in three languages: English, Spanish and Vietnamese~~
- ~~OneCare Connect member materials are provided in five languages: English, Spanish, Vietnamese, Korean and Farsi.~~
- ~~PACE participant materials are provided in four languages: English, Spanish, Vietnamese and Korean.~~

:

CalOptima is committed to Member Centric care that recognizes the beliefs, traditions, customs and individual differences of the diverse population we serve.- Beginning with identification of needs through a Group Needs Assessment, programs are developed to address the specific education, treatment and cultural norms of the population impacting the overall wellness of the community we serve. -Identified needs and planned interventions involve member input and are vetted through the Member and Provider Advisory Committees prior to full implementation. -See CalOptima Policy DD. 2002 – Cultural and Linguistic Services for a detailed description of the program.

Objectives for serving a culturally and linguistically diverse membership include:

- Analyze significant health care disparities in clinical areas
- Use practitioner and provider medical record reviews to understand the differences in care provided and outcomes achieved
- Consider outcomes of member grievances and complaints
- Conduct patient-focused interventions with culturally competent outreach materials that focus on race/ethnicity/language specific risks
- Identify and reduce a specific health care disparity with culture and race
- Provide information, training and tools to staff and practitioners to support culturally competent communication

- ~~Objectives for serving a culturally and linguistically diverse membership include:~~

~~Analyze significant health care disparities in clinical areas~~

~~Use practitioner and provider medical record reviews to understand the differences in care provided and outcomes achieved~~

~~Consider outcomes of member grievances and complaints~~

~~Conduct patient focused interventions with culturally competent outreach materials that focus on race/ethnicity/language specific risks~~

~~Identify and reduce a specific health care disparity with culture and race~~

- ~~• Provide information, training and tools to staff and practitioners to support culturally competent communication~~

COMPREHENSIVE CREDENTIALING PROGRAM STANDARDS

The comprehensive credentialing process is designed to provide on-going verification of the practitioner's ability to render specific patient care and treatment within limits defined by licensure, education, experience, health status, and judgment, thus ensuring the competency of practitioners working within the CalOptima contracted delivery system.

Practitioners are credentialed and re-credentialed according to regulatory and accreditation standards (DHCS, DMHC, CMS, and NCQA). The scope of the credentialing program includes all licensed M.D.s, D.O.s, allied health and midlevel practitioners, which include, but are not limited to: behavioral health practitioners, Certified Nurse Midwives, Nurse Practitioners, Optometrist, etc., both in the delegated and CalOptima Direct environments.

Health Care Delivery Organizations:

CalOptima performs credentialing and re-credentialing of ancillary providers and HDOs (these include, but are not limited to, acute care hospitals, home health agencies, skilled nursing facilities, free standing surgery centers, dialysis centers, etc.) upon initial contracting, and every three years thereafter. The intent of this process is to assess that these entities meet standards for quality of care and are in good standing with State and Federal regulatory agencies.

Use of Quality Improvement Activities in the Re-credentialing Process

÷ Findings from quality improvement activities are included in the re-credentialing process.

Monitoring for Sanctions and Complaints:

CalOptima has adopted policies and procedures for ongoing monitoring of sanctions, which include, but are not limited to, ~~state~~State or ~~federal~~Federal sanctions, restrictions on licensure, or limitations on scope of practice, Medicare and Medicaid sanctions, potential quality concerns, and member complaints between re-credentialing periods.

FACILITY SITE REVIEW, MEDICAL RECORD AND PHYSICAL ACCESSIBILITY REVIEW SURVEY

CalOptima does not delegate Primary Care Practitioner (PCP) site and medical records review to its contracted HMOs, PHCs, SRGs, MBHO, and PMGs. CalOptima does, however, delegate this function to designated health plans in accordance with standards set forth by MMCD Policy Letter 02-02. -CalOptima assumes responsibility and conducts and coordinates FSR/MRR for the non-delegated SRGs and PMGs. -CalOptima retains coordination, maintenance, and oversight of the FSR/MRR process. -CalOptima collaborates with the SRGs and PMGs to coordinate the FSR/MRR process, minimize the duplication of site reviews, and support consistency in PCP site reviews for shared PCPs.

Site reviews are completed as part of the initial credentialing process, except in those cases where the requirement is waived because the provider received a passing score on another full scope site review performed by another health plan in the last three years, in accordance with MMCD Policy Letter 02-02 and CalOptima policies. Medical records of new providers shall be reviewed within ninety ~~(90)~~ calendar days of the date on which members are first assigned to the provider. -An additional extension of ninety ~~(90)~~ calendar days may be allowed only if the provider does not have sufficient assigned members to complete review of the required number of medical records.

Physical Accessibility Review Survey for Seniors and Persons with Disabilities (SPD)

CalOptima conducts an additional DHCS-required facility audit for American with Disabilities Act compliance for ~~s~~Seniors and ~~P~~persons with ~~D~~disabilities (SPD) members, which includes access evaluation criteria to determine compliance with ADA requirements.

- Parking
- Exterior ramps
- Exterior stairways
- Entrances
- Interior circulation
- Interior doors
- Interior ramps
- Interior stairways

- Elevators
- Controls
- Sanitary facilities
- Reception and waiting areas
- Diagnostic and treatment areas

Medical Record Documentation Standards

CalOptima requires that its contracted HMOs, PHCs, SRGs, MBHO, and PMGs make certain that each member medical record is maintained in a accurate and timely manner that is current, detailed, organized, and easily accessible to treating practitioners. -All patient data should be filed in the medical record in a timely manner (i.e., lab, x-ray, consultation notes, etc).- The medical record should also promote timely access by members to information that pertains to them.

The medical record should provide appropriate documentation of the member's medical care, in such a way that it facilitates communication, coordination, and continuity of care, and promotes efficiency and effectiveness of treatment. All medical records should, at a minimum, include all information required by Sstate and federal laws and regulations, and the requirements of Cal Optima's contracts with CMS, DHCS, and MRMIB.

The medical record should be protected in that medical information is released only in accordance with applicable Federal and/or Sstate law.

CORRECTIVE ACTION PLAN(S) TO IMPROVE CARE/ SERVICE

When monitoring by either CalOptima Quality Improvement Department or Audit & Oversight Department identifies an opportunity for improvement, the delegated or functional areas will determine the appropriate action(s) to be taken to correct the problem. -Those activities specific to delegated entities will be conducted at the direction of the Audit and Oversight Department as overseen by the Delegation Oversight Committee, reporting to the Compliance Committee. Those activities specific to CalOptima's functional areas will be overseen by the Quality Improvement Department as overseen by and reported to QIC. -Actions for either delegates or functional areas may include the following:

- Development of cross-departmental teams utilizing continuous improvement tools to identify root causes, develop and implement solutions, and develop quality control mechanisms to maintain improvements.
- Discussion of the data/problem with the involved practitioner, either in the respective committee or by a Medical Director.
- Further observation of performance via the appropriate clinical monitor. (This process shall determine if follow up action has resolved the original problem.)

- Discussion of the results of clinical monitoring. -(The committee/functional area may refer an unresolved matter to the appropriate committee/functional area for evaluation and, if necessary, action.)
- Intensified evaluation when a trigger for evaluation is attained, or when further study needs to be designed to gather more specific data, i.e. when the current data is insufficient to fully define the problem.
- Changes in policies and procedures: tThe monitoring and evaluation results may indicate a problem, which can be corrected by changing policy or procedure.
- Prescribed continuing education
- Intensive monitoring and oversight
- De-delegation
- Contract termination

Performance Improvement Evaluation Criteria for Effectiveness

The effectiveness of actions taken and documentation of improvements made are reviewed through the monitoring and evaluation process. - Additional analysis and action will be required when the desired [statestate](#) of performance is not achieved. - Analysis will include use of the statistical control process, use of comparative data, and benchmarking when appropriate.

COMMUNICATION OF QUALITY IMPROVEMENT ACTIVITIES

Results of performance improvement activities will be communicated to the appropriate department, multidisciplinary committee; or administrative team as determined by the nature of the issue. - The frequency will be determined by the receiving groups, and be reflected on the work plan or calendar. - The QI Subcommittees will report their summarized information to the QIC quarterly in order to facilitate communication along the continuum of care. - The QIC reports activities to the Board of Directors, and/or the QAC, through the CMO or designee, on a quarterly basis. QIC participants are responsible for communicating pertinent, non-confidential QI issues to all members of CalOptima staff. Communication of QI trends to Cal-Optima's contracted entities and practitioners and providers is through the following:

- Practitioner participation in the QIC and its subcommittees
- Health Network Forums, Medical Director meeting, and other ongoing ad-hoc meetings
- Annual synopsisd QI report (both web-site and hardcopy availability for both practitioners and members) shall be posted on Cal-Optima's website, in addition to the annual article in both practitioner and member newsletter. - The information includes a QI Program Executive Summary or outline of highlights

applicable to the Quality Program, its goals, processes and outcomes as they relate to member care and service. -Notification on how to obtain a paper copy of QI Program information is posted on the web, and is made available upon request

- Annual PCP pamphlet

ANNUAL PROGRAM EVALUATION

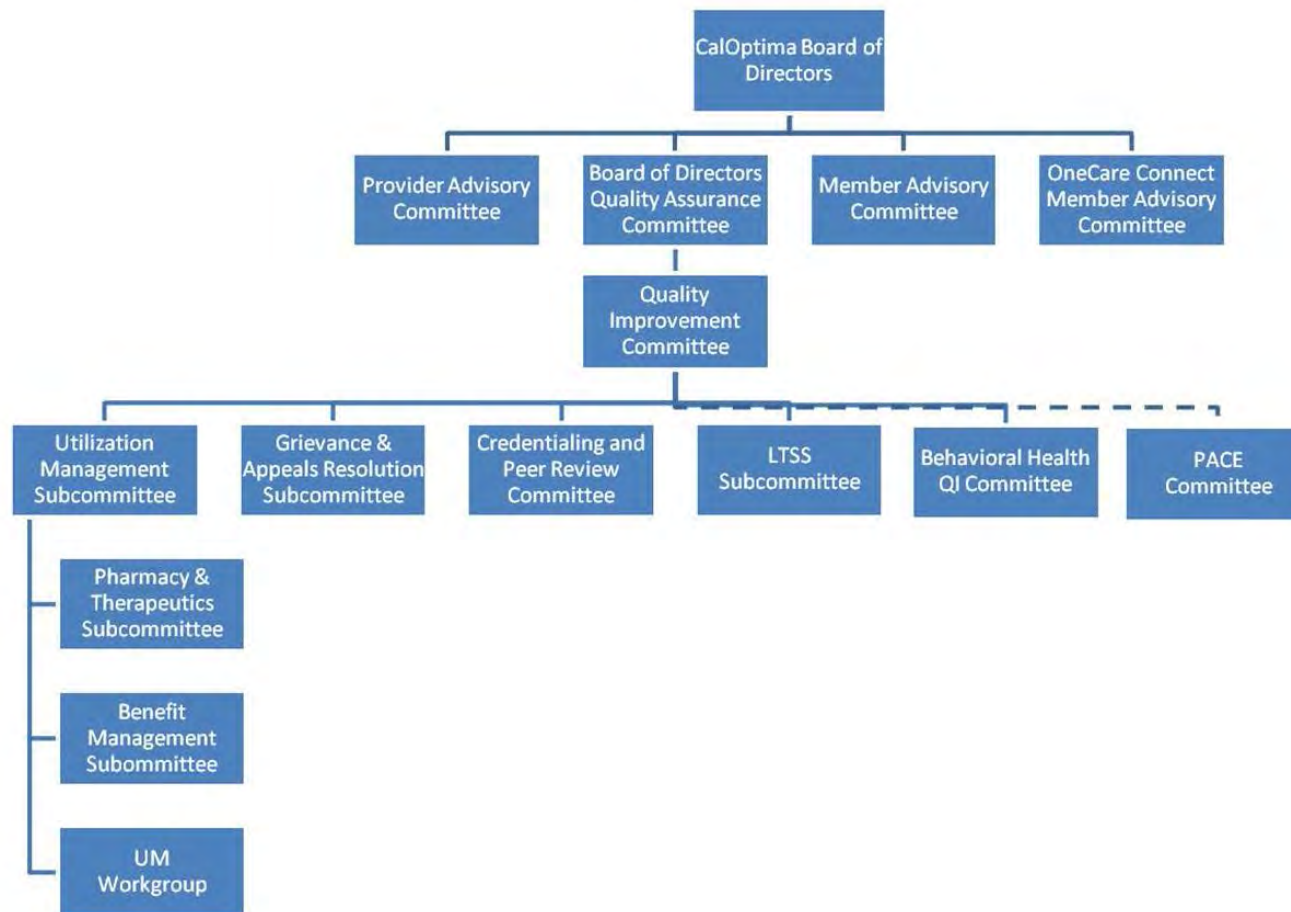
The objectives, scope, organization and effectiveness of Cal-Optima's QI Program are reviewed and evaluated annually by the QIC, QAC, and approved by the Board of Directors, as reflected on the QI Work Plan. -Results of the written annual evaluation are used as the basis for formulating the next year's-year's initiatives and incorporated into the QI Work Plan and reported to DHCS & CMS on an annual basis. -In the evaluation, the following are reviewed:

- A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of services, including the achievement or progress towards goals, as outlined in the QI Work Plan, and identification of opportunities for improvement
- Trending of measures to assess performance in the quality and safety of clinical care and quality of service, including aggregate data on utilization,
- An assessment of the accomplishments from the previous year, as well as identification of the barriers encountered in implementing the annual plan through root cause and barrier analyses, to prepare for new interventions
- An evaluation of each QI Activity, including Quality Improvement Projects (QIPs), with any area showing improvements in care or service as a result of QI activities receiving continued interventions to sustain improvement
- An evaluation of member satisfaction surveys and initiatives
- A report to the QIC and QAC of a summary of all quality indicators and identification of significant trends
- A critical review of the organizational resources involved in the QI Program through the CalOptima strategic planning process
- The recommended changes, included in the revised QI Program Description for the subsequent year, for QIC, QAC, and the Board of Directors for review and approval

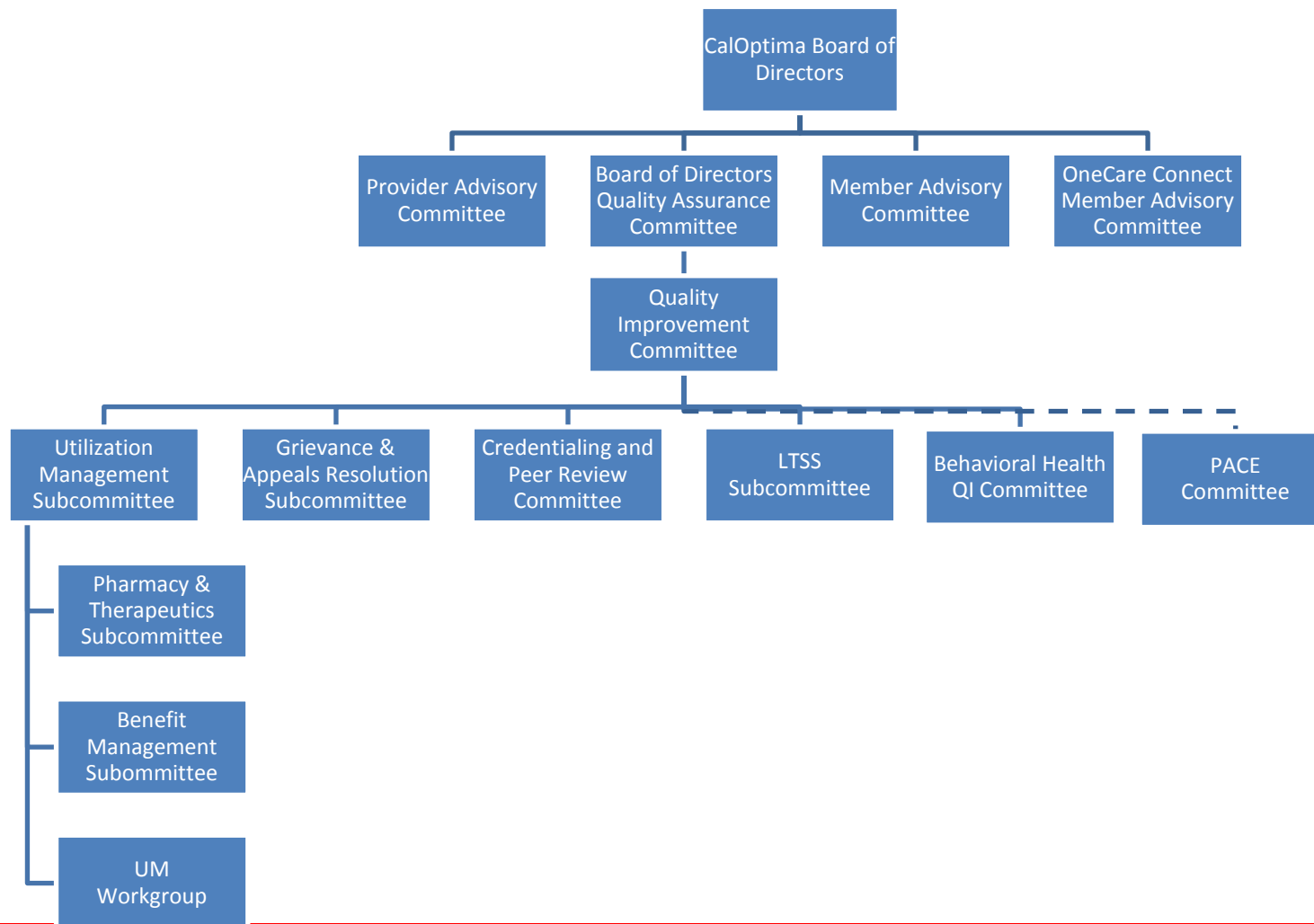
IN SUMMARY

As stated earlier, we cannot achieve our mission and our vision alone. We must work together with providers, community health centers, county agencies, State and Federal agencies and other community stakeholders to provide quality health care to our members. Together, we can be innovative in developing solutions that meet our diverse members' health care needs. We are truly "Better. Together."

QUALITY IMPROVEMENT COMMITTEE STRUCTURE – 2016



~~QUALITY IMPROVEMENT COMMITTEE STRUCTURE - 2015~~



**CalOptima
2016 Quality Improvement ~~Workplan~~ Work Plan
OneCare Connect/OneCare and Medi-Cal
February, 2016**

I. Program Oversight

- A. Program scope- QI Annual oversight of programs and work plans
- B. Program Scope- 2015 QI Program Annual Evaluation
- C. Program Scope- UM Program and UM Work Plan annual oversight
- D. Program Scope- 2015 UM Program Annual Evaluation
- E. Quality of Care- Case Management Program annual oversight
- F. Quality of care- 2015 Case Management Program Evaluation
- G. Quality of Care- Disease Management Program annual oversight
- H. Quality of Care- 2015 Disease Management Program Evaluation
- I. Quality of Care- Credentialing Peer Review Committee (CPRC) Oversight
- J. NCQA Monitoring & Compliance

INITIAL ~~WORKPLAN~~ WORK PLAN AND APPROVAL:

Submitted and approved by QIC Date:
Submitted and approved by Board Date:

Submitted and approved by Board of Director's Date:
Quality Assurance Committee (QAC)

Quality Improvement Committee Chairperson:

II. Case Management

- A. Quality of Clinical Care- Review of health risk assessments to OCC, OC, SPD members
- B. Quality of Clinical Care- Continuity & Coordination of Medical/BH
- C. Quality of Clinical Care- Review of emergency department communications with PCPs
- D. Patient Safety, Quality of Care Case Management- High ER utilization
- E. Quality of Clinical Care-Review of member satisfaction with CM programs

Medical Director Date:

Board of Directors' Quality Assurance Committee Chairperson:

III. Behavioral Health

- A. Quality of Clinical Care: Integration of BH services
- B. Quality of Care- Clinical BH Practice Guidelines adoption for Medi-Cal line of business
- C. Quality of Service and Quality of Clinical Care- Review of behavioral health providers communications with PCPs

Viet Van Dang, MD Date:

IV. LTSS

- A. Safety of Clinical Care and Quality of Clinical Care- Review and assess LTSS placement for members participating with each organization/program
- B. Safety of Clinical Care and Quality of Clinical Care- Review and assess emergency department visits for LTSS members participating with each organization/program
- C. Safety of Clinical Care and Quality of Clinical Care- Review and assess readmissions for LTSS members participating with each organization/program
- D. Quality of Clinical Care- Review of health risk assessment (HRA) for OneCare Connect (OCC) Long Term Care (LTC) members
- E. CBAS Member Satisfaction
- F. SNF Member Satisfaction

- V. Health Education & Disease Management**
 - A. Quality of Care- All new members will complete the Initial Health Assessment and related IHEBA/SHAs
 - B. Quality of Clinical Care, review of Disease Management Program (Asthma)
 - C. Quality of Clinical Care, review of Disease Management Program (Diabetes)
 - D. Quality of Clinical Care, review of Disease Management Program (CHF)
 - E. Quality of Care- Clinical Practice Guidelines adoption for Medi-Cal line of business
 - F. Quality of Clinical Care, review of member satisfaction with DM programs
 - G. Quality of Clinical Care- Review of cardiovascular Disease
 - H. Quality of clinical Care- Review of Diabetes and All Cause Readmissions
 - I. Implementation of the Childhood Obesity (Shape Your Life) Program
 - J. Implement Weight Watchers (WW) for Medi-Cal Members
 - K. Implement Home Assessments for member participating in Care Management Programs
 - L. Conduct 2016 Group Needs Assessment (GNA)
- VI. Access & Availability**
 - A. Quality of Service and Quality of Clinical Care- Review of notification to members
 - B. Access to Care- Credentialing of provider network is monitored
 - C. Access to Care- Recredentialing of provider network is monitored
 - D. Accessibility: Review of access to care
 - E. Availability: Review of availability of practitioners
- VII. Patient Safety**
 - A. Safety of Clinical Care- Providers shall have timely and complete facility site reviews
 - B. Safety of Clinical Care- Review and follow-up on member's potential Quality of Care Complaints
 - C. Safety of Clinical Care and Quality of Clinical Care- reviewed through Pharmacy Management
 - D. Safety of Clinical care and Quality of Clinical Care- review of Specialty Drug Utilization
 - E. Patient Safety- Review and assessment of CBAS Quality Monitoring
 - F. Patient Safety- Review and assessment of SNF Quality Monitoring
 - G. Safety of Clinical Care- Review of antibiotic usage
 - H. Implementation of the new PBM
- VIII. Member Experience**
 - A. Quality of Service- Review of Member Satisfaction
 - B. Quality of Service- Reviewed through customer service first call resolution
 - C. Quality of Service- Reviewed through customer service access
 - D. Quality of Care & Service reviewed through GARS & PQI (MOC)
- IX. HEDIS/STARS Improvement**
 - A. Improve identified HEDIS Measures listed on “Measures” worksheet
 - B. Improve identified STARS measures listed on “Measure” worksheet
 - C. Improve CAHPS measures listed on “Measures” worksheet
 - D. HEDIS: Launch pediatric wellness clinic
 - E. STARS improvement- Medication Adherence Measures

F. HEDIS: Health Network support of HEDIS & CAHPS Improvement

X. Delegation Oversight

- A. Delegation Oversight of CM**
- B. Quality of Care & service of UM through delegation oversight reviews**
- C. Delegation Oversight of BH Services**

XI. Organizational Projects

- A. Implementation of the 2016 Value Based P4P program**
- B. Value Based P4P 2016-2019**

***Previously identified issues to be monitored**

Preface

I. Program Oversight

A. Program Scope- QI Annual oversight of programs and work plans

Owner: Medical Director, Quality & Analytics

1. Activity

- QI Program and QI Work Plan will be adopted on an annual basis
- QI Program Description- QIC-BOD
- QI Work Plan- QIC-QAC

Approved by QIC: _____

Approved by QAC: _____

_____ Approved by Board: _____

2. Goals

- Annual Adoption

B. Program Scope- 2015 QI Program Annual Evaluation

Owner: Medical Director, Quality & Analytics

1. Activity

- QI Program and QI Work Plan will be evaluated for effectiveness on an annual basis

2. Goals

- Annual Evaluation

Approved by QIC: _____

Approved by QAC: _____

• _____ Approved by Board: _____

Approved by QIC: _____

Approved by QAC: _____

Approved by Board: _____

• _____ Annual Evaluation

C. Program Scope- UM Program and UM Work Plan annual oversight

Owner: Terrie Stanley, ED Clinical Operations

1. Activity

- UM Program and UM Work Plan will be adopted on an annual basis
- Delegate UM annual oversight reports-from DOC

Approved by UMC: _____

Approved by QIC: _____

Approved by QAC: _____

Approved by Board: _____

2. Goals

- Annual Adoption

2. _____ Goals

D. Program Scope- 2015 UM Program Annual Evaluation

Owner: Terrie Stanley, ED Clinical Operations

1. Activity

- UM Program and UM Work Plan will be evaluated for effectiveness on an annual basis
- Delegate oversight from DOC

____ Approved by QIC: _____
Approved by QAC: _____
Approved by Board: _____

2. Goals

- Annual Evaluation

E. Quality of Care- 2015 Case Management Program Annual Oversight

Owner: Tracy Hitzeman, Director, CM

1. Activity

- CM Program will be adopted on an annual basis
- Delegation oversight reported by DOC

Approved by QIC: _____
Approved by QAC: _____
Approved by Board: _____

2. Goals

- Annual Adoption

F. Quality of Care 2015 Case Management Program Evaluation

Owner: Tracy Hitzeman, Director, CM

1. Activity

- CM Program will be evaluated by members including member feedback and complaints and to measure effectiveness of the overall CM Program, including interventions and actions for re-measurements
- Delegation oversight reported by DOC

Approved by QIC: _____
Approved by QAC: _____
Approved by Board: _____

2. Goals

- Annual Evaluation

G. Quality of Care- 2015 Disease Management Program Annual Oversight

Owner: Pshyra Jones, Dir of Health Ed & DM

1. Activity

- DM Program will be adopted on an annual basis

____ Approved by QIC: _____
Approved by QAC: _____
Approved by Board: _____

2. Goals

- Annual Adoption

H. Quality of Care- 2015 Disease Management Program Evaluation

Owner: Pshyra Jones, Dir. Health Ed and DM

1. Activity

- DM Program will be evaluated by members including member feedback and complaints and to measure effectiveness of the overall DM Program, including interventions and actions for re-measurement

Approved by QIC: _____

Approved by QAC: _____

Approved by Board: _____

2. Goals

- Annual Evaluation

I. Quality of Care- Credentialing Peer Review Committee (CPRC) Oversight

Owner: Medical Director, Quality

1. Activity

- Review of initial and recredentialing applications, related quality of care issues, approvals, denials, and reported to QIC
- Delegation oversight reported by DOC

Approved by QIC: _____

Approved by QAC: _____

Approved by Board: _____

Q1 _____

Q2 _____

Q3 _____

Q4 _____

2. Goals

- Quarterly Adoption of Report

J. NCQA Monitoring & Compliance

Owner: Kelly Rex-Kimmet, Director, QA

1. Activity

- Evaluate NCQA standards, HEDIS & CAHPS for improvement opportunities to achieve Commendable status

Approved by QIC: _____

Goals Approved by QAC: _____

Approved by Board: _____

2.

Q2

Q1

Q3

- Annual HIP Ranking
- 2. Goals**
- Annual HIP ranking

Q4

II. Case Management

A. *Quality Of Clinical Care-Review of health risk assessments to OCC, OC, SPD members Owner: Tracy Hitzeman Director, CM

The Approach

1. Objective

- **OCC-** Health Risk Assessment Outreach Appraisals for members in the OneCare Connect Program monitored for completeness
- **OC-** Health Risk Assessment Outreach for members in the OneCare Program monitored for completion

- **SPD-** Health Risk Assessment Outreach for Seniors and Persons with Disabilities monitored for completion

2. **Activity**

- **OCC-** Administer the initial HRA to the high risk beneficiary within:
 1. 90 days of a beneficiary's enrollment
 2. Administer the annual HRA to the beneficiary
- **OCC-** Administer the initial HRA to the low risk beneficiary within:
 1. 45 days of a beneficiary's enrollment
 2. Administer the annual HRA to the beneficiary
- **OC-** Administer the annual HRA to the beneficiary
 1. 90 days of a beneficiary's enrollment
 2. Administer the annual HRA to the beneficiary
- **SPD-** Administer the initial HRA to the high risk beneficiary within:
 1. 45 days of a beneficiary's eligibility
 2. Administer the annual HRA to the beneficiary
- **SPD-** Administer the initial HRA to the low risk beneficiary within:
 1. 90 days of a beneficiary's eligibility
 2. Administer the annual HRA to the beneficiary

3. **Goals**

- **OCC-**100% of eligible population improvement over 2016
- **OC-** 100% of eligible population
- **SPD-** 100% of eligible population

2016 Quality Improvement ~~Workplan~~Work Plan- Case Management

Owner: Tracy Hitzeman, Director, CM

Monitoring	<u>Narrative Assessments, Findings, Monitoring of Previous Issues</u>	Next Steps	<u>Target Completion</u>
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Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	Results / Metrics	Next Steps	<u>Target Completion</u>
Q1			
Q2			
Q3			
Q4			
Year End			

II. Case Management

B. *Quality of Clinical Care-Continuity & Coordination of Medical/BH

Owner: Tracy Hitzeman, Director, CM

The Approach

1. Objective

- Continuity and Coordination between Medical & Behavioral Health

2. Activity

- Monitor and identify opportunities to improve continuity & coordination of care across settings and/or transitions of care through ICT/ICP or other processes

3. Goals

- 85%

|

2016 Quality Improvement ~~Workplan~~Work Plan- Case Management **Owner: Tracy Hitzeman, Director CM**

Monitoring	<u>Narrative Assessments, Findings, Monitoring of Previous Issues</u>	Next Steps	<u>Target Completion</u>
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	Results / Metrics	Next Steps	<u>Target Completion</u>
Q1			
Q2			
Q3			
Q4			
Year End			

II. Case Management

- C. ***Quality of Clinical Care-Review of emergency department communications with PCPs** Owner: Tracy Hitzeman Director, CM; Novella Quesada, Manager, QI

The Approach

1. **Objective**
 - Continuity and Coordination of Care reviewed and assessed
2. **Activity**
 - Assessment of medical records for communication from emergency department to primary care providers
3. **Goals**
 - 85%

2016 Quality Improvement ~~Workplan~~Work Plan- Case Management Owner: Tracy Hitzeman, Director, CM; Novella Quesada, Manager QI

Monitoring	<u>Narrative Assessments, Findings, Monitoring of Previous Issues</u>	Next Steps	<u>Target Completion</u>
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	Results / Metrics	Next Steps	<u>Target Completion</u>
Q1			
Q2			
Q3			
Q4			
Year End			

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II. Case Management

D. Patient Safety, Quality of Care Case Management- High ER utilization

Owner: Tracy Hitzeman Director, CM;
Novella Quesada, Manager, QI

The Approach

1. **Objective**

- Evaluation and intervention for ongoing review of high ER utilizers

2. **Activity**

- Ongoing monitoring of ER utilization; findings reported to Case Management for follow-up and/or further interventions

3. **Goals**

- 35%

E. Quality of Clinical Care-Review of member satisfaction with CM programs

The Approach

1. **Objective**

- Annual review of member feedback on the case management programs to assure high satisfaction and improved health status

2. **Activity**

- Review annual satisfaction survey results, define areas for improvement and implement interventions to monitor and improve the member experience in CM programs

3. **Goals**

- Satisfaction with Case Management - 85%TBD

2016 Quality Improvement ~~Workplan~~Work Plan- Case Management

Owner: Tracy Hitzeman, Director, CM; Novella Quesada, Manager QI

Monitoring	<u>Narrative Assessments, Findings, Monitoring of Previous Issues</u>	Next Steps	<u>Target Completion</u>
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	Results / Metrics	Next Steps	<u>Target Completion</u>
Q1			
Q2			
Q3			
Q4			
Year End			

III. Behavioral Health

A. ***Quality of Clinical Care: Integration of BH Services** **BHI Terrie Stanley, ED Clinical Operations**

Owner: **Dr. Donald Sharps, Medical Director,**

The Approach

1. **Objective**

- Behavioral Health services, continuity & coordination of care and BH HEDIS measures will be monitored and measured

2. **Activity**

- Monitor and identify opportunities to improve continuity & coordination of care across settings and/or transitions of care through ICT/ICP or other processes
- Design and implement activities to improve HEDIS/ STARS measures relating to Behavioral Health

3. **Goals**

- 10% improvement over 20156

2016 Quality Improvement ~~Workplan~~Work Plan- Behavioral Health
Owner: Terrie Stanley, ED Clinical Operations

Monitoring	<u>Narrative Assessments, Findings, Monitoring of Previous Issues</u>	Next Steps	<u>Target Completion</u>
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	Results / Metrics	Next Steps	<u>Target Completion</u>
Q1			
Q2			
Q3			
Q4			
Year End			

III. Behavioral Health

B. ***Quality of Care-Clinical BH Practice Guidelines adoption for Medi-Cal Line of business**

**Owner: Dr. Donald Sharps, Medical
Director, BH**

The Approach

1. Objective

- BH Clinical Practice Guidelines will be reviewed and adopted

2. Activity

- Adoption of Clinical Practice Guidelines, at least two (2) behavioral health will be reviewed and adopted
- Depression & Autism CPGs reviewed annually

3. Goals

- 100%

2016 Quality Improvement ~~Workplan~~ Work Plan - Behavioral Health
Owner: DR. Donald Sharps, Medical Director, BH

Monitoring	<u>Narrative Assessments, Findings, Monitoring of Previous Issues</u>	Next Steps	<u>Target Completion</u>
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	Results / Metrics	Next Steps	<u>Target Completion</u>
Q1			
Q2			
Q3			
Q4			
Year End			

III. Behavioral Health

C. ***Quality of Service and Quality of Clinical Care-Review of Behavioral Health Providers communications with PCPs** Owner: Dr. Donald Sharps, Medical Director, BH

The Approach

1. **Objective**

- Continuity and Coordination of Care reviewed and assessed for medical care with behavioral health care

2. **Activity**

- Assessment of medical records for communication between primary care providers and behavioral health providers

3. **Goals**

- 85%

2016 Quality Improvement ~~Workplan~~ Work Plan - Behavioral Health
Owner: Dr. Donald Sharps, Medical Director, BH

Monitoring	<u>Narrative Assessments, Findings, Monitoring of Previous Issues</u>	Next Steps	<u>Target Completion</u>
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	Results / Metrics	Next Steps	<u>Target Completion</u>
Q1			
Q2			
Q3			
Q4			
Year End			

IV. LTSS

A. Safety of Clinical Care and Quality of Clinical Care- Review and assess LTSS placement for members participating with each organization/program

Owner: Suzanne Harvey, Director, LTSS

The Approach

1. Objective

- Member review of Hospital Admissions (for each organization/program)

2. Activity

- Measure those members participating in each program for hospital admissions:
 1. CBAS
 2. IHSS
 3. LTC
 4. MSSP

3. Goals

- 2% CBAS; Establishing goals in 2016 for IHSS, LTC & MSSP

2016 Quality Improvement ~~Workplan~~ Work Plan- LTSS
Owner: Suzanne Harvey, Director, LTSS

Monitoring	<u>Narrative Assessments, Findings, Monitoring of Previous Issues</u>	Next Steps	<u>Target Completion</u>
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	Results / Metrics	Next Steps	<u>Target Completion</u>
Q1			
Q2			
Q3			
Q4			
Year End			

IV. LTSS

- B. *Safety of Clinical Care and Quality of Clinical Care- Review and assess emergency department visits for LTSS members participating with each organization/program** **Owner: Suzanne Harvey, Director, LTSS**

The Approach

1. Objective

- Member review of Emergency Department Visits (for each organization/program)

2. Activity

- Measure those members participating in each program for hospital admissions:
 1. CBAS
 2. IHSS
 3. LTC
 4. MSSP

3. Goals

- 9% CBAS; Establishing goals in 2016 for IHSS, LTC, MSSP

2016 Quality Improvement ~~Workplan~~Work Plan- LTSS
Owner: Suzanne Harvey, Director, LTSS

Monitoring	<u>Narrative Assessments, Findings, Monitoring of Previous Issues</u>	Next Steps	<u>Target Completion</u>
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	Results / Metrics	Next Steps	<u>Target Completion</u>
Q1			
Q2			
Q3			
Q4			
Year End			

IV. LTSS

C. ***Safety of Clinical Care and Quality of Clinical Care-Review and assess readmissions for LTSS members participating with each organization/program**

Owner: Suzanne Harvey, Director, LTSS

The Approach

1. **Objective**

- Members reviewed for Hospital Readmissions (for each organization/program)

2. **Activity**

- Measure and assess readmissions within 30 days for members in each program to drive interventions to minimize hospital readmissions:
 1. CBAS
 2. IHSS
 3. LTC
 4. MSSP

3. **Goals**

- 2.5% CBAS; Establishing goals in 2016 for IHSS, LTC, MSSP

2016 Quality Improvement ~~Workplan~~Work Plan- LTSS
Owner: Suzanne Harvey, Director, LTSS

Monitoring	<u>Narrative Assessments, Findings, Monitoring of Previous Issues</u>	Next Steps	<u>Target Completion</u>
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	Results / Metrics	Next Steps	<u>Target Completion</u>
Q1			
Q2			
Q3			
Q4			
Year End			

IV. LTSS

D. Quality of Clinical Care-review of Health Risk Assessment (HRA) for OneCare Connect (OCC) Long Term Care (LTC) members

Owner: Suzanne Harvey, Director, LTSS

The Approach

1. Objective

- Health risk assessment for members in the OCC line of business monitored for completeness

2. Activity

- HRA to comprehensively assess each newly enrolled OCC LTC member's current health risk.
- Completion of an HRA process must be performed within 90 calendar days of enrollment for those identified by the risk stratification mechanism as lower risk who are residing in LTC facilities

3. Goals

- 100%

2016 Quality Improvement ~~Workplan~~Work Plan- LTSS
Owner: Suzanne Harvey, Director, LTSS

Monitoring	<u>Narrative Assessments, Findings, Monitoring of Previous Issues</u>	Next Steps	<u>Target Completion</u>
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	Results / Metrics	Next Steps	<u>Target Completion</u>
Q1			
Q2			
Q3			
Q4			
Year End			

IV. LTSS

E. CBAS Member Satisfaction

Owner: Novella Quesada, Manager, QI

The Approach

1. Objective

- Monitor and/or improve member satisfaction in CBAS/LTSS

2. Activity

- Measure, assess and identify areas for improvement and implement interventions to assure high member satisfaction

3. Goals

- TBD-5% Improvement over previous year

2016 Quality Improvement ~~Workplan~~Work Plan- LTSS
Owner: Novella Quesada, Manager, QI

Monitoring	<u>Narrative Assessments, Findings, Monitoring of Previous Issues</u>	Next Steps	<u>Target Completion</u>
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	Results / Metrics	Next Steps	<u>Target Completion</u>
Q1			
Q2			
Q3			
Q4			
Year End			

IV. LTSS

F. SNF Member Satisfaction

Owner: Novella Quesada, Manager, QI

The Approach

1. **Objective**

- Monitor and/or improve member satisfaction in SNF

2. **Activity**

- Measures, assess and identify areas for improvement and implement interventions to assure high member satisfaction

3. **Goals**

- ~~TBD~~ 5% Improvement over previous year

2016 Quality Improvement ~~Workplan~~ Work Plan- LTSS
Owner: Novella Quesada, Manager, QI

Monitoring	<u>Narrative Assessments, Findings, Monitoring of Previous Issues</u>	Next Steps	<u>Target Completion</u>
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	Results / Metrics	Next Steps	<u>Target Completion</u>
Q1			
Q2			
Q3			
Q4			
Year End			

V. Health Education & Disease Management

A. ***Quality of Care-All new members will complete the Initial Health Assessment and related IHEBA/SHAs**

Owner: Pshyra Jones, Director, Health ED and DM

The Approach

1. **Objective**

- To assure all new members are connected with a PCP and their health risks are assessed

2. **Activity**

- IHA/IHEBA [Staying Healthy Assessment(SHA)] will be completed with 120 days of enrollment
- Reports will be available for Health Networks on IHA/SHA completion
- Facility Site Reviews will review sample of medical records for compliance with completing appropriate age level IHA/SHA
- If use of alcohol or drugs, the member will have an SBIRT documented (Screening, Brief intervention, and Referral to Treatment)

3. **Goals**

- Improve plan performance over 2015 by 10%

2016 Quality Improvement ~~Workplan~~Work Plan- Health Education & Disease Management &DM Owner: Pshyra Jones, Director, Health ED

Monitoring	<u>Narrative Assessments, Findings, Monitoring of Previous Issues</u>	Next Steps	<u>Target Completion</u>
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	Results / Metrics	Next Steps	<u>Target Completion</u>
Q1			
Q2			
Q3			
Q4			
Year End			

V. Health Education & Disease Management

B. Quality of Clinical Care, review of Disease Management Program (Asthma)

Owner: Pshyra, Jones, Director, Health Ed and DM

The Approach

1. Objective

- Disease Management activity reviewed to assess clinical care delivered to members with Asthma

2. Activity

- Increase Asthma Medication Ratio (AMR) rates for members with persistent asthma in our Asthma DM program
- Incorporate HEDIS improvement for Asthma into DM program interventions
- Evaluate more technology-based interventions into DM programs
- Assure DM programs are implemented across all populations
- Conduct annual member satisfaction of DM programs
- Evaluate the overall effectiveness of the Asthma Program-Participation Member Rates, ED, IP and RX related utilization

3. Goals

- Increase to 50th percentile for members between 5-18 yrs old

2016 Quality Improvement ~~Workplan~~Work Plan- Health Education & Disease Management Owner: Director Health Ed & DM

Monitoring	<u>Narrative Assessments, Findings, Monitoring of Previous Issues</u>	Next Steps	<u>Target Completion</u>
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	Results / Metrics	Next Steps	<u>Target Completion</u>
Q1			
Q2			
Q3			
Q4			
Year End			

V. Health Education & Disease Management

C. Quality of Clinical Care-Review of Disease Management Program (Diabetes) Owner: Pshyra Jones, Director, Health Ed and DM

The Approach

1. Objective

- Disease Management activity reviewed to assess clinical care delivered to members with Diabetes

2. Activity

- A1C Control for members with existing A1C>9 and receiving Health Coach interventions in 2016
- Incorporate HEDIS improvement for CDC into DM program interventions
- Evaluate more technology-based interventions into DM programs
- Assure DM programs are implemented across all populations
- Conduct annual member satisfaction of DM programs
- Evaluate the overall effectiveness of the Diabetes Program-Member Participation rates, ED, IP, and RX related utilization

3. Goals

- Maintain 90th percentile for Medi-Cal; increase to 75th percentile for Medicare

2016 Quality Improvement ~~Workplan~~Work Plan- Health Education & Disease Management Owner: Pshyra Jones, Director Health Ed & DM

Monitoring	<u>Narrative Assessments, Findings, Monitoring of Previous Issues</u>	Next Steps	<u>Target Completion</u>
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	Results / Metrics	Next Steps	<u>Target Completion</u>
Q1			
Q2			
Q3			
Q4			
Year End			

V. Health Education & Disease Management

D. Quality of Clinical Care-Review of Disease Management Program (CHF)

Owner: Pshyra Jones, Director, Health ED and DM

The Approach

1. Objective

- Disease Management activity reviewed to assess clinical care delivered to members with CHF

2. Activity

- Establish baseline for unplanned readmissions with an admitting diagnosis of heart failure for members in the Heart Failure DM program
- Incorporate HEDIS improvement for CHF into DM program interventions
- Evaluate more technology-based interventions into DM programs
- Assure DM programs are implemented across all populations
- Evaluate the overall effectiveness of the CHF Program-Member Participation Rates, ED, IP and RX related utilization

3. Goals

- CHF - Establish baseline for unplanned readmissions with an admitting diagnosis of heart failure for members in the Heart Failure DM Program
- Satisfactions with DM - 90% Goal TBD

|

2016 Quality Improvement ~~Workplan~~Work Plan- Health Education & Disease Management
**Owner: Pshyra Jones, Director Health
Ed & DM**

Monitoring	<u>Narrative Assessments, Findings, Monitoring of Previous Issues</u>	Next Steps	<u>Target Completion</u>
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	Results / Metrics	Next Steps	<u>Target Completion</u>
Q1			
Q2			
Q3			
Q4			
Year End			

V. Health Education & Disease Management

E. *Quality of Care-Clinical Practice Guidelines adoption for Medi-Cal line of business

Owner: Pshyra Jones, Director
Health Ed & DM

The Approach

1. Objective

- Clinical Practice Guidelines will be reviewed and adopted

2. Activity

- Adoption of Clinical Practice Guidelines, as least three (3) will be reviewed and adopted (linked to DM: Diabetes, Asthma, CHF)

3. Goals

- 100%

2016 Quality Improvement ~~Workplan~~Work Plan- Health Education & Disease Management
Owner: Pshyra Jones, Director Health Ed & DM

Monitoring	<u>Narrative Assessments, Findings, Monitoring of Previous Issues</u>	Next Steps	<u>Target Completion</u>
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	Results / Metrics	Next Steps	<u>Target Completion</u>
Q1			
Q2			
Q3			
Q4			
Year End			

V. Health Education & Disease Management

F. Quality of Clinical Care-Review of member satisfaction with DM programs

Owner: Pshyra Jones, Director, Health ED and DM

The Approach

1. Objective

- Annual review of member feedback on the disease management programs to assure high satisfaction and improved health status

2. Activity

- Review annual satisfaction survey results, define areas for improvement and implement interventions to monitor and improve the member experience in DM programs
- Transition manual satisfaction survey to alternate process to gather ongoing feedback

3. Goals

- [TBD90% satisfaction with the DM program](#)

2016 Quality Improvement ~~Workplan~~Work Plan- Health Education & Disease Management
 Ed & DMDM

Owner: Pshyra Jones, Director Health

Monitoring	<u>Narrative Assessments, Findings, Monitoring of Previous Issues</u>	Next Steps	<u>Target Completion</u>
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	Results / Metrics	Next Steps	<u>Target Completion</u>
Q1			
Q2			
Q3			
Q4			
Year End			

V. Health Education & Disease Management

G. Quality of Clinical Care-Review of Cardiovascular Disease

Owner: Pshyra Jones, Director, Health Ed and DM

The Approach

1. Objective

- CCIP Chronic Care Improvement Projects

2. Activity

- CCIP-CMS Mandatory topic New Goal
- Achieve high BP control or improvement among 50% of the members actively opt-ing into health coaching OneCare
- Achieve high BP control or improvement among 50% of OC members and receiving health coaching interventions
- Achieve high BP medication adherence or improvement for 50% of OC members as identified through PBM data and receiving health coaching interventions OneCare Connect
- Reduced unplanned readmissions by 1% below the national readmission rates for OCC members with admitting diagnosis specific to heart failure
- Achieve high BP medication adherence for 50% of members opt-ing into health coaching identified through PBM data

3. Goals

- As determined by CMS

2016 Quality Improvement ~~Workplan~~Work Plan- Health Education & Disease Management Ed & DM
Owner: Pshyra Jones, Director Health

Monitoring	<u>Narrative Assessments, Findings, Monitoring of Previous Issues</u>	Next Steps	<u>Target Completion</u>
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	Results / Metrics	Next Steps	<u>Target Completion</u>
Q1			
Q2			
Q3			
Q4			
Year End			

V. Health Education & Disease Management

H. Quality of Clinical Care-Review of Diabetes and All Cause Readmissions

Owner: Kelly Rex-Kimmet, Director, QA PIPS

The Approach

1. Objective

- PIP Performance Improvement Projects

2. Activity

- PIP-DHCS Mandatory Projects-Readmission & Diabetes

3. Goals

- As determined by CMS& DHCS

2016 Quality Improvement ~~Workplan~~Work Plan- Health Education & Disease Management **Owner: Kelly Rex-Kimmet, Director, QA PIPS**

Monitoring	<u>Narrative Assessments, Findings, Monitoring of Previous Issues</u>	Next Steps	<u>Target Completion</u>
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	Results / Metrics	Next Steps	<u>Target Completion</u>
Q1			
Q2			
Q3			
Q4			
Year End			

V. Health Education & Disease Management

I. Implementation of the Childhood Obesity (Shape your Life) Program

Owner: Pshyra Jones, Director, Health ED and DM

The Approach

1. Objective

- Evaluate, identify and develop clinical and operational content for revisions to existing Childhood Obesity Prevention and Treatment Program (COPTP), and develop network of providers to support program for 2016 and beyond

2. Activity

- Evaluate existing COPTP program goals, objectives and interventions
- Develop clinical and operational components to revise existing program design to expand the reach and capability
- Identify program resources and vendor support (Provider, Health ED/RD linkages)
- Implementation of revised program design

3. Goals

- Implement revised program design-2017
- Evaluate progress semi-annually

2016 Quality Improvement ~~Workplan~~Work Plan- Health Education & Disease Management Ed & DM
Owner: Pshyra Jones, Director Health

Monitoring	<u>Narrative Assessments, Findings, Monitoring of Previous Issues</u>	Next Steps	<u>Target Completion</u>
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	Results / Metrics	Next Steps	<u>Target Completion</u>
Q1			
Q2			
Q3			
Q4			
Year End			

“Attachment A”

V. Health Education & Disease Management

J. Implement Weight Watchers (WW) for Medi-Cal members

Owner: Pshyra Jones, Director, Health ED and DM

The Approach

1. Objective

- Design weight Watchers benefit for CalOptima Medi-Cal members age 15yrs or greater

2. Activity

- Obtain MOU and finalize contract between WW and CalOptima organization
- Establish criteria and program goals for participating CalOptima members
- Identify appropriate regulatory approvals for member materials and program incentives

3. Goals

- Implement revised program design-2017
- Evaluate progress semi-annually

2016 Quality Improvement ~~Workplan~~Work Plan- Health Education & Disease Management —Owner: Pshyra Jones. Director Health Ed & DM

Monitoring	<u>Narrative Assessments, Findings, Monitoring of Previous Issues</u>	Next Steps	<u>Target Completion</u>
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	Results / Metrics	Next Steps	<u>Target Completion</u>
Q1			
Q2			
Q3			
Q4			
Year End			

V. Health Education & Disease Management

K. Implement Home Assessments for member participating in Care Management Programs

Owner: Pshyra Jones, Director, Health ED and DM

The Approach

1. Objective

- Design a face to face assessment and coaching option for high risk members with chronic conditions participating in CalOptima Care management programs

2. Activity

- Obtain MOU and contracts with appropriate vendors (TBD)
- Establish criteria and program goals for participating CalOptima members
- Identify appropriate regulatory approvals for member materials and program incentives

3. Goals

- Implement revised program design-2016
- Evaluate progress semi-annually

2016 Quality Improvement ~~Workplan~~Work Plan- Health Education & Disease Management
Owner: Pshyra Jones, Director Health Ed & DM

Monitoring	<u>Narrative Assessments, Findings, Monitoring of Previous Issues</u>	Next Steps	<u>Target Completion</u>
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	Results / Metrics	Next Steps	<u>Target Completion</u>
Q1			
Q2			
Q3			
Q4			
Year End			

V. Health Education & Disease Management

L. Conduct 2016 Group Needs assessment (GNA)

Owner: Pshyra Jones, Director, Health ED and DM

The Approach

1. Objective

- The GNA supports identification of health risks, beliefs, practices, and cultural and linguistic needs for CalOptima’s Medi-Cal membership

2. Activity

- Complete Request for Proposal
- Identify eligible CalOptima survey participants based on methodology required by Department of Healthcare Services (DHCS)
- [Male-Mail](#) assessment tool available in all 7 threshold languages
- Submit Executive Summary and supporting reports to DHCS by October, 2016

3. Goals

- Complete GNA requirement for 2016

2016 Quality Improvement ~~Workplan~~Work Plan- Health Education & Disease Management Ed & DM
Owner: Pshyra Jones, Director Health

Monitoring	<u>Narrative Assessments, Findings, Monitoring of Previous Issues</u>	Next Steps	<u>Target Completion</u>
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	Results / Metrics	Next Steps	<u>Target Completion</u>
Q1			
Q2			
Q3			
Q4			
Year End			

“Attachment A”

VI. Access & Availability

A. *Quality of Service and Quality of Clinical Care- Review of notification to members

Owner: Laura Grigoruk
Dir. Provider Relations

The Approach

1. Objective

- Continuity and coordination of Care reviewed and assessed

2. Activity

- Communication to members when a primary care provider is terminated from the network will be assessed. Standard is 30 days notice. (CCN & HN/Delegation reports)
- Exception: CalOptima is notified in less than 30 days of termination, then notification would be within three business days.

3. Goals

- 85%

2016 Quality Improvement ~~Workplan~~Work Plan- Access & Availability **Owner: Laura Grigoruk, Director, Provider Relations**

Monitoring	<u>Narrative Assessments, Findings, Monitoring of Previous Issues</u>	Next Steps	<u>Target Completion</u>
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	Results / Metrics	Next Steps	GTa <u>Target Completion</u>
Q1			
Q2			
Q3			
Q4			
Year End			

VI. Access & Availability

B. *Access to Care: Credentialing of provider network is monitored

Owner: Novella Quesada, Manager, QI

The Approach

1. Objective

- Credentialing program activities monitored for timeliness

2. Activity

- New applicants processed within 180 calendar days of receipt of application
- **Report from CPRC

3. Goals

- 100%

C. Access to Care-Recredentialing of provider network is monitored

The Approach

1. Objective

- Recredentialing of practitioners is completed timely

2. Activity

- Recredentialing is processed with 36 month report of Admin term due to missed recredentialing cycle
- Report of # of providers termed due to move, retired, etc
- Quarterly Access & Availability report
- **Report from CPRC

3. Goals

- 100%

2016 Quality Improvement ~~Workplan~~Work Plan- Access & Availability Owner: Novella Quesada, Manager, QI

Monitoring	<u>Narrative Assessments, Findings, Monitoring of Previous Issues</u>	Next Steps	<u>Target Completion</u>
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	Results / Metrics	Next Steps	<u>Target Completion</u>
Q1			
Q2			
Q3			
Q4			
Year End			

VI. Access and Availability

D. *Accessibility: Review of access to care

Owner: Esther Okajima, Manager, QA

The Approach

1. Objective

- Practitioner accessibility (medical services in a timely manner) is measured, assessed and adjusted as necessary to standard

2. Activity

- Data against goals will be measured and analyzed for the following through the implementation of our annual Timely Access study and Customer Service monitoring of wait time
 1. Non-urgent primary care appointments within 10 business days
 2. Urgent appointments with prior authorization with 96 hours of request
 3. Non-urgent primary care appointments within 10 business days
 4. Appointment with specialist within 15 business days
 5. First pre-natal visit within 10 business days
 6. Member services, by telephone ASA 30 seconds with abandonment rate <5%
- Health Networks will be issued Corrective Action Plans for their areas of non-compliance
 1. Urgent Care appointments with 48 hours of request
 2. Appointments with specialist within 15 business days
 3. Member services, by telephone ASA 30 seconds with abandonment rate <5%
 4. Non-urgent acute care within 3 days of request

3. Goals

- Appt.: 90%
- Phone: <5%

2016 Quality Improvement ~~Workplan~~Work Plan- Access & Availability
Owner: Esther Okajima, Manager, QA

Monitoring	<u>Narrative Assessments, Findings, Monitoring of Previous Issues</u>	Next Steps	<u>Target Completion</u>
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	Results / Metrics	Next Steps	<u>Target Completion</u>
Q1			
Q2			
Q3			
Q4			
Year End			

VI. Access and Availability

E. *Availability: Review of Availability of Practitioners

Owner: Esther Okajima, Manager, QA;
Dr. Donald Sharps, Medical Director, BH

The Approach

1. Objective

- Practitioner availability (geographic distribution) is measured, assessed and adjusted to meet standard
- Practitioner availability (cultural, ethnic, racial and linguistic member needs) is measured, assessed and adjusted as necessary to standard
- Availability of practitioners is measured and assessed to Behavioral Health services
- Availability of practitioners is measured and assessed by geographic distribution specific to Behavioral health
- Practitioner availability (practitioner to member ratio) is measured, assessed and adjusted to meet standard

2. Activity

- Practitioner network to determine how the network is meeting the needs and preferences of the plans membership will be measured and analyzed and adjusted as necessary. Each type of PCP and high volume specialist' geographic distribution performance will be measured against set standards
 1. Members within ten (10) miles or thirty (30) minutes of a practitioner
 2. Member within thirty (30) miles or forty-five (45) minutes of a high volume specialist
- Practitioner network on the cultural, ethnic, racial and linguistic needs of membership will be measured and analyzed
- Analyses performance against established quantifiable standards for the number of each type of high volume BH practitioners
- Measure and analyze BH practitioner network to determine how the network is meeting the needs and preferences of the plans membership and adjusts as necessary.
- Measured through quantifiable and measurable standards for each type of BH practitioner by geographic distribution performance against standards
- Member within thirty (30) miles or forty-five (45) minutes of a high volume specialist
- Availability of practitioners against goals will be measured and analyzed and adjusted as necessary
 1. Practitioner to Member
 2. Ratio of PCP to Members

3. Ratio Specialists to Members (Neurology 1:10,000)

3. Goals

- 1:2,000
- 1:2,000
- 1:5,000
- 95%
- 90%
- 1:100
- 100%

2016 Quality Improvement ~~Workplan~~Work Plan- Access & Availability Owner: Esther Okajima, Manager, QA; ~~Dr.~~ Donald Sharps, MD, Medical Director, BH

Monitoring	<u>Narrative Assessments, Findings, Monitoring of Previous Issues</u>	Next Steps	<u>Target Completion</u>
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	Results / Metrics	Next Steps	<u>Target Completion</u>
Q1			
Q2			
Q3			
Q4			
Year End			

“Attachment A”

VII. Patient Safety

A. ***Safety of Clinical Care-Providers shall have timely and complete facility site reviews**

Owner: Novella Quesada, Manager, QI

The Approach

1. **Objective**

- To assure all new and recredentialed providers are compliant with FSR/MRR/PAR requirements

2. **Activity**

- Facility Site Reviews (FSR), Medical Record reviews (MRR) and Physical Accessibility Reviews (PARs) are completed as part of initial & recredentialing cycles

3. **Goals**

- 80%

2016 Quality Improvement ~~Workplan~~Work Plan- Patient Safety
Owner: Novella Quesada, Manager, QI

Monitoring	<u>Narrative Assessments, Findings, Monitoring of Previous Issues</u>	Next Steps	<u>Target Completion</u>
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	Results / Metrics	Next Steps	<u>Target Completion</u>
Q1			
Q2			
Q3			
Q4			
Year End			

VII. Patient Safety

B. Safety of Clinical care-review and follow-up on member’s potential Quality of Care complaints Owner: Novella Quesada Manager, QI

The Approach

1. Objective

- To assure all PQI’s are evaluated for severity and investigated in a timely fashion (90 days)

2. Activity

- QI Nurse Specialists and Med Directors review cases....reported to CPRC
- Report to CPRC
- Report PQI Productivity activity Report
- Discuss PQIs with a severity code of 3 and 4

3. Goals

- 80%

2016 Quality Improvement ~~Workplan~~Work Plan- Patient Safety
Owner: Novella Quesada, Manager, QI

Monitoring	<u>Narrative Assessments, Findings, Monitoring of Previous Issues</u>	Next Steps	<u>Target Completion</u>
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	Results / Metrics	Next Steps	<u>Target Completion</u>
Q1			
Q2			
Q3			
Q4			
Year End			

VII. Patient Safety

C. ***Safety of Clinical Care and Quality of Clinical Care Management reviewed through Pharmacy Management**

Owner: Kris Gericke, **PharmD**, Director, Pharmacy

The Approach

1. **Objective**

- To promote access to clinically sound, cost-effective pharmaceutical care for all CalOptima Members.

2. **Activity**

- Review and update the CalOptima Plan Formularies on an ongoing basis in order to ensure access to quality pharmaceutical care which is consistent with the program's scope of benefits
- Review anticipated and actual utilization trends including specialty medications
- Review and evaluate pharmacy-related issues related to delivery of health care to CalOptima's members
- Report on medication recalls and process for informing members and providers
- Report on Underutilization of Asthmatics not receiving long term controllers, Diabetics not receiving statins, Diabetics with Hypertension not receiving ACE/ARB
- Overutilization/PolyPharmacy-Report on interventions for preventing opioid overuse to include Pharmacy home, Monthly RX limit, Opioid overutilization (MED over 120mg.)

3. **Goals**

- 100%

2016 Quality Improvement ~~Workplan~~Work Plan- Patient Safety Owner: Kris Gericke, PharmD, Director, Pharmacy Management

Monitoring	<u>Assessments, Findings, Monitoring of Previously Identified Issues</u> <u>Narrative</u>	Next Steps	<u>Target Completion</u>
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	Results / Metrics	Next Steps	<u>Target Completion</u>
Q1			
Q2			
Q3			
Q4			
Year End			

VII. Patient Safety

D. *Safety of Clinical Care and Quality of Clinical Care- Services Review of Specialty Drug Utilization

Owner: Kris Gericke, PharmD, Director, Pharmacy

The Approach

1. Objective

- Provide ongoing monitoring of specialty drug trends

2. Activity

- Review and reporting of Specialty Drug trends, identify any actions necessary with the member or provider/HN

3. Goals

- TBD

2016 Quality Improvement ~~Workplan~~Work Plan- Patient Safety
Owner: Kris Gericke, Director, Pharmacy Services

Monitoring	<u>Assessments, Findings, Monitoring of Previously Identified Issues</u> <u>Narrative</u>	Next Steps	<u>Target Completion</u>
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	Results / Metrics	Next Steps	<u>Target Completion</u>
Q1			
Q2			
Q3			
Q4			
Year End			

E. *Patient Safety-Review and assessment of CBAS Quality Monitoring

Owner: Novella Quesada, Manager, QI

The Approach**1. Objective**

- Review of CBAS Quality monitoring of services provided

2. Activity

- CBAS Quality Assurance-continue to assess compliance of contracted CBAS centers.
- Report to LTSS QIC
- Report Member Satisfaction Survey Results
- Report CDA audit results in comparison to past results

3. Goals

- 100% CDA Audit Results

F. Patient Safety-Review and assessment of SNF Quality Monitoring**The Approach****1. Objective**

- Review of SNF Quality monitoring of services provided

2. Activity

- SNF Quality Assurance-continue to assess compliance of contracted SNF centers.
- Report to LTSS QIC
- Report on progress of on-site visits and CAPs issued
- Report on Member Satisfaction Survey Results

3. Goals

- 100% DHCS Audit results

2016 Quality Improvement ~~Workplan~~ Work Plan - Patient Safety
Owner: Novella Quesada, Manager, QI

Monitoring	<u>Assessments, Findings, Monitoring of Previously Identified Issues</u> <u>Narrative</u>	Next Steps	<u>Target Completion</u>
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	Results / Metrics	Next Steps	<u>Target Completion</u>
Q1			
Q2			
Q3			
Q4			
Year End			

“Attachment A”

VII. Patient Safety

G. ***Safety of Clinical Care-Review of antibiotic usage**

Owner: Kelly Rex-Kimmet Dir of Quality Analytics

The Approach

1. **Objective**

- Increase the appropriate testing for children with Pharyngitis rate
- Appropriate treatment for children with upper respiratory infection (URI) to meet goals

2. **Goals**

- 68.53%
- 91.21%

2016 Quality Improvement ~~Workplan~~ Work Plan - Patient Safety
Owner: Kelly Rex-Kimmet, Director, QA

Monitoring	<u>Assessments, Findings, Monitoring of Previously Identified Issues</u> <u>Narrative</u>	Next Steps	<u>Target Completion</u>
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	Results / Metrics	Next Steps	<u>Target Completion</u>
Q1			
Q2			
Q3			
Q4			
Year End			

VII. Patient Safety

H. Implementation of the new PBM

Owner: Kris Gericke, Dir of Pharmacy

The Approach

1. Objective

- Provide ongoing monitoring of the implementation of the new PBM: quality of care, service, clinical metrics

2. Activity

- Review and report on clinical and service metrics for Med Impact, as it relates to STARS, HEDIS, Quality of care, Quality of Service

3. Goals

- TBD

2016 Quality Improvement ~~Workplan~~Work Plan- Patient Safety
Owner: Kris Gericke, Director, Pharmacy

Monitoring	<u>Assessments, Findings, Monitoring of Previously Identified Issues</u> <u>Narrative</u>	Next Steps	<u>Target Completion</u>
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	Results / Metrics	Next Steps	<u>Target Completion</u>
Q1			
Q2			
Q3			
Q4			
Year End			

VIII. Member Experience

A. Quality of Service-Review of Member Satisfaction

Owner: Kelly Rex-Kimmet, Director, Quality Analytics

The Approach

1. Objective

- Annual review of member feedback (CAHPS, complaints & grievances); identification of areas for improvement

2. Activity

- Identify key areas of concern and implement related activities to improve Member Experience (CAHPS)
- Work in conjunction with the Health Networks and other Delegates to monitor and improve the Member Experience

3. Goals

- Annual CAHPS results

2016 Quality Improvement ~~Workplan~~ Work Plan - Member Experience
Owner: Kelly Rex-Kimmet, Director, QA

Monitoring	<u>Assessments, Findings, Monitoring of Previously Identified Issues</u> <u>Narrative</u>	Next Steps	<u>Target Completion</u>
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	Results / Metrics	Next Steps	<u>Target Completion</u>
Q1			
Q2			
Q3			
Q4			
Year End			

VIII. Member Experience

B. ***Quality of Service-Reviewed through customer service first call resolution** Owner: Belinda Abeyta, Director, Customer Service

The Approach

1. **Objective**

- Gather data and information from members after interface with Customer Service to assure expectations/reason for call was resolved

2. **Activity**

- Monitor port call information and determine key strategies to assure first call resolution/member satisfaction with customer service

3. **Goals**

- ~~TBD~~[85% of calls resolved at first call](#)

2016 Quality Improvement ~~Workplan~~Work Plan- Member Experience **Owner: Belinda Abeyta, Director, Customer Service**

Monitoring	<u>Assessments, Findings, Monitoring of Previously Identified Issues</u> <u>Narrative</u>	Next Steps	<u>Target Completion</u>
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	Results / Metrics	Next Steps	<u>Target Completion</u>
Q1			
Q2			
Q3			
Q4			
Year End			

VIII. Member Experience

C. *Quality of Service-Reviewed through Customer Service access

Owner: Belinda Abeyta, Director, Customer Service

The Approach

1. Objective

- Customer Service call lines evaluated for average speed to answer
- Customer Service call line evaluated for call abandonment rate
- Customer Service call lines evaluated for hold times

2. Activity

- Customer Service lines monitored for average speed to answer
- Customer service lines monitored for abandonment rate
- Customer service lines monitored for hold time

3. Goals

- ASA 30 seconds
- <3%
- Hold time under 30 seconds
- First Call Resolution 85%

|

2016 Quality Improvement ~~Workplan~~ Work Plan - Member Experience Owner: Belinda Abeyta, Director, Customer Service

Monitoring	<u>Assessments, Findings, Monitoring of Previously Identified Issues</u> <u>Narrative</u>	Next Steps	<u>Target Completion</u>
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	Results / Metrics	Next Steps	<u>Target Completion</u>
Q1			
Q2			
Q3			
Q4			
Year End			

VIII. Member Experience

D. Quality of Care & Service Reviewed through GARS & PQI (MOC)

Owner: Janine Kodama, Director, GARS
Novella Quesada, Manager, QI

The Approach

1. Objective

- Global review of member “pain points” (Grievances, Complaints and Quality of Care); assure appropriate actions are taken to assist the member experience

2. Activity

- Quarterly review of all GARS and PQI data to identify issues and trends; implement any necessary corrections
- Report QIC
- HN quarterly totals by PMPM of grievance and PQI and steps taken to address with HN

3. Goals

- Improve over 2015 performance

|

2016 Quality Improvement Workplan Work Plan- Member Experience Owner: Janine Kodama, Director, GARS; Novella Quesada, Manager, QI

Monitoring	<u>Assessments, Findings, Monitoring of Previously Identified Issues</u> Narrative	Next Steps	<u>Target Completion</u>
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	Results / Metrics	Next Steps	<u>Target Completion</u>
Q1			
Q2			
Q3			
Q4			
Year End			

IX. HEDIS/STARS Improvement

A. Improve identified HEDIS Measures listed on “Measure” worksheet

Owner: Kelly Rex-Kimmet Director, Quality Analytics

The Approach

1. **Objective**
 - Regain “Commendable” NCQA accreditation rating
 - Maintain or exceed NCQA 4.0 health plan rating
2. **Activity**
 - See measures worksheet for specific activities
3. **Goals**
 - See measures worksheet

B. Improve identified STARS measures listed on “Measures” worksheet

The Approach

1. **Objective**
 - Maintain or exceed 4.0 CMS STAR rating
2. **Activity**
 - See measures worksheet for specific activities
3. **Goals**
 - See measures worksheet

IX. HEDIS/STARS Improvement

C. Improve CAHPS measures listed on “Measures” worksheet

The Approach

1. **Objective**
 - Achieve 3.0 CAHPS score
2. **Activity**
 - See Measures worksheet for specific activities
3. **Goals**
 - See Measures worksheet

D. HEDIS: Launch pediatric wellness clinic

The Approach

1. **Objective**
 - Improve child and adolescent HEDIS measures (i.e. adolescent immunizations, childhood immunizations, adolescent well care)
2. **Activity**
 - Evaluate options to deliver pediatric preventive care, including immunizations in unique settings to achieve higher adherence
 - Work in conjunction with the HN and CCN providers on this initiative
3. **Goals**
 - Improve HEDIS rates per measure worksheet

IX. HEDIS/STARS Improvement

E. STARS Improvement-Medication Adherence Measures

Owner: Kris Gericke, Director, Pharmacy

The Approach

1. Objective

- Improve the 3 Medication Adherence Measures to achieve 4 Star Performance in each measure

2. Activity

- Comprehensive member & provider outreach to identified members who appear non-compliant with medication management (interventions based on unique member characteristics)

3. Goals

- See measures worksheet

F. HEDIS: Health Network support of HEDIS & CAHPS improvement

Owner: Kelly Rex-Kimmet, Director, Quality Analytics

The Approach

1. Objective

- Provider regular reporting to the Health Networks to ensure HEDIS improvement for expected measures

2. Activity

- Provide ongoing reports to Health Networks on their specific HEDIS & CAHPS performance, including patient lists for intervention
- Gather feedback from Health Networks on tools to assist in HEDIS & CAHPS improvement activities

3. Goals

- 24.33%

HEDIS Measures Worksheet

Scope	Objective	Activity	Goals or Baseline	Target Completion
**HEDIS/STARS: Review and assessment Comprehensive Diabetes Care (CDC)	Increase the comprehensive diabetes care measures MC and OC members - in conjunction with Diabetes Disease Management Program	<p>Comprehensive diabetes care will increase through member education to identified members with diabetes and collaboration with targeted providers to better outreach to their patients for comprehensive screening and care.</p> <p>Also explore the use of member engagement technologies to improve rates.</p> <p>These measures are also incentivized through our P4V program. (interventions based on unique member characteristics)</p>	90th percentile for all subsmeasures	2016 April, July, October
**HEDIS/STARS Improvement: Review and assessment Controlling Blood Pressure*	Increase the BP control for MC and OC members to meet goal	Blood pressure control will increase through member outreach and education with member diagnosed with hypertension.	MC: 70.32% (90th percentile) OC 79.15% (75th percentile)	2016 April, July, October
**HEDIS/STARS Improvement: Review all-cause hospital readmissions with Medi-Cal & OneCare Connect members (PCR)	Reduce 30 day All Cause Readmissions (PCR)	<p>Readmission Rate will be minimized through member education and Quality Incentive Program.</p> <p>A reporting mechanism will be established followed by analysis of data.</p>	<p>Medi-Cal <15% Readmission rate</p> <p>Medicare <14% Readmission rate</p>	2016 April, July, October
**HEDIS/STARS Improvement: Review of flu and pneumococcal immunization rates*	Increase the flu and pneumococcal screening rate in: 1. MC members 18-64 years old and 2. OC members 65 years old and older	Compliance with flu and pneumococcal immunizations will increase through flu reminders and education.	90%	2016 April, July, October

Scope	Objective	Activity	Goals or Baseline	Target Completion
	to meet goal			
HEDIS: Review of prenatal & postpartum care services (PPC)	Increase the prenatal and postpartum care rate for all Medi-Cal deliveries to meet goal	The number of prenatal and postpartum care visits will increase through provider education to submit Prenatal Notification Reports, member and provider education and sharing of provider data. Utilize Text-For-Baby custom messages to encourage member compliance.	MC Prenatal: 85.19% (50th percentile) MC Postpartum: 68.85% (75th percentile)	2016 April, July, October
HEDIS: Review and assessment prescribed ADHD medication (ADHD)	Increase the follow-up care for children prescribed ADHD medication rate in MC children who were newly prescribed an ADHD medication to meet goal	Follow-up care for children with newly prescribed ADHD medication will increase through member and provider education and reminder letter to members.	Initiation Phase: 40.79% (50th percentile) Maintenance Phase: 50.61% (50th percentile)	2016 April, July, October
HEDIS: Review and assessment of antidepressant medication management (AMM)	Increase the antidepressant medication management rate in MC and OC members with a diagnosis of major depression to meet goal	Antidepressant medication management rates will increase with the distribution of member health education material.	Acute Phase Treatment: MCAL 62.56% (90th percentile) Continuation Phase Treatment: 33.93% OneCare: Effective Phase Treatment 66.67% Continuation Phase Treatment 52.87%	2016 Mar Jun Sep Dec
**HEDIS/STARS: Review and assessment of osteoporosis management (OMW)	Increase the osteoporosis management in women who had a fracture rate in OC women who suffered a fracture to meet goal	Osteoporosis management in women who had a fracture will increase through improved member identification using claims and pharmacy data and provider education.	OC: 49.48% (75th percentile)	2016 April, July, October
HEDIS: Review and assessment of treatment of bronchitis (AAB)	Increase the avoidance of antibiotic treatment in adults with acute bronchitis rate in MC members with a diagnosis of acute bronchitis to meet goal	Avoidance of antibiotic treatment in adults with a diagnosis of acute bronchitis rate in MC members 18-64 years old will increase through member and provider education.	MC: 26.30% (50th percentile)	2016 April, July, October

Scope	Objective	Activity	Goals or Baseline	Target Completion
HEDIS: Review and assessment of childhood immunization rates	Increase the childhood immunization status rate in children 2 years old (combo 10) to meet goal	Immunization in children by their 2 nd birthday will increase through member reminders and education (Combo 10) This measure is also incentivized in our P4V program.	MC: Combo 10: 49.63% (90 th percentile)	2016 April, July, October
HEDIS: Review and assessment of adolescent Immunization rates	Increase the adolescent immunization rate to meet goal	Adolescent immunizations will improve through a adolescent focused event that will provide immunization opportunities, member education and member resources.	75th percentile (or above) 59.98%	2016 April, July, October
HEDIS: Review and assessment of appropriate testing for pharyngitis rates	Increase the appropriate testing of pharyngitis in children 2-18 years of age to meet goal	Appropriate testing for pharyngitis will improve through the distribution of strep A tests and provider education.	MC: 71.48% (50th percentile)	2016 April, July, October
HEDIS: Review and assessment of use of imaging studies for low back pain	Increase the use of appropriate treatment for low back pain (decrease the use of imaging studies for persons with low back pain)	Imaging studies will decrease for persons diagnosed with low back pain through provider outreach and education	MC: 74.95% (50th percentile)	2016 April, July, October
*STARS Improvement - Medication Adherence Measures	Improve the 3 Medication Adherence Measures to achieve 4 Star performance in each measure	Comprehensive member & provider outreach to identified members who appear non-compliant with medication management (interventions based on unique member characteristics)	4 Stars	2016 Mar Jun Sep Dec
CAHPS: Rating of Health Plan	Increase CAHPS score on Rating of Health Plan	Utilize results from CalOptima's supplemental survey and explorations of other methods to "hear" our member will assist in developing strategies to improve Rating of Health Plan.	50th Percentile or higher	2016 Mar Jun Sep Dec

Scope	Objective	Activity	Goals or Baseline	Target Completion
CAHPS: Getting Needed Care	Increase CAHPS score on Getting Needed Care	Sharing of HN specific CAHPS reports, member education on referrals and prior authorization processes, and review and monitoring of provider capacity and geoaccess standards will improve rating of Getting Needed Care.	50th Percentile or higher (2.52)	2016 Mar Jun Sep Dec
CAHPS: Getting Care Quickly	Increase CAHPS score on Getting Care Quickly	Sharing of HN specific CAHPS reports, member education on referrals and prior authorization processes, and review and monitoring of provider capacity and geoaccess standards will improve rating of Getting Care Quickly.	50th Percentile or higher	2016 Mar Jun Sep Dec
CAHPS: How Well Doctors Communicate	Increase CAHPS score on How Well Doctors Communicate	Tips on "Preparing for your Dr. Visit," toolkits/decision tools for PCPs, and provider and office staff in-service on customer service will improve rating on How Well Doctors Communicate.	50th percentile or higher	2016 Mar Jun Sep Dec
CAHPS: Customer Service	Increase CAHPS score on Customer Service	Customer service post-call survey and evaluation and trending of member pain points will improve rating of Customer Service.	50th percentile or higher	2016 Mar Jun Sep Dec
HOS: Health Outcome Survey Measures	Improve HOS measures for Star Rating	Develop and implement activities around: 1)Reducing Risk of Falls 2)Improving Physical Health Status 3)Improving Mental Health Status	50th percentile or higher	2016 Mar Jun Sep Dec

HEDIS Measures

 Owner: ~~Novella Quesada~~Marsha Choo, Manager, ~~QA~~

	Results / Metric	Next Steps	<u>Target Completion</u>
Diabetes care			
Controlling Blood Pressure			
30 Day Readmissions			
Flu & Pneumococcal Rates			
Prenatal Care			
Post Partum			
ADMD			
Antidepressant Medication Mgmt			
Osteoporosis Mgmt			
Antibiotics Use/ Bronchitis			
Childhood Immunizations.			

Combo 10			
Adolescent Immunizations			
Low Back Pain			

CAHPS Measures

Owner: Member Experience Team

	Results / Metric	Next Steps	<u>Target Completion</u>
Rating of Health			
Getting Needed Care			
Getting Care Quickly			
How well Doctors Communicate			
Customer Service			

|

STARSOwner: Kris Gericke, **PharmD,** Director, Pharmacy

	Results / Metric	Next Steps	<u>Target Completion</u>
Cholesterol			
Hypertension			
Diabetes			

Health Outcomes Survey

Owner: ~~Novella Quesada~~ Marshag Choo, Manager, ~~QIA~~

	Results / Metric	Next Steps	<u>Target Completion</u>
Reducing Risk of Falls			
Improving Physical Health Status			
Improving Mental Health Status			

X. Delegation Oversight

A. Delegation Oversight of CM

Owner: Tracy Hitzeman, Director, CM

The Approach

1. **Objective**

- Regular review of the Health Network’s performance of CM functions

2. **Activity**

- Assure compliance to all regulatory and accreditation delegation oversight requirements
- **Report from DOC

3. **Goals**

- 100%

|

2016 Quality Improvement ~~Workplan~~ Work Plan - Delegation Oversight
Owner: Tracy Hitzeman, Director, CM

Monitoring	<u>Assessments, Findings, Monitoring of Previously Identified Issues</u> Narrative	Next Steps	<u>Target Completion</u>
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	Results / Metrics	Next Steps	<u>Target Completion</u>
Q1			
Q2			
Q3			
Q4			
Year End			

X. Delegation Oversight

B. Quality of Care & Service of UM through delegation oversight reviews

Owner: Solange Marvin Director, Audit & Oversight

The Approach

1. Objective

- Delegation Oversight of Health Networks to assess compliance

2. Activity

- Delegated entity oversight supports how UM delegated activities are performed to expectations and compliance with standards, such as Prior Authorizations
- **Report from DOC

3. Goals

- 98%

2016 Quality Improvement ~~Workplan~~ Work Plan - Delegation Oversight
Owner: Solange Marvin, Director, Audit & Oversight

Monitoring	<u>Assessments, Findings, Monitoring of Previously Identified Issues</u> <u>Narrative</u>	Next Steps	<u>Target Completion</u>
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	Results / Metrics	Next Steps	<u>Target Completion</u>
Q1			
Q2			
Q3			
Q4			
Year End			

X. Delegation Oversight

C. Delegation oversight of BH Services

Owner: Solange Marvin Director, Audit & Oversight

The Approach

1. Objective

- Regular review of the MBHO’s performance of BH functions

2. Activity

- Assure compliance to all regulatory and accreditation delegation oversight requirements
- **Report from DOC

3. Goals

- 98%

2016 Quality Improvement ~~Workplan~~ Work Plan - Delegation Oversight
Owner: Solange Marvin, Director, Audit & Oversight

Monitoring	<u>Assessments, Findings, Monitoring of Previously Identified Issues</u> <u>Narrative</u>	Next Steps	<u>Target Completion</u>
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	Results / Metrics	Next Steps	<u>Target Completion</u>
Q1			
Q2			
Q3			
Q4			
Year End			

XI. Organizational Projects

A. Implementation of the 2016 Value Based P4P Program

Owner: Medical Director, Quality & Analytics

The Approach

1. Objective

- Confirm and implement the 2016 Value Based P4P Program (Medi-Cal & OCC)

2. Activity

- Complete review of 2014 & 2015; confirm measures, align with auto-assignment quality measures and define weighting for 2016
- Incentivize Health Networks via a P4P to achieve high quality scores on targeted accreditation, health plan rating and STARS measures

3. Goals

- Improve performance over 2015

2016 Quality Improvement ~~Workplan~~Work Plan- Organizational Projects
Owner: Medical Director, QA

Monitoring	<u>Assessments, Findings, Monitoring of Previously Identified Issues</u> <u>Narrative</u>	Next Steps	<u>Target Completion</u>
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	Results / Metrics	Next Steps	<u>Target Completion</u>
Q1			
Q2			
Q3			
Q4			
Year End			

XI. Organizational Projects

B. Value Based P4P 2016-2019

Owner: Kelly Rex-Kimmet, Director, QA

The Approach

1. Objective

- Design longer term Value Based P4P Program and gain board approval by 7/1/16

2. Activity

- Design new program in conjunction with provider/ Health Network Stakeholders, PAC & MAC input; develop COBAR for presentation to board
- Define analytics and matching resources to support new P4Value Program

3. Goals

- National & State Benchmarks

2016 Quality Improvement ~~Workplan~~Work Plan- Organizational Projects
Owner: Kelly Rex-Kimmet, Director, QA

Monitoring	<u>Assessments, Findings, Monitoring of Previously Identified Issues</u> <u>Narrative</u>	Next Steps	<u>Target Completion</u>
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	Results / Metrics	Next Steps	<u>Target Completion</u>
Q1			
Q2			
Q3			
Q4			
Year End			

										"Attachment B"
Dom_Ele	Element Name	CO	HN	Sub-De	Kaiser	CHIPA	Sub-Bea	PBM	HIP	Comments
QI1A	QI Program Structure	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CO Resp P&P, even if delegated
QI1B	Annual Evaluation	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CO Resp P&P, even if delegated
QI2A	QI Committee Responsibilities	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CO Resp P&P, even if delegated
QI2B	Informing Members and Practitioners	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CO Resp P&P, even if delegated
QI3A	Practitioner Contracts	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CO Resp P&P, even if delegated
QI3B	Affirmative Statement	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CO Resp P&P, even if delegated
QI3C	Provider Contracts	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CO Resp P&P, even if delegated
QI4A	Member Services Telephone Access	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
QI4B	BH Telephone Access Standards	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CO Resp P&P, even if delegated
QI4C	Annual Assessment-Member Experience	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CO fields CAHPS, Kaiser complaint data included CO
QI4D	Opportunities for Improvement-Member Experience	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	activities may not be delegated
QI4E	Annual Assessment of BH and Services-Member Experience	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kaiser F1&2, CO F1, CHIPA F2 only
QI4F	BH Opportunities for Improvement-Member Experience	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	not delegated to CHIPA or Kaiser
QI4G	Assessing Experience With the UM Process	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	F3&4 activities may not be delegated, CO get Kaiser data
QI5A	Population Assessment	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CalOptima assesses entire pop including Kaiser
QI5B	Program Description-CCM	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
QI5C	Identifying Members for CCM	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
QI5D	Access to Case Management-CCM	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
QI5E	Case Management Systems-CCM	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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Dom_Ele	Element Name	CO	HN	Sub-De	Kaiser	CHIPA	Sub-Bea	PBM	HIP	Comments
QI5F	Case Management Process-CCM	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CO Resp P&P, even if delegated
QI5G	Initial Assessment-CCM	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
QI5H	Case Management- Ongoing Management-CCM	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
QI5I	Experience With Case Management-CCM	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
QI5J	Measuring Effectiveness-CCM	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
QI5K	Action and Remeasurement-CCM	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
QI6A	Program Content-DM	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
QI6B	Identifying Members for DM Programs	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
QI6C	Frequency of Member Identification-DM	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
QI6D	Providing Members With Information-DM	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
QI6E	Interventions Based on Assessment-DM	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
QI6F	Eligible Member Active Participation-DM	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
QI6G	Informing and Educating Practitioners-DM	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
QI6H	Intergrating Member Information-DM	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
QI6I	Experience With DM	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
QI6J	Measuring Effectiveness-DM	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
QI7A	Adoption and Distribution of Guidelines	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
QI7C	Relation to DM Programs	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
QI8A	Identifying Opportunities-C&C	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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Dom_Ele	Element Name	CO	HN	Sub-De	Kaiser	CHIPA	Sub-Bea	PBM	HIP	Comments
QI8B	Acting on Opportunities-C&C	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
QI8C	Measuring Effectiveness-C&C	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
QI8D	Transition to Other Care-C&C	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
QI9A	Data Collection- C&C Behavioral Health	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	not delegated to CHIPA or Kaiser
QI9B	Collaborative Activities- C&C Behavioral Health	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	not delegated to CHIPA or Kaiser
QI9C	Measuring Effectiveness- C&C Behavioral Health	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	not delegated to CHIPA or Kaiser
QI10A	Delegation Agreement	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
QI10B	Provision of Member Data to the Delegate	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
QI10D	Predelegation Evaluation-NA	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
QI10E	Review of QI Program	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
QI10F	Opportunities for Improvement	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
NET1A	Cultural Needs and Preferences	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CO Resp P&P, even if delegated
NET1B	Practitioners Providing Primary Care	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CO Resp F1-2 P&P, even if delegated
NET1C	Practitioners Providing Specialty Care	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CO Resp F1-3 P&P, even if delegated
NET1D	Practitioners Providing BH	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CO Resp F1-3 P&P, even if delegated, CHIPA/Kaiser F4
NET2A	Access to Primary Care	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CO Resp P&P, even if delegated,
NET2B	Access to BH	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CO Resp P&P, even if delegated
NET2C	Access to Specialty Care	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
NET3A	Assessment of Member Experience Accessing the Network	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	For BH See QI4E: Kaiser F1&2, CO F1, CHIPA F2 only

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Dom_Ele	Element Name	CO	HN	Sub-De	Kaiser	CHIPA	Sub-Bear	PBM	HIP	Comments
NET3B	Opportunities to Improve Access to Nonbehavioral Healthcare Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
NET3C	Opportunities to Improve Access to BH Services	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	For BH See QI4E: Kaiser F1&2, CO F1, CHIPA F2 only
NET5A	Notification of Termination	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
NET5B	Continued Access to Practitioners	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
NET6A	Physician Directory Data	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	not delegated to CHIPA
NET6B	Physician Directory Updates	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	not delegated to CHIPA
NET6C	Assessment of Physician Directory Accuracy	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
NET6D	Identifying and Acting on Opportunities	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
NET6E	Physician Information Transparency	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	not delegated to CHIPA
NET6F	Searchable Physician Web-Based Directory	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	not delegated to CHIPA
NET6G	Hospital Directory Data	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	not delegated to CHIPA
NET6H	Hospital Directory Updates	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	not delegated to CHIPA
NET6I	Hospital Information Transparency	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	not delegated to CHIPA
NET6J	Searchable Hospital Web-Based Directory	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	not delegated to CHIPA
NET6K	Usability Testing	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	not delegated to CHIPA
NET6L	Availability of Directories	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	not delegated to CHIPA
NET7A	Delegation Agreement	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
NET7B	Provisions of Member Data to the Delegate	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
NET7D	Predelegation Evaluation	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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Dom_Ele	Element Name	CO	HN	Sub-De	Kaiser	CHIPA	Sub-Bear	PBM	HIP	Comments
NET7E	Review of Delegated Activities	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
NET7F	Opportunities for Improvement	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
UM1A	Written Program Description	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CO Resp P&P, even if delegated
UM1B	Physician Involvement	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CO Resp P&P, even if delegated
UM1C	BH Practitioner Involvement	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CO Resp P&P, even if delegated
UM1D	Annual Evaluation	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CO Resp P&P, even if delegated
UM2A	UM Criteria	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CO Resp P&P, even if delegated
UM2B	Availability of Criteria	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CO Resp P&P, even if delegated
UM2C	Consistency in Applying Criteria	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CO Resp P&P, even if delegated
UM3A	Access to Staff	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CO Resp P&P, even if delegated
UM4A	Licensed Health Professionals	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CO Resp P&P, even if delegated
UM4B	Use of Practitioners for UM Decisions	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CO Resp P&P, even if delegated
UM4C	Practitioner Review of Nonbehavioral Healthcare Denials	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
UM4D	Practitioner Review of BH Denials	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
UM4E	Practitioner Review of Pharmacy Denials	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
UM4F	Use of Board-Certified Consultants	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
UM4G	Affirmative Statement About Incentives	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
UM4H	Appropriate Classification of Denials	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
UM5A	Timeliness of Nonbehavioral UM Decision Making	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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Dom_Ele	Element Name	CO	HN	Sub-De	Kaiser	CHIPA	Sub-Bea	PBM	HIP	Comments
UM5B	Notification of Nonbehavioral Decisions	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
UM5C	Timeliness of Behavioral Healthcare UM Decision Making	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
UM5D	Notification of Behavioral Healthcare Decisions	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
UM5E	Timeliness of Pharmacy UM Decision Making	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
UM5F	Notification of Pharmacy Decisions	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
UM5G	UM Timeliness Report	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
UM6A	Relevant Information for Nonbehavioral Decisions	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
UM6B	Relevant Information for BH Decisions	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
UM6C	Relevant Information for Pharmacy Decisions	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
UM7A	Discussing a Denial With a Reviewer	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
UM7B	Written Notification of Nonbehavioral Healthcare Denials	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
UM7C	Nonbehavioral Notice of Appeal Rights/Process	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
UM7D	Discussing a BH Denial with a Reviewer	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
UM7E	Written Notification of BH Denials	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
UM7F	BH Notice of Appeal Rights/Process	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
UM7G	Discussing a Pharmacy Denial With a Reviewer	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
UM7H	Written Notification of Pharmacy Denials	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
UM7I	Pharmacy Notice of Appeal Rights/Process	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
UM8A	Internal Appeals (Policies and Procedures)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CO Resp P&P, even if delegated

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Dom_Ele	Element Name	CO	HN	Sub-De	Kaiser	CHIPA	Sub-Bea	PBM	HIP	Comments
UM9A	Preservice and Postservice Appeals	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CO Resp P&P, even if delegated
UM9B	Timeliness of the Appeal Process	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
UM9C	Appeal Reviewers	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
UM9D	Notification of Appeal Decision/Rights	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
UM11A	Coverage of Emergency Services(Policies and Procedures)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
UM12A	Pharmaceutical Management Procedures(Policies and Procedures)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
UM12B	Pharmaceutical Restrictions/Preferences	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
UM12C	Pharmaceutical Patient Safety Issues	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
UM12D	Reviewing and Updating Procedures	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
UM12E	Considering Exceptions	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
UM13A	Triage and Referral Protocols	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
UM13B	Supervision and Oversight	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
UM14A	Delegation Agreement	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
UM14B	Provision of Member Data to the Delegate	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
UM14D	Predelegation Evaluation	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
UM14E	Review of the UM Program	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
UM14F	Opportunities for Improvement	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
CR1A	Practitioner Credentialing Guidelines	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CO Resp P&P, even if delegated
CR1B	Practitioner Rights	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CO Resp P&P, even if delegated

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Dom_Ele	Element Name	CO	HN	Sub-De	Kaiser	CHIPA	Sub-Bea	PBM	HIP	Comments
CR2A	Credentialing Committee	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
CR3A	Verification of Credentials	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
CR3B	Sanction Information	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
CR3C	Credentialing Application	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
CR4A	Recredentialing Cycle Length	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
CR5A	Performance Standards and Thresholds	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
CR5B	Site Visits and Ongoing Monitoring	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
CR6A	Ongoing Monitoring and Interventions	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
CR7A	Actions Against Practitioners	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CO Resp P&P, even if delegated
CR7B	Reporting to Appropriate Authorities	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CO Resp P&P, even if delegated
CR7C	Practitioner Appeal Process	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CO Resp P&P, even if delegated
CR8A	Review and Approval of Provider	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
CR8B	Medical Providers	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
CR8D	Assessing Medical Providers	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
CR9A	Delegation Agreement	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
CR9C	Predelegation Evaluation	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
CR9D	Review of Delegate's Credentialing Activities	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
CR9E	Opportunities for Improvement	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
CR1C	Performance Monitoring for ReCred (CMS/DHCS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CMS/DHCS Requirement

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Dom_Ele	Element Name	CO	HN	Sub-De	Kaiser	CHIPA	Sub-Bear	PBM	HIP	Comments
CR1D	Contracts Opt-Out Provisions (CMS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CMS Requirement
CR1E	Medicare-Exclusions/Sanctions (CMS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CMS Requirement
CR3D	Hospital Admitting Privileges (CMS/DHCS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CMS/DHCS Requirement
CR6B	Monitoring Medicare Opt Out (CMS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CMS Requirement
CR6C	Monitoring Medi-Cal Suspended and Ineligible Provider Reports (DHCS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	DHCS Requirement
CR7D	Appeals Process for Termination/Suspension (CMS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CMS Requirement
CR10A	ID of HIV/AIDS Specialists: Written Process	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	DHCS Requirement
CR10B	ID of HIV/AIDS Specialists: Evidence of Implementation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	DHCS Requirement
CR10C	ID of HIV/AIDS Specialists: Distribution of Findings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	DHCS Requirement
RR1A	Rights and Responsibilities Statement	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	activities may not be delegated
RR1B	Distribution of Rights Statement	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	activities may not be delegated
RR2A	Policies and Procedures for Complaints	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CO Resp P&P, even if delegated
RR2B	Policies and Procedures for Appeals	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CO Resp P&P, even if delegated
RR3A	Subscriber Information	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	activities may not be delegated
RR3B	Interpreter Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
RR4A	Adopting Written Policies	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	activities may not be delegated
RR4B	Physical and Electronic Access	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	activities may not be delegated
RR4C	Protection for PHI Sent to Plan Sponsors	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	activities may not be delegated
RR4D	Authorization	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	activities may not be delegated

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Dom_Ele	Element Name	CO	HN	Sub-De	Kaiser	CHIPA	Sub-Bear	PBM	HIP	Comments
RR4E	Communication of PHI Use and Disclosure	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	activities may not be delegated
RR4F	Accountability and Responsibility	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	activities may not be delegated
RR4G	Chief Privacy Officer/Privacy Committee	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	activities may not be delegated
RR4H	Web Site	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	activities may not be delegated
MEM1A	HA Components	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Auto Credit avail w HIP Certified
MEM1B	HA Disclosure	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Auto Credit avail w HIP Certified
MEM1C	HA Scope	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Auto Credit avail w HIP Certified
MEM1D	HA Results	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Auto Credit avail w HIP Certified
MEM1E	Formats	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Auto Credit avail w HIP Certified
MEM1F	Frequency of HA Completion	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Auto Credit avail w HIP Certified
MEM1G	Review and Update Process	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Auto Credit avail w HIP Certified
MEM2A	Topics of Tools	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Auto Credit avail w HIP Certified
MEM2B	Usability Testing	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Auto Credit avail w HIP Certified
MEM2C	Review and Update Process	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Auto Credit avail w HIP Certified
MEM2D	Formats	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Auto Credit avail w HIP Certified
MEM3B	Functionality: Telephone Requests	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
MEM4A	Pharmacy Benefit Information: Website	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Vendor delegate possibility for factors 6-8
MEM4B	Pharmacy Benefit Information: Telephone	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
MEM4C	QI Process on Accuracy of Information	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 7, 2016

Regular Meeting of the CalOptima Board of Directors

Consent Calendar

4. Approve the 2016 CalOptima Utilization Management Program and 2016 Work Plan

Contact

Richard Bock, M.D., Deputy Chief Medical Officer, (714) 246-8400

Recommended Action

Approve the recommended revisions to the 2016 Utilization Management Program and 2016 Work Plan.

Background

Utilization Management activities are conducted to ensure that member's needs are always at the forefront of any determination regarding care and services. The program is established and conducted as part of CalOptima's purpose and mission to ensure the delivery of medically necessary, achievable, quality member care through the consistent delivery of health care services. It provides for the consistent delivery of quality health care services in a coordinated, comprehensive manner, without discrimination based on health status, and in a culturally competent manner. It also ensures that medical decision making is not influenced by financial considerations, does not reward practitioners or other individuals for issuing denials of coverage, nor does the program encourage decisions that result in underutilization. Additionally, the Utilization Management Program is conducted to ensure compliance with CalOptima's obligations to meet contractual, regulatory and accreditation requirements.

CalOptima's Utilization Management Program ("the UM Program") must be reviewed and evaluated annually by the Board of Directors. The UM Program defines the structure within which utilization management activities are conducted, and establishes measurable processes for systematically coordinating, managing and monitoring members to achieve positive member outcomes.

CalOptima has updated the 2016 program with revisions and a change to format to ensure that it is aligned to reflect required regulatory and accreditation changes, along with strategic organizational changes, to ensure that all regulatory and accreditation requirements are met.

Discussion

The 2016 Utilization Management Program is based on the Board-approved 2015 Utilization Management Program and describes: (i) the scope of the program as well as structure and services provided; (ii) the populations served- including both Medi-Cal and Medicare members; (iii) key business processes and the integration across CalOptima; and (iv) important aspects of care and service for all lines of business. It is consistent with regulatory requirements, NCQA standards and CalOptima's own Success Factors.

The revisions are summarized as follows:

- Added information regarding Medi-Cal Managed Long Term Services and Supports
- Reflect the name change of Long Term Care to Long Term Support Services and added

- Multipurpose Senior Services Program (MSSP) and In Home Support Services (IHSS)
- Revised and added Behavioral Health Services
- Revised Services Not Provided by CalOptima
- Added Regional Center of Orange County
- Added responsibilities for Chief Medical Officer
- Added Director of Utilization Management description
- Added Executive Director of Quality and Analytics description
- Added Director of Long Term Services and Supports description
- Added Long Term Services and Supports Resources
- Removed Team Leads
- Revised Committee Structure organizational chart
- Revised and added detail regarding Behavioral Health Quality Improvement Committee
- Added Long Term Services and Supports QISC structure and responsibilities
- Added information on Pharmacy Department denial and appeals rights and process
- Added Long Term Services and Supports review criteria reference guidelines
- Added Pharmaceutical turnaround time guidelines
- Updated criteria and guidelines used for UM decision making

The recommended changes are necessary to meet the requirements specified by the Centers for Medicare & Medicaid Services, California Department of Health Care Services, and NCQA accreditation standards.

Fiscal Impact

There is no fiscal impact.

Concurrence

CalOptima Utilization Management Subcommittee
Gary Crockett, Chief Counsel
Board of Directors' Quality Assurance Committee

Attachments

PowerPoint Presentation – 2016 Utilization Management Program Description
2016 Utilization Management Program – Executive Summary
2016 Utilization Management Program – Program Changes
Draft 2016 CalOptima Utilization Management Program

/s/ Michael Schrader
Authorized Signature

04/01/2016
Date



CalOptima
Better. Together.

2016 Utilization Management Program Description

**Board of Directors Meeting
April 7, 2016**

**Debra Armas
Director of Utilization Management**

CalOptima's 2016 UM Program

The 2016 Utilization Management Program is based on the Board-approved 2015 Utilization Management Program and describes:

- (i) the scope of the program as well as structure and services provided;
- (ii) the populations served- including both MediCal and Medicare members;
- (iii) key business processes and the integration across CalOptima; and
- (iv) important aspects of care and service for all lines of business. It is consistent with regulatory requirements, NCQA standards and CalOptima's own Success Factors.

Approval Process

- Must be reviewed and evaluated annually by the Board of Directors.
- Document has been vetting by the following committees:
 - Internal Utilization Management Group
 - External Utilization Management Committee
 - Composition includes currently practicing Community Physicians-Member of the OCMA
 - Quality Assurance Committee
 - Extensive discussion on the 2015 Program Evaluation and the 2016 Program Work Plan and Evaluation as a basis for the development of the revised document

Background

- Utilization Management activities ensure member's needs are always at the forefront of any determination regarding care and services.
- Provides for consistent delivery of quality health care services in a coordinated, comprehensive manner, without discrimination based on health status, and in a culturally competent manner.

Background

- Medical decision making not influenced by financial consideration
 - does not reward for issuing denials of coverage
 - does not encourage decisions that result in underutilization.
- Defines the structure within which utilization management activities are conducted, and establishes measurable processes for systematically coordinating, managing and monitoring members to achieve positive member outcomes.
- Reflects required regulatory and accreditation changes, strategic organizational changes, and ensures that all regulatory and accreditation requirements are met.

Program Updates:

- Criteria and Guidelines used for UM decision making

Program Additions:

- Description for Executive Director of Quality and Analytics
- Responsibilities for Chief Medical Officer
- Description for Director of Utilization Management
- Description for Director of Long Term Services and Supports
- Long Term Services and Supports structure and description and review criteria reference guidelines
- Regional Center of Orange County description
- Pharmacy turnaround time guidelines
- Pharmacy denial and appeals rights and process

Program Changes/Revisions:

- Behavioral Health services description
- Services not provided by CalOptima
- UM Committee organizational chart

Program Items Removed

- Team leads from UM department structure

2016 UTILIZATION MANAGEMENT (UM) PROGRAM EXECUTIVE SUMMARY

ADMINISTRATIVE UPDATES

Updated the Scope to include Home and Community Based Services, (CBAS). Updated Goals to include Long Term Services and Supports, In-Home Supportive Services, (IHSS), Multipurpose Senior Services Program, (MSSP), and CBAS.

Committee Structure Organizational Chart updated to reflect all programs with Utilization Management Oversight.

RESPONSIBILITY, AUTHORITY AND ACCOUNTABILITY

The following positions were added as resources to the UM Department as they play a key role in the assurance that both the department and all delegated entities meet CalOptima's standards and requirements

Defined the Deputy Chief Medical Officer in conjunction with the Chief Medical Officer.

Director of Utilization Management assists in the development and implementation of the Utilization Management Program, policies, and procedures. Ensures the appropriate use of evidenced-based clinical review criteria/guidelines for medical necessity determinations. The Director of Utilization Management also provides supervisory oversight and administration of the Utilization Management Program, oversees all clinical decisions rendered for concurrent, prospective and retrospective reviews that support UM medical management decisions, serves on the Utilization and Quality Improvement Committees, participates in the Utilization Management Committee and the Benefit Management Subcommittee.

Executive Director of Quality and Analytics provides oversight of key medical affairs functions including: Quality Management, Quality Analytics, Health Education and Disease Management. The ED of Quality and Analytics serves as a member of the executive team and, with the CMO, ensures that Medical Affairs is aligned with CalOptima's strategic and operational priorities. This position is a key leader within the health plan and has the accountability to lead the areas assigned to next-level capabilities and operational efficiencies consistent with the strategic plan, goals, and objectives for CalOptima. Position will anticipate, continuously improve, communicate and leverage resources. The ED of Quality and Analytics will balance achieving set accountabilities with constraints of limited resources.

Director of Long Term Services and Supports is responsible for LTSS programs which include Community Based Adult Services, (CBAS), In-Home Supportive Services, (IHSS), Long Term Care Services, (LTC), and Multipurpose Senior Services Program, (MSSP). The position supports a "Member-Centric" approach to help to keep members in the least restrictive living

environment. Collaborates with stakeholders including community partners and ensures LTSS services provided are procedures and processes related to the LTSS program operations. Also, added LTSS supporting roles to provide a multidisciplinary program structure.

NEW PROGRAMS

Medi-Cal Managed Long Term Services and Supports

Beginning July 1, 2015, Long Term Services and Supports, (LTSS) became a CalOptima benefit for all Medi-Cal enrollees. CalOptima ensures LTSS services are available to members who have health care needs and meet the program eligibility criteria and guidelines. The LTSS program has two primary components with four programs.

- Community Based Adult Services, (CBAS)
- Nursing Facility Services for Long Term Care Services
- Multipurpose Senior Services Program, (MPSS)
- In-Home Supportive Services, (IHSS)

Expanded Behavioral Health to include OneCare and OneCare Connect behavioral health services.

Expanded Services Not Provide by CalOptima, defining the Regional Center of Orange County, (RCOC).

CALOPTIMA APPROVED GUIDELINES

Updated list to reflect all guidelines that are utilized and indicate that delegated entities must use the same or similar nationally recognized criteria. These include:

- Medi-Cal Manual of Criteria, published by the State of California;
- National Comprehensive Cancer Network (NCCN) Guidelines;
- Centers of Excellence guidelines;
- Specialty Guidelines such as the American Academy of Pediatric Guidelines (AAP);
- Evidence based nationally recognized criteria such as MCG;
- CalOptima Level of Care Criteria for outpatient behavioral health services;
- CalOptima Medical Policy and Medi-Cal Benefits Guidelines;
- National and Local Determination Guidelines.

Updated UM Decision and Notification Timelines to add pharmacy timeliness guidelines for clinical decision making. Also, added guidelines for denial review and notification for pharmacy determinations.

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ADMINISTRATIVE UPDATES			
<p><u>Services Not Provided by CalOptima</u></p> <p>Under its Medi-Cal Program, CalOptima provides a comprehensive scope of acute and preventive care services for Orange County’s Medi-Cal and dual eligible populations. Certain health care services are not provided by CalOptima, as determined by law and/or regulatory contract. Other services may be provided by different agencies including those indicated below:</p> <ul style="list-style-type: none"> • Specialty mental health services are administered by the Orange County Health Care Agency (HCA) County Mental Health Plan. • Dental services are provided through California’s Denti-Cal program. • California Children’s Services (CCS) is a statewide program managed by the Department of Health Care Services (DHCS) and authorizes and pays for specific medical services and equipment provided by CCS-approved specialists for children with certain physical limitations and chronic health conditions or diseases. • Regional Center of Orange County as a local agency contracted by the State by the State of California to coordinate lifelong services and supports for people with developmental disabilities, Regional Center of Orange County, (RCOC), provides services and supports that are as diverse as the people served. Each person serviced by RCOC has an individual Family Service Plan, (IFSP), - that addresses his or her individual needs. The following are types of services and supports available through RCOC, or that RCOC can assist clients and families access through other sources: <ul style="list-style-type: none"> ○ Prenatal Diagnostic Evaluation ○ Early Intervention Services, (Birth to 		Services Not Provided by CalOptima	11

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<p>36 months)</p> <ul style="list-style-type: none"> o Therapy Services o Respite Care Services o Child Care Services o Adult Day Program Services, (Employment and Community-Based Activities) o Transportation Services o Residential Services o Psychological, Counseling and Behavioral Services o Medical and Dental Services o Equipment and Supplies o Social and Recreational Services <p>In addition, CalOptima provides linkages with community programs to ensure that members with special health care needs, or high risk or complex medical and developmental conditions, receive wrap around services that enhance their medical benefits. These linkages are established through special programs, such as the CalOptima Community Liaisons, and specific program Memoranda of Understanding (MOU) with other community agencies and programs, such as the Orange County Heath Care Agency’s California Children’s Services, Orange County Department of Mental Health, and the Regional Center of Orange County. The UM staff and delegated entity practitioners are responsible for identification of such cases, and coordination of referral to appropriate State agencies and specialist care when the benefit coverage of the member dictates. The UM Department coordinates activities with the Case Management and/or Disease Management Departments to assist members with the transition to other care, if necessary, when benefits end. This may include informing the member about ways to obtain continued care through other sources, such as community resources.</p> <p><u>Added:</u></p> <p><u>Deputy Chief Medical Officer</u> fulfills all of the roles and responsibilities of the office of the CMS in conjunction with and/or in the absence of the CMO, (as outlined above).</p> <p><u>Director of Utilization Management</u> assists in the development</p>	Human Resources	<p>CalOptima Officers and Directors</p> <p>CalOptima Officers and</p>	<p>13</p> <p>14</p>

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<p>and implementation of the Utilization Management Program, policies, and procedures. Ensures the appropriate use of evidenced-based clinical review criteria/guidelines for medical necessity determinations. The Director of Utilization Management also provides supervisory oversight and administration of the Utilization Management Program, oversees all clinical decisions rendered for concurrent, prospective and retrospective reviews that support UM medical management decisions, serves on the Utilization and Quality Improvement Committees, participates in the Utilization Management Committee and the Benefit Management Subcommittee.</p> <p><u>Executive Director of Quality and Analytics</u> provides oversight of key medical affairs functions including: Quality Management, Quality Analytics and Disease Management which includes health education programs. The ED of Quality and Analytics serves as a member of the executive team and, with the CMO, ensures that Medical Affairs is aligned with CalOptima’s strategic and operational priorities. This position is a key leader within the health plan and has the accountability to lead the areas assigned to next-level capabilities and operational efficiencies consistent with the strategic plan, goals, and objectives for CalOptima. Position will anticipate, continuously improve, communicate and leverage resources. The ED of Quality and Analytics will balance achieving set accountabilities with constraints of limited resources.</p> <p><u>Committee Structure Org Chart</u> Addition of the newly formed OneCare Connect Member Advisory Committee (OCC MAC)</p>	<p>Human Resources</p> <p>Utilization Management Program</p>	<p>Directors</p> <p>CalOptima Officers and Directors</p> <p>Committee Structure</p>	<p>15</p> <p>24</p>
<p>NEW PROGRAMS</p> <p><u>Medi-Cal Managed Long Term Services and Supports</u></p> <p>Beginning July 1, 2015, Long Term Services and Supports, (LTSS) became a CalOptima benefit for all Medi-Cal enrollees. CalOptima ensures LTSS services are available to members who have health care needs and meet the program eligibility criteria and guidelines. The LTSS program has two primary components</p>	<p>Long Term Care</p>	<p>Medi-Cal Managed Long Term Services and Supports</p>	<p>4 and 5</p>

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<p>with four programs.</p> <ul style="list-style-type: none"> • Community Based Adult Services (CBAS) - CalOptima provides CBAS as a health plan benefit. CalOptima utilizes the Department of Health Services, (DHCS), approved CBAS Eligibility Determination Tool, (CEDT), criteria to assess a member's health condition and make a medical determination for the program. The Community Bases Adult Services is an outpatient, facility-based program that offers health and social services to seniors and persons with disabilities. • Nursing Facility Services for Long Term Care Services - CalOptima utilizes the DHCS Medi-Cal Criteria Chapter, Criteria for Long Term Care Services and Title 22, CCR, Sections: 51003, 51303, 51511(b), 51334, 51335, and 51343. CalOptima is responsible for the clinical review, medical determination and performs authorization functions for Long Term Care services for the following levels of care: <ul style="list-style-type: none"> ○ Nursing Facility Level B, (Long Term Care) ○ Nursing Facility Level A ○ Subacute Adult and Pediatric ○ Intermediate Care Facility / Developmentally Disabled, (ICF/DD) ○ Intermediate Care Facility / Developmentally Disabled Habilitative, (ICF/DD-H) ○ Intermediate Care Facility / Developmentally Disabled Nursing, (ICF/DD-N) • Multipurpose Senior Services Program, (MPSS) - CalOptima is responsible for identification referral and coordination of integrated services within the MSSP Site. The CalOptima MSSP Site adheres to the California Department of Aging contract and eligibility determination criteria. • In-Home Supportive Services, (IHSS), - CalOptima and the health networks are responsible for identification, referral and provide care coordination. CalOptima collaborates with Orange County Social Services Agency, (SSA), In-Home Supportive Services, Orange County Public Authority and health networks to ensure members receive appropriate level of care services. 			

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<p><u>Director of Long Term Services and Supports</u> is responsible for LTSS programs which include Community Based Adult Services, (CBAS), In-Home Supportive Services, (IHSS), Long Term Care Services, (LTC, and Multipurpose Senior Services Program, (MSSP). The position supports a "Member-Centric" approach to help to keep members in the least restrictive living environment. Collaborates with stakeholders including community partners and ensures LTSS services provided are procedures and processes related to the LTSS program operations.</p> <p><u>Long Term Services and Supports Resources</u></p> <p>The following staff positions provide support for LTSS operations:</p> <p><u>LTSS Director, (CBAS/IHSS/LTC/MSSP)</u> The Director of Long Term Services and Support, (LTSS), will develop, manage and implement the Long Term Care Services and Support including long Term Care facilities, In-Home Supportive Services, Community Bases Adult Services and the Multipurpose Senior Services Program and staff associated with those programs. S/he will be responsible for ensuring high quality and responsive service for CalOptima members residing in Long Term Care facilities, (all levels of care), and to those members enrolled in other LTSS programs. Develops, evaluates programs and policy initiatives affecting seniors and (SNF/Subacute/ICF/ICF-DD/N/H) and other LTSS services.</p> <p><u>Experience & Education</u></p> <ul style="list-style-type: none"> • 5 – 7 years varied related experience, including 5 years of supervisory experience with experience in supervising groups of staff in a similar environment. • Bachelor's degree in Nursing or in a related field required. • Master's degree in Health Administration, Public Health, Gerontology, or Licensed Clinical Social Worker is desirable. • Some experience in government or public environment preferred • Experience in the development and implementation of 	Human Resources	Director of Long Term Services and Supports	16

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<p>new programs</p> <p><u>LTSS Manager, RN, (CBAS/IHSS/LTC)</u> The Manager is expected to develop and manage the Long Term Services and Supports Department's work activities and personnel. S/he will ensure that services standards are met and operations are consistent with the health plan's policies and regulatory and accrediting agency requirements to ensure high quality and responsive service for CalOptima's members who are receiving long term care services and supports. The Manager must have strong team leadership, problem solving, organizational, and time management skills with the ability to work effectively with management, staff, providers, vendors, health networks, and other internal and external customers in a professional and competent manner. This position will work in conjunction with various department managers and staff to coordinate, develop, and evaluate programs and policy initiatives affecting members receiving long term care services</p> <p><u>Experience and Education</u></p> <ul style="list-style-type: none"> • A current and unrestricted RN license in the State of California • A Bachelor's degree or relevant experience in a healthcare field preferred • 5 - 7 years varied clinical experience required • 3 - 5 years supervisory/management experience in a managed care setting and /or nursing facility • Experience in government or public environment preferred • Experience in death with geriatrics and persons with disabilities <p><u>LTSS Supervisor, RN,(CBAS, IHSS, LTC)</u> The Supervisor is responsible for planning, organizing, developing and implementing the principles, programs, policies and procedures employed in the delivery of long term care services and supports to members in the community and institutionalized setting. The Supervisor is responsible for the management of the day-to-day operational activities for LTSS programs: Long Term Care, (LTC), Community Based Adult Services, (CBAS), and In-Home Support Services, (IHSS), and personnel, while interacting with internal/external management staff, providers, vendors, health networks, and other internal and external customers in a</p>			

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<p>professional, positive and competent manner. The position's primary responsibilities are the supervision and monitoring of the ongoing and daily activities of the department's staff. In addition, the supervisor will be resolving members and providers issues and barriers ensuring excellent customer service. Additional responsibilities include: Managing staff coverage in all areas of LTSS to complete assignments, orienting, and training of new employees to ensure contractual and regulatory requirements are met.</p> <p><u>Experience and Education</u></p> <ul style="list-style-type: none"> • A current unrestricted RN license in the State of California • A bachelor's degree or relevant experience in a healthcare field preferred • 3 years varied experience at a health plan, medical group, or skilled nursing facilities required • Experience in interacting/managing with geriatrics and persons with disabilities • Supervisory/management experience in utilization management activities • Valid driver's license and vehicle, or other approved means of transportation, an acceptable driving record, and current auto insurance will be required for work away from the primary office approximately 30% of the time. <p><u>Medical Case Managers</u> The LTSS Medical Case Manager, (MCM), is part of an advanced specialty collaborative practice, responsible for case management, care coordination and function, provides coordination of care, and provides ongoing case management services for CalOptima members in Long term Care, (LTC), facilities and members receiving Community Based Adult Services, (CBAS). Reviews and determines medical eligibility based on approved criteria/guidelines, NCQA standards, Medicare and Medi-Cal guidelines, and facilitates communication and coordination amongst all participants of the health care team and the member to ensure services are provided to promote quality, cost-effective outcomes. The LTSS MCM provides case management in a collaborative process that includes assessment, planning, implementation, coordination, monitoring and evaluation of the member's needs. The LTSS MCM is the subject</p>			

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<p>matter expert and acts as a liaison to Orange County bases community agencies, CBAS center, skilled nursing facilities, and to members and providers.</p> <p><u>Experience and Education</u></p> <ul style="list-style-type: none"> • A current and unrestricted RN license in the State of California • A current unrestricted LVN license in the State of California • Minimum of 3years managed care or nursing facility experience • Excellent interpersonal skills • Computer literacy required <p>Valid driver's license and vehicle, or approved means of transportation , an acceptable driving record, and current auto insurance will be required for work away from the primary office approximately 95% of the time</p> <p><u>CBAS Program Manager (MSW/MS)</u> The CBAS Program Manager is responsible for managing the day-to-day operations of the CBAS Program and educates CBAS centers on various topics. The Program Manager is responsible for the annual CBAS Provider Workshop, CBAS process improvement, reporting requirements, reviews monthly files audit, develops inter-rater reliability questions, performs psychosocial and functional assessments, a liaison and a key contact person for California Department of Health Care Services (DHCS), California Department Office of Aging (CDA), CBAS Coalition and CBAS centers. The CBAS Program Manager is responsible developing strategies and solutions to effectively implement CBAS project deliverables that require collaboration across multiple agencies.</p> <p><u>Experience & Education</u></p> <ul style="list-style-type: none"> • Bachelor's degree in Sociology, Psychology, Social Work or Gerontology is required. Masters preferred. • Minimum of three (3) years 3-5 years CBAS and program development experience • Working experience with seniors and persons with disabilities, community-based organizations, and mental illness desired. • Previous work experience in managing programs and 			

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<p>building relationships with community partners is preferred.</p> <ul style="list-style-type: none"> • Excellent interpersonal skills • Computer literacy required • Valid driver's license and vehicle, or other approved means of transportation, an acceptable driving record, and current auto insurance will be required for work away from the primary office approximately 5% of the time or more while traveling to CBAS centers and community events. <p><u>LTSS Committee QISC</u></p> <p>The purpose of the LTSS QISC:</p> <ul style="list-style-type: none"> • Engage stakeholders input on ways to best integrate the LTSS programs with managed care delivery system and improved quality of care • Improving and providing coordinated care for CalOptima Members who resides in long term care facilities and those who receive Home- and Community Based Services (HCBS). <p><u>The LTSS QISC Responsibilities:</u></p> <ul style="list-style-type: none"> • Identify barriers to keeping Members safe in their own homes or in the community, develop solutions, make appropriate recommendations to improve discharge planning process and preventing inappropriate admissions • Evaluate the performance, success, and challenges of LTSS program providers of the following services: CBAS, IHSS, MSSP and other Home and Community Based Services (HCBS) • Monitor the important aspects of quality of care, qualify of services, patient safety by collecting and organizing data for all selected indicators • Provide input on enhancing the capacity and coordination among LTSS providers, community-based organizations, housing providers, and managed care plans to care for individuals discharged from institutions. 	Long Term Care	Long Term Services and Supports Quality Improvement Subcommittee (LTSS QISC)	28, 29 and 30

2016 UTILIZATION MANAGEMENT PROGRAM

Change	Source	Section -2016 Program Draft	Page –2016Program Draft
<ul style="list-style-type: none"> • Identify and recommend topics for LTSS providers workshops, educations and trainings <p>The LTSS QISC Structure:</p> <ul style="list-style-type: none"> • The designated Chairman of the LTSS QISC is the Medical Director, Senior Programs, who is responsible for chairing the Committee. • The composition of the LTSS QISC includes but is not limited to the following: <ul style="list-style-type: none"> ○ Nursing Facility Administrators ○ Community Based Adult Services (CBAS) Administrators ○ Orange County Social Services Agency, Deputy Director or Designee ○ Multipurpose Senior Services Program, Site Director or Designee ○ Chief Medical Officer/Deputy Medical Officer ○ Medical Director QI and Analytics ○ Medical Director UM ○ Executive Director Clinical Operations ○ Executive Director Quality Analytics ○ LTSS Manager(s) ○ LTSS Director • The LTSS QISC meets quarterly at a minimum or more frequently as needed. • The LTSS Activity Summary includes, but is not limited to, will be reported to QIC. <ul style="list-style-type: none"> ○ Member review of Hospital Admission for each LTSS program; ○ Member review of Emergency Department visit for each LTSS program; ○ Members review for Hospital Readmissions for each LTSS program; ○ Health Risk Assessment results for LTC OCC members; ○ LTC Provider Annual Workshop; ○ CBAS Provider Workshop; ○ CBAS Centers Profile ○ LTC Profile ○ Care Coordination and Interdisciplinary Care Team Participation by LTSS staff; 			

2016 UTILIZATION MANAGEMENT PROGRAM

Change	Source	Section -2016 Program Draft	Page –2016Program Draft
<ul style="list-style-type: none"> ○ Total number of participants by LTSS program ● In addition, LTSS utilization activities include, but are not limited to, will be reported to UMC. <ul style="list-style-type: none"> ○ Community Based Adult Services (CBAS) statistics such as to number of participants, assessment type, turnaround time, denials rates; ○ Long Term Care (LTC) Statistics include, but is not limited to, bed type, turnaround time, denials rate; ○ Multipurpose Senior Services Program (MSSP) statistics such as total number of participants, total number of termination, number of ER visits, ALOS, SNF admissions. ○ LTSS Inter-Rater Reliability study result; ○ Rate Adjustments for LTC facilities 			
<p>CHANGES TO CURRENT PROGRAMS</p> <p><u>Behavioral Health Services</u></p> <p><u>OneCare and OneCare Connect Behavioral Health Services</u></p> <p>CalOptima has contracted with Windstone Behavioral Health for the behavioral health services portion of care for the OneCare line of business. CalOptima is responsible for credentialing the provider network and for Grievances and Appeals (GARS). CalOptima delegates Utilization Management to Windstone. Evidence based MCG guidelines are utilized in the UM decision making process.</p> <p>CalOptima members access Behavioral Health Services by calling Windstone at 1-800-577-4701. If office based services are appropriate, the member is registered and referrals to the appropriate provider are given to the member. If ambulatory Specialty Mental Health needs are identified, services may be rendered at the County Mental Health Plan.</p> <p>CalOptima offers screening, brief intervention, and referral to</p>	Behavioral Health	OneCare and OneCare Connect Behavioral Health Services	6

2016 UTILIZATION MANAGEMENT PROGRAM

Change	Source	Section -2016 Program Draft	Page –2016Program Draft
<p>treatment (SBIRT) services to members 18 and older who misuse alcohol. Providers in primary care settings screen for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse and/or referral to mental health and/or alcohol use disorder services as medically necessary.</p> <p><u>Behavioral Health Quality Improvement Committee (BHQIC)</u></p> <ul style="list-style-type: none"> • Ensure adequate provider availability and accessibility to effectively serve the membership • Oversee the functions of delegated activities • Monitor that care rendered is based on established clinical criteria, clinical practice guidelines, and complies with regulatory and accrediting agency standards • Ensure that Member benefits and services are not underutilized and that assessment and appropriate interventions are taken to identify inappropriate over utilization • Utilize Member and Network Provider satisfaction study results when implementing quality activities • Maintain compliance with evolving National Committee for Quality Assurance (NCQA) accreditation standards • Communicate results of clinical and service measures to Network Providers • Document and report all monitoring activities to appropriate committees <p>The designated Chairman of the BHQIC is the Medical Director of the Behavioral Health Integration who is responsible for chairing the Committee, as well as reporting findings and recommendations to the QIC. The composition of the BHQI Committee is defined in the BHQI Charter.</p> <p>The BHQI meets quarterly at a minimum or more frequently as needed.</p>	Behavioral Health	Behavioral Health Quality Improvement Committee (BHQIC)	27
<p><u>Pharmacy</u></p> <p>CalOptima's written notification of pharmacy denials to members and their treating practitioners contains:</p> <ul style="list-style-type: none"> • A description of appeal rights, including the member's 	Pharmacy	Pharmacy Determinations	36

2016 UTILIZATION MANAGEMENT PROGRAM

Change	Source	Section -2016 Program Draft	Page –2016Program Draft
<p>right to submit written comments, documents or other information relevant to the appeal</p> <ul style="list-style-type: none"> • Shall also contain an explanation of the appeal process, including the appeal time frames and the member's right to representation • A description of the expedited appeal process for urgent preservices or urgent concurrent denials • Notification that expedited external review can occur concurrently with the internal appeal process for urgent care • A qualified pharmacist may approved an appeal, however all appeals upheld must be reviewed by a licensed physician reviewer. <p>CalOptima gives practitioners the opportunity to discuss pharmacy UM denial decisions</p>			
<p>CALOPTIMA APPROVED GUIDELINES</p> <ul style="list-style-type: none"> • Updated to reflect current guidelines that are utilized and indicate that delegated entities must use the same or similar nationally recognized criteria for Utilization Management Activities • Added Pharmaceutical Authorization Guidelines • Added Long Term Services and Supports Guidelines <p><u>UM Decision Notification Timelines</u></p> <ul style="list-style-type: none"> • Updated to include Pharmaceutical decision making timeframes for all lines of business 	<p>Preventative and Clinical Practice Guidelines</p> <p>Utilization Management Timeliness Standards</p>	<p>Authorization Review Roles</p> <p>UM Decision and Notification Timelines</p>	<p>41 and 42</p> <p>47 and 48</p>
NEW BENEFITS			
SYSTEMS			



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2016 UTILIZATION MANAGEMENT PROGRAM DESCRIPTION





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20165
UTILIZATION MANAGEMENT PROGRAM
SIGNATURE PAGE

Utilization Management Committee Chairperson:

Richard Helmer, M.D. Francesco Federico M.D.
Date
Chief Medical Officer UM Medical Director

DATE:

Board of Directors' Quality Assurance Committee Chairperson:

Viet Van Dang, MD

Date

Board of Directors Chairperson:

Mark Refowitz

Date

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20165 UTILIZATION MANAGEMENT PROGRAM DESCRIPTION

Purpose

The mission of CalOptima is to provide members with access to quality health care services delivered in a cost effective and compassionate manner.

The purpose of the Utilization Management (UM) Program Description is to define the structures and processes within the Utilization Management Department, including assignment of responsibility to appropriate individuals, in order to deliver quality, coordinated healthcare services to CalOptima members. All services are designed to serve the culturally diverse needs of the CalOptima population and are delivered at the appropriate level of care, in an effective, timely manner by delegated and non-delegated providers.

Scope

The scope of the Utilization Management Program (UM Program) is comprehensive and applies to all eligible members across all product types, age categories and range of diagnoses. The UM Program incorporates all care settings including preventive, emergency, primary, specialty, behavioral health, [home and community based services](#), as well as acute, short term, long term facility and ancillary care services.

Goals

The goals of the UM Program are to optimize members' health status, sense of well-being, productivity, and access to quality, cost efficient health care, while at the same time actively managing the appropriate utilization of health plan services in order to ensure that appropriate processes are used to review and approve the provision of medically necessary covered services. The clinical goals include but are not limited to:

- Assist in the coordination of medically necessary medical and behavioral healthcare services as indicated by evidence based clinical criteria.
- Assure that care provided conforms to acceptable clinical quality standards.
- Enhance the quality of care for members by promoting coordination and continuity of care and service, especially during member transitions between different levels of care.
- Provide a mechanism to address access, availability, and timeliness of care.
- Clearly define staff responsibility for clinical activities specifically regarding decisions of medical necessity.
- Establish the process used to review and approve the provision of medical and behavioral healthcare services, including timely notification to members and/or providers of an appeal process for adverse determinations.
- Identify high-risk, high cost members for referral to the - Case Management and Care Coordination Programs- including Complex Case Management, [Long Term Services and Supports](#), and/or the Disease Management/Health Education Programs - when indicated and provided by CalOptima.
- Promote a high level of satisfaction across members, practitioners, stakeholders, and client organizations.
- Comply with all applicable regulatory and accrediting agency rules, regulations and standards, and applicable state and federal laws that govern the utilization management process.

- Protect the confidentiality of member protected health information and other personal/provider information.
- Provide a mechanism and process for identifying potential quality of care issues and reporting them to the Quality Improvement Department for further action when necessary.
- Identify and resolve problems and issues that result in over or under utilization and the inefficient or inappropriate delivery of health care services.
- Identify opportunities to optimize the health of members through quality initiatives for disease/health education management programs, focused population interventions, and preventive care services, and coordinating the implementation of these initiatives with the activities delegated to contract Health Maintenance Organizations (HMOs), Physician-Hospital Consortias (PHCs), Shared Risk Medical Groups (SRGs) and Provider Medical Groups (PMGs).
- Optimize the member's health benefits by linking and coordinating services with the appropriate county/state sponsored programs [such as Community Based Adult Services \(CBAS\), In-Home Supportive Services \(IHSS\), and Multipurpose Senior Services Program \(MSSP\)](#).
- Educate practitioners, providers, HMOs, PHCS, SRGs and PMGs on CalOptima's Utilization Management policies, procedures and program requirements to ensure compliance with the goals and objectives of the UM Program.
- Monitor utilization practice patterns of practitioners to identify variations and implement best practice guidelines.

Providers

Contracted Health Networks/ Network Providers/Hospitals

In 2014, CalOptima contracted with a variety of Health Networks to provide care to Orange County's beneficiaries. Since 2008 CalOptima has also included Health Maintenance Organizations (HMOs), Physician/Hospital Consortias (PHCs), and Shared Risk Medical Groups (SRGs). CalOptima's HMOs, PHCs, and SRGs include over 3,500 Primary Care Providers (PCPs) and 30 hospitals and clinics. New networks that demonstrate the ability to comply with CalOptima's delegated requirements will be added as needed.

Payment Arrangements

Each PHC is composed of a Primary Medical Group and one hospital. The SRGs are composed of a physician group which assumes risk for professional services, while the hospital risk resides at the CalOptima level. The Physician group is capitated, and responsible for all primary and specialty physician services. The Hospitals are reimbursed by CalOptima on a fee-for-service basis. Members must access in-network physicians and CalOptima-contracted hospitals. Select physician groups are delegated for the following clinical and administrative function. See next section.

Under Shared Risk in Medi-Cal, CalOptima maintains greater financial risk than under the current PHC model, but the provider medical group (PMG) participates in risk sharing through a risk pool agreement and/or incentive pool with CalOptima. OneCare (dual eligible program) is comprised of a variety of provider groups in a delegated model with a variety of payor arrangements for administrative services (medical and behavioral health).

Delegation

CalOptima Physician groups are delegated for the following clinical and administrative functions:

- Utilization and Case Management
- Claims ~~professional~~
- Contracting
- Credentialing of practitioners
- Member Services
- Cultural and Linguistic Services

CalOptima delegates various UM activities to entities that demonstrate the ability to meet CalOptima's standards, as outlined in the UM plan and policies and procedures. CalOptima conducts ongoing oversight on a regular basis and performs an annual review of each delegate's UM program. Delegation is dependent upon the following factors:

- A pre-delegation review to determine the ability to accept assignment of the delegated function(s).
- Executed Delegation Agreement with the organization to which the UM activities have been delegated clarify the responsibilities of the delegated group and CalOptima. This agreement specifies the standards of performance to which the contracted group has agreed.
- Conformation to CalOptima's UM standards; including timeframes outlined in CalOptima's policy and procedure. (GG.1508: Authorization and Processing of Referrals; Attachment A, Timeliness of UM Decisions and Notifications).
- Delegate's written UM Program Description/Plan are reviewed annually and approval by CalOptima's Quality Improvement Committee (QIC).
- Submission of required monthly reports which include but are not limited to; UM data, denial information and quality assurance/improvement issues and activities.

CalOptima retains accountability for all delegated functions and services, and monitors the performance of the delegated entity through the following processes:

- Annual approval of the delegate's UM program (or portions of the program that are delegated); as well as any significant program changes that occur during the contract year.
- Routine reporting of key performance metrics that are required and/or developed by CalOptima's Audit and Oversight Department, UMC and/or QIC.
- Annual or more frequent evaluation to determine whether the delegated activities are being carried out according to Plan standards and state program requirements.

In the event that the delegated provider does not perform contractually specified delegated duties, CalOptima may take action up to and including selected reviews, corrective actions, sanctions, capitation adjustments, probation, suspension or de-delegation.

~~In the instance where the delegate is NCQA Accredited, CalOptima may assume that the delegate is carrying out responsibilities in accordance with NCQA standards and revise the annual audit or evaluation, per state or CMS contract requirements.~~ At the time of pre-delegation, CalOptima evaluates the compatibility of the delegate's UM Program with CalOptima's UM Program. Once delegation is approved, CalOptima requires that the delegate provide the appropriate reports as determined by CalOptima to monitor the delegate's continued compliance with the needs of CalOptima. [CalOptima annually reviews ongoing accreditation](#)

~~status and compliance. CalOptima annually reviews ongoing accreditation status and compliance.~~
Oversight for all delegated activities is performed by CalOptima's Audit and Oversight Department.

Member Focused Program

CalOptima is committed to "Member Centric" care that recognizes the beliefs, traditions, customs and individual differences of the diverse population served. Beginning with the identification of needs, through a Group Needs Assessment, programs are developed to address the specific education, treatment, and cultural norms of the population while impacting the overall wellness of a specific community. Identified needs and planned interventions involve member input and are vetted through the Member and Provider Advisory Committees prior to full implementation. Please refer to CalOptima's Cultural and Linguistic Services Policies DD 2002 (Medi-Cal) and MA 4002 (OneCare) for a detailed description of the program.

CalOptima Products

Medi-Cal Program

~~1. — General Scope of Services~~

Healthcare services provided include, but are not limited to, the following:

- Preventive Services
- Inpatient and Ambulatory Behavioral Health Services
- Dental Services
- Long Term Supportive Services
- Primary Care
- Specialty Care
- Complex Case Management
- Emergency Services
- Urgent Care
- Inpatient and Ambulatory Medical Services
- Ancillary Services

Medi-Cal Managed Long Term Services and Supports

Beginning July 1, 2015, Long Term Services and Supports, (LTSS) became a CalOptima benefit for all Medi-Cal entoltees. CalOptima ensures LTSS services are available to members who have health care needs and meet the program eligibility criteria and guidelines. The LTSS program has two primary components with four programs.

Nursing Facility:

- Nursing Facility Services for Long Term Care Services - CalOptima utilizes the DHCS Medi-Cal Criteria Chapter, Criteria for Long Term Care Services and Title 22, CCR, Sections: 51003, 51303, 51511(b), 51334, 51335, and 51343. CalOptima is responsible for

the clinical review, medical determination and performs authorization functions for Long Term Care services for the following levels of care:

- o Nursing Facility Level B, (Long Term Care)
- o Nursing Facility Level A
- o Subacute Adult and Pediatric
- o Intermediate Care Facility / Developmentally Disabled, (ICF/DD)
- o Intermediate Care Facility / Developmentally Disabled Habilitative, (ICF/DD-H)
- o Intermediate Care Facility / Developmentally Disabled Nursing, (ICF/DD-N)

Home and Community Based Services:

- Community Based Adult Services (CBAS) - CalOptima provides CBAS as a health plan benefit. CalOptima utilizes the Department of Health Services, (DHCS), approved CBAS Eligibility Determination Tool, (CEDT), criteria to assess a member's health condition and make a medical determination for the program. The Community Based Adult Services is an outpatient, facility-based program that offers health and social services to seniors and persons with disabilities.
- Multipurpose Senior Services Program, (MSSP) - CalOptima is responsible for identification, referral and coordination of integrated services within the MSSP Site. The CalOptima MSSP Site adheres to the California Department of Aging contract and eligibility determination criteria.
- In-Home Supportive Services, (IHSS), - CalOptima and the health networks are responsible for identification, referral and provide care coordination. CalOptima collaborates with Orange County Social Services Agency, (SSA), In-Home Supportive Services, Orange County Public Authority and health networks to ensure members receive appropriate level of care services.

Behavioral Health Services

Medi-Cal Ambulatory Behavioral Health Services

~~Beginning January 1, 2014, CalOptima contracted with College Health IPA (CHIPA) for essential behavioral health services mandated by the Affordable Care Act.~~ CalOptima delegates College Health Independent -CHIPA for utilization Management of the Provider Network. CHIPA sub-contracts and delegates to Beacon Health Strategies, LLC (Beacon) other functions that include credentialing the provider network, the Access Line, and several quality improvement functions.

CalOptima is responsible for providing outpatient mental health services to members with mild to moderate impairment of mental, emotional, or behavioral functioning, resulting from a mental health disorder, as defined in the current diagnostic and statistical manual of mental disorders. Mental Health services include but are not limited to: individual and group psychotherapy; psychology, psychiatric consultation and treatment medication management, and psychological testing when clinically indicated to evaluate a mental health condition.

CalOptima members access Behavioral Health Services by calling the [CalOptima Behavioral Health Line at: 1-855-877-3885](#)~~00-723-8461 Access Line~~. A [CHIPA / Beacon clinician](#)~~contracted, employed clinician on the Access Line~~ assesses the level of care needed. If office based services are appropriate, the member is registered in the [CHIPA / Beacon](#) system and referrals to an appropriate provider are given to the member. If more complex needs are identified, the member is referred to the County for Specialty Mental Health [Plan for Specialty Mental Health s](#)~~s~~, ~~these services. These services are “carved out” by the California Department of Health Care Services to the Orange County Department of Mental Health Services and~~ are not the responsibility of CalOptima.

~~Effective September 15, 2014,~~ CalOptima covers behavioral health treatment (BHT) for members 20 and younger with a diagnosis of Autism Spectrum Disorder (ASD). BHT services are managed by [CHIPA / Beacon](#). Members can access BHT services by calling the 24/7 [CalOptima Behavioral Health Line at 1-855-877-3885](#)~~Access Line~~.

CalOptima offers screening, brief intervention, and referral to treatment (SBIRT) services to members 18 and older who misuse alcohol. Providers in primary care settings screen for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse and/or referral to mental health and/or alcohol use disorder services as medically necessary.

CalOptima ensures members with coexisting medical and behavioral health care needs have adequate coordination and continuity of their care. ~~The UM staff identifies members with combined medical and psychiatric diagnoses through various means, including, but not limited to, internal resources, such as case management and the delegated entities’ case management staff. These members are managed throughout the continuum of care, and~~ communication with both the medical and behavioral health specialists occurs as needed to enhance continuity by ensuring members receive timely and appropriate ~~access and to facilitate communication care, and to facilitate communication~~ between the medical and behavioral health practitioners involved ~~in the care~~.

Services Not Provided by CalOptima

Under its Medi-Cal Program, CalOptima provides a comprehensive scope of acute and preventive care services for Orange County’s Medi-Cal and dual eligible populations. Certain health care services are not provided by CalOptima, as determined by law and contract. Other services may be provided by different agencies including those indicated below:

- Specialty mental health services are administered by the Orange County Health Care Agency (HCA) County Mental Health Plan.
- Dental services are provided through California’s Denti-Cal program.
- California Children’s Services (CCS) is a statewide program managed by the Department of Health Care Services (DHCS) and authorizes and pays for specific medical services and equipment provided by CCS-approved specialists for children with certain physical limitations and chronic health conditions or diseases.
- Regional Center of Orange County as a local agency contracted by the State by the State of California to coordinate lifelong services and supports for people with developmental

disabilities, Regional Center of Orange County, (RCOC), provides services and supports that are as diverse the the people served. Each person serviced by RCOC has an individual Family Service Plan, (IFSP), - that addresses his or her individual needs. The following are types of services and supports available through RCOC, or that RCOC can assist clients and families access through other sources:

- o Prenatal Diagnostic Evaluation
- o Early Intervention Services, (Birth to 36 months)
- o Thereapy Services
- o Respite Care Services
- o Child Care Services
- o Adult Day Program Services, (Employment and Community-Based Activities)
- o Transportation Services
- o Residential Services
- o Psychological, Counseling and Behavioral Services
- o Medical and Dental Services
- o Equipment and Supplies
- o Social and Recreational Services

In addition, CalOptima provides linkages with community programs to ensure that members with special health care needs, or high risk or complex medical and developmental conditions, receive wrap around services that enhance their medical benefits. These linkages are established through special programs, such as the CalOptima Community Liaisons, and specific program Memoranda of Understanding (MOU) with other community agencies and programs, such as the Orange County Heath Care Agency's California Children's Services, Orange County Department of Mental Health, and the Regional Center of Orange County. The UM staff and delegated entity practitioners are responsible for identification of such cases, and coordination of referral to appropriate State agencies and specialist care when the benefit coverage of the member dictates. The UM Department coordinates activities with the Case Management and/or Disease Management Departments to assist members with the transition to other care, if necessary, when benefits end. This may include informing the member about ways to obtain continued care through other sources, such as community resources.

OneCare- and OneCare Connect Behavioral Health Services

CalOptima has contracted with Windstone Behavioral Health for the behavioral health services portion of care for the OneCare and OneCare Connect line of business. CalOptima is responsible for credentialing the provider network and for grievances and appeals. CalOptima delegates Utilization Management to Windstone. Evidence based MCG guidelines are utilized in the UM decision making process.

CalOptima members access Behavioral Health Services by calling Windstone at 1-800-577-4701. If office based services are appropriate, the member is registered and referrals to the appropriate provider are given to the member. If ambulatory Specialty Mental Health needs are identified, services may be rendered at the County Mental Health Plan.

CalOptima offers screening, brief intervention, and referral to treatment (SBIRT) services to members 18 and older who misuse alcohol. Providers in primary care settings screen for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse and/or referral to mental health and/or alcohol use disorder services as medically necessary.

Cal MediConnect (OneCare Connect) Behavioral Health Services

CalOptima has contracted with Windstone Behavioral Health for the behavioral health services portion of care for the OneCare Connect line of business. CalOptima is responsible for credentialing the provider network and for Grievances and Appeals (GARS). CalOptima delegates Utilization Management to Windstone. Evidence based MCG guidelines are utilized in the UM decision making process.

CalOptima members access Behavioral Health Services by calling Windstone at 1-800-577-4701. If office based services are appropriate, the member is registered and referrals to the appropriate provider are given to the member. If ambulatory Specialty Mental Health needs are identified, services may be rendered at the County Mental Health Plan.

CalOptima offers screening, brief intervention, and referral to treatment (SBIRT) services to members 18 and older who misuse alcohol. Providers in primary care settings screen for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse and/or referral to mental health and/or alcohol use disorder services as medically necessary.

Continuity and coordination of behavioral health care may involve CalOptima or a delegated HMO, PHC, SRG or PMG Case Managers communicating and coordinating care directly between PCPs and behavioral health specialists. These Case Managers are responsible for assuring that individual members with coexisting medical and behavioral disorders receive appropriate treatment in the appropriate ambulatory and/or inpatient setting.

Services Not Provided by CalOptima

Under its Medi-Cal Program, CalOptima provides a comprehensive scope of acute and preventive care services for Orange County's Medi-Cal and dual eligible populations. Certain health care services are not provided by CalOptima, as determined by law and/or regulatory contract. Other services may be provided by different agencies including those indicated below:

- Specialty mental health services are administered by the Orange County Health Care Agency (HCA).
- Dental services are provided through California's Denti-Cal program.
- California Children's Services (CCS) is a statewide program managed by the Department of Health Care Services (DHCS) and authorizes and pays for specific medical services and equipment provided by CCS approved specialists for children with certain physical limitations and chronic health conditions or diseases.

In addition, CalOptima provides linkages with community programs to ensure that members with special health care needs, or high risk or complex medical and developmental conditions, receive

wrap-around services that enhance their medical benefits. These linkages are established through special programs, such as the CalOptima Community Liaisons, and specific program Memoranda of Understanding (MOU) with other community agencies and programs, such as the Orange County Health Care Agency's California Children's Services, Orange County Department of Mental Health, and the Regional Center of Orange County. The UM staff and delegated entity practitioners are responsible for identification of such cases, and coordination of referral to appropriate State agencies and specialist care when the benefit coverage of the member dictates. The UM Department coordinates activities with the Case Management and/or Disease Management Departments to assist members with the transition to other care, if necessary, when benefits end. This may include informing the member about ways to obtain continued care through other sources, such as community resources.

2. CalOptima Direct (COD)

CalOptima Direct is a fee-for-service program administered by CalOptima to serve Medi-Cal members in special situations, including foster children, dual eligible (those with both Medicare and Medi-Cal who elect not to participate in CalOptima's Medicare Advantage (MA) SNP, members in skilled nursing facilities, and share-of-cost members. COD also currently includes the following categories of vulnerable and complex/catastrophic care members: transplants, hemophilia, HIV, end stage renal disease (ESRD), and the Seniors and Persons with Disabilities Program.

To date, CalOptima has contracted with over 700 specialists and various ancillary providers and hospitals. Some of these specialists are hospitalist physicians who collaborate with CalOptima's Utilization Management staff to manage inpatient services.

[REDACTED]

- a. [REDACTED]
- b. CalOptima Care Network (CCN) is designed to ensure that all members in this network have a primary care physician (PCP) who is accountable for coordinating all aspects of the member's care, including making referrals to contracted specialists. CCN members have the opportunity to select a contracted PCP of their choice, or are assigned to a PCP if they do not select one. CCN-PCPs are reimbursed on a fee-for-service basis. Members enrolled in CCN include foster care children, members with qualifying conditions, such as End Stage Renal Disease, Seniors and Persons with Disabilities, University of California Irvine (UCI) Federally Qualified Health Center (FQHC) members, transplant patients, breast and cervical cancer patients, and long-term care patients.

3. CalOptima Community Network

Beginning in March 2015, the CalOptima Community Network (CN) is scheduled to be operationalized was open to new members beginning in March of 2015. .CN-This is a managed

care program administered by CalOptima to serve Medi-Cal members and dual eligibles (those with both Medicare and Medi-Cal), who elect to participate in the Cal MediConnect program detailed below. This network is open to participation of any willing and qualified provider. CalOptima already contracts with a variety of providers: Physician Hospital Consortia, one HMOs, and many [Shared Risk Groups](#). ~~Medi-Cal networks~~. With the new launch of Community Network, individual providers will now have the option of contracting directly with CalOptima.

Dual Eligible Program

1. OneCare

a. ~~Scope of Services~~

OneCare provides a comprehensive scope of services for the dual eligible members. These services include, but are not limited to the following:

- ⊖ Preventive Services
- ⊖ Behavioral Health
- ⊖ Dental Services
- ⊖ Long Term ~~Services and Supports~~ Supportive Services
- ⊖ Primary Care
- ⊖ Specialty Care
- ⊖ Complex Case Management
- ⊖ Emergency Services
- ⊖ Inpatient Services
- ⊖ Urgent Care Services
- Ancillary Services
- ⊖ Pharmacy

OneCare provides health care services to seniors and persons with disabilities (SPDs) and only enrolls beneficiaries who Medicaid qualifies as a zero cost sharing Medicaid subset.

OneCare members qualify for Medicare by age (turning 65) or by disability (24 months of SSDI, ESRD, or ALS.) Nearly one third of OneCare members are under 65. OneCare members qualify for Medicaid by standards established by the State of California and administered at the county social services agency level. The standards for qualifying for State Medicaid include a review of income, assets, and in some cases, medical condition.

The threshold languages spoken by the majority of OneCare members are English, Spanish, Farsi and Vietnamese. OneCare members represent over twenty ethnic groups including White, Asian/Pacific Islander, Alaskan native, American Indian, Black, and Hispanic.

The management of OneCare's Medicare covered benefits is delegated to the PMGs. CalOptima manages the Medi-Cal wrap around and taxi transportation determinations. Cal Optima performs concurrent review for members who are admitted to out of area hospitals.

~~CalOptima has contracted with Windstone Behavioral Health for the behavioral health services portion of care as part of the OneCare line of business. CalOptima is responsible for credentialing the provider network and for Grievances and Appeals (GARS). CalOptima delegates Utilization~~

~~Management of the Provider Network to Windstone. Evidence-based MCG guidelines are utilized in the UM decision-making process.~~

~~MCG supports the application of criteria based on individual needs and assessment of the health care delivery system. Additionally all UM decision makers are involved in the inter-rater reliability process on a new hire and annual basis.~~

~~CalOptima members access Behavioral Health Services by calling Windstone at 1-800-577-4701. If office-based services are appropriate, the member is registered and referrals to the appropriate provider are given to the member. If more complex needs are identified, the member is referred to the County for Specialty Mental Health Services. These services are “carved out” by the California Department of Health Care Services to the Orange County Department of Mental Health Services and are not the responsibility of CalOptima.~~

~~Providers in primary care settings screen for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse and/or referral to mental health and/or alcohol use disorder services as medically necessary. Windstone provides the outpatient counseling services for those members referred for service under OneCare membership. For more intensive non-Medicare reimbursable services the responsibility would fall under Drug Medi-Cal and these members would be routed to services at County Alcohol and Drug Services or community services providers in the region.~~

~~Continuity and coordination of behavioral health care may involve CalOptima or a delegated PMG Case Manager communicating and coordinating care directly between PCPs and behavioral health specialists.~~

CalOptima works with community programs to ensure that individual needs are met for members with special health care needs and/or chronic or high risk complex medical conditions, including, but not limited to, Meals on Wheels, Dayle MacIntosh Developmental Center, Orange County Social Service Agency, Orange County Goodwill and Orange County Community Centers with direct links to the Long Term Support Services [and Supports](#) (LTSS) and the Orange County Aging and Disability Resource Center (ADRC).

To ensure that coordinated community and clinical services are accessible and available to these Seniors and Persons with Disabilities (SPD) members, CalOptima has developed a robust Model of Care that defines case management activities that includes nurses, social workers, behavioral health specialists, and personal care coordinators (PCCs). These case management services are designed to ensure coordination and continuity of care for every member and are described in the Case Management Program Description.

Certain covered services are not provided by CalOptima, or may be provided by a different agency including those indicated below:

- ~~Dental Services (benefit expired 1/1/15)~~
- Vision
- Non-Medical Transportation (benefit decreased for 2015)

2. Cal MediConnect (OneCare Connect)

~~Beginning July 1st, 2015 CalOptima will launch its Cal MediConnect program (Cal Optima's OneCare Connect Program OneCare Connect).~~ The Cal MediConnect program is a three (3) year demonstration project in an effort by California and the federal government to begin the process, through a single organized health care delivery system, of integrating the delivery of medical, behavioral health, long term care services and support and community based services for dual eligible beneficiaries. The program's goal is to help members stay in their homes for as long as possible and shift services out of institutional settings and into the home and community. A key feature of CalOptima is identifying high-risk enrollees who need comprehensive care coordination, and assembling an appropriate care team to develop and track an individualized care plan.

~~Regional Center of Orange County (ADD description here)~~

CalOptima Board of Directors

Authority, Responsibility and Accountability

The CalOptima Board of Directors has ultimate authority, accountability and responsibility for the quality of care and service provided to CalOptima members. The responsibility to oversee the Utilization Management program is delegated by the Board of Directors to the Board's Quality Assurance Committee (QAC). The Board holds the Chief Executive Officer (CEO) and the Chief Medical Officer (CMO) accountable and responsible for the quality of care and service provided to members. The responsibility for the direction and management of the UM Program has been delegated to the Chief Medical Officer (CMO). Before coming to the Board of Directors for approval, the UM Program is reviewed and approved by the Utilization Management Sub-Committee (UMC), the Quality Improvement Committee (QIC) and the Quality Assurance Committee (QAC) on an annual basis.

CalOptima Officers and Directors

Chief Medical Officer

The Chief Medical Officer (CMO) has operational responsibility for and provides support to CalOptima's UM Program. CalOptima's CMO, Deputy CMO, and Executive Vice President of Clinical Operations, and/or any designee as assigned by CalOptima's CEO are the senior executives responsible for implementing the UM program including appropriate use of health care resources, medical and behavioral quality improvement, medical and behavioral utilization review and authorization, case management, disease management and health education program implementations, with successful operation of the QIC, QAC and UMC.

The CMO's responsibilities include, but are not limited to coordination and oversight of the following activities:

- Assists in the development/revision of UM policies and procedures as necessary to meet state and federal statutes, regulations and accrediting agency requirements;
- Monitors compliance with the UM Program;
- Appoints the Chairperson of the UMC;
- Chairs the Utilization Management Workgroup (UMG);

- Provides clinical support to the UM staff in the performance of their UM responsibilities;
- Assures that the medical necessity criteria used in the UM process are appropriate and reviewed by physicians and other practitioners according to policy but not less than annually;
- Assures that the medical necessity criteria are applied in a consistent manner;
- Ensures that there are no financial incentives for practitioners or other individuals conducting utilization review for issuing denials of coverage, services, or care;
- Assures that reviews of cases that do not meet medical necessity criteria are conducted by appropriate physicians or other appropriate healthcare professionals in a manner that meets all pertinent statutes and regulations and takes into consideration the individual needs of the involved members;
- Assures that appropriate healthcare professionals review, approve, and sign denial letters for cases that do not meet medical necessity criteria after appropriate review has occurred in accordance with UM Policy and Procedure GG.1508: Authorization and Processing of Referrals;
- Assures the medical necessity appeal process is carried out in a manner that meets all applicable contractual requirements, as well as all federal and state statutes and regulations, is consistent with all applicable accreditation standards, and is done in a consistent and efficient manner;
- Provides a point of contact for practitioners calling with questions about the UM process;
- Communicates/consults with practitioners in the field as necessary to discuss UM issues;
- Coordinates and oversees the delegation of UM activity as appropriate and monitors that delegated arrangement to ensure that all applicable contractual requirements and accreditation standards are met;
- Assures there is appropriate integration of physical and behavioral health services for all Plan members;
- Participates in and provides oversight to the UMC and all other physician committees or Subcommittees;
- Recommends and assists in monitoring corrective actions, as appropriate, for practitioners with identified deficiencies related to UM;
- Serves as a liaison between UM and other Plan departments;
- Educates practitioners regarding UM issues, activities, reports, requirements, etc.;
- Reports UM activities to the QIC as needed.

Deputy Chief Medical Officer fulfills all of the roles and responsibilities of the office of the CMS in conjunction with and/or in the absence of the CMO, (as outlined above).

Executive Director of Clinical Operations (ED) is responsible for oversight of all operational aspects of key Medical Affairs functions including: Utilization Management, Case Management, Behavioral Health, Managed Long Term Services and Support (MLTSS) programs, along with all new program implementations related to initiatives in these areas. The ED of Clinical Operations serves as a member of the executive team and, with the CMO, ensures that Medical Affairs is aligned with CalOptima's strategic and operational priorities. This position is a key leader within the health plan and has the accountability to lead the areas assigned to next level capabilities and operational efficiencies consistent with CalOptima's strategic plan, goals, and objectives. The Executive Director is expected to anticipate, continuously improve, communicate and leverage resources, as well as balance achieving set accountabilities with constraints of limited resources.

Medical Director of Utilization Management assists in the development and implementation of the Utilization Management Program, policies, and procedures. Ensures that an appropriate licensed professional conducts reviews on cases that do not meet medical necessity and utilizes evidence based review criteria/guidelines for any potential adverse determinations of care and/or service. In collaboration with the CMO, the Medical Director of Utilization Management also provides supervisory oversight and administration of the Utilization Management Program, oversees all clinical decisions rendered for concurrent, prospective and retrospective reviews that support UM medical management decisions, serves on the Utilization and Quality Improvement Committees, serves as the Chair of the Utilization Management Committee and the Benefit Management Subcommittee, and may participate in the CalOptima Medical Directors Forum. Other related duties may also be performed at the discretion of the Chief Medical Officer.

Part-Time Utilization Management Medical Director Ensures quality medical service delivery to members managed directly by CalOptima and is responsible for medical direction and clinical decision making in utilization management. In this role, the Medical Director oversees the utilization management activities of staff that work in concurrent, prospective and retrospective medical management activities, and works with the clinical staff that supports the utilization management process. The Medical Director works closely with the nursing leadership of these departments, and also works in collaboration with the Chief Medical Officer and all clinical staff within CalOptima.

Medical Director, Behavioral Health provides leadership and program development expertise in the creation, expansion and/or improvement of services and systems ensuring the integration of physical and behavioral health care services for CalOptima members. Provides clinical and operational oversight for behavioral health benefits and services provided to members. Works closely with all departments to ensure appropriate access and coordination of behavioral healthcare services, improves member and provider satisfaction with services and ensures quality behavioral health outcomes. The Behavioral Health Medical Director is involved in the implementation, monitoring and directing of the behavioral health aspects of the UM Program.

Medical Director, Senior Programs, is a key member of the medical management team and is responsible for the MediConnect (OneCare), Managed Long Term Support and Services (MLTSS) programs, and Case Management and Transitions of Care programs. Provides physician leadership in the Medical Affairs division, including acting as liaison to other CalOptima operational and support departments. The Medical Director is also expected to work in collaboration with the other Medical Directors and the clinical staff within Disease Management, Grievance and Appeals, and Provider Relations. The Medical Director works closely with the nursing and non-clinical leadership of these departments.

Medical Director Disease Management/Health Education/Program for All Inclusive Care for the Elderly (PACE) Programs is responsible for providing physician leadership in the clinical and operational oversight of the development and implementation of disease management and health education programs while also providing clinical quality oversight of the PACE Program.

Director of Utilization Management assists in the development and implementation of the Utilization Management Program, policies, and procedures. Ensures the appropriate use of

evidenced-based clinical review criteria/guidelines for medical necessity determinations. The Director of Utilization Management also provides supervisory oversight and administration of the Utilization Management Program, oversees all clinical decisions rendered for concurrent, prospective and retrospective reviews that support UM medical management decisions, serves on the Utilization and Quality Improvement Committees, participates in the Utilization Management Committee and the Benefit Management Subcommittee.

Director of Clinical Pharmacy Management leads the development and implementation of the Pharmacy Management Program, develops and implements Pharmacy Management Department policies and procedures; ensures that a licensed pharmacist conducts reviews on cases that do not meet review criteria/guidelines for any potential adverse determinations, provides supervision of the coordination of Pharmacy related clinical affairs, and serves on the Pharmacy and Therapeutics Subcommittee and Quality Improvement Committees. A Pharmacist oversees the implementation, monitoring and directing of pharmacy services.

Executive Director of Behavioral Health Integration provides leadership and program development expertise in the creation, expansion and improvement of services and systems that leads to the integration of physical and behavioral health care services for CalOptima members. S/he leads and assists the organization in developing and successfully implementing short and long term strategic goals and objectives toward integrated care. This position plays a key leadership role in coordinating with all levels of CalOptima staff, including the Board of Directors and executive staff, members, providers, health network management, legal counsel, State and Federal officials, and representatives of other agencies. S/he is responsible for monitoring, analyzing, and reporting to senior staff on changes in the healthcare delivery environment and program opportunities affecting or available to assist CalOptima in integrating physical and behavioral health care services.

Executive Director of Quality and Analytics Compliance provides oversight of key medical affairs functions including: Quality Management, Quality Analytics and Disease Management which includes health education programs. The ED of Quality and Analytics serves as a member of the executive team and, with the CMO, ensures that Medical Affairs is aligned with CalOptima's strategic and operational priorities. This position is a key leader within the health plan and has the accountability to lead the areas assigned to next-level capabilities and operational efficiencies consistent with the strategic plan, goals, and objectives for CalOptima. Position will anticipate, continuously improve, communicate and leverage resources. The ED of Quality and Analytics will balance achieving set accountabilities with constraints of limited resources.

Director of Quality is responsible for ensuring that CalOptima and its HMOs PHCs, SRGs and PMGs meet the requirements set forth by Department of Health Care Services (DHCS), Center for Medicare/Medicaid Services (CMS), and Department of Managed Health Care (DMHC). The Compliance staff works in collaboration with the CalOptima Quality Improvement Department to refer any potential sustained noncompliance issues or trends encountered during audits of health networks, provider medical groups, and other functional areas, such as Utilization Management and Credentialing, and Grievance & Appeals Resolution Services, as appropriate. The staff evaluates the results of performance audits to determine the appropriate course of action to achieve desired results. Functions relating to fraud and abuse investigations, referrals, and prevention are handled by the Office of Compliance.

Director, Audit and Oversight oversees and conducts independent performance audits of CalOptima operations, Pharmacy Benefits Manager (PBM) operations and Physician Medical Group (PMG) delegated functions with an emphasis on efficiency and effectiveness and in accordance with State/Federal requirements, CalOptima policies, and industry best practices. This Director role is to ensure that CalOptima and its subcontracted health networks perform consistently with both CMS and State requirements for all programs. Specifically, this position leads the department in developing audit protocols for all internal and delegated functions to ensure adequate performance relative to both quality and timeliness. Responsible to ensure the implementation of strategic and tactical direction to improve the efficiency and effectiveness of internal processes and controls as well as delegated functions. This position interacts with the Board of Directors, CalOptima executives, departmental management, health network management and Legal Counsel.

Director of Case Management is responsible for Case Management, Transitions of Care and the clinical operations ~~for~~ the Medi-Cal, OneCare, and MediConnect programs. S/he supports improving quality and access through seamless care coordination for targeted member populations. Develops and implements policies, procedures and processes related to program operations.

Director of Disease Management/Health Education is responsible for the development and implementation of Disease Management/Health Education programs and determines priorities for health education and member self-care management. The position also oversees the group needs assessments to identify health education, and cultural and linguistic opportunities that improve the well-being of specific member populations. The position is also responsible for provider clinical office education for the promotion of quality initiatives.

Director of Long Term Services and Supports is responsible for LTSS programs which include Community Based Adult Services, (CBAS), In-Home Supportives Services, (IHSS), Long Term Care Services, (LTC, and Multipurpose Senior Services Program, (MSSP). The position supports a "Member-Centric" approach to help to keep members in the least restrictive living environment. Collaborates with stakeholders including community partners and ensures LTSS services provided are procedures and processes related to the LTSS program operations.

Utilization Management Resources

The following staff positions provide support for organizational/operational UM Department's functions and activities:

RN Managers (Referral/Prior Authorization/Retrospective Review and Concurrent Review) manage the day-to-day operational activities of the department to ensure staff compliance with company policies and procedures, and regulatory and accreditation agency requirements. The Managers develop, implement and maintain processes and strategies to ensure the delivery of quality healthcare services to members while establishing and maintaining collaborative working relationships with internal and external resources in order to ensure appropriate support for utilization activities.

Experience & Education

- A current and unrestricted RN license in the State of California.
- A Bachelor's degree or relevant experience in a healthcare field.
- 5 years varied clinical experience required.
- 5-7 years managed care experience preferred.
- 2-3 years supervisory/management experience in utilization management activities.

RN Supervisor (Concurrent Review) monitors and oversees the daily departmental work activities to ensure that service standards are met, makes recommendations regarding assignments based on assessment of workload, and is a resource to the Concurrent Review staff regarding CalOptima policies and procedures as well as regulatory and accreditation requirements governing inpatient concurrent review and authorization processing while providing ongoing monitoring and development of staff.

Experience & Education

- A Bachelor's Degree or relevant experience in a healthcare field.
- Current and unrestricted Registered Nurse (RN) license
- 5 - 7 years of managed care experience
- Supervisor experience in Managed Care/Utilization Management preferred.

RN Supervisor (Referral/Prior/Retrospective Authorization) monitors and oversees the daily departmental work activities to ensure that service standards are met, makes recommendations regarding assignments based on assessment of workload, and is a resource to the Prior Authorization staff regarding CalOptima policies and procedures as well as regulatory requirements governing prior and retrospective authorization processing while providing ongoing monitoring and development of staff.

Experience & Education

- A Bachelor's Degree or relevant experience in a healthcare field.
- Current and unrestricted Registered Nurse (RN) license
- 3 - 5 years of managed care experience.
- Supervisor and/or Lead experience in Managed Care/Utilization Management preferred.

~~Team Leads are responsible for achieving overall clinical performance goals through day to day direction of the designated clinical care team, coordinating operational processes, and monitoring performance to achieve consistent process standards and metrics through quality assessments, training, and improvement tactics, and in compliance with regulatory and accreditation standards.~~

Education and/or Experience

- ~~• Current and unrestricted California Registered Nurse (RN) or Licensed Vocational Nursing (LVN) license.~~
- ~~• Minimum two years recent acute clinical experience; two years' experience in utilization management in a health plan, medical group or IPA setting is preferred.~~
- ~~• Current Certified Case Manager (CCM) preferred.~~

Case Managers (RN/LVN) provide utilization review and authorization of services in support of members. The Case Manager is responsible for assessing the medical appropriateness, quality, and cost effectiveness of proposed inpatient hospital and outpatient medical/surgical services, in accordance with established evidence based criteria. This activity is conducted prospectively, concurrently, or retrospectively. The Case Manager also provides concurrent oversight of referral/prior authorization and inpatient case management functions performed at the HMOs, PHCs, SRGs and PMGs, and acts as a liaison to Orange County based community agencies in the delivery of healthcare services. All potential denial, and/or modifications of Provider service requests are discussed with the appropriate Medical Director, who makes the final determination.

Experience & Education

- Current and unrestricted California Board Licensed Vocational Nurse (LVN) or Registered Nurse (RN) license
- Minimum of three (3) years current clinical experience.
- Excellent telephone skills required.
- Computer literacy required.
- Excellent interpersonal skills.

Medical Assistants are responsible for effective, efficient and courteous interaction with practitioners, members, family and other customers, under the direction of the licensed Case Manager. The Medical Assistant performs medical, administrative, routine medical administrative tasks specific to the assigned unit and office support functions. The Medical Assistant also authorizes requested services according to departmental guidelines. All potential denial, and/or modifications of Provider service requests are discussed with the appropriate Medical Director, who makes the final determination.

Experience & Education

- High school graduate or equivalent; a minimum of 2 years of college preferred.
- 2 years of related experience that would provide the knowledge and abilities listed.

Program Specialist~~Administrative Assistant~~ provides high level administrative ~~secretarial~~ support to the Director of Utilization Management, the RN Managers, Supervisors and the UM Medical Directors.

Experience & Education

- High school diploma or equivalent; a minimum of 2 years of college preferred.
- Courses in basic administrative education that provide the knowledge and abilities listed or equivalent clerical/administrative experience.
- 2-3 years previous administrative experience preferred.

Pharmacy Department Resources

Pharmacy Director develops, implements, and administers all aspects of the CalOptima pharmacy management program as part of the managed care system, with closed formulary rebate programs, Drug Utilization Evaluation (DUE) and Drug Utilization Review (DUR) programs,

contracts with and manages the pharmacy network and oversees the day-to-day functions of the contracted pharmacy benefit management vendor (PBM). The Pharmacy Director is also responsible for administration of pharmacy services delivery, including, but not limited to, the contract with the third party auditor, and has frequent interaction with external contacts, including local and state agencies, contracted service vendors, pharmacies, and pharmacy organizations.

Experience & Education

- A current, valid, unrestricted California State Pharmacy License and Pharm.D. required.
- American Society of Health System Pharmacists (ASHP) accredited residency in Pharmacy Practice or equivalent experience required.
- Experience in clinical pharmacy, formulary development and implementation that would have developed the knowledge and abilities listed.

Pharmacy Manager assists the Pharmacy Director and pharmacy staff with the ongoing development and implementation of targeted drug utilization and disease state management strategies to control costs and improve the quality and outcomes of healthcare provided to Members enrolled in the CalOptima Delegated Health Plans and CalOptima Direct. Through various modalities (e.g., provider/plan profiling, member drug profile reviews, development and updating of drug utilization criteria, and case-by-case intervention), the Pharmacy Manager promotes clinically appropriate prescribing practices that conform to CalOptima, as well as national practice guidelines and on an ongoing basis, researches, develops, and updates drug utilization management strategies and intervention techniques. The Pharmacy Manager develops and implements methods to measure the results of these programs, assists the Pharmacy Director in preparing drug monographs and reports for the Pharmacy & Therapeutics Committee, interacts frequently and independently with other department directors, managers, and staff, as needed to perform the duties of the position, and has frequent interaction with external contacts, including the pharmacy benefit managers' clinical department staff.

Experience & Education

- At least 3 years experience in clinical pharmacy practice, including performing drug use evaluations and preparing drug monographs and other types of drug information for Pharmacy & Therapeutics Committees.
- Current knowledge and expertise in clinical pharmacology and disease states required.
- Basic working knowledge of the Medi-Cal or Medicaid programs preferred.
- A current, valid, unrestricted California State Pharmacy License and Pharm.D. required.
- ASHP accredited residency in Pharmacy Practice or equivalent background/experience required.

Clinical Pharmacists assist the Pharmacy Director and pharmacy staff with the ongoing development and implementation of targeted drug utilization and disease state management strategies to control costs and improve the quality and outcomes of healthcare provided to Members enrolled in the CalOptima Health Networks and CalOptima Direct. Through various modalities (e.g., provider/plan profiling, member drug profile reviews, development and updating of drug utilization criteria, and case-by-case intervention), they promote clinically appropriate prescribing practices that conform to CalOptima, as well as national practice guideline. On an

ongoing basis, research, develop, and update drug utilization management strategies and intervention techniques and develop and implement methods to measure the results of these programs. They assist the Pharmacy Director in preparing drug monographs and reports for the Pharmacy & Therapeutics Committee, interacts frequently and independently with other department directors, managers, and staff as needed to perform the duties of the position, and have frequent interaction with external contacts, including the pharmacy benefit managers' clinical department.

Experience & Education

- Three (3) years experience in clinical pharmacy practice including performing drug use evaluations and preparing drug monographs and other types of drug information for Pharmacy & Therapeutics Committees.
- Current knowledge and expertise in clinical pharmacology and disease states required.
- Basic working knowledge of the Medi-Cal or Medicaid programs preferred.
- A current, valid, unrestricted California State Pharmacy License and Pharm.D. required.
- ASHP accredited residency in Pharmacy Practice or equivalent background/experience required.

Pharmacy Resident program occurs within an integrated managed care setting. The residents are trained in the role of the pharmacist in the development and implementation of clinical practice guidelines, formulary development, medication use management, pharmacy benefit design, pharmacy network management, pharmacy benefit management, and drug-use policy development. In addition, residents are trained to function as leaders in developing and implementing pharmaceutical care plans for specific patients in an integrated health plan and delivery system setting.

Experience & Education

- PharmD degree from an accredited college of pharmacy.
- Eligibility for licensure in California.

PBM (Pharmacy Benefits Manager) staff evaluates pharmacy prior authorization requests in accordance with established drug Clinical Review Criteria that are consistent with current medical practice and Title 22, California Code of Regulations definition of medical necessity and that have been approved by CalOptima's Pharmacy and Therapeutics Committee. CalOptima pharmacists, with a current license to practice without restriction, review all pharmacy prior authorization requests that do not meet drug Clinical Review Criteria. CalOptima pharmacists with a current license to practice without restriction perform all denials.

Long Term Services and Supports Resources

The following staff positions provide support for LTSS operations:

LTSS Director, (CBAS/IHSS/LTC/MSSP) The Director of Long Term Services and Supports, (LTSS), will develop, manage and implement the Long Term Care Services and Support including long Term Care facilities, In-Home Supportive Services, Community Bases Adult Services and the Multipurpose Senior Services Program and staff associated with those programs. S/he will be

responsible for ensuring high quality and responsive service for CalOptima members residing in Long Term Care facilities, (all levels of care), and to those members enrolled in other LTSS programs. Develops, evaluates programs and policy initiatives affecting seniors and (SNF/SubAcute/ICF/ICF-DD/N/H) and other LTSS services.

Experience & Education

- 5 – 7 years varied related experience, including 5 years of supervisory experience with experience in supervising groups of staff in a similar environment.
- Bachelor's degree in Nursing or in a related field required.
- Master's degree in Health Administration, Public Health, Gerontology, or Licensed Clinical Social Worker is desirable.
- Some experience in government or public environment preferred
- Experience in the development and implementation of new programs

LTSS Manager, RN, (CBAS/IHSS/LTC) The Manager is expected to develop and manage the Long Term Services and Supports Department's work activities and personnel. S/he will ensure that services standards are met and operations are consistent with the health plan's policies and regulatory and accrediting agency requirements to ensure high quality and responsive service for CalOptima's members who are receiving long term care services and supports. The Manager much have strong team leadership, problem solving, organizational, and time management skills with the ability to work effectively with management, staff, providers, vendors, health networks, and other internal and external customers in a professional and competent manager. This position will work in conjunction with various department managers and staff to coordinate, develop, and evaluate programs and policy initiatives affecting members receiving long term care services

Experience and Education

- A current and unrestricted RN license in the State of California
- A Bachelor's degree or relevant experience in a healthcare field preferred
- 5 - 7 years varied clinical experience required
- 3 - 5 years supervisory/management experience in a managed care setting and /or nursing facility
- Experience in government or public environment preferred
- Experience in dealing with geriatrics and persons with disabilities

LTSS Supervisor, RN,(CBAS, IHSS, LTC) The Supervisor is responsible for planning, organizing, developing and implementing the principles, programs, policies and procedures employed in the delivery of long term care services and supports to members in the community and institutionalized setting. The Supervisor is responsible for the management of the day-to-day operational activities for LTSS programs: Long Term Care, (LTC), Community Based Adult Services, (CBAS), and In-Home Support Services, (IHSS), and personnel, while interacting with internal/external management staff, providers, vendors, health networks, and other internal and external customers in a professional, positive and competent manner. The position's primary responsibilities are the supervision and monitoring of the ongoing and daily activities of the department's staff. In addition, the supervisor will be resolving members and providers issues and barriers ensuring excellent customer service. Additional responsibilities include: Managing staff

coverage in all areas of LTSS to complete assignments, orienting, and training of new employees to ensure contractual and regulatory requirements are met.

Experience and Education

- A current unrestricted RN license in the State of California
- A bachelor's degree or relevant experience in a healthcare field preferred
- 3 years varied experience at a health plan, medical group, or skilled nursing facilities required
- Experience in interacting/managing with geriatrics and persons with disabilities
- Supervisory/management experience in utilization management activities
- Valid driver's license and vehicle, or other approved means of transportation, an acceptable driving record, and current auto insurance will be required for work away from the primary office approximately 30% of the time.

Medical Case Managers The LTSS Medical Case Manager, (MCM), is part of an advanced specialty collaborative practice, responsible for case management, care coordination and function, provides coordination of care, and provides ongoing case management services for CalOptima members in Long term Care, (LTC), facilities and members receiving Community Based Adult Services, (CBAS). Reviews and determines medical eligibility based on approved criteria/guidelines, NCQA standards, Medicare and Medi-Cal guidelines, and facilitates communication and coordination amongst all participants of the health care team and the member to ensure services are provided to promote quality, cost-effective outcomes. The LTSS MCM provides case management in a collaborative process that includes assessment, planning, implementation, coordination, monitoring and evaluation of the member's needs. The LTSS MCM is the subject matter expert and acts as a liaison to Orange County based community agencies, CBAS center, skilled nursing facilities, and to members and providers.

Experience and Education

- A current and unrestricted RN license in the State of California
- A current unrestricted LVN license in the State of California
- Minimum of 3 years managed care or nursing facility experience
- Excellent interpersonal skills
- Computer literacy required
- Valid driver's license and vehicle, or approved means of transportation, an acceptable driving record, and current auto insurance will be required for work away from the primary office approximately 95% of the time

CBAS Program Manager (MSW/MS) The CBAS Program Manager is responsible for managing the day-to-day operations of the CBAS Program and educates CBAS centers on various topics. The Program Manager is responsible for the annual CBAS Provider Workshop, CBAS process improvement, reporting requirements, reviews monthly files audit, develops inter-rater reliability questions, performs psychosocial and functional assessments, a liaison and a key contact person for California Department of Health Care Services (DHCS), California Department Office of Aging

(CDA), CBAS Coalition and CBAS centers. The CBAS Program Manager is responsible developing strategies and solutions to effectively implement CBAS project deliverables that require collaboration across multiple agencies.

Experience & Education

- Bachelor's degree in Sociology, Psychology, Social Work or Gerontology is required. Masters preferred.
- Minimum of three (3) years 3-5 years CBAS and program development experience
- Working experience with seniors and persons with disabilities, community-based organizations, and mental illness desired.
- Previous work experience in managing programs and building relationships with community partners is preferred.
- Excellent interpersonal skills
- Computer literacy required
- Valid driver's license and vehicle, or other approved means of transportation, an acceptable driving record, and current auto insurance will be required for work away from the primary office approximately 5% of the time or more while traveling to CBAS centers and community events.

Qualifications and Training

CalOptima seeks to recruit highly-qualified individuals with extensive experience and expertise in UM for staff positions. Qualifications and educational requirements are delineated in the position descriptions of the respective position.

Each new employee is provided an intensive hands-on training and orientation program with a staff preceptor. The following topics are covered during the program, as applicable to specific job descriptions:

- CalOptima New Employee Orientation
- HIPPA and Privacy/Corporate Compliance
- Use of technical equipment (phones, computers, printers, facsimile machines, etc.)
- UM Program, policies/procedures, etc.
- MIS data entry
- Application of Review Criteria/Guidelines
- Appeals Process
- Seniors and Persons with Disabilities Awareness Training

CalOptima encourages and supports continuing education and training for employees, which increases competency in their present jobs and/or prepares them for career advancement within CalOptima. Each year, a specific budget is set for continuing education for each licensed UM employee. Licensed nursing and physician staff is monitored for appropriate application of Review Criteria/Guidelines, processing referrals/service authorizations, and inter-rater reliability. Training opportunities are addressed immediately as they are identified through regular administration of

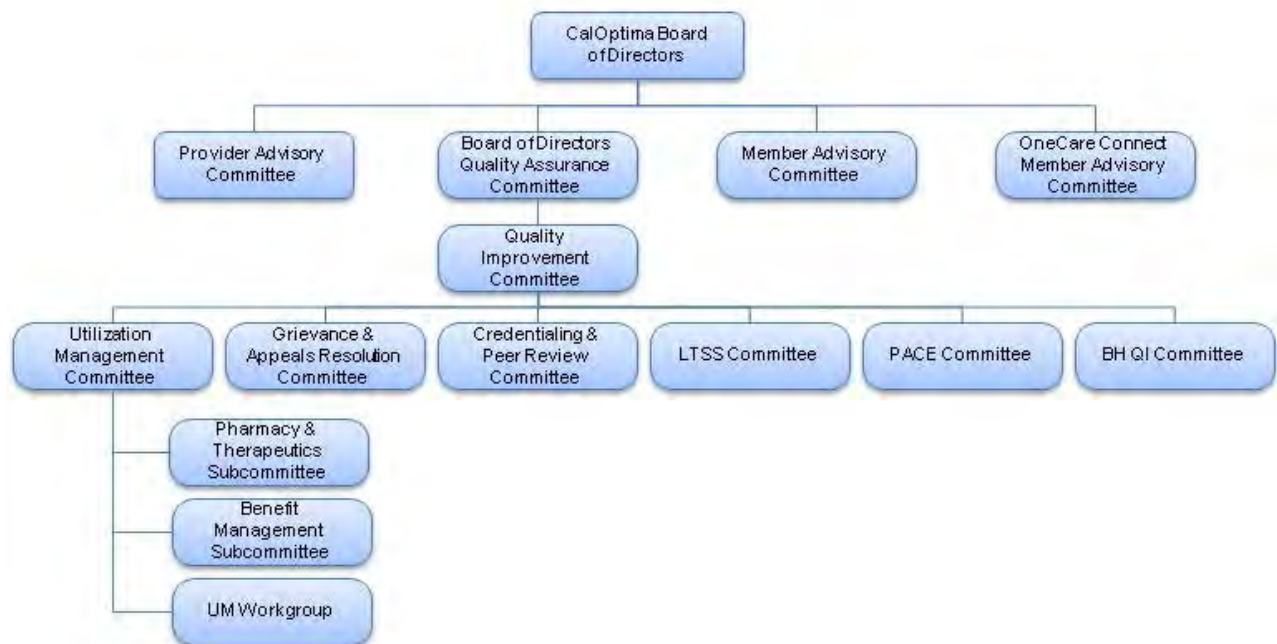
proficiency evaluations. Any employee who fails the evaluation is provided additional training and provided with a work improvement process. Formal training, including seminars and workshops, are provided to all UM staff on an annual basis.

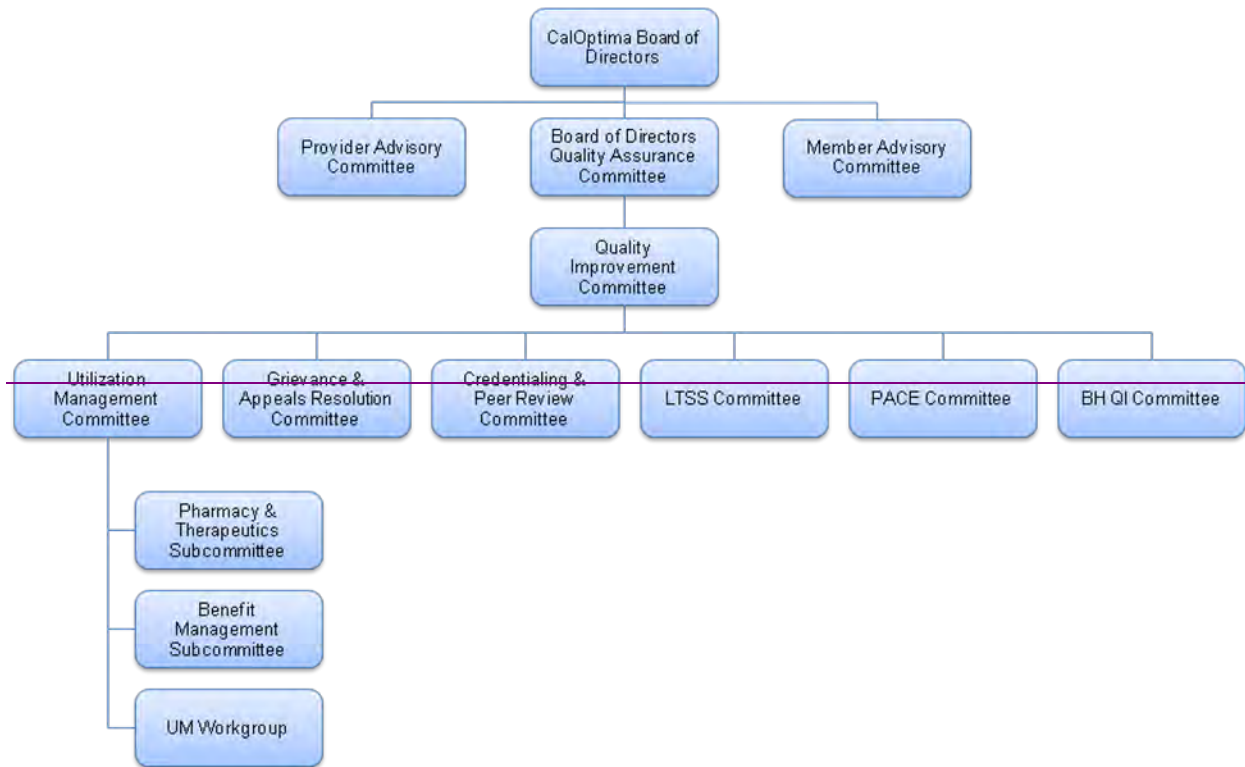
Appropriately licensed, qualified health professionals supervise the utilization management process and all medical necessity decisions. A physician or other appropriately licensed health care professional (as indicated by case type) reviews all medical necessity denials of healthcare services offered under CalOptima's medical and behavioral health benefits. Personnel employed by or under contract to perform utilization review are appropriately qualified, trained and hold current unrestricted professional licensure. This licensure is specific to the state of California. UM employee compensation includes hourly and salaried positions. All medical management staff is required to sign an Affirmative Statement regarding compensation annually. Compensation or incentives to staff or agents based on the amount or volume of adverse determinations; reductions or limitations on lengths of stay, benefits, services; or frequency of telephone calls or other contacts with health care practitioners or patients is prohibited.

CalOptima and its delegated Utilization Review agents do not permit or provide compensation or anything of value to its employees, agents, or contractors based on:

- The percentage of the amount by which a claim is reduced for payment, or the number of claims or the cost of services for which the person has denied authorization or payment; or
- Any other method that encourages the rendering of an adverse determination.

Committee Structure





Utilization Management Committee

The Utilization Management Committee (UMC) is responsible for the review and approval of medical necessity criteria and protocols and utilization management policies, procedures and programs. The UMC monitors and analyzes relevant data to detect and correct patterns of under or over utilization, coordination of care, appropriate use of services and resources, and member and practitioner satisfaction with the UM process.

The UMC meets quarterly and coordinates an annual review and revision of the Utilization Management Program Description, Work Plan and Annual UM Program Evaluation. Before coming to the Board of Directors for approval the documents are reviewed and approved by the Quality Improvement Committee (QIC) and Quality Assurance Committee (QAC). The Director of Utilization Management maintains detailed records of all UMC meeting minutes and recommendations for UM improvement activities made by the UMC. The UMC routinely submits meeting minutes as well as written reports regarding analysis of the above tracking and monitoring processes and status of corrective action plans to the QIC. Daily oversight and operating authority of utilization management activities is delegated to the UMC which reports up through CalOptima's QIC and ultimately to CalOptima's QAC and the Board of Directors.

Utilization Management Committee Scope

- Oversees the UM activities of CalOptima in regard to compliance with contractual requirements, Federal and State statutes and regulations, and National Committee for Quality Assurance (NCQA) requirements;
- Develops and annually reviews/approves the UM Program Description, Work Plan, criteria, policies and procedures;
- Reviews practitioner specific UM reports to identify trends and/or utilization patterns and makes recommendations to the QIC for further review;
- Reviews reports specific to facility and/or geographic areas for trends and/or patterns of under or over utilization;
- Examines appropriateness of care reports to identify trends and/or patterns of under or over utilization and refers identified practitioners to the QIC for performance improvement and/or corrective action;
- Examines results of annual member and practitioner satisfaction surveys to determine overall satisfaction with the UM program and identify areas for performance improvement;
- Provides a feedback mechanism to the QIC for communicating findings, recommendations, and a plan for implementing corrective actions related to UM issues;
- Identifies opportunities where UM data can be utilized in the development of quality improvement activities and submitted to the QIC for recommendations;
- Provides feedback to the QIC regarding effectiveness of CalOptima's P4P programs;
- Report's findings of UM studies and activities to the QIC;
- Liaisons with the QIC for ongoing review of quality indicators.

Utilization Management Committee Members

The UMC actively involves a number of actively participating network practitioners in utilization review activities as available and to the extent that there is not a conflict of interest. CalOptima's UMC is [chaired by the UM Medical Director and is](#) comprised of the:

- CMO;
- Deputy CMO;
- Executive Director Clinical Operations;
- CalOptima Medical Directors of Behavioral Health, Senior Programs, Quality and Analytics, and network Medical Directors and practitioners;
- The UMC is supported by the Medical Directors of Referral/Prior Authorization and Concurrent Review and the Director and Managers of Utilization, and any additional staff may also attend the Utilization Management Committee as appropriate.

Benefit Management Subcommittee (BMSC)

The Benefit Management Subcommittee is a subcommittee of the Utilization Management Committee. The BMSC was chartered by the UMC, directed to establish a process for maintaining a consistent set of benefits and benefit interpretations for all lines of business and revise and update CalOptima's authorization rules based on benefit updates. Benefit sources include, but are not limited to, Operational Instruction Letters (OILs), Medical Managed Care Division (MMCD) All Plan Letters (APLs), and the Medi-Cal Manual.

The BMSC is responsible for the following:

- Recommending how to implement new or modified benefits;
- Clarifying the financial responsibility of benefit coverage;
- Recommending benefit decisions to the UMC;
- Updating and maintaining the Benefit Matrix, and
- Communicating benefit changes to staff, providers, and health networks for implementation.

The Subcommittee membership consists of the following:

- Medical Director, Utilization Management
- Executive Director Clinical Operations
- [Director of Utilization Management](#)
- Director Case Management
- Director Disease Management/Health Education
- Director Regulatory Affairs
- Director Clinical Pharmacy Management
- Director Quality and Analytics
- Director Managed Long Term Support and Services (MLTSS)
- Director Claims Management
- Director Grievance and Appeals Resolution
- Director Coding Initiatives

The BMSC meets ten times per year, and recommendations from the BMSC are reported to the UMC on a Quarterly basis.

Behavioral Health Quality Improvement Committee (BHQIC)

The Behavioral Health Quality Improvement Committee was established in 2011 with the intended purpose of:

- Ensuring members receive timely and satisfactory behavioral health care services;
 - Enhancing the continuity and coordination between physical health and behavioral health care providers, and
 - Guiding CalOptima towards the vision of bi-directional behavioral health care integration.
- [Monitoring key areas of service utilization by s-to-members and providers, and identifying areas of improvement.](#)

The BHQIC responsibilities are to: ~~is responsible for:~~

- ~~• Monitoring key areas of service to members and providers through review of reports and presentations;~~
- ~~• Identifying quality concerns, trends or systemic issues and opportunities for improvement, and~~
- ~~• Communicating to the QIC its findings and recommendations.~~
- [Ensure adequate provider availability and accessibility to effectively serve the membership](#)
- [Oversee the functions of delegated activities](#)

- Monitor that care rendered is based on established clinical criteria, clinical practice guidelines, and complies with regulatory and accrediting agency standards
- Ensure that Member benefits and services are not underutilized and that assessment and appropriate interventions are taken to identify inappropriate over utilization
- Utilize Member and Network Provider satisfaction study results when implementing quality activities
- Maintain compliance with evolving National Committee for Quality Assurance (NCQA) accreditation standards
- Communicate results of clinical and service measures to Network Providers
- Document and report all monitoring activities to appropriate committees

The designated Chairman of the BHQIC is the Medical Director of the Behavioral Health Integration who is responsible for chairing the Committee, as well as reporting findings and recommendations to the QIC. The composition of the BHQI Committee is defined in the BHQIC Charter.

The BHQIC meets quarterly at a minimum or more frequently as needed.

~~The designated Chairman of the BHQIC is the Medical Director of Behavioral Health who is responsible for chairing the Committee, as well as reporting findings and recommendations to the QIC.~~

~~The composition of the BHQI Committee is defined in the BHQI Charter and includes, but not limited to the following:~~

- ~~• Medical Director, Behavioral Health (Chair)~~
- ~~• Chief Medical Officer/Deputy Medical Officer~~
- ~~• Medical Director Quality and Analytics~~
- ~~• Medical Director Utilization Management~~
- ~~• Medical Director QI and Analytics~~
- ~~• Medical Director OneCare Medical Director Medi-Cal MBHO~~
- ~~• Medical Director Regional Center of Orange County~~
- ~~• Chief Clinical Officer Medi-Cal MBHO~~
- ~~• Executive Director Clinical Operations~~
- ~~• Director Behavioral Health Integration~~
- ~~• Clinical Pharmacist~~
- ~~• Contracting Behavioral Health Care Practitioners~~
- ~~• Medical Director Orange County Health Care Agency~~

The BHQIC meets quarterly at a minimum or more frequently as needed.

Long Term Services and Supports Quality Improvement Subcommittee (LTSS QISC)

In 2014, the Long Term Services and Supports Improvement SubCommittee replaced the Long Term Care Quality Improvement Subcommittee. The LTSS QISC was created to provide a forum for LTSS programs to share best practices, identify challenges and barriers, and together find solutions that are member person-centered, maximize available resources and reducing duplicate

services while providing quality of care and ability for members to safely reside in the least restrictive living environment.

The purpose of the LTSS QISC:

- Engage stakeholders input on ways to best integrate the LTSS programs with managed care delivery system and improved quality of care
- Improving and providing coordinated care for CalOptima Members who resides in long term care facilities and those who receive Home- and Community Based Services (HCBS).

The LTSS QISC Responsibilities:

- Identify barriers to keeping Members safe in their own homes or in the community, develop solutions, make appropriate recommendations to improve discharge planning process and preventing inappropriate admissions
- Evaluate the performance, success, and challenges of LTSS program providers of the following services: CBAS, IHSS, MSSP and other Home and Community Based Services (HCBS)
- Monitor the important aspects of quality of care, qualify of services, patient safety by collecting and organizing data for all selected indicators
- Provide input on enhancing the capacity and coordination among LTSS providers, community-based organizations, housing providers, and managed care plans to care for individuals discharged from institutions.
- Identify and recommend topics for LTSS providers workshops, educations and trainings

The LTSS QISC Structure:

- The designated Chairman of the LTSS QISC is the Medical Director, Senior Programs, who is responsible for chairing the Committee.
- The LTSS Activity Summary is reported to QIC, and includes, but is not limited to the following:
 - Nursing Facility Administrators
 - Community Based Adult Services (CBAS) Administrators
 - Orange County Social Services Agency, Deputy Director or Designee
 - Multipurpose Senior Services Program, Site Director or Designee
 - Chief Medical Officer/Deputy Medical Officer
 - Medical Director QI and Analytics
 - Medical Director UM
 - Executive Director Clinical Operations
 - Executive Director Quality Analytics
 - LTSS Manager(s)
 - LTSS Director
- The LTSS QISC meets quarterly at a minimum or more frequently as needed.
- The LTSS Activity Summary includes, but is not limited to, will be reported to QIC.
 - Member review of Hospital Admission for each LTSS program;
 - Member review of Emergency Department visit for each LTSS program;
 - Members review for Hospital Readmissions for each LTSS program;
 - Health Risk Assessment results for LTC OCC members;

- LTC Provider Annual Workshop;
 - CBAS Provider Workshop;
 - CBAS Centers Profile
 - LTC Profile
 - Care Coordination and Interdisciplinary Care Team Participation by LTSS staff;
 - Total number of participants by LTSS program
- In addition, LTSS utilization activities' summary is reported to UMC, and includes, but is not limited to, the following:
 - Community Based Adult Services (CBAS) statistics such as to number of participants, assessment type, turn around time, denials rates;
 - Long Term Care (LTC) Statistics include, but is not limited to, bed type, turn around time, denials rate;
 - Multipurpose Senior Services Program (MSSP) statistics such as total number of participants, total number of termination, number of ER visits, ALOS, SNF admissions.
 - LTSS Inter-Rater Reliability study result;
 - Rate Adjustments for LTC facilities

Integration with the Quality Improvement Program

The UM Program and Workplan are evaluated and submitted for review and approval annually by both the CalOptima Utilization Management Committee and the Quality Improvement Committee (QIC), with final review and approval by the Board of Director's Quality Assurance Committee (QAC).

- Utilization data is collected, and aggregate UM data, member grievances, denials, and appeals are reviewed at the CalOptima Utilization Management Committee and recommendations are presented to the CalOptima QIC, and are presented to the participating HMOs, PHCs, SRGs and PMGs on a quarterly basis.
- The UM staff may identify actual or potential quality issues during utilization review activities. These issues are referred to the QI staff for follow-up.
- The CalOptima Quality Improvement Committee reports to the Board Quality Assurance Committee.
- The Utilization Management Committee is a sub-committee of the Quality Improvement Committee (QIC) and routinely reports activities to the QIC.

Conflict of Interest

CalOptima maintains a Conflict of Interest policy to ensure that conflicts of interest are avoided by staff and members of Committees. This policy precludes using proprietary or confidential CalOptima information for personal gain or the gain of others, as well as direct or indirect financial interests in, or relationships with, current or potential providers, suppliers, or members, except when it is determined that the financial interest does not create a conflict.

As stated in CalOptima's Human Resource Manual, a Conflict of Interest policy is provided to all employees when hired, and all Committee members, regardless of employment status (i.e., CalOptima or entity), sign a Conflict of Interest statement on an annual basis.

Fiscal and clinical interests are separated. CalOptima and its delegates do not specifically reward practitioners or other individuals conducting utilization review for issuing denials of coverage, services or care. There are no financial incentives for UM decision makers that could encourage decisions that result in under-utilization.

Confidentiality

CalOptima adheres to the following:

- Staff and consultants are required to sign a Confidentiality Statement and Business Associate Agreement;
- All members of the Utilization Management Committee are required to sign a Confidentiality statement at least annually;
- All employees and practitioners are allowed to access and disclose confidential information only as necessary to fulfill assigned duties and responsibilities;
- Medical information sent by mail or fax to the attention of the recipient is clearly marked “personal and confidential”;
- All medical information is secured in a locked location with access limited to essential personnel only;
- Medical information stored in the software system is protected under multiple levels of security by system configuration, which includes user access passwords;
- Confidential information is destroyed by a method that induces complete destruction when no longer needed;
- CalOptima abides by all federal and state laws governing the issue of confidentiality.

The UM department complies with CalOptima’s HIPPA policies and procedures and state and federal laws in the handling and protection of member and provider confidential information.

Integration with Other Processes

The UM Program, Case Management Program, Behavioral Health Program, Managed Long Term Support and Services Programs, Pharmacy and Therapeutics (P&T) Program, Quality Improvement (QI), Credentialing, and the Compliance and Audit and Oversight Programs are closely linked in function and process. The UM process utilizes quality indicators as a part of the review process and provides the results to CalOptima’s QI department. As case managers perform the functions of utilization management, quality indicators, prescribed by CalOptima as part of the patient safety plan, are identified. The required information is documented on the appropriate form and forwarded to the QI department for review and resolution. As a result, the utilization of services is inter-related with the quality and outcome of the services.

Any adverse information that is gathered through interaction between the UM staff and the practitioner or facility staff is also vital to the re-credentialing process. Such information may relate, for example, to specific case management decisions, discharge planning, prior authorization of non-covered benefits, etc. The information is forwarded to the QI Department in the format prescribed by CalOptima for review and resolution as needed. The CMO or Medical Director determines if the information warrants additional review by CalOptima’s Peer Review or Credentialing Committee. If committee review is not warranted, the information is

filed in the practitioner's folder and is reviewed at the time of the practitioner's re-credentialing.

UM policies and processes serve as integral components in preventing, detecting, and responding to Fraud and Abuse among practitioners and members. The Utilization Management Department works closely with the Compliance Officer and Fraud and Abuse Unit to resolve any potential issues that may be identified.

In addition, CalOptima coordinates utilization/care management activities with local community practitioners for activities that include, but are not limited to:

- Early childhood intervention;
- State protective and regulatory services;
- Women, Infant and Children Services (WIC);
- EPSDT Health Check;
- Services provided by local public health departments.

Utilization Management Process

The utilization management process encompasses the following program components: 24-hour seven day week nurse triage, second opinions, referral/prior authorization, concurrent review, ambulatory review, retrospective review, discharge planning and care coordination. All approved services must be medically necessary. The clinical decision process begins when a request for authorization of service is received at CalOptima level. Request types may include authorization of specialty services, second opinions, outpatient services, ancillary services, or scheduled inpatient services. The process is complete when the requesting practitioner and member (when applicable) have been notified of the determination.

Benefits

CalOptima administers health care benefits for members, as defined by contracts with the Department of Health Care Services (Medi-Cal), a variety of programs, regulations, policy letters and all the Center for Medicare and Medicaid Services benefit guidelines are maintained by CalOptima to support UM decisions. Benefit coverage for a requested service is verified by the UM staff during the authorization process. CalOptima has standardized authorization processes in place, and requires that all delegated entities to have similar program processes. Routine auditing of delegated entities is performed by the CalOptima Audit and Oversight Department via its delegation oversight team for compliance.

Utilization Management Program Structure

The UM Program is designed to work collaboratively with delegated entities, including but not limited to, physicians, hospitals, healthcare delivery organizations, and ancillary service providers in the community in an effort to assure that the member receives appropriate, cost efficient, quality-based healthcare.

The UM Program is reviewed and evaluated for effectiveness and compliance with the standards of the Department of Health Care Services (DHCS), Department of Managed Healthcare (DMHC), Centers for Medicare and Medicaid Services (CMS), California Department of Aging (CDA) and National Committee on Quality Assurance (NCQA) at least annually. Recommendations for

revisions and improvements are made, as appropriate, and subsequently annually. The Utilization Management Work Plan is based on the findings of the annual program Workplan evaluation. The structure of the UM Program is designed to promote organizational accountability and responsibility in the identification, evaluation, and appropriate utilization of health care services delivered by the CalOptima health care delivery network. Additionally, the structure is designed to enhance communication and collaboration on UM issues that affect delegated entities and multiple disciplines within the organization.

The Organization Chart and the program Committee's reporting structure accurately reflect CalOptima's Board of Directors as the governing body, identifies senior management responsibilities, as well as committee reporting structure and lines of authority. Position job descriptions and policies and procedures define associated responsibilities and accountability. The composition and functions of the Utilization Management Workgroup (UMG), and the UMC and QIC, which serve as the oversight committees for CalOptima UM functions, are contained and delineated in the Committees Charters.

The CalOptima UM Program is evaluated on an ongoing basis for efficacy and appropriateness of content by the Chief Medical Officer, Medical Directors of UM, the Executive Director of Clinical Operations, and the UMC and QIC. CalOptima-contracted delegates are delegated UM responsibilities, including the Utilization Management Program and work plans, which are presented annually to the QIC as part of CalOptima's Delegation Oversight Program. The QIC then reviews and approves or does not approve the delegate's UM Program and work plans.

Methods of Review and Authorization

Prior Authorization

Prior authorization requires the provider or practitioner to submit a formal medical necessity determination request to CalOptima prior to the service being rendered. Upon receipt, the prior authorization request is screened for eligibility and benefit coverage and assessed for medical necessity and appropriateness of the health care services proposed, including the setting in which the proposed care will take place.

Prior authorization is required for select services such as non-emergent inpatient admissions, elective out-of-network services, and certain outpatient services, ancillary services and specialty injectables as described on the Prior Authorization List. This list is accessible on the CalOptima website at www.caloptima.org.

Clinical Information

Prior Authorization is required for selected services appearing on a prior authorization list in the provider section on the CalOptima website at www.caloptima.org. Clinical information submitted by the provider justifies the rationale for the requested service through the authorization process which assesses medical necessity and appropriateness utilizing evidence-based guidelines upon which a determination is made.

A new medical management system, Altruista/GuidingCare ~~is scheduled to be~~ was implemented in the first quarter of 2015. This member- centric system utilizes evidence- based clinical guidelines and allows each member's care needs to be directed from a single integrated care plan that is

shared with internal and external care team members to enable collaboration, minimize barriers, and support continuity and coordination of care. The system captures data on medical, behavioral, social and personal care needs of members supporting the identification of cultural diversity and complex care needs.

In April 2012, CalOptima Link launched. The system allows for on-line authorizations to be submitted by the health networks and processed electronically. The referrals are auto-adjudicated through referral intelligence rules (RIR). 45% of the on-line referrals met the RIR guidelines for auto approval in the 4th quarter of 2015⁴. Practitioners also send referrals and requests to the Utilization Management Department by mail, fax and/or telephone based on the urgency of the request.

Referrals

A referral is considered a request to CalOptima for authorization of services as listed on the Prior Authorization List. Primary Care Providers (PCP) are not required to issue paper referrals, but are required to direct the member's care and must obtain a prior authorization for referrals to certain specialty physicians and all non-emergent out-of-network practitioners as noted on the Prior Authorization List.

Second Opinions

A second opinion may be requested when there is a question concerning diagnosis or options for surgery or other treatment of a health condition, or when requested by any member of the member's health care team, including the member, parent and/or guardian. A social worker exercising a custodial responsibility may also request a second opinion. Authorization for a second opinion is granted to a network practitioner or an out-of-network practitioner, if there is no in-network practitioner available.

Extended Specialist Services

Established processes are in place by which a member requiring ongoing care from a specialist may request a standing authorization. Additionally, the "Standing Referral" policy and procedure Standing Referral: GG.1112 includes guidance on how members with life-threatening conditions or diseases which require specialized medical care over a prolonged period of time can request and obtain access to specialty care centers.

Out-of-Network Providers

If a member or provider requires or requests a provider out-of-network for services that are not available from a qualified network provider, the decision to authorize use of an out-of-network provider is based on a number of factors including, but not limited to, continuity of care, availability and location of an in-network provider of the same specialty and expertise, lack of network expertise, and complexity of the case.

Network providers are prohibited from making referrals for designated health services to health care entities with which the practitioner or a member of the practitioner's family has a financial relationship.

Pharmaceutical Management

The Pharmacy Management Program is overseen by the CMO, and CalOptima Director of Pharmacy. All policies and procedures utilized by CalOptima related to pharmaceutical management include the criteria used to adopt the procedure as well as a process that uses clinical evidence from appropriate external organizations. The program is reviewed at least annually by the Pharmacy and Therapeutics Committee (P&T) and updated as new pharmaceutical information becomes available.

Policies and procedures for pharmaceutical management promote the clinically appropriate use of pharmaceuticals, and are made available to practitioners via the Provider newsletter and/or CalOptima website.

The CalOptima Pharmacy and Therapeutics Committee is responsible for development of the CalOptima Formulary, which is based on sound clinical evidence, and is reviewed at least annually by actively practicing practitioners and pharmacists. Updates to the CalOptima Approved Drug List are communicated to both members and providers.

If the following situations exist, CalOptima evaluates the appropriateness of prior authorization of non-formulary drugs:

- No formulary alternative is appropriate and the drug is medically necessary.
- The member has failed treatment or experienced adverse effects on the formulary drug.
- The member's treatment has been stable on a non-formulary drug, and change to a formulary drug is medically inappropriate.

To request prior authorization for outpatient medications not on the CalOptima Formulary, the physician or physician's agent must provide documentation to support the request for coverage. Documentation is provided via the CalOptima Pharmacy Prior Authorization (PA) form, which is faxed to CalOptima's Pharmacy Benefits Manager (PBM) for review. All potential authorization denials are reviewed by a Pharmacist at CalOptima, as per DHCS and DMHC regulations. The Pharmacy Management Department profiles drug utilization by members to identify instances of polypharmacy that may pose a health risk to the member. Medication profiles for members receiving multiple medication fills per month are reviewed by a Clinical Pharmacist. Prescribing practices are profiled by practitioner and specialty groups to identify educational needs and potential over-utilization. Additional prior authorization requirements may be implemented for physicians whose practices are under intensified review.

Pharmacy Determinations

Medi-Cal

CalOptima Pharmacy Management Department delegates initial prior authorization review to the Pharmacy Benefits Manager (PBM) based on clinical prior authorization criteria developed by the CalOptima Pharmacy Management staff and approved by the CalOptima Pharmacy and Therapeutics (P&T) Committee. The PBM may approve or defer for additional information, but

final denial and appeal determinations may only be made by a CalOptima Pharmacist or CalOptima Medical Director. Final decisions for requests that are outside of the available criteria must be made by a CalOptima Pharmacist or CalOptima Medical Director.

CalOptima's written notification of pharmacy denials to members and their treating practitioners contains:

- A description of appeal rights, including the member's right to submit written comments, documents or other information relevant to the appeal
- An explanation of the appeal process, including the appeal time frames and the member's right to representation
- A description of the expedited appeal process for urgent preservices or urgent concurrent denials
- Notification that expedited external review can occur concurrently with the internal appeal process for urgent care

CalOptima gives practitioners the opportunity to discuss pharmacy UM denial decisions

OneCare

CalOptima does not delegate Pharmacy UM responsibilities. Pharmacy determinations follow the appropriate UM timeliness guidelines for medical necessity review.

The following edit checks are completed on-line, real-time, as a prescription is being dispensed:

- Duplicate Drug Therapy
- Too-Early Refill
- Low-Dose/High-Dose Alert
- Incorrect Daily Dosage
- Excessive or Questionable Days' Supply
- Drug to Drug Interaction
- Drug/Age Interaction
- Drug/Gender Interaction
- Drug/Pregnancy Interaction

Formulary

The CalOptima drug Formulary was created to offer a core list of preferred medications to all practitioners. Occasionally it is necessary to address requests from local providers to review specific drugs for addition to the Formulary. The Formulary is developed and maintained by the CalOptima Pharmacy and Therapeutics (P&T) Committee. Final approval from the P&T must be received to add drugs to the Formulary. CalOptima Formulary is available on the CalOptima website or in hard copy upon request.

Pharmacy Benefit Manager

The PBM is responsible for pharmaceutical administrative and clinical operations, including pharmacy network contracting and credentialing, pharmacy claims processing system and data operations, customer service, pharmacy help desk, prior authorization, clinical services and quality improvement functions. The PBM makes denial decisions based on lack of medical necessity, drugs not included in the Formulary, prior authorization not obtained, etc. The PBM follows and maintains compliance with health plan policies and all pertinent state and federal statutes and regulations. As a delegated entity the PBMs monitored according to the Audit and Oversight department's policies and procedures.

Specialty Injectables

CalOptima contracts with community pharmacies for the provision of specialty injectables not available through the delegated Pharmacy Benefit Manager's network.

CalOptima is responsible for medically necessary determinations related to specialty injectables. The pharmacies are not a subcontracted vendor and do not make medical necessity decisions. In the first Quarter of 2015 the responsibility for authorizing specialty injectables will transition from the UM Department to the Pharmacy Management Department to align the authorization process with the most appropriate health care professionals organizationally.

Medical Necessity Review

Covered services are those medically necessary health care services provided to members as outlined in CalOptima's contract with the State of California. Medically necessary means services or supplies that: are appropriate proper and needed for the diagnosis or treatment of a member's medical condition; are provided for the diagnosis, direct care, and treatment of the member's medical condition; meet the standards of good medical practice in the local area; and are not mainly for the convenience of the member or the doctor.

The CalOptima UM process uses an active, ongoing coordination and evaluation of requested or provided health care services, performed by licensed health care professionals, to ensure medically necessary, appropriate health care or health services are rendered in the most cost efficient manner, without compromising quality. Physicians, or other appropriate healthcare professionals, review and determine all final denial decisions for requested medical and behavioral health care services. The review of the denial of a pharmacy prior authorization, however, may be carried out by a qualified Physician or Pharmacist.

The Medical Directors are responsible for providing clinical expertise to the Utilization Management staff and exercising sound professional judgment during review determinations regarding health care and services. The CMO and Medical Directors, with the support of the UMC, have the authority, accountability and responsibility for denial determinations. For those contracted delegated PMGs that are delegated UM responsibilities, that entity's Medical Director, or designee, has the sole responsibility and authority to deny coverage. The Medical Director may also provide clarification of policy and procedure issues, and communicate with delegated entity practitioners regarding referral issues, policies, procedures, processes etc.

CalOptima's Utilization Management Department is responsible for the review and authorization of health care services for CalOptima Direct members utilizing the following medical determination review processes:

- Referral/Prior Authorization for selected conditions/services;
- Admission Review;
- Concurrent/Continued Stay Review for selected conditions;
- Discharge Planning Review;
- Retrospective Review;
- Emergency Service Authorization is not required but may be reviewed;
- Identification of Opportunities for Case Management, Disease Management or Health Education of CalOptima members;
- Evaluation for potential transplant services for health network members;

The following standards are applied to all prior authorization, concurrent review, and respective review determinations:

- Qualified health care professionals supervise review decisions, including care or service reductions, modifications, or termination of services;
- There is a set of written criteria or guidelines for Utilization Review that is based on sound medical evidence, is consistently applied, regularly reviewed, and updated;
- Member characteristics are considered when applying criteria in order to address the individual needs of the member. These characteristics include, but are not limited to:
 - Age
 - Co-morbidities
 - Complications
 - Progress of treatment
 - Psychological situation
 - Home environment, when applicable;
- Availability of facilities and services in the local area to address the needs of the members are considered when making determinations consistent with the current benefit set. In the event that member circumstances or the local delivery system prevent the application of approved criteria or guidelines in making an organizational determination, the request is forwarded to the Utilization Management Medical Director to determine an appropriate course of action;
- Reasons for decisions are clearly documented in the [medical management](#) system;
- Notification to Members regarding denied, deferred, or modified referrals is made in accordance with mandated regulatory and accreditation agency timeframes, and members and providers are notified of appeals and grievance procedures;
- Decisions related to appeals or grievances are made in a timely manner in accordance with timelines established by CalOptima's Grievance and Appeals Resolution process, and as the member's condition requires, for medical conditions requiring time sensitive services;
- Prior Authorization requirements are not applied to Emergency Services, Minor Consent/Sensitive Services, Family Planning, Preventive Services, basic Prenatal Care, Sexually Transmitted Disease services, and HIV testing;

- Records, including an oral or written Notice of Action, are retained for a minimum of five (5) years from the end of the fiscal year in which the date of service occurred, unless a longer period is required by law;
- Requesting provider is notified, orally or in writing, of any decision to deny, approve, modify, or delay a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested;
- All members are notified in writing of any decision to deny, modify, or delay a service authorization request.
- All providers are encouraged to request information regarding the criteria used in making a determination. Contact can be made directly to the Medical Director involved in the decision, utilizing the contact information included in the Notice of Action. A provider may request a discussion with the Medical Director, or a copy of the specific criteria utilized.

The following is appropriate clinical information used to make medical necessity determinations and includes, but is not limited to:

- Office and hospital records
- A history of the presenting problem
- A clinical examination
- Diagnostic test results
- Treatment plans and progress notes
- Patient's psychological history
- Information on consultations with the treating provider
- Evaluations from other health care providers
- Photographs
- Operative and pathological experts
- Rehabilitation evaluations
- A printed copy of criteria related to the request
- Information regarding benefits for services or procedures
- Information regarding the local delivery system
- Patient characteristics and information
- Information from responsible family members

CalOptima's Utilization Management Committee reviews the Prior Authorization List regularly, in conjunction with CalOptima's CMO, Medical Directors and Executive Director of Clinical Operations, to determine if any services should be added or removed from the list. The Provider Services, Member Services and Network Management departments are also consulted on proposed revisions to the Prior Authorization List. Such decisions are based on CalOptima's program requirements, or to meet federal or state statutory or regulatory requirements. Practitioners are appropriately notified when such modifications occur.

Appropriate Professionals for UM Decision Process

The UM decision process requires that qualified, licensed health professionals assess the clinical information used to support UM decisions. If the clinical information included with a request for services does not meet the appropriate clinical criteria, the Utilization Management Nurse Case

Managers and Medical Authorization Assistants are instructed to forward the request to the appropriate qualified, licensed health practitioner for a determination. Only practitioners or pharmacists can make decisions/determinations for denial, or modification of care based on medical necessity, and must have education, training, and professional experience in medical or clinical practice and have an unrestricted license to practice in the specific discipline for which an adverse determination is being rendered.

CalOptima distributes a statement to all members in the Member Handbook, and at least annually to all practitioners and employees who make UM decisions, affirming that UM decision making is based only on appropriateness of care and services and existence of coverage. The organization does not specifically reward practitioners or other individuals for issuing denials of coverage of service or care, and CalOptima ensures that UM decision makers are not unduly influenced by fiscal and administrative management by requiring that UM decisions be based on evidence-based clinical criteria, the member's unique medical needs, and benefit coverage.

Authorization Review Roles				
Authorization Type*	Criteria Utilized	Medical Assistant	Nurse	Medical Director / Physician Reviewer
Chemotherapy	InterQual / MCG / Medi-Cal and Medicare Manuals / CalOptima Pharmacy Authorization Guidelines		X	X
DME (Custom & Standard)	InterQual / MCG / Medi-Cal and Medicare Manuals		X	X
Diagnostics	InterQual / MCG / Medi-Cal and Medicare Manuals		X	X
Dialysis	InterQual / MCG / Medi-Cal and Medicare Manuals	X	X	X
Hearing Aids	Medi-Cal and Medicare Manuals	X	X	X
Home Health	InterQual / MCG / Medi-Cal and Medicare Manuals		X	X
Imaging	InterQual / MCG / Medi-Cal and Medicare Manuals		X	X
In Home Nursing (EPSDT)	Medi-Cal and Medicare Manuals		X	X
Incontinence Supplies	Medi-Cal and Medicare Manuals	X	X	X
Injectables	InterQual / MCG / Medi-Cal and Medicare Manuals		X	X
Medical Supplies (DME Related)	Medi-Cal and Medicare Manuals	X	X	X
NEMT	Title 22 Criteria		X	X
Office Consultations	InterQual / MCG / Medi-Cal and Medicare Manuals	X	X	X
Office Visits (Follow-up)	InterQual / MCG / Medi-Cal and Medicare Manuals	X	X	X
Orthotics	InterQual / MCG / Medi-Cal and Medicare Manuals		X	X
Pharmaceutics	CalOptima Pharmacy Authorization Guidelines	Pharmacy Technician		Pharmacists Physician Reviewer
Procedures	InterQual / MCG / Medi-Cal and Medicare Manuals		X	X
Prosthetics	InterQual / MCG / Medi-Cal and Medicare Manuals		X	X
Radiation Oncology	InterQual / MCG / Medi-Cal and Medicare Manuals		X	X
Therapies (OT/PT/ST)	InterQual / MCG / Medi-Cal and Medicare Manuals	RCOC Referral	X	X

		s		
Transplants	DHCS Guidelines	Referral	X	X
Administrative Denial	CalOptima Policy	X	X	
Medical Necessity Denial	InterQual / MCG / Medi-Cal and Medicare Manuals / CalOptima Pharmacy Authorization Guidelines			X

*If Medical Necessity is not met, the request is referred to the Medical Director / Physician Reviewer for review and determination.

Long Term Services and Supports

<u>Authorization Type*</u>	<u>Criteria Utilized</u>	<u>Medical Assistant</u>	<u>Nurse</u>	<u>Medical Director / Physician Reviewer</u>
Community Based Adult Services (CBAS)	DHCS CBAS Eligibility Determination Tool (CEDT)		<u>X</u>	<u>X</u>
Long Term Care: Nursing Facility B Level	Medi-Cal Criteria Manual Chapter 7: Criteria for Long Term Care Services / Title 22, CCR, Section 51335		<u>X</u>	<u>X</u>
Long Term Care: Nursing Facility A Level	Medi-Cal Criteria Manual Chapter 7: Criteria for Long Term Care Services / Title 22, CCR, Section 51334		<u>X</u>	<u>X</u>
Long Term Care: Subacute	Medi-Cal Criteria Manual Chapter 7: Criteria for Long Term Care Services / Title 22, CCR, Sections 51003 and 51303		<u>X</u>	<u>X</u>
Long Term Care: Intermediate Care Facility / Developmentally Disabled	Medi-Cal Criteria Manual Chapter 7: Criteria for Long Term Care Services / Title 22, CCR, Sections 51343 and 51164	<u>X</u> <u>DDS or DMH Certified</u>	<u>X</u>	<u>X</u>
Hospice Services	Medi-Cal Criteria Manual Chapter 11: Criteria for Hospice Care / Title 22, California Code of Regulations	<u>X</u>	<u>X</u>	<u>X</u>

*If Medical Necessity is not met, the request is referred to the Medical Director / Physician Reviewer for review and determination.

Board Certified Clinical Consultants

In some cases, such as for authorization of a specific procedure or service or certain appeal reviews, the clinical judgment needed for a UM decision is specialized. In these instances, the Medical Director may consult with a board certified physician from the appropriate specialty for

additional or clarifying information when making medical necessity determinations or denial decisions. Clinical experts outside CalOptima may be contacted, when necessary to avoid a conflict of interest. CalOptima defines conflict of interest to include situations in which the practitioner who would normally advise on a UM decision made the original request for authorization or determination or is in, or is affiliated with the same practice group as the practitioner who made the original request or determination.

For the purposes of Behavioral Health review and oversight as a delegated vendor, College Health IPA (CHIPA) ensures there are Peer Reviewers/Clinical Consultants. Peer Reviewers are behavioral health professionals who are qualified, as determined by CHIPA's Medical Director, to render a clinical opinion about the behavioral health condition, procedure, and/or treatment under review. Peer reviewers must hold a current unrestricted California license to practice medicine in the appropriate specialty to render an opinion about whether a requested service meets established medical necessity criteria.

New Technology Review

Medi-Cal, OneCare, OneCare Connect

CalOptima's Pharmacy and Therapeutics Committee and Benefit Management Subcommittee shall study the medical, social, ethical, and economic implications of new technologies in order to evaluate the safety and efficacy of use for Members in accordance with policy GG.1534

~~Medi-Cal:~~

~~For Medi-Cal, CalOptima is not responsible for review and approval of new technology. This function is the contractual responsibility of the State of California.~~

~~OneCare:~~

~~A request for experimental or new medical technology for a OneCare member follows the process outlined in OneCare policy MA.7005: Evaluation of New Medical Technologies and Uses. In cases where it is not covered under Medicare, it follows procedures for Medi-Cal.~~

Preventive and Clinical Practice Guidelines (CPG)

Clinical Guidelines are developed and implemented via the QIC, and assist in making health care decisions and improving the quality of care provided to members. Medication use guidelines have been developed that are reviewed by the Pharmacy & Therapeutics Committee, which includes outside physician and pharmaceutical participants, whose recommendations are forwarded to the QIC for review and approval. These guidelines are posted on the CalOptima website. Additional condition specific guidelines are in development, and are based on a compilation of current medical practices researched from current literature and professional expert consensus documents. Guidelines are reviewed and updated at least annually by the respective committees. These standards for patient care are to be used as guidelines, and are not intended to replace the clinical medical judgment of the individual physician. CPGs are shared with the delegated HMOs, PHCs, SRGs and PMGs as they are approved.

While clinical practice guidelines (such as those distributed by American Diabetes Association, American Academy of Pediatrics and the American College of Obstetrics and Gynecology) are not used as criteria for medical necessity determinations, the Medical Director and UM staff make UM decisions that are consistent with guidelines distributed to network practitioners. Such guidelines

include, but are not limited to, Adult and Child Preventive Health, Asthma, Prenatal Care, Diabetes, Lead Screening, Immunizations, and ADHD/ADD Guidelines for both adults and children.

UM criteria are nationally recognized, evidence based standards of care and include input from recognized experts in the development, adaption and review of the criteria. UM criteria and the policies for application are reviewed and approved at least annually and updated as appropriate.

CalOptima uses the following criteria sets for all medical necessity determinations:

- Medi-Cal and Medicare Manual of Criteria;
- National Comprehensive Cancer Network (NCCN) Guidelines;
- Centers of Excellence guidelines;
- Specialty Guidelines such as the American Academy of Pediatric Guidelines (AAP) and American Heart Association;
- Evidence- based nationally recognized criteria such as MCG and InterQual;
- CalOptima Level of Care Criteria for outpatient behavioral health services;
- CalOptima Medical Policy and Medi-Cal Benefits Guidelines;
- National (CMS) and Local (State) Determination Guidelines.
- National Guideline Clearinghouse

Delegated HMOs, PHCs, SRGs and PMGs must utilize the same or similar nationally recognized criteria.

Due to the dynamic state of medical/health care practices, each medical decision must be case-specific, and based on current medical knowledge and practice, regardless of available practice guidelines. Listed criteria in fields other than primary care, such as OB/GYN, surgery, etc., are primarily appended for guidance concerning medical care of the condition or the need for a referral.

Practitioner and Member Access to Criteria

At any time, members or treating practitioners may request UM criteria pertinent to a specific authorization request by contacting CalOptima's Utilization Management Department or may discuss the UM decision with CalOptima Medical Director. Each contracted practitioner receives a Provider Manual, a quick reference guide, and a comprehensive orientation that contains critical information about how and when to interact with the Utilization Management Department. The manual also outlines CalOptima's Utilization Management policies and procedures. Similar information is found in the Member Handbook and on the CalOptima website at www.caloptima.org.

Inter-Rater Reliability

At least annually, the CMO and Executive Director of Clinical Operations assess the consistency with which Medical Directors and other UM staff making clinical decisions apply UM criteria in decision-making. The assessment is performed as a periodic review by the Executive Director of Clinical Operations or designee to compare how staff members manage the same case or some forum in which the staff members and physicians evaluate determinations, or they may perform periodic audits against criteria. When an opportunity for improvement is identified through this

process, CalOptima's Utilization Management leadership takes corrective action. New UM staff is required to successfully complete inter-rater reliability testing prior to being released from training oversight.

Communication

Members and practitioners can access UM staff through a toll free telephone number (1-888-587-8088) at least eight hours a day during normal business hours for inbound or outbound calls regarding UM issues or questions about the UM process. TDD/TTY services for deaf, hard of hearing or speech impaired members are available at 1-800-735-2929. The phone numbers for these are included in the member handbook, on the web, and in all member letters. Additionally, language assistance for members to discuss UM issues is provided either by bilingual staff or through Language Line services.

Inbound and outbound communications may include directly speaking with practitioners and members, or faxing, electronic or telephone communications (e.g. sending email messages or leaving voicemail messages). Staff identifies themselves by name, title and CalOptima UM Department when both making and receiving phone calls regarding UM processes. After normal business hours and on holidays, calls to the UM department are automatically routed to an on-call contracted vendor. The vendor is not a delegated UM entity and therefore does not make authorization decisions. The vendor staff takes authorization information for the next business day response by CalOptima or notifies CalOptima on-call nurse in cases requiring immediate response. A log is forwarded to the UM Department daily identifying those issues that need follow-up by the UM staff the following day.

Access to Physician Reviewer

The CalOptima Medical Director or appropriate practitioner reviewer (behavioral health and pharmacy) serves as the point of contact for practitioners calling in with questions about the UM process and/or case determinations. Providers are notified of the availability of the appropriate practitioner reviewer to discuss any UM denial decisions through the Provider Manual, New Provider Orientation, and the Provider Newsletter. Notification of the availability of an appropriate practitioner reviewer to discuss any UM denial decision, and how to contact a reviewer for specific cases, is also provided verbally and/or in the written notification at the time of an adverse determination. The CalOptima Medical Director may be contacted by calling CalOptima's main toll-free phone number and asking for the CalOptima Medical Director. A CalOptima Case Manager may also coordinate communication between the CalOptima Medical Director and requesting practitioner.

Requesting Copies of Medical Records

Utilization Management staff does not routinely request copies of medical records on all patients reviewed. During prospective and concurrent telephonic review, copies of medical records are only required when difficulty develops in certifying the medical necessity or appropriateness of the admission or extension of stay during a verbal review. In those cases, only the necessary or pertinent sections of the record are required. Medical records may also be requested to complete an investigation of a member grievance or when a potential quality of care issue is identified through the UM process. Confidentiality of information necessary to conduct UM activities is maintained at all times. Members requesting a copy of CalOptima's designated record set are not charged for the copy.

Sharing Information

CalOptima's Utilization Management staff share all clinical and demographic information on individual patients among various divisions (e.g. discharge planning, case management, disease management, health education, etc.) to avoid duplicate requests for information from members or practitioners.

Provider/Member Communication

CalOptima's UM program in no way prohibits or otherwise restricts a healthcare professional acting within the lawful scope of practice from advising or advocating on behalf of a member who is his or her patient for the following:

- The member's health status, medical care or treatment options, including any alternative treatments that may be self-administered;
- Any information the member needs in order to decide among all relevant treatment options;
- The risks, benefits and consequences of treatment or absence of treatment;
- The member's right to participate in a decision regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

Timeliness of UM Decisions

Utilization management decisions are made in a timely manner to accommodate the clinical urgency of the situation and to minimize any disruption in the provision of health care. Established timelines are in place for providers to notify CalOptima of a service request and for the health plan to make UM decisions and subsequent notifications to the member and practitioner.

UM Decision and Notification Timelines

Medi-Cal [and](#)

OneCare (Medicare)

[OneCare Connect](#)

Medical and Pharmaceutical - Decision Making	Medical and Pharmaceutical - Decision Making
<ul style="list-style-type: none"> Processed by CalOptima Utilization Management Department for members in direct or non-delegated network Processed by Utilization Management Department at the Physician Medical Groups Qualified physician review for any modifications or denials Qualified pharmacist review for any modifications of denials 	<ul style="list-style-type: none"> Processed by Utilization Management Department at the Physician Medical Groups Processed by Case Management Department at CalOptima for out of area and Medi-Cal wrap authorizations Processed by Pharmacy Management Department at CalOptima or Pharmacy Benefits Manager for pharmaceutical prior authorizations Qualified physician review for any modifications or denials Qualified pharmacists or physician review for any pharmaceutical partial approvals or denials
<p>Timeframes for Determinations:</p> <ul style="list-style-type: none"> Routine 5 business days Urgent 72 hours Retrospective 30 days <p>Timeframes for Notification:</p> <p>Authorization Request Type:</p> <p>Routine (Non-Urgent) Pre-Service: (Oral or Electronic)</p> <p>Provider: Initial within 24 hours of the decision</p> <p>Member: None specified</p> <p>Provider: Within 2 working days of making the decision</p> <p>Member: Within 2 working days of making the decision not to exceed 14 calendar days from the receipt of the request</p> <p>Routine (Non-Urgent): Pre-Service Extension Needed:</p> <p>Provider: Within 24 hours of making the</p>	<p>Timeframes for Determinations (non-Part B):</p> <p>Routine 14 calendarbusiness days</p> <ul style="list-style-type: none"> Urgent 72 hours Retrospective 30 days <p>Timeframes for Determinations (Part D):</p> <ul style="list-style-type: none"> Routine: 72 hours Urgent: 24 hours Retrospective: 14 days <p>Timeframes for Notification (non-Part D)</p> <p>Authorization Request Type::</p> <p>For Expedited requests, oral notification to the member must be made within 72 hours from the receipt of the request and must include expedited appeal rights. Written notification must be sent to the member and provider within three days of oral notification</p> <p>For standard determinations the member must be notified of the decision no later than 14 days after receipt of the request.</p>

<p>decision</p> <p>Member: None specified</p> <p>Written Notification of Denial or Modification:</p> <p>Provider: Within 2 working days of making the decision</p> <p>Member: Within 14 calendar of making the decision, not to exceed 28 calendar days from receipt of the request</p> <p>Expedited Authorization (Pre-Service): (Oral or Electronic)</p> <p>Provider: Within 24 hours of making the decision</p> <p>Member: None specified</p> <p>Written Notification of Denial or Modification:</p> <p>Provider: Within 2 working days of making the decision.</p> <p>Member: Within 2 working days of making the decision.</p> <p>Expedited Authorization (Pre-Service) – Extension Needed: (Oral or Electronic)</p> <p>Provider: Within 24 hours of making the decision</p> <p>Member: None specified</p> <p>Written Notification of Denial or Modification:</p> <p>Provider: Within 2 working days of making the decision</p> <p>Member: Within w working days of making the decision.</p> <p>Concurrent: (Oral or Electronic)</p> <p>Practitioner: Within 24 hours of making the decision (for approvals and denials).</p> <p>Member: None Specified</p> <p>Written Notification of Denial or Modification:</p> <p>Provider: Within 2 working days of making the decision.</p> <p>Member: Within 2 working days of making the</p>	<p>If an extension is requested the member must be notified no later than the expiration of the request (28 days maximum.) Notification includes the reason for the delay and their right to file an expedited grievance if they disagree with the extension request.</p> <p>Pharmaceutical - Timeframes for Notification (Part D)</p> <p>Authorization Request Type:</p> <p>For expedited requests, written notification must be provided to the member within 24 hours from the receipt of the request. If initial notification is made orally, then written notification must be provided within 3 calendar days of the oral notification.</p> <p>For standard requests, written notification must be provided to the member within 72 hours from the receipt of the request. If initial notification is made orally, then written notification must be provided within 3 calendar days of the oral notification.</p> <p>For retrospective requests, written notification must be provided to the member within 14 calendar days from the receipt of the request. If initial notification is made orally, then written notification must be provided within 3 calendar days of the oral notification.</p>
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<p>decision.</p> <p>NOTE: For Provider and Member: If oral notification is given within 24 hours of request, written notification must be given no later than 3 working days after the oral notification.</p> <p>Post Service – Retrospective Review: (Oral or Electronic)</p> <p>Member and Provider: None specified</p> <p>Written Notification of Denial or Modification: Provider and Member: Within 30 calendar days of receipt of request.</p> <p>Post- Service – Extension Needed: (Oral or Electronic)</p> <p>Provider and Member: None specified</p> <p>Written Notification of Denial or Modification: Provider and Member: Within 30 calendar days of receipt of the information necessary to make the determination</p>	
<p>Denial Letter/Member Notification</p> <p>State mandated “Notice of Action”</p>	<p>Denial Letter/Member Notification</p> <p>CMS mandated “Medicare Notice of Non-Coverage” including specific language for expedited appeal for expedited initial organization determination</p>

Urgent/Expedited Prior Authorization Services

For all pre-scheduled services requiring prior authorization, the provider must notify CalOptima within five (5) days prior to the requested service date. Prior authorization is never required for emergent or urgent care services. Facilities are required to notify CalOptima of all inpatient admissions and long-term care facility admissions within one (1) business day following the admission. Post-stabilization services (at out of network facilities) require authorization. Once the member’s emergency medical condition is stabilized, certification for hospital admission or authorization for follow-up care is required.

Routine/Standard Prior Authorization Services

CalOptima makes determinations for standard, non-urgent, pre-service prior authorization requests within five (5) ~~business~~calendar days of receipt of necessary information, not to exceed 14 calendar days of receipt of the request. A determination for urgent pre-service care (expedited prior authorization) will be issued within 72 hours of receiving the request for service. CalOptima makes a determination for urgent concurrent, expedited continued stay, post stabilization review or in cases for ongoing ambulatory care or if the lack of treatment may result in an emergency visit or emergency admission within 24 hours of receipt of the request for services. A request made

while a member is in the process of receiving care is considered to be an urgent concurrent request if the care requested meets the definition of urgent, even if the earlier care was not previously approved by CalOptima. If the request does not meet the definition of urgent care, the request may be handled as a new request and decided within the time frame appropriate for the type of decision (i.e., pre-service and post-service). Medical necessity of post service decisions (retrospective review) and subsequent member/practitioner notification will occur no later than 30 calendar days from receipt of request.

Nurse Advice Line

~~It is expected that~~ CalOptima ~~has~~will implement a twenty-four hour, seven days per week NCQA accredited Nurse Advice Line accessible to all lines of business ~~in 2015~~. The health line is designed to reduce unwarranted ER visits and associated costs; elevate member knowledge, engagement, health and satisfaction; and boost clinical, financial and operational outcomes. Multiple communication options allow the member access by web, email, and phone.

Bilingual staffs of Registered Nurses (RNs) assess and triage symptoms, make urgent and non urgent care recommendations using evidence based guidelines and resources, give provider and facility referrals and educate members on diagnoses, conditions and medications. The Advise Line also helps support CalOptima member's comprehensive needs by cross referring members to existing programs such as case or disease management, Pre-Natal Support Services, In Home Support Services, Multipurpose Senior Services, Health Education, and local resources available in the community.

Emergency Services

Emergency room services are available 24 hours/day 7days/week. Prior authorization is not required for emergency services and coverage is based on the severity of the symptoms at the time of presentation. Emergency services are covered inpatient and outpatient services when furnished by a qualified provider that are needed to evaluate or stabilize an emergency medical condition. CalOptima covers emergency services when the presenting symptoms are of sufficient severity to constitute an emergency medical condition in the judgment of a prudent layperson.

An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairments of bodily functions, or serious dysfunction of any bodily organ or part. An emergency medical condition is not defined on the basis of lists of diagnoses or symptoms.

Emergency services are covered when furnished by a qualified practitioner, including non-network practitioners, and are covered until the member is stabilized. CalOptima also covers any screening examination services conducted to determine whether an emergency medical condition exists.

If a Plan network practitioner, or Plan representative, instructs a member to seek emergency

services, the medical screening examination and other medically necessary emergency services are covered without regard to whether the condition meets the prudent layperson standard. Once the member's emergency medical condition is stabilized, certification for hospital admission or prior authorization for follow-up care is required as previously stated.

Although CalOptima may establish guidelines and timelines for submittal of notification regarding the provision of emergency services, including emergent admissions, CalOptima does not refuse to cover an emergency service based on the practitioner's or the facility's failure to notify CalOptima of the screening and treatment within the required timeframes, except as related to any claim filing timeframes. Members who have an emergency medical condition are not required to pay for subsequent screening and treatment needed to diagnose the specific condition or stabilize the member.

Admission/Concurrent Review Process

The admission/concurrent review process assesses the clinical status of the member and verifies the need for continued hospitalization and facilitates the implementation of the practitioner's plan of care, validates the appropriateness of the treatment rendered and the level of care, and monitors the quality of care to verify professional standards of care are met. Information assessed during the review includes:

- Clinical information to support the appropriateness and level of service proposed,
- Validating the diagnosis;
- Assessment of the clinical status of the member to determine special requirements to
- facilitate a safe discharge to another level of care;
- Additional days/service/procedures proposed, and
- Reasons for extension of the treatment or service.

Concurrent review for inpatient hospitalization is conducted throughout the inpatient stay, with each hospital day approved based on review of the patient's condition and evaluation of medical necessity. Concurrent review can occur on-site or telephonic. The frequency of reviews is based on the severity/complexity of the member's condition and/or necessary treatment and discharge planning activity.

If, at any time, services cease to meet inpatient criteria, discharge criteria are met, and/or alternative care options exist, the nurse case manager contacts the attending physician and obtains additional information to justify the continuation of services. When the medical necessity for a continued inpatient stay cannot be determined, the case is referred to the Medical Director for review. When an acceptable discharge plan is mutually agreed upon by the attending physician and the Utilization Management Medical Director, a Notice of Action (NOA) letter is issued immediately by fax or via overnight Certified Mail to the attending physician, hospital and the member.

The need for case management, disease management, or discharge planning services is assessed during the admission review and each concurrent review, meeting the objective of planning for the most appropriate and cost efficient alternative to inpatient care. If at any time the UM staff become aware of potential quality of care issues, the concern is referred to CalOptima Quality Improvement Department for investigation and resolution.

Hospitalist/SNFist Program

The goal of the Hospitalist/SNFist Program is for early identification and management of members, either in the Emergency Room or Inpatient setting, with prompt linkage to an identified hospitalist/SNFist to ensure that the member receives the appropriate care in the most appropriate setting. Appropriate setting is determined by medical providers using established evidence based clinical and administrative criteria. Other program objectives include:

Initiate appropriate care plan consistent with:

- Established estimated length of stay criteria
- Medical necessity criteria to establish appropriate level of care
- Member psychosocial needs impacting ongoing care
- Communication of current and ongoing needs impacting discharge planning and after-care requirements to PCP and others involved in the members care
- Facilitation of transfer of members from non-contracted facilities to facilities with a contracted hospitalist team

Contracted hospitalist groups, facilities case management staff, and Emergency Room personnel receive training from CalOptima staff on:

- Early identification of CalOptima Direct (COD) members
- Process for notification of Hospitalists
- Face sheet and/or telephonic notification to CalOptima
- Care Plan development and implementation
- Discharge Planning

The role of the hospitalist is to work together with the Emergency Department team to determine the optimal location and level of care for the member's treatment needs. If, based on clinical information and medical necessity criteria, the member requires admission to the facility; the hospitalist assumes primary responsibility for the member's care as the admitting physician and will coordinate the member's care together with CalOptima medical management staff. If at any time the member is appropriate for transfer to a lower level of care, whether directly from the emergency room or after admission, the hospitalist will facilitate the transfer to the appropriate setting, in concert with the accepting facility and with CalOptima staff.

Discharge Planning Review

Discharge planning begins within 48 hours of an inpatient admission, and is designed to identify and initiate a cost effective, quality driven treatment intervention for post-hospital care needs. It is a cooperative effort between the attending physician, hospital discharge planner, UM staff, health care delivery organizations, and community resources to coordinate care and services.

Objectives of the Discharge Planning Review are:

- Early identification during a member's hospitalization of medical/psycho-social issues with potential for post-hospital intervention;

- Development of an individual care plan involving an appropriate multi-disciplinary team and family members involved in the members care;
- Communication to the attending physician and member, when appropriate, to suggest alternate health care resources;
- Communication to attending physician and member regarding covered benefits, to reduce the possibility of a financial discrepancy regarding non-covered services and denied days of hospitalization;
- Coordination of care between the member, PCP, attending physician, specialists, hospital UM/Discharge Planning staff, and UM staff.

The UM staff obtains medical record information and identifies the need for discharge to a lower level of care based on discharge review criteria/guidelines. If the attending physician orders discharge to a lower level of care, the UM staff assists the hospital UM/Discharge Planner in coordinating post-hospital care needs. The same process is utilized for continued stay approval or denial determinations by the Utilization Medical Director as previously noted in the Concurrent Review Process.

Denials

A denial of services, also called an adverse organization determination, is a reduction, modification, suspension, denial or termination of any service based on medical necessity or benefit limitations. Upon any adverse determination for medical or behavioral health services made by CalOptima Medical Director or other appropriately licensed health care professional (as indicated by case type) a written notification, at a minimum, will be communicated to the member and requesting practitioner. Verbal notification of any adverse determination is provided when applicable.

All notifications are provided within the timeframes as noted in the Referral/Authorization Processing Policy and Procedure. The written notification is easily understandable and includes the member specific reason/rationale for the determination, specific criteria and availability of the criteria used to make the decision as well as the availability, process and timeframes for appeal of the decision. All templates for written notifications of decision making are DHCS approved prior to implementation.

Practitioners are provided with the opportunity to discuss any medical or behavioral health UM denial decisions with a physician or other appropriate reviewer. CalOptima Medical Director or appropriate practitioner reviewer (behavioral health practitioner, pharmacist, etc.) serves as the point of contact the peer to peer discussion. This is communicated to the practitioner at the time of verbal notification of the denial, as applicable, and is included in the standard denial letter template.

Utilization Management Appeals Process

CalOptima has a comprehensive review system to address matters when Medi-Cal or OneCare members wish to exercise their right to review of a utilization management decision to deny, delay, terminate or modify a request for services. This process is initiated by contact from a member, a member's representative, or practitioner to CalOptima. Appeals for members enrolled in COD, or one of the contracted HMOs, PHCs, SRGs and PMGs, are submitted to CalOptima's Grievance and

Appeals Resolution Services (GARS). The process is designed to handle individual disagreements in a timely fashion, and to ensure an appropriate resolution. The appeals process is in accordance with CalOptima Policy and Procedure HH.1102: Grievance and Appeals Resolution Services. This process includes:

- Collection of data
- Communication to the member and provider
- Thorough evaluation of the substance of the appeal
- Resolution of operational or systems issues
- Referral to an appropriately licensed professional in Medical Affairs for evaluation and further management of clinical issues, such as timeliness of care, access to care, and appropriateness of care, including review of the clinical judgments involved in the case

The UM appeal process for COD, HMOs, PHCs and SRGs is handled by the CalOptima Grievance and Appeals Resolution Services (GARS). CalOptima works collaboratively with the delegated entity in the gathering of information and supporting documentation. If a member is not satisfied with the initial decision, he/she may file for a State Hearing with the California Department of Social Services.

UM Appeals can be initiated by a member, a member's representative or a practitioner. Pre-service appeals may be processed as expedited or standard appeals, while post-service appeals will be processed as standard appeals only.

| All medical necessity decisions are made by a licensed physician reviewer. -Appeals are reviewed by an objective reviewer, other than the reviewer who made the initial denial determination; however, the initial reviewer may participate in the appeal process if new or additional information is submitted.

The UM or CM Medical Director or designee evaluates appeals regarding the denial, delay, termination, or modification of care or service. The UM Medical Director or designee may request a review by a board-certified, specialty-matched Peer Reviewer to evaluate the determination. An "Expert Panel" roster is maintained from which, either via Letter of Agreement or Contract, a Board Certified Specialist reviewer is engaged to complete a review and provide a recommendation regarding the appropriateness of a pending and/or original decision that is now being appealed.

CalOptima sends written notification to the member and/or practitioner of the outcome of the review within the required timelines. If the denial was upheld, even in part, the letter includes the appropriate appeal language to comply with applicable regulations.

When quality of care issues are identified during the investigation process, further review of the matter is indicated. This portion of the review is conducted under the Peer Review process.

Upon request, members can have access to and copies of all documents relevant to the member's appeal by calling the CalOptima Customer Service Department.

Expedited Appeals

A member or member's representative may request the appeal process to be expedited if it is felt that there is an imminent and serious threat to the health of the member, including, but not limited to, severe pain, or potential loss of life, limb, or major bodily function. All expedited appeal requests shall be reviewed and resolved in as expeditious a manner as the matter requires, but no later than 72 hours after receipt.

At the time of the request, the information is reviewed and a decision is made as to whether or not the appeal meets the expedited appeal criteria. Under certain circumstances, where a delay in an appeal decision may adversely affect the outcome of treatment, or the member is terminally ill, an appeal may be determined to be urgent in nature, and will be considered expedited. These appeals are managed in an accelerated fashion in an effort to provide appropriate, timely care to members when the regular timeframes of the review process could seriously jeopardize the life or health of the member, or could jeopardize the member's ability to regain maximum functionality.

Provider Preventable Conditions (PPCs)

The federal Affordable Care Act (ACA) requires that providers report all Provider Preventable Conditions (PPCs) that are associated with claims for Medi-Cal payment or with courses of treatment furnished to a Medi-Cal patient for which Medi-Cal payment would otherwise be available. The ACA also prohibits Medi-Cal from paying for treatment of PPCs.

There are two types of PPCs health care acquired conditions (HCAC), 1). Those occurring in inpatient acute care hospitals, and 2) Provider-preventable conditions (OPPC), which are reported when they occur in any health care setting.

Once identified the PPC is reported to CalOptima's Quality Improvement Division for further research and reporting to government and/or regulatory agencies.

Long Term Support Services (LTSS)

Long Term Care

The Long Term Care case management program includes authorizations for the following facilities: skilled nursing, intermediate care, sub-acute care, intermediate care—developmentally disabled, intermediate care—developmentally disabled—habilitative, and intermediate care—developmentally disabled—nursing. It excludes institutions for mental disease, special treatment programs, residential care facilities, board and care, and assisted living facilities. Facilities are required to notify CalOptima of admissions within 21 days. An on-site visit is scheduled to assess patient's needs through review of the Minimum Data Set, [member's care plan](#), medical records, and social service notes, as well as bedside evaluation of the member and support system. Ongoing case management is provided for members whose needs are changing or complex. LTC services also include coordination of care for members transitioning out of a facility, such as education regarding community service options, or a referral to the Multipurpose Senior Services Program (MSSP), In Home Supportive Services (IHSS) program or to a Community Based Adult Services (CBAS) facility. In addition, the LTC staff provides education to facilities and staff through [monthly onsite visits](#), quarterly [and annual](#) workshops, or in response to individual facility requests, and when new programs are implemented.

Community Based Adult Services (CBAS)

An outpatient, facility based program offering daytime care and health and social services to frail

seniors and adults with disabilities to enable participants to remain living at home instead of a nursing facility.

Services may include: health care coordination, meal service (at least one per day at center), medication management, mental health services, nursing services, personal care and social services, physical, occupational, and speech therapy, recreational activities, training and support for family and caregivers, and transportation to and from center.

Multipurpose Senior Services Program (MSSP)

~~Effective July 1, 2015~~ CalOptima ~~has will assume~~ responsibility for the payment of the MSSP in the County of Orange for individuals who have Medi-Cal. The program provides services and support to help persons 65 and older who have a disability that puts them at risk of going to a nursing home. Services include, but are not limited to: senior center programs, case management, money management and counseling, respite, housing assistance, assistive devices, legal services, transportation, nutrition services, home health care, meals, personal care assistance with hygiene, personal safety and activities of daily living.

In Home Supportive Services (IHSS)

~~Effective July 1, 2015~~ CalOptima ~~has will assume~~ responsibility of the payment of services for CalOptima members who receive services from the IHSS program which is operated by the County of Orange. The program provides services to those members who are disabled, blind, or 65 years of age or older and are unable to live safely at home without help who meet the financial need requirement. Services are provided by a caretaker that the member hires. The County will still make the determination of eligibility under the program as well as determine the number of hours that an individual will be receiving services. Under an MOU with the county, CalOptima will be working collaboratively to ensure that referrals are being made and to involve members and their caregivers, when agreed to, in the care planning process.

Retrospective Review

Retrospective review is an initial review of services that have already been rendered. This process encompasses services performed by a participating or non-participating provider without CalOptima notification and/or authorization and when there was no opportunity for concurrent review. The Director of Utilization Management, or designee, reviews the request for retrospective authorization. If supporting documentation satisfies the administrative waiver of notification the request is reviewed utilizing the standard medical necessity review process. If the supplied documentation meets medical necessity criteria, the request is authorized. If the supporting documentation is questionable, the Director of Utilization Management or designee requests a Medical Director review. The request for a retrospective review must be made within 60 days of the service provided. The decision, to authorize or deny, is made within thirty (30) calendar days of receipt.

Transitions of Care (TOC)

TOC is a 4-week patient-centered intervention, managed by the Case Management Department, which employs a coaching, rather than doing, approach. It provides patients or caregivers with tools and support to encourage and sustain self-management skills in an effort to minimize a possible readmission and optimize the member's quality of life.

TOC focuses on four conceptual areas determined to be crucial in preventing readmission. These are:

- Knowledge of Red Flags: Patient is knowledgeable about indications that their condition is worsening and how to respond;
- Medication Self-Management: Patient is knowledgeable about medications and has a medication management system;
- Patient-Centered Health Record: Patient understands and uses a Personal Health Record (PHR) to facilitate communication with their health care team and ensure continuity of care across providers and settings;
- Physician Follow-Up: Patient schedules and completes follow-up visit with the primary care physician or specialist physician and is empowered to be an active participant in these interactions.

The program is introduced by the TOC coach, typically, at four touch points over one month: a pre-discharge hospital visit, a post-discharge home visit, and two follow-up phone calls. Coaches are typically community workers, social workers or nurses.

Complex Case Management

The Case Management Program is an ongoing outpatient collaborative process that strives to assure the delivery of health care services in a responsible, optimally cost-efficient manner. Case Management is a distinct and unique program that identifies eligible persons, with specific health care needs, in order to facilitate the development and implementation of a care plan to efficiently use health care resources to achieve optimum member outcomes. Case Management activities are complimentary, not duplicative, of Utilization Management activities.

Case Managers are licensed Nurses with caseloads that are variable, depending on the complexity of the cases managed.

The case management program includes:

- Standardized mechanisms for member identification through use of data;
- Multiple avenues for referrals to case management;
- Following members across the continuum of health care from outpatient or ambulatory to inpatient settings;
- Use of evidence-based clinical practice guidelines or algorithms;
- Initial assessment and ongoing management process;
- Developing, implementing and modifying an individualized care plan through an interdisciplinary and collaborative team process, in conjunction with the member and/or his or her family and/or care giver(s);
- Developing comprehensive long and short term goals;
- Analyzing all data for formulating appropriate recommendations;
- Coordinating services for members for appropriate levels of care and resources;
- Documenting all findings;
- Monitoring, reassessing, and modifying CalOptima of care to ensure quality, timeliness, and effectiveness of services;
- Mechanism for identification and referral of quality of care issues to QI Department;

- Assessing the outcomes of case management and presenting findings to the Medical Director of Case Management.

Case Management Process

- Referral/Case Identification
- Intake
- Assessment
- Risk Stratification
- Care Plan development, with long and short term goals

For further details of the structure, process, staffing, and overall program management please refer to the 2016 Case Management Program document.

Transplant Program

The CalOptima transplant program is [coordinated by CalOptima's medical director and](#) managed by the Case Management Department's [collaboration](#). ~~Transplants are and is not~~ delegated to the HMOs, PHCs, SRGs and PMGs, other than Kaiser Foundation Health Plan. It provides the resources and education needed to proactively manage members identified as potential transplant candidates. The CalOptima Case Management Department works in conjunction with the contracted practitioners and the DHCS Center(s) of Excellence, or CMS Center(s) of Excellence for OneCare, as needed to assist members through the transplant review process. Patients are monitored on an inpatient and outpatient basis, and the member, physician, and facilities are assisted in order to assure timely, efficient, and coordinated access to the appropriate level of care and services within the member's benefit structure. In this manner, the transplant program benefits the member, the community of transplant staff, and the facilities. CalOptima monitors and maintains oversight of the transplant program, and reports to the UM Committee to oversee the accessibility, timeliness and quality of the transplant process across networks.

Coordination of Care Services

Coordination of services and benefits is a key function of case management both during inpatient acute episodes of care as well as for complex or special needs cases which are referred to the Case Management and/or Disease Management Department for follow-up after discharge. Coordination of care encompasses synchronization of medical, social, and financial services and may include management across payer sources. The Case Manager must promote continuity of care by ensuring appropriate referrals and linkages are made for the member to the applicable provider or community resource, even if these services are outside of the required core benefits of the health plan or the member has met the benefit limitation. Because Medicaid is always the payer of last resort, CalOptima must coordinate benefits with other payers including Medicare, Worker's Compensation, commercial insurance, etc. in order to maintain access to appropriate services.

Other attempts to promote continuity and coordination of care include member notifications to those affected by a PCP or practice group termination from CalOptima. CalOptima assists the member as needed to choose a new PCP and transfer the medical records to the new PCP. If the provider is not termed due to a quality issue, the health plan may also authorize continued treatment with the provider under certain situations. CalOptima also coordinates continuity of care with other

Medicaid health plans when a new member comes onto CalOptima or a member terminates from CalOptima to a new health plan.

Disease Management (DM)

Disease Management is a multidisciplinary, continuum-based approach to healthcare delivery that proactively identifies populations with, or at risk for, chronic medical conditions. CalOptima's Disease Management Program is a system of coordinated healthcare interventions and communications for populations with conditions in which patient self-care efforts are significant. The diagnosis based programs are offered telephonically, involving interaction with a trained healthcare professional, and require an extended series of interactions, including a strong educational element. CalOptima's disease management programs emphasize prevention and members are expected to play an active role in managing their diseases.

Disease Management Process

CalOptima's DM programs are disease specific and evaluated for relevance to CalOptima's membership demographics and utilization patterns. DM programs may include, but are not limited to: Asthma, Chronic Kidney Disease, COPD, Diabetes, Pregnancy Management, and Depression. The major components of each disease management program include:

- Identification of members with specified diagnosis;
- Stratification or classification of these members according to the severity of their disease, the appropriateness of their treatment, and the risk for complications and high resource utilization;
- Provision of proven interventions that will improve the clinical status of the member and reduce the risk for complications and long-term problems;
- Involvement of the member, family/caregiver(s), and physician to promote appropriate use of resources;
- Education of patient and family/caregiver(s) to promote increased understanding of the disease and increase self-management of the disease in an effort to decrease exacerbations;
- Ongoing measurement of the process and its outcomes in order to document successes and/or identify necessary revisions of the program.

Members with a potential diagnosis applicable to the specific DM program are identified through various sources, including, but not limited to: inpatient census reports, medical claims data (office, emergency department, outpatient, and inpatient levels of care), pharmaceutical claims data, health risk assessments (HRA) results, laboratory reports, data from UM/CM processes, new member welcome calls, member self-referral, and physician referral.

Based on the data received during the identification phase, members are stratified into risk groups that guide the care coordination interventions provided. Members are stratified into Low, Moderate, or High Risk categories. Definitions for each risk category are program specific and are outlined in the program's description document. Members may change between risk groups based on data retrieved during each reporting period, as well as through collaboration/interaction with the member or PCP.

Members enrolled into a disease management program receive some level of intervention, which may include, but is not limited to: identification, assessment, disease specific education,

reminders about preventive/monitoring services, assistance with making needed appointments and transportation arrangements, referral to specialists as needed, authorization for services and/or medical equipment, coordination of benefits, and coordination with community based resources. Education is a crucial component of the disease management program. Education is presented to members and their treating physician(s) and may be provided through mailings, telephone calls, or home visits.

High-risk members are referred to CalOptima's complex case management program for development of an individualized care plan. Both the member/family/caregiver(s) and the physician will be included in the development of the care plan. Including the member/family/caregiver(s) in the development of the individualized goals and interventions promotes ownership of the program and stimulates a desire for success. Care plan goals and interventions are reviewed routinely and CalOptima of care is adjusted as necessary by the care coordinator to assure an optimal outcome for the member.

Measuring Effectiveness

Effectiveness of both the complex case management and disease management programs are measured on, at a minimum, an annual basis. Methods of evaluation include condition specific indicators (e.g. HEDIS measures for Comprehensive Diabetes Care), utilization data, such as frequency of ER visits or inpatient admissions, and self-reported member information such as satisfaction with the program, level of understanding of the disease, or improvement in life impact, such as days of school or work missed. This measurement and analysis is documented as part of the annual UM program evaluation.

State Fair Hearing (Medi-Cal Line of Business Only)

CalOptima Medi-Cal members have the right to request a State Fair Hearing from the California Department of Social Services at any time during the appeals process, or within 90 days of an adverse decision. A member may file a request for a State Fair Hearing and a request for an appeal at the same time. CalOptima and the HMOs, PHCs and SRGs comply with State Aid Paid Pending requirements, as applicable. Information on filing a State Fair Hearing is included annually in the member newsletter, in the member's evidence of coverage, and with each resolution letter sent to the member or the member's representative.

Independent Medical Review

OneCare [and OneCare Connect](#) members have a right to request an independent review if they disagree with the termination of services from a skilled nursing facility (SNF), home health agency (HHA) or a comprehensive outpatient rehabilitation facility (CORF). The Center for Medicare and Medicaid Services (CMS) contracts with a Quality Improvement Organizations (QIO) to conduct the reviews. OneCare is notified when a request is made by a member or member representative. OneCare supports the process with providing the medical records for the QIC's review. The QIO notifies the member or member representative and OneCare of the outcome of their review. If the decision is overturned, OneCare complies by issuing a reinstatement notice ensuring services will continue as determined by the QIO.

Program Evaluation

The UM Program is evaluated at least annually, and modifications made as necessary. The CMO

and Executive Director of Clinical Operations evaluate the impact of the UM program by using:

- Member complaint, grievance and appeal data
- The results of member satisfaction surveys
- Practitioner complaint, and practitioner satisfaction surveys
- Relevant UM data
- Practitioner profiles
- Drug Utilization Review (DUR) profiles (where applicable)

The evaluation covers all aspects of the UM Program. Problems and/or concerns are identified and recommendations for removing barriers to improvement are provided. The evaluation and recommendations are submitted to the UMC for review, action and follow-up. The final document is then submitted to the Board of Directors through the QIC for approval.

Satisfaction With the UM Process

CalOptima provides an explanation of the grievance and appeal process, Administrative Hearing, Independent Review, and DHCS Board of Appeals review processes to newly enrolled members upon enrollment and annually thereafter. The process is explained in the Member Handbook and Provider Manual and may also be highlighted in member newsletter articles, member educational flyers, postings at provider offices. Complaints or grievances regarding potential quality of care issues are referred to CalOptima Quality Improvement Department for investigation and resolution.

Annually, CalOptima evaluates both members' and providers' satisfaction with the UM process. Mechanisms of information gathering may include, but are not limited to: member satisfaction survey results (CAHPS), member/provider complaints and appeals that relate specifically to UM, provider satisfaction surveys with specific questions about the UM process, and soliciting feedback from members/providers who have been involved in appeals related to UM. When analysis of the information gathered indicates that there are areas of dissatisfaction, CalOptima develops an action plan and interventions to improve on the areas of concern which may include staff retraining and member/provider education.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 7, 2016 **Regular Meeting of the CalOptima Board of Directors**

Consent Calendar

5. Approve the 2016 CalOptima Program of All-Inclusive Care for the Elderly (PACE) Quality Assessment and Performance Improvement Plan

Contact

Richard Bock, M.D., Deputy Chief Medical Officer, (714) 246-8400

Recommended Action

Approve the 2016 CalOptima PACE Quality Assessment and Performance Improvement (QAPI) Plan.

Background

The Board of Directors first authorized the Chief Executive Officer to submit CalOptima's application to become a PACE Provider on October 7, 2010. The CalOptima PACE program opened its doors for operation in October of 2013. PACE is viewed as a natural extension of CalOptima's commitment to integration of acute and long-term care services for its members. This program provides the link between our healthy, elderly seniors with those seniors who need costly long-term nursing home care. PACE is a unique model of managed care service delivery in which the PACE organization is a combination of the health plan, and the provider who provides direct service delivery. PACE takes care of the frail elderly by integrating acute, chronic, and long-term care for nursing home certified seniors. The goals of PACE are to prevent unnecessary institutionalization and maintain or improve the functional status of the program's participants. CalOptima's program is the first PACE program offered to Orange County residents and continues to grow. As of March 1, 2016, CalOptima PACE had 151 members enrolled. Independent evaluations of PACE have consistently shown that it is a highly effective program for its target population that delivers high quality outcomes.

Discussion

PACE organizations are required to have a written Quality Assessment and Performance Improvement (QAPI) Plan that is reviewed and approved annually by the PACE governing body and, if necessary, revised. The QAPI Plan reflects the full range of services furnished by CalOptima PACE. The goal of the QAPI Plan is to improve future performance through effective improvement activities driven by identifying key, objective performance measures, tracking them and reliably reporting them to decision-making and care-giving staff.

The 2016 CalOptima PACE QAPI Plan updates are based on CalOptima's first two full years of data collection, review and analysis with specific data driven goals and objectives. The objectives were developed based on the opportunities for quality improvement that were revealed in the 2015 CalOptima PACE QAPI Plan Evaluation. The target goals are based on national benchmarks, CalPACE data, or internal CalOptima PACE metrics.

Fiscal Impact

There is no fiscal impact for the recommended action to have a written Quality Assessment and Performance Improvement (QAPI).

Rationale for Recommendation

PACE organizations are required to establish a Quality Assessment and Performance Improvement (QAPI) program. Through 42 CFR §460.132(b), the Centers for Medicare & Medicaid Services (CMS) requires PACE Organizations to have their QAPI plan reviewed annually by the PACE governing body and, if necessary, revised. As per 42 CFR §460.132(a) and (b), the PACE organization leadership presents their QAPI plan and any revisions to their governing body for annual approval to assure effective organizational oversight. CMS and the State will review the plan during subsequent monitoring visits.

Concurrence

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

Attachments

PowerPoint Presentation – 2016 PACE QAPI Description and Work Plan
Proposed 2016 CalOptima PACE QAPI Plan

/s/ Michael Schrader
Authorized Signature

04/01/2016
Date



CalOptima
Better. Together.

2016 PACE Quality Assurance Performance Improvement (QAPI) Description and Work Plan

Board of Directors Meeting

April 7, 2016

Miles Masatsugu, M.D.

Medical Director

2016 Program Description

- Our program description
 - Encompasses all clinical care, clinical services & organizational services provided to our members
 - Aligns with our vision and mission
 - Focuses on optimal health outcomes for our members
 - Uses evidence-based guidelines, data and best practices tailored to our populations
 - Extends across the healthcare continuum

2016 Program Description

- Our program description revisions since 2015
 - Added new patient satisfaction metrics/goals
 - Decrease grievances related to transportation by 20%
 - Reduce the percentage of members who disenroll from PACE
 - Changed goals around Physician Orders for Life-Sustaining Treatment (POLST)
 - Added new clinical measures around diabetes (annual eye exams) with a goal of 90%
 - Adding more detailed utilization management metrics to enhance oversight and management
 - Updated CMS Level 2 Guidance to reporting unusual incidents
 - Updated plan to include new PACE QA Manager

2016 PACE QAPI Work Plan

- Our 2016 Work Plan elements include
 - Preventative Care
 - Quality Of Care
 - Infection Control
 - Access & Availability
 - Patient Safety
 - Utilization of Services
 - Patient Satisfaction/Member Experience
- Enhancements to 2016 PACE QAPI Work Plan
 - Formal reporting/sharing of work plan elements with the QIC
 - Enhanced Patient Satisfaction/Member experience metrics
 - Enhanced focus on Utilization Management

CALOPTIMA PACE

QUALITY ASSESSMENT

PERFORMANCE IMPROVEMENT PLAN

20165

Quality Improvement Subcommittee Chairperson:

Richard Helmer, M.D.
Chief Medical Officer

Date

Board of Directors' Quality Assurance Committee Chairperson:

Viet Van Dang, M.D.

Date

Board of Directors Chairperson:

Mark Refowitz

Date

Introduction

The Quality Assessment Performance Improvement [Plan](#) (QAPI) ~~Plan~~ at CalOptima's Program of All Inclusive Care for the Elderly (PACE) is the data-driven assessment program that drives continuous quality improvement for all the PACE organizations' ~~s~~ services. It is designed and organized to support the mission, values, and goals of CalOptima PACE.

Overview

- The goals of the CalOptima PACE QAPI Plan is to improve future performance through effective improvement activities, driven by identifying key objective performance measures, tracking them and reliably reporting them to decision-making and care-giving staff.
- The CalOptima ~~s~~ PACE QAPI Plan is developed by the PACE Quality Improvement Committee (PQIC). As CalOptima's governing body, the Board [of Directors](#) has the final authority to review, approve and, if necessary, revise the QAPI Plan annually. (See Appendix A). It is comprised of both the Program Description and specific goals and objectives described in the Work ~~P~~lan. (See Appendix B).
- The PACE Medical Director has oversight and responsibility for implementation of the PACE QAPI Plan. The PACE QI Coordinator will ensure timely collection and completeness of data.
- CalOptima PACE QAPI Committee will complete an annual evaluation of the approved QAPI Plan. This evaluation and analysis will help to find opportunities for quality improvement and will drive appropriate additions or revisions in the QAPI Plan goals and objectives for the following year.

Goals

- To provide quality health care services for all CalOptima ~~s~~ PACE participants through comprehensive service delivery leading to improved clinical outcomes.
- To coordinate all QAPI activities into a well-integrated system that oversees quality of care services.
- To achieve a coordinated ongoing and effective QAPI Program that involves all providers of care.
- To ensure that all levels of care are consistent with professionally recognized standards of practice.
- To assure compliance with regulatory requirements of all responsible agencies.
- To promote continuing education and training of staff, ~~pr~~actitioners, administration and the executive board.
- [To analyze data and studies for outcome patterns and trends](#)
- To annually assess the effectiveness of the QAPI Plan and enhance the program by finding opportunities to improve the CalOptima PACE QAPI Plan.

Objectives

- Improve the quality of health care for participants-
 - Involve the physicians and other providers in establishing the most current, evidenced-based clinical guidelines to ensure standardization of care. Professional standards of CalOptima PACE Staff will be measured against those outlined by their respective licensing agency in the State of California (i.e. The State Board of Nursing of California).
 - Implement population health management techniques for specific participant populations, (such as immunizations).
 - Identify and address areas for improvement that arise from unusual incidents, sentinel events, and annual death review.
 - Meet or exceeds minimum levels of performance on standardized quality measures as established by CMS and the SAA which includes achieving an immunization rate for both influenza and pneumococcal vaccinations of 80% for the participant population that is appropriate.
- Improve on the patient experience
 - Use the annual participant satisfaction survey, grievances and appeals, and feedback from participant committees to identify areas for improvement related to participant experience.
 - Provide education to staff on the multiple dimensions of patient experience.
 - Identify and implement ways to better engage participants in the PACE experience, i.e., (menu selection, PACE Member Advisory Committee [\(PMAC\)](#)).
- Ensure appropriate use of resources-
 - Review and analyze utilization data regularly including hospital admissions, hospital readmissions, ER visits, and hospital 30-day all-cause readmission.
- Provide oversight of contracted services
 - Meet or exceed community standards for credentialing of licensed providers and perform due diligence in assuring that contracted facilities meet community and regulatory standards for licensure.
 - Evaluate customer service, access, and timeliness of care provided by contracted licensed providers.
 - Review documentation and coordination of care for participants receiving care in institutional settings and perform site visits on an ongoing-basis.
 - Monitor staff and contractors to ensure that appropriate standards of care are met.
- Communication of Quality and Process Improvement Activities and Outcomes\
 - Communicate all QAPI activities and outcomes to the PACE staff and contractors, the PACE Member Advisory Committee, [and the Board of Directors.](#) ~~Board.~~
 - Results of QAPI-identified benchmarks are shared with staff and contracted providers at least annually.

- Reduce potential risks to safety and health of PACE participants through ongoing Risk Management
 - Every member of the PACE staff organization has responsibility for risk assessment and management.
 - Monitor, analyze and report the aggregated data elements required by CMS via the Health Plan Management System in order to identify areas needing of quality improvement.
 - Monitor, report and ~~perform~~ a Root Cause Analysis on all participant-involved events, resulting in a significant adverse outcome, for the purpose of identifying areas for quality improvement.

Organizational and Committee Structure (See Appendix A for Organizational Chart)

CalOptima Board of Directors (Board)

CalOptima Board of Directors provides oversight and direction to CalOptima PACE Organization. The Board has the final authority to ensure that adequate resources are committed and that a culture is created that allows the QAPI Plan efforts to flourish. The Board, while maintaining ultimate authority, has delegated the duty of immediate oversight of the quality improvement programs at CalOptima. This includes, including the CalOptima PACE QAPI Program, to the CalOptima Board of Director's Quality Assurance Committee (QAC), which performs the functions of the Quality Improvement Committee (QIC) described in CalOptima's State and Federal contracts, and to CalOptima's Chief Executive Officer who is responsible to allocate operational resources to fulfill quality objectives.

The CalOptima Board of Director's QAC is a subcommittee of the Board and consists of currently active Board members. The CalOptima Board of Director's QAC reviews the quality and utilization review data that are discussed during the PACE Quality Improvement Committee (PQIC). The CalOptima Board of Director's QAC provides progress reports, reviews the annual PACE QAPI Plan and makes recommendations to the full Board regarding these items, which are ultimately approved by the Board.

CalOptima PACE Quality Improvement Committee (PQIC)

Purpose

This committee provides oversight for the overall administrative and clinical operations of the organization. The PQIC may create new committees or task forces to improve specific clinical or administrative processes that have been identified as critical to participants, families or staff. On a quarterly basis, the PQIC will review all QAPI Plan initiatives, review the results of monitoring activities, provide oversight for proposed changes to improve quality of service and review follow-up of all changes implemented. The PQIC may create Ad Hoc Focused Review Committees for limited time periods in order to address quality problems in any clinical or administrative process. It will also discuss Level One data and Level Two incidents. Potential areas for improvement will be identified through analysis of the data and through Level Two root cause analysis. This meeting will be facilitated by the PACE Medical Director who will report its activities up to the CalOptima Board of Director's QAC, who will then report up to the Board. The PACE Director or the PACE

QA Coordinator may report up to the CalOptima Board of Director's QAC if the PACE Medical Director is not available.

Membership

Membership shall be comprise ~~made up~~ of the PACE Medical Director, PACE Program Director, PACE Center Manager, PACE Clinical Operations Manager, QA Coordinator, and Intake/Enrollment Manager. At least four regular members shall constitute a quorum. The PACE Medical Director will act as the standing Chair of the committee.

See Appendix C for QI Committee Minutes Template.

CalOptima PACE Focused Review Committees

Purpose

These committees will be formed to respond to or to proactively address specific quality issues which rise to the level of warranting further study and action. Key performance elements are routinely reviewed by administrative staff as part of ongoing operations, including, ~~but not limited to,~~ deaths and other adverse outcomes, inpatient utilization and other clinical areas that indicate significant over/under utilization.

Membership

Membership will be flexible based on those with knowledge of the specific issues being addressed, but will consist of at least four members to include at least two of the following positions and/or functions: PACE Medical Director, PACE Program Director, Center Manager, Clinical Operations Manager, QA Coordinator, and Intake/Enrollment Coordinator or direct care staff. The Committee will be chaired by the PACE Medical Director. If the PACE Medical Director is not a member of the committee, then the committee will be chaired by the PACE Director. The chair, ~~who~~ will report on activities and results to the PQIC. The committee will meet on an ad hoc basis as needed to review those critical indicators assigned to them by the PQIC. This Committee will be responsible for managing all peer review activities, performed by independent reviewers, related to adverse outcomes.

CalOptima PACE Member Advisory Committee (PMAC)

Purpose

This committee provides advice to the Board on issues related to participant care concerns that arise with participant care decisions and program operations from a community perspective. A member of the PMAC shall report its activities to both the PQIC and the ~~Caloptima~~ CalOptima Board of Directors ~~s' s-QAC,~~ which then will be reported to the Board.

Membership

The PMAC comprises representatives of participants, participants' families, and communities from which participants are referred. Participants and representatives of participants shall constitute a majority of membership. The committee will be comprised of at least seven members. At least four regular members shall constitute a quorum. The PACE Program Director will act as the standing Chair and will facilitate for the committee.

CalOptima PACE Ethics Advisory Committee

Purpose

The purpose of this committee is to provide a forum to discuss ethical dilemmas in the provision of care and to respond to participant, family members or staff requests for information on ethical aspects of participant care. It allows for a case review and non-binding recommendations to the Interdisciplinary Team (IDT). – The committee or consultants will report and advise the IDT and the PQIC. In addition, it can advise the Board on policy development related to ethics.

Membership

It will be composed of five members. ~~The PACE Medical Director~~ The PACE Director will act as the standing Chair of the committee. Community professionals with expertise in geriatrics and long-term care, and who do not have ~~no a~~ significant affiliation with CalOptima PACE, will compose at least one-half of the membership Committee ~~membership~~ seats. At least 3 members will constitute a quorum of the Ethics Committee.

Quality and Performance Improvement Activities, Outcomes and Reporting

Quality Indicators and Opportunities for Improvement

Routine quality indicators appropriate the CalOptima PACE population are identified on analysis and trending of data related to the care and services provided at PACE. Other indicators and opportunities for performance improvement are identified through:

- Utilization of Services
 - CalOptima PACE will collect, analyze and report any utilization data it deems necessary to evaluate both quality of care and fiscal well-being of the organization.
 - Data analysis will allow for analyzing both over and under utilization for areas of quality improvement.
- Participant and Caregiver Satisfaction
 - The organization shall survey the participants and their caregivers on at least an annual basis. Additionally, we will continue to look for other opportunities for feedback in order to improve quality of services.
 - Due to the nature of the participants in PACE, caregiver feedback is an integral part of our data elements.
- Outcome Measures From Data Collected During Patient Assessments
 - This would include evaluations from all Interdisciplinary Team Members.
 - Physiological and clinical well-being, functional status, cognitive functioning, and emotional and mental health status assessments will be used. Standardized, evidenced based assessments will be used whenever available.
- Effectiveness and safety of staff-provided and contract-provided services
 - This will be measured by participants' ability to achieve treatment goals as reviewed by the Interdisciplinary Team with each reassessment, review of medical records, and success of infection control efforts.
 - All clinical and certain non-clinical positions have competency profiles specific to their positions.
 - CalOptima PACE staff will monitor providers by methods such as: review of providers' quality improvement activities, medical record review, grievance investigations, observation of care, and interviews.
 - Unannounced visits to inpatient providers' sites will be made by CalOptima PACE staff as necessary.

- Non-clinical areas
 - The PACE ~~QAPI Committee~~ PQIC has oversight to all activities offered by PACE.
 - Member Grievances will be forwarded to the QA Coordinator for tracking, trending and data gathering. These results will be forwarded to the PACE Director and PACE Medical Director for review and further direction on any corrective actions that may be implemented. Participants and caregivers will be informed of decisions and will be assisted with furtherment of the process as needed. Results will also be reported to the PQIC for direction on how appropriate staff should implement any corrective actions.
 - Member Appeals will be forwarded to the QA Coordinator for tracking, trending and data gathering. This will be forwarded to the PACE Director and PACE Medical Director for review and decision implementation and shared with the Interdisciplinary Team who will inform caregivers and participants of decisions and assist them with furtherment of the process as needed.
 - Transportation services will continue to be monitored through monthly metrics and grievance trending and reported via quarterly ~~PQIC QAPI committee~~ meetings.
 - Meal quality will be monitored through daily checks of food temperatures as well as comments solicited by the CalOptima PACE Member Advisory Committee.
 - Life safety will be monitored internally via quarterly fire drills and annual mock code and mock disaster drills as well as regulatory agency inspections.
 - Plans of correction on problems noted will be implemented by center staff and reviewed by the PACE Program Director, PACE Medical Director or the PACE QA Manager. ~~QA Coordinator.~~
 - The internal environment will be monitored through ongoing preventive maintenance of equipment and through repair of equipment or physical plant issues as they arise.

Priority setting for performance improvement initiatives is based on:

- Potential impact on quality of care, clinical outcomes, improved participant function and improved participant quality of life.
- Potential impact on participant access to necessary care or services.
- Potential impact on participant safety.
- Participant, caregiver, or other customer satisfaction.
- Potential impact on efficiency and cost-effectiveness.
- Potential mitigation of high-risk, high volume, or high frequency events.
- Relevance to the mission and values of CalOptima PACE.

■

External Monitoring and Reporting

CalOptima PACE will report both aggregate and individual-level data to CMS and State Administering Agencies to allow them to monitor CalOptima's PACE performance. This includes Level One and Level Two Reporting, Health Outcomes Survey Modified (HOS-M) participation, and any other required reporting elements. Certain data elements are tracked in response to federal and state mandates and will be reported up through the PACE monitoring module of the Health Plan Management System (HPMS).

- Level One Reporting Indicators
 - Routine Immunizations
 - Grievances and Appeals
 - Enrollments

- Disenrollments
- Prospective Enrollees
- Readmissions
- Emergency (Unscheduled) Care
- Unusual Incidents
- Deaths

- Level Two Reporting Indicators

- When usual incidents reach specified thresholds, CalOptima must notify CMS and the State Administering Agency in the required timetables, complete a Root Cause Analysis and present the results of the analysis on a conference call with both agencies as well as internally at the PACE QIC. The goal of this analysis is to identify systems failures and improvement opportunities. -Examples of Level Two Events are:

- Deaths related to suicide or homicide, unexpected and with active coroner investigation-
- Falls that result in death, a fracture ~~requiring surgery,~~ or an injury requiring hospitalization ~~on related directly to the fall, on more than 5 days or that results in an injury for which the determination is made within 48 hours of the fall that permanent loss of function is expected.~~
- Infectious ~~d~~Disease oOutbreak that meet the threshold of three or more cases linked to the same infectious agent within the same time frame
- Pressure ~~u~~Ulcer acquired while enrolled in the PACE Program
- Traumatic ~~i~~Injuries which result in death or hospitalization of five days or more or result in permanent loss of function-
- ~~Any e~~Elopement-
- Health Outcomes Survey-Modified (HOS-M)
 - CalOptima PACE will participate in the annual HOS-M to assess the frailty of the population in our center-
- Other External Reporting Requirements
 - Suspected elder abuse shall be reported to appropriate state agency-
 - Equipment failure or serious adverse reaction to any administered medications will be reported to the FDA-
 - Any ~~i~~Infectious ~~d~~Disease oOutbreak will be reported to the CDC-

Corrective Action Plans

- When opportunities for improvement are identified, a corrective plan will be created.
- Each corrective plan will include: an explanation of the problem, the individual who is responsible for implementing the corrective plan, the time frame for each step of the plan, and an evaluation process to determine effectiveness-
- Corrective Action Plans from contracted providers will be requested by the QA ~~Coordinator~~ Manager or other member of the PQIC, as appropriate-

Urgent Corrective Measures

- Problems that are found to threaten the immediate health and safety of participants or staff will be reported immediately to the CalOptima PACE Medical Director and the CalOptima PACE Director
- The QA Manager or QA Coordinator will consult with relevant CalOptima PACE staff and be responsible for developing an appropriate corrective plan within 24 hours of notification-
- Urgent corrective measures will be discussed during IDT morning meetings and, when appropriate, with participants-
- Disciplinary action and/or the use of appropriate community resources such as Adult Protective Services, notification and cooperation with law enforcement agencies, emergency placement of participants, etc. will be implemented immediately-

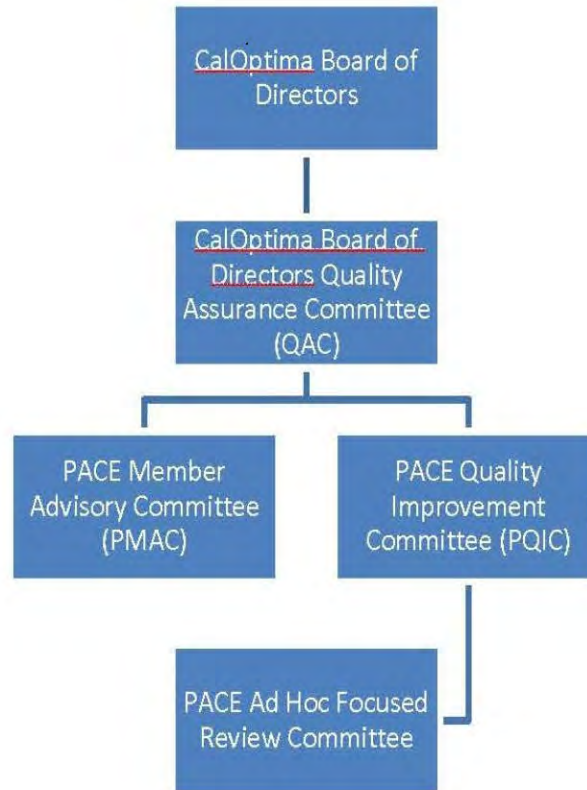
Re-Evaluation and Follow-up

- Monitoring activities will be conducted to determine the effectiveness of plans of action. The timeliness of follow-up is dependent upon the following:
 - Severity of the problem
 - Frequency of occurrence
 - Impact of the problem on participant outcomes
 - Feasibility of implementation
- If follow-up shows the desired results have been achieved, the issue will be re-evaluated on a periodic basis to ensure continued improvement-
- If follow-up indicates that the desired results are not being achieved, then a more in-depth analysis of the problem and further determination of the source of variation are needed. A subcommittee of the PQIC or other workgroup may be established to address specific problems.
- All quality assessment and improvement steps and follow-up results will be shared with appropriate staff for discussion.

Annual Review of PACE QAPI Plan

- The PACE QAPI Plan will be assessed annually for effectiveness-
- Enhancements to the plan will be made through appropriate additions and revisions to the specific goals and objectives in the QAPI Plan
- The CalOptima Board of Directors will review, revise and approve the CalOptima PACE QAPI Plan to assure organizational oversight and commitment

Appendix A: 2016 CalOptima PACE QAPI Program Reporting Structure



2016 CalOptima PACE Quality Assessment Performance Improvement (QAPI) Work Plan DRAFT

QAPI Item#	Scope	Objective	Activity	Goal	Responsible Person	Reporting Frequency	Target completion
QAPI14.01	PACE Quality of Care-2016 PACE QAPI Plan and Work Plan Annual Oversight	PACE QAPI Plan and Work Plan will be reviewed and updated annually	QAPI and QAPI Work Plan will be approved and adopted on an annual basis	Annual Adoption	PACE Medical Director	Annually	March, 2016
QAPI14.02	PACE Quality of Care-2015 PACE QAPI Plan and Work Plan Annual Evaluation	PACE QAPI Plan and Work Plan will be evaluated annually.	PACE QAPI Plan and Work Plan will be evaluated for effectiveness on an annual basis	Annual Evaluation	PACE Medical Director	Annually	March, 2016
QAPI14.03	PACE Preventative Care-Influenza Immunization Rates	Increase Influenza immunization rates for all eligible PACE participants	Improve compliance with influenza immunizations recommendations	> 90% of members will have influenza vaccination	PACE QA Manager	Quarterly	12/31/2016
QAPI14.04	PACE Preventative Care-Pneumococcal Immunization Rates	Increase Pneumococcal immunization rates for all eligible PACE participants	Improve compliance with pneumococcal immunizations recommendations	> 90% of members will have pneumococcal vaccination	PACE QA Manager	Quarterly	12/31/2016
QAPI14.05	PACE Quality of Care-Infection Control	Reduce common infections in PACE participants	Monitor and analyze the incidence of common infections in the elderly at PACE and compare against national benchmarks to find opportunities for quality improvement	Maintain common infection rates less than the following national benchmarks: Respiratory Tract 0.1-2.4 episodes/1000 participant days Urinary Tract 0.46-4.4 episodes/1000 participant days Skin and Soft Tissue 0.1-2.1 episodes/1000 participant days Gastrointestinal Tract 0-0.9 episodes/1000 participant days	PACE QA Manager	Quarterly	12/31/2016

QAPI14.06	PACE Quality of Care-Physician Orders for Life-Sustaining Treatment (POLST) Utilization	Increase POLST utilization for PACE participants who have been enrolled in PACE for at least 12 months	Ensure all PACE members are offered a POLST every six months until they have one completed in order to improve utilization of POLST	Improve POLST utilization by 10% over 2015 rate (65%)	PACE Center Manager	Quarterly	12/31/2016
QAPI14.07	PACE Access and Availability	Improve access to specialty practitioners	Access to high impact specialty practitioners will be measured, analyzed and adjusted as necessary such that appointments occur within 14 business days	> 90% of specialty practitioners will have appointments available within 14 business days	PACE QA Manager	Quarterly	12/31/2016
QAPI14.08	PACE Utilization of Services- Acute Hospital Days	Reduce the rate of acute hospital days by PACE participants	PACE participants hospital days will be monitored and analyzed by the PACE QA department who will work with the PACE interdisciplinary and clinical teams to develop strategies to lower that rate through preventative care and education	< 3,462 hospital days per 1000 per year (20% reduction from the CalOptima PACE utilization in 2015)	PACE Medical Director	Quarterly	12/31/2016
QAPI14.09	PACE Utilization of Services- Emergency Room Utilization	Reduce the rate of ER utilization by PACE participants	ER utilization by PACE participants will be monitored and analyzed by the PACE QA department who will work with the PACE interdisciplinary and clinical teams to develop strategies to lower that rate through preventative care and education	< 428 emergency room visits per 1000 per year (CalPACE Average for 2015)	PACE Medical Director	Quarterly	12/31/2016
QAPI14.10	PACE Utilization of Services- 30-Day All Cause Readmission Rates	Reduce the 30-day all cause readmission rates by PACE participants	30-day all cause readmission rates for hospitalized PACE participants will be monitored and analyzed by the PACE QA department who will work with PACE interdisciplinary and clinical teams to find opportunities for quality improvement	<16.8% (20% reduction from the CalOptima PACE utilization in 2015)	PACE Medical Director	Quarterly	12/31/2016
QAPI14.11	PACE Quality of Care-Diabetic Eye Exams	Increase the percentage of PACE participants with diabetes who get their annual diabetic eye exam completed	PACE participants with diabetes will be monitored by the PACE QA department who will work with the interdisciplinary and clinical teams to develop strategies for improvement	> 90% of members with diabetes will have their annual eye exam completed	PACE Medical Director	Quarterly	12/31/2016
QAPI14.12	PACE Participant Satisfaction-Transportation	Improve the satisfaction of participants and their families with the CalOptima PACE transportation department	Review and analyze the grievances related to transportation, define areas for improvement and implement interventions to improve the participant and their families satisfaction with the PACE transportation department	Reduce transportation grievances by 20% from 2015	PACE Director	Quarterly	12/31/2016
QAPI14.13	PACE Participant Satisfaction-Withdrawals and Disenrollment's	Reduce the percentage of participants who have withdrawn or have disenrolled from the PACE program within the first 90 days of enrollment.	Review and analyze the participants who have either withdrawn or disenrolled from PACE within 90 days of enrollment to develop strategies for improvement	Reduce the percentage below 10%	PACE Marketing and Enrollment Manager	Quarterly	12/31/2016
QAPI14.14	PACE Participant Satisfaction- Overall Satisfaction	Improve the overall satisfaction of participants and their families with the CalOptima PACE program	Review and analyze the annual satisfaction survey results, define areas for improvement and implement interventions to improve the participant and their families satisfaction with the PACE program	> 90% will answer 3/4 (satisfied), very satisfied (4/4) on this question.	PACE Director	Annually	12/31/2016

Appendix C: PACE QAPI Committee Meeting Minutes Template

<p align="center">PACE Quality Improvement Committee Meeting Minutes</p> <p align="center">Date _____</p> <p align="center">Time: _____</p> <p align="center">Place: PACE conference Room 109</p>		
<p>Meeting Attendees: PACE Medical Director, PACE Program Director, PACE Center Manager, PACE Clinical Operations Manager, PACE QA Coordinator, and the PACE Intake/Enrollment Manager.</p>		
<p>Meeting Notes Taker: QA Coordinator</p>		
Topic	Presentation/Discussion	Recommendation/Action
Roll Call and Introduction		
Review and Approval of Last PQIC Meeting Minutes		
<p>Old Business:</p>		
<p>New Business:</p>		
Level II Issues		
HPMS Data Analysis		
<p>Standing Agenda Item</p>		
Clinical Logs and Updates		
Operational Logs and Updates		
Site Logs and Updates		
PMAC Update Report		

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to Be Taken April 7, 2016 **Regular Meeting of the CalOptima Board of Directors**

Consent Calendar

6. Approve and Reinstate Updated Policy GG.1643, Minimum Physician Standards

Contact

Richard Bock, M.D., Deputy Chief Medical Officer, (714) 246-8400

Recommended Action

Approve and reinstate CalOptima Policy GG.1643, Minimum Physician Standards.

Background

On August 6, 2002, staff recommended the approval of proposed minimum practitioner standards (MPS) for practitioners furnishing services to CalOptima members. At the time, CalOptima was in the process of reviewing a contracted network for CalOptima Direct (COD) members and a credentialing process for the COD network. The MPS were designed to be distributed to physicians as part of a pre-application attestation process. Physicians were required to satisfy all MPS in order to be eligible to submit claims and/or be reimbursed for services. Your Board approved the proposed MPS which were incorporated into Policy GG.1632 Minimum Practitioner Standards. Policy GG.1632 required that practitioners meet these requirements: hold a valid California license to practice medicine, have certain malpractice insurance, not be currently ineligible to participate in federal and/or state health care programs and never excluded or suspended based on certain categories (e.g., conviction of patient neglect or abuse), actively practice medicine 18 of the past 24 months or participating in a residency program during that period, and not have a felony conviction in the seven years prior to the questionnaire. The MPS also incorporated the standalone board certification requirements discussed below.

In 2010, CalOptima Staff recommended that the MPS and the requirement for physicians to complete the MPS form prior to credentialing be eliminated as part of several other changes to credentialing and provider participation requirements. On October 7, 2010, your Board approved the elimination of MPS and Policy GG.1632 was retired.

Discussion

CalOptima has recently experienced a significant increase in membership. Additional providers are needed to appropriately provide services to all of the CalOptima members. Staff recommends that a Minimum Physician Standards policy be reinstituted to ensure the quality of new physicians.

As part of existing regulatory and accreditation mandated oversight processes, CalOptima must maintain and support an active credentialing program for physicians. Modifications that would significantly impact the credentialing process, such as imposing a minimum standard for new applicants must be reviewed, evaluated, and approved by the Board.

Pursuant to its authority under the State Medi-Cal Contract, CalOptima, currently delegates credentialing and recredentialing functions to its health networks. CalOptima retains oversight of the delegated credentialing and recredentialing process and regularly audits the health networks' credentialing performance.

The proposed updated policy differs from the retired policy in the following ways:

- The minimum physician standards will only apply to all new (first time applicants to CalOptima) Physicians (Doctors of Medicine, Doctors of Osteopathy, and Doctors of Podiatric Medicine), who are applying to participate in a CalOptima or a CalOptima delegated network.
- Added new objective criteria that the applicant practitioner must not currently be on probation or have an accusation pending with their licensing board.
 - Accusation defined as a legal document that begins the formal disciplinary process after an investigation finds evidence that the physician has violated the laws governing the physician's practice area, and the violation warrants disciplinary action. An accusation lists the charges and/or the section(s) of law alleged to have been violated, and is served on the physician.
 - These new criteria will assist in:
 - Improving quality, and
 - Potentially avoiding the cost and lengthy administrative processes to evaluate accusations and probations when limited information is available.
- Added section that the applicant must be board certified in their specialty per Policy GG.1633.
- The proposed minimum physician standards would be distributed to physicians as part of a pre-application attestation process. Physicians would have to satisfy all of the minimum physician standards to be eligible to be credentialed in CalOptima or through a CalOptima delegated network.
 - An incomplete attestation would be returned to the physician.
 - A physician whose completed attestation reflects that he or she meets all of the minimum practitioner standards would receive an application and proposed contract.
 - A physician whose attestation reflects that he or she does not meet one (1) or more of the minimum practitioner standards would not be eligible and would not receive an application and/or proposed contract.

The following requirements would be retained from the prior version of the policy:

- Valid California license to practice medicine
- Current professional liability insurance
- Able to fully participate in State or Federal health care programs
- Never been excluded from participation in State or Federal programs
- No felony convictions within the 10 years prior to applying

Current physicians who are presently credentialed & recredentialed with CalOptima are held to the administrative standards in CalOptima Policy GG.1609: Credentialing and Recredentialing.

With the addition of the Minimum Physician Standards process, CalOptima will be able to address in a timely fashion, new, potential applicants to CalOptima. Staff believes that the proposed policy changes will help to ensure the quality of physicians providing care to CalOptima members.

Fiscal Impact

There is no fiscal impact for the recommended action related to the reinstitution of Minimum Physician Standards policy.

Concurrence

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

Attachments

PowerPoint Presentation – Minimum Physician Standards
Policy GG.1643, Minimum Physician Standards
Form GG.1643, CalOptima Minimum Physician Standards Attestation

/s/ Michael Schrader
Authorized Signature

04/01/2016
Date



CalOptima
Better. Together.

Minimum Physician Standards

Board of Directors Meeting
April 7, 2016

Caryn Ireland
Executive Director, Quality and Analytics

Background

- Minimum Practitioner Standards (MPS) approved in 2002 and incorporated into CalOptima Policy GG.1632
- MPS retired in 2010 and requirements included in credentialing application
- Board Certification Policy No. GG.1633 was approved in 2008, amended in 2013 and 2016 (in process)
 - Requires that contracted Physicians be Board Certified in their specialty within five years of completing their residency (exempting Physicians first licensed in the U.S. before January 1, 2008).

Staff Recommendation

- Revive MPS for first time credentialing applicants to the CalOptima program, including adopting new criteria.
- Proposed changes:
 - Require verification of MPS before credentialing application is provided—previous MPS was only an attestation
 - No CMO exception to ensure consistent application
 - New objective criteria included: no current accusation pending, and not currently on probation. Intended outcomes:
 - Improve quality
 - Potentially avoid time and cost of lengthy administrative processes to evaluation accusations and probations when limited information is available.
- CalOptima's currently contracted and credentialed physicians are held to the administrative standards in credentialing policy GG.1609.

Comparison

Old Standards	Proposed Standards
Valid California license to practice medicine	Valid California license to practice medicine
Current professional liability insurance	Current professional liability insurance
Able to fully participate in State or Federal health care programs	Able to fully participate in State or Federal health care programs
No felony convictions within the 7 years prior to applying	No felony convictions within the 10 years prior to applying
Never been excluded from participation in State or Federal programs	Never been excluded from participation in State or Federal programs
Actively practice medicine 18 of the past 24 months	Applicant physician must not currently be on probation for any reason
	Applicant must not have an accusation pending before their licensing board

Process

- For purposes of proposed MPS policy:
 - “Physicians” include Doctors of Medicine, Doctors of Osteopathy, and Doctors of Podiatric Medicine.
 - “Accusation” is a legal document that begins the formal disciplinary process after an investigation finds evidence that the physician has violated the laws governing the physician’s practice area, and the violation warrants disciplinary action. An accusation lists the charges and/or the section(s) of law alleged to have been violated, and is served on the physician.
- Part of a pre-application attestation process
 - An incomplete attestation would be returned to the physician.
 - A physician whose completed and verified attestation reflects that he or she meets all of the minimum physician standards would receive an application and proposed contract.
 - A physician whose attestation reflects that he or she does not meet one (1) or more of the minimum physician standards would not be eligible and would not receive an application and/or proposed contract.
- Applies to CalOptima and its delegated networks

Policy #: GG.1643Δ
 Title: **Minimum ~~Practitioner~~Physician Standards**
 Department: Medical Affairs
 Section: Quality Improvement
 CEO Approval: Michael Schrader _____

Effective Date: TBD
 Last Review Date: N/A
 Last Revised Date: N/A

This policy shall apply to the following CalOptima line of business (LOB):

- Medi-Cal
- OneCare
- OneCare Connect
- PACE

I. PURPOSE

To identify the Minimum ~~Practitioner~~Physician Standards that must be met in order for a ~~Practitioner~~Physician to be credentialed for participation in CalOptima programs.

II. DEFINITIONS

Term	Definition
Accusation	A legal document that begins the formal disciplinary process after an investigation finds evidence that the Practitioner Physician has violated the laws governing the Practitioner Physician's practice area, and the violation warrants disciplinary action. An accusation lists the charges and/or the section(s) of law alleged to have been violated, and is served on the practitioner Physician.
Health Network	A Physician Hospital Consortium (PHC), Physician Medical Group (PMG) under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Health Delivery Organization	Includes hospitals, home health agencies, skilled nursing facilities, extended care facilities, nursing homes, and free-standing surgical, laboratory, or other centers.
Practitioner Physician	For the purposes of this policy, a licensed independent practitioner includes, but is not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), or Doctor of Podiatric Medicine (DPM)), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), and Doctor of Psychology (PhD or PsyD).

III. POLICY

- A. Effective [DATE], CalOptima requires that all new ~~Practitioners-Physicians~~ (as defined above) who wish to provide services to CalOptima Members, whether through CalOptima Direct ~~or~~, a

CalOptima Health Network, ~~or a contracted Healthcare Delivery Organization (HDO)~~, meet the Minimum ~~Practitioner~~Physician Standards as defined in this policy and be credentialed in accordance with CalOptima GG.1609Δ: Credentialing and Recredentialing. The Minimum ~~Practitioner~~Physician Standards include:

1. Current valid California license to practice;
 2. Current valid Drug Enforcement Agency (DEA) certificate (for Physicians and Surgeons or Physician Assistants);
 3. Current professional liability (malpractice) insurance or self-insurance (e.g. trust, escrow accounts, etc.) coverage in the minimum amounts of \$1 million per occurrence and \$3 million aggregate per year;
 4. Not currently excluded, suspended, or otherwise ineligible to participate in any State or Federal health care programs;
 5. Not currently on probation or have an Accusation pending, with their licensing board.
 6. Never been excluded from participation in Federal or State health care programs based on conduct that supports a mandatory exclusion under the Medicare program set forth in Title 42, United States Code, Section 1320a-7(a) as follows:
 - a. A conviction of a criminal offense related to the delivery of an item or service under Federal or State health care programs;
 - b. A felony conviction related to the neglect or abuse of patients in connection with the delivery of a health care item or service;
 - c. A felony conviction related to health care fraud; or
 - d. A felony conviction related to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.
 7. No felony conviction in the ten (10) year period prior to the date of execution of the attestation containing these Minimum ~~Practitioner~~Physician Standards.
 8. If a physician, Board certified in their specialty in accordance with CalOptima Policy GG.1633Δ: Board Certification Requirements for Physicians.
- B. Health Networks ~~and Health Delivery Organizations (HDO)~~ that are delegated to perform credentialing and recredentialing shall incorporate the Minimum ~~Practitioner~~Physician Standards into their credentialing processes.
- C. A Health Network shall establish policies and procedures to evaluate and select ~~Practitioner~~Physicians to participate in CalOptima that, at minimum, meet the requirements as outlined in this policy.

- 1 D. The Minimum ~~Practitioner~~Physician Standards will apply to all new, first-time
2 ~~Practitioner~~Physician applicants to CalOptima who wish to provide covered services to CalOptima
3 members, without exception.
4
- 5 E. All new ~~Practitioner~~Physicians must meet the Minimum ~~Practitioner~~Physician Standards to contract
6 with CalOptima ~~or~~ its Health Networks, ~~or its HDO providers~~ to furnish services to CalOptima
7 Members and bill and receive reimbursement for such services (subject to compliance with all other
8 applicable CalOptima Policies).
9

10 IV. PROCEDURE

- 11
- 12 A. CalOptima's Provider Relations staff will distribute the Minimum ~~Practitioner~~Physician Standards
13 attestation to ~~Practitioner~~Physicians as part of a pre-application process. ~~Practitioner~~Physicians must
14 satisfy all of the Minimum ~~Practitioner~~Physician Standards to be eligible to be credentialed in
15 CalOptima or through a CalOptima delegated Health Network. Any incomplete attestations shall be
16 returned to the ~~Practitioner~~Physician by Provider Relations staff.
17
- 18 1. If the ~~Practitioner~~Physician does not fully complete the attestation within one hundred eighty
19 (180) days after receipt of the attestation, the ~~Practitioner~~Physician's attestation shall be
20 considered expired.
21
 - 22 2. CalOptima's Quality Improvement Department shall review the attestation and documentation
23 and communicate results to Provider Relations. A ~~Practitioner~~Physician shall ensure that all
24 information included in the attestation is no more than six (6) months old.
25
 - 26 3. A ~~Practitioner~~Physician whose completed attestation reflects that he or she meets all of the
27 Minimum ~~Practitioner~~Physician Standards is eligible to receive a credentialing application, and
28 if the credentialing application is approved, a contract to participate in the CalOptima Program.
29
 - 30 4. A ~~Practitioner~~Physician whose attestation reflects that he or she does not meet one (1) or more
31 of the Minimum ~~Practitioner~~Physician Standards shall not be eligible to participate in the
32 CalOptima Program.
33
 - 34 5. CalOptima's Quality Improvement (QI) department shall verify all answers and notify the
35 ~~Practitioner~~Physician by certified mail that the ~~Practitioner~~Physician did not meet the Minimum
36 ~~Practitioner~~Physician Standards within three (3) business days of receipt of a signed and
37 completed attestation.
38
 - 39 6. If CalOptima or a Health Network is unable to render a decision within one hundred eighty
40 (180) calendar days after receipt of the attestation for any ~~Practitioner~~Physician, the
41 ~~Practitioner~~Physician's attestation shall be considered expired.
42
- 43 B. Health Networks ~~and HDOs~~ that are delegated to perform credentialing and recredentialing shall
44 adopt a procedure to ensure that new ~~Practitioner~~Physicians seeking to contract with that Health
45 Network ~~or HDO~~ satisfy all Minimum ~~Practitioner~~Physician Standards before receiving a
46 credentialing application or any contract documents for the CalOptima program.
47
- 48 C. CalOptima ~~or~~ a Health Network ~~or HDO~~, shall verify the information provided through primary or
49 secondary source verification using industry-recognized verification sources or a credentials

Policy #: GG.1643Δ

Title: Minimum ~~Practitioner~~Physician Standards

Effective Date: DATE

verification organization according to CalOptima Policy GG.1609Δ: Credentialing and Recredentialing.

V. ATTACHMENTS

A. CalOptima Minimum ~~Practitioner~~Physician Standards Attestation

VI. REFERENCES

- A. CalOptima Compliance Plan
- B. CalOptima Contract With Department of Health Care Services (DHCS)
- C. Contract For Health Care Services
- D. GG.1609Δ: Credentialing and Recredentialing
- E. GG.1633Δ: Board Certification Requirements for Physicians
- F. Title 42, United States Code, section 1320a-7(a)
- G. Welfare and Institutions Code section 14043.36

VII. REGULATORY APPROVALS

None to Date

VIII. BOARD ACTION

None to Date

IX. REVIEW/REVISION HISTORY

Version	Version Date	Policy Number	Policy Title
Original Date	DATE	GG.1643	Minimum Practitioner Physician Standards

CalOptima Minimum Physician Standards Attestation

CalOptima's Board of Directors approved "minimum physician standards" for medical doctors, doctors of osteopathic medicine, and doctors of podiatric medicine, who wish to contract with CalOptima to provide services to CalOptima Members. All physicians in these categories who wish to participate in the CalOptima program must meet all minimum physician standards in order to submit an application for credentialing, the successful approval of which is a pre-requisite to contracting with CalOptima or its contracted Health Networks. All potential providers who have not contracted with CalOptima prior to _____ must submit this Attestation in order to be considered for issuance of a credentialing application.

Please answer the following questions either Yes (Y) or No (N).

A. Do you have a current valid California license to practice the profession for which you are seeking participation in CalOptima?	Y <input type="checkbox"/>	N <input type="checkbox"/>
B. Do you possess a current valid DEA certificate?	Y <input type="checkbox"/>	N <input type="checkbox"/>
C. (1) were you certified in your specialty within five years of the completion of your residency training, and do you continue to be so certified, by a CalOptima-approved specialty Board, or (2) has it been less than five years since completion of your residency training, and you have been making adequate progress towards being so certified before the expiration of five years from the completion of my residency training, or (3) were you first licensed to practice medicine in a United States jurisdiction before January 1, 2008?	Y <input type="checkbox"/>	N <input type="checkbox"/>
D. Do you have current professional liability (malpractice) insurance or self-insurance (e.g. trust, escrow accounts, etc.) coverage in the minimum amounts of \$1 million per occurrence and \$3 million aggregate per year that covers all aspects of your practice?	Y <input type="checkbox"/>	N <input type="checkbox"/>
E. Are you currently excluded, suspended, or otherwise ineligible to participate in any State or Federal health care programs?	Y <input type="checkbox"/>	N <input type="checkbox"/>
F. Are you currently on probation with the board that issued your license to practice?	Y <input type="checkbox"/>	N <input type="checkbox"/>
G. Do you currently have an accusation or other disciplinary proceeding pending against you with the board that issued your license to practice?	Y <input type="checkbox"/>	N <input type="checkbox"/>

(over)

H. Have you ever been excluded from participation in Federal and/or State health care programs based on conduct that supports a mandatory exclusion under the Medicare program set forth in 42 U.S.C. § 1396a-7(a) as follows: (1) a conviction of a criminal offense related to the delivery of an item or service under Federal and/or State health care programs; (2) a felony conviction related to the neglect or abuse of patients in connection with the delivery of a health care item or service; (3) a felony conviction related to health care fraud and/or (4) a felony conviction related to the unlawful manufacture, distribution, prescription or dispensing of a controlled substance?

Y ☐ N ☐

I. Do you have any felony convictions in the ten (10)-year period prior to the date of execution of this questionnaire set forth below?

Y ☐ N ☐

By signing this attestation, I hereby: (1) give CalOptima permission to investigate and verify the accuracy of any and all statements and representations in this Attestation; and (2) authorize any relevant person or entity to provide information requested by CalOptima that may be related to any and all statements and representations made in this Attestation.

I declare, under penalty of perjury, under the laws of the State of California, that all statements contained in this Attestation are true and correct. I understand that any and all statements made in this Attestation are subject to verification and that any false or dishonest statement may be grounds for limiting or terminating my participation in CalOptima programs.

Print Name Here: _____ **License #:** _____

Physician Signature: _____ **Date:** _____
(Stamped Signature is NOT acceptable)

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 7, 2016

Regular Meeting of the CalOptima Board of Directors

Consent Calendar

7. Approve Measurement Year CY 2016 Pay for Value Programs for Medi-Cal and OneCare Connect

Contact

Richard Bock, M.D., Deputy Chief Medical Officer, (714) 246-8400

Recommended Action

Approve Measurement Year CY 2016 “Pay for Value (P4V) Programs for Medi-Cal and OneCare Connect (OCC)” which defines measures and allocations for performance, as described in Attachment 1, subject to regulatory approval, as applicable.

Background

CalOptima has implemented a comprehensive Health Network Performance Measurement System consisting of recognizing outstanding performance and supporting on-going improvement that will strengthen CalOptima’s mission of providing quality health care.

The purpose of the Health Network performance measurement system, which includes both delegates and the CalOptima Community Network as previously approved by the Board on March 1, 2014, is three-fold:

1. To recognize and reward Health Networks and their physicians for demonstrating quality performance;
2. To provide comparative information for members, providers, and the public on CalOptima’s performance; and
3. To provide industry benchmarks and data-driven feedback to Health Networks on their quality improvement efforts.

Discussion

For the Measurement Year CY 2016 programs, staff recommends maintaining many of the elements from the prior year with some modifications. Changes to measures and scoring methodology address the need to consider the complexity or member acuity (SPD compared to Non-SPD members) and the subsequent higher consumption of physician/health network resources to care for SPD members. Additionally, the scoring methodology will reward performance and improvement. The program will include both Adult and Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures, thereby expanding our focus on the member experience.

In order to sustain improvements and leverage resources that the health networks have allocated towards improvement in P4V measures, staff recommends the following modifications:

Medi-Cal Changes:

- All health networks will have performance measures for both adult and child care. This addresses the unique needs of children in all networks.
- Introduction of an “acuity” calculation to address the unique health needs in the populations.
- Addition of access to care measures:
 - Adults Access to Preventative/Ambulatory Care Services
 - Children’s Access to Primary Care Physicians
- Retirement of the “provider satisfaction with the health network and UM process” measure.
- The weighting of each domain in the Medi-Cal Pay for Performance program has been adjusted accordingly. Increased weighting has been allocated to member experience. This aligns with CalOptima’s increased focus on improving member experience.

The proposed Measurement Year CY 2016 Medi-Cal Pay for Value program is a one year program which uses calendar year (CY) 2016 HEDIS measurements and for which payments will be made in 2017.

OneCare:

The OneCare Pay for value program will be retired due to the transition of the majority of former OneCare members to OneCare Connect. Quality Performance metrics for the One Care population of approximately 1200 members will continue to be reported via our annually required HEDIS submission to CMS. However, the reduced OneCare membership is too small to produce statistically significant results by individual health network. In lieu of an allocated incentive fund, OneCare health network capitation rates were increased 1% on January 1, 2016.

OneCare Connect:

- To incentivize quality care in our new OneCare Connect program and to better align with the CMC Quality withhold program, four new measures are proposed. Included in the proposed measure set for OneCare Connect is also a new measure type with an emphasis on clinical outcomes (blood pressure control).
- OneCare Connect measures are pending regulatory approval.

Windstone:

- Reinstate pay for value measures for Windstone Behavioral Health.

Distribution of Incentive Dollars

Performance allocations are distributed upon final calculation and validation of each measurement rate. Payment for Medi-Cal will be paid proportional to acuity level, as determined by aid category. To qualify for payment for each of the clinical and CAHPS measures, the Health Network must have a minimum denominator in accordance with statistical principles.

In order to qualify for payments, a physician group must be contracted with CalOptima during the entire measurement period, period of pay for value accrual, and must be in good standing with CalOptima at the time of disbursement of payment.

Any separate OCC Quality Withhold incentive dollars earned will be distributed based upon Board of Directors approved methodology developed by staff and approved by CMS.

Fiscal Impact

Staff estimates that the fiscal impact of the Medi-Cal P4V will be no more than \$2 pmpm for the Measurement period of January 1, 2016 through December 31, 2016 and expects to present these expenses with the CalOptima FY 2016-2017 Operating Budget.

Staff estimates that the fiscal impact of the OneCare Connect P4V will be no more than \$20 pmpm for the Measurement period of January 1, 2016 through December 31, 2016, and expects to present these expenses with the CalOptima FY 2016-2017 Operating Budget.

Rationale for Recommendation

This alignment leverages improvement efforts and efficiencies that the Health Networks implement for other health plans. CalOptima has modified each program for applicability to the membership, measurement methodology, and strategic priorities.

Concurrence

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

Attachments

2016 Medi-Cal, Windstone, and OneCare Connect Pay for Value Programs
PowerPoint Presentation – 2016 Pay for Value Programs

/s/ Michael Schrader
Authorized Signature

04/01/2016
Date

**Attachment to:
2016 Medi-Cal Pay for Value Program
Measurement Set**

Adult Measures	2016 Measurement Year HEDIS 2017 Specifications Anticipated Payment Date: Q4 2017	Measurement Assessment Methodology
<p>Clinical Domain- HEDIS</p> <p>Weight: 60.00%</p> <p>SPD Weight 4.0</p> <p>TANF Weight 1.0</p>	<p>Prevention</p> <ul style="list-style-type: none"> Breast Cancer Screening (BCS) Cervical Cancer Screening (CCS) <p>Diabetes</p> <ul style="list-style-type: none"> HbA1c Testing Retinal Eye Exams <p>Access to Care:</p> <ul style="list-style-type: none"> Adults Access to Preventive/Ambulatory Care <p>Adult & Child Measure:</p> <ul style="list-style-type: none"> Medication Management for People with Asthma 	<p>A relative point system by measure based on:</p> <ul style="list-style-type: none"> NCQA National HEDIS Percentiles Percent improvement
<p>Patient Experience Domain- CAHPS</p> <p>Weight: 40%</p>	<p>Adult Satisfaction Survey</p> <ol style="list-style-type: none"> Getting Appointment with a Specialist Timely Care and Service Rating of PCP Rating of All Healthcare 	<p>A relative point system by measure based on:</p> <ul style="list-style-type: none"> NCQA National CAHPS Percentiles Percent improvement

Pediatric Measures	2016 Measurement Year HEDIS 2017 Specifications Anticipated Payment Date: Q4 2017	Measurement Assessment Methodology
Clinical Domain HEDIS Weight: 60.00% SPD Weight 4.0 TANF Weight 1.0	Respiratory <ul style="list-style-type: none"> Medication Management for People with Asthma Appropriate Testing for Children with Pharyngitis (CWP) Appropriate Treatment for Children with Upper Respiratory Infection (URI) Prevention <ul style="list-style-type: none"> Childhood Immunization Status Hepatitis Combo 10 (CIS) Well-Care Visits in the 3-6 Years of Life (W34) Adolescent Well-Care Visits (AWC) Access to Care <ul style="list-style-type: none"> Children's Access to Primary Care Physicians 	A relative point system by measure based on: <ul style="list-style-type: none"> NCQA National HEDIS Percentiles Percent improvement
Patient Experience Domain-CAHPS Weight: 40%	Child Satisfaction Survey (Child CAHPS) <ol style="list-style-type: none"> Getting Appointment with a Specialist Timely Care and Service Rating of PCP Rating of All Healthcare 	A relative point system by measure based on: <ul style="list-style-type: none"> NCQA National CAHPS Percentiles Percent improvement

Windstone Behavioral Health

Calculations for these measures will be the responsibility of CalOptima.

Measures	Allocation CY 2016	Data Source	Anticipated Payment Date	Benchmark
Quality of Care				
1. Follow-up After Hospitalization for Mental Illness <ul style="list-style-type: none"> Follow-up Visit after 7 days Follow-up Visit after 30 days 	\$15,000 <ul style="list-style-type: none"> 50% at 50th percentile- 100% if score is at or above 75th percentile \$15,000 <ul style="list-style-type: none"> 50% at 50th percentile 	HEDIS 2017	October 2017	Most current NCQA Quality Compass Medicare Percentiles
2. Reduction in ED use for Seriously Mentally Ill and Substance Use Disorders	\$30,000	CA State Defined Measure	October 2017	Significant improvement based on CMS methodology.

OneCare Connect	2016 Measurement Year Anticipated Payment Date: (Q4)	Measurement Assessment Methodology
<p>Clinical Domain Weight:100%</p> <p>Each measure weighted equally</p>	<p>Measures:</p> <ul style="list-style-type: none"> • Plan All Cause Readmissions • Antidepressant Medication Management Outcome Measures: • Blood Pressure Control • Part D Medication Adherence for Diabetes 	<p>A relative point system by measure based on:</p> <ul style="list-style-type: none"> • NCQA National HEDIS Percentiles • Percent improvement <p>For the Part D Medication Adherence Measure:</p> <p>A relative point system by measure based on:</p> <ul style="list-style-type: none"> • CMS Star Rating Percentiles • Percent improvement

Participation in Quality Improvement Initiatives

For each measure in which a Health Network/medical group performs below the 50th percentile, Health Networks/medical groups must submit a corrective action plan to CalOptima which outlines, at a minimum, the following items:

- Interim measures and goals
- Measurement cycle
- Member interventions including education and outreach
- Provider interventions including education and training
- Timeline for interventions

Health networks/medical groups must submit quarterly work plans which document implementation of the corrective action plan and progress made towards goals.

In conjunction with the Health Networks, CalOptima will lead quality improvement initiatives for measures that fall below the 50th percentile. Funding for these initiatives will come from forfeited dollars.

MEASUREMENT DETAILS:

I. Clinical Domain (HEDIS measures)

Program Specific Measurement Sets

Performance measures were selected as appropriate per program based on the following criteria:

- Measures are appropriate for membership covered by the program
- Measures are based on regulatory requirements
- Measures are used by the industry for performance measurement and incentive payment

Criteria

The following criteria were considered in selecting these indicators:

- Each of these indicators measures the delivery of services that are critical to the health of the respective segments of CalOptima's membership. In addition, these measures collectively address the range of age appropriate services.
- The measures use administrative data for all except Blood Pressure only reporting since they are single point of service measures.
- CBP will be captured with a specific chart review activity for this P4V program.

Each measure is calculated per HEDIS methodology except that continuous enrollment is assessed at the health network level instead of at the health plan level

Incentive Measure Definition

Please refer to HEDIS Technical Specifications Volume 2 for measure definitions. For each HEDIS indicator, members will be identified according to the most recent HEDIS technical specifications.

II. Customer Satisfaction

Member Satisfaction

Background

CalOptima conducts annual member satisfaction surveys that are carefully designed to provide network-level satisfaction information to meet precision requirements and to support comparisons between networks and at the CalOptima agency level. The goal is to survey different subsets of the CalOptima membership (e.g. Children, persons with disabilities) on a rotating basis so that we develop 1) trend information over time about individual networks' performance for a specific population and 2) comparable performance information across networks both for a specific time period as well as trended over time.

Survey Methodology

The surveys are administered using the CAHPS protocol, including a mixed-mode methodology of mail and telephone contact to notify members of the study, distribute questionnaires, and encourage participation by non-respondents. Both surveys have been conducted in three threshold languages as defined by our Medi-Cal contract.

CalOptima has worked with outside technical and substantive consultants to refine its survey instruments and sampling and weighting strategies and has employed a nationally known survey research group to conduct both surveys.

The samples consisted of randomly selected Medi-Cal members who met specific requirements for inclusion as specified by the CAHPS and by our interest in targeted subgroups. The sample is a disproportionately stratified random sample with strata defined by health network. CalOptima required sample sizes and allocations across strata be developed to provide estimates of population proportions at the network level that were within 2.5 percentage points of the true value with 95% statistical confidence.



CalOptima
Better. Together.

2016 Pay For Value Programs

Board of Directors Meeting

April 7, 2016

Richard Bock, M.D.

Deputy Chief Medical Officer

Pay for Performance - Current

- We identified opportunities to build on the current P4P program:
 - Half of our children are linked to Health Networks outside of CHOC
 - There wasn't the ability to recognize performance and improvement efforts
 - Only Child CAHPS was used to measure member experience; Adult CAHPS was not included in the program
 - The current methodology resulted in inadequate incentive for improved performance

Pay for *Value* - 2016

- Goals of the new program and methodology
 - Adult and Child measures are included for every Health Network
 - Populations are weighted based on the acuity of the membership
 - Payment considers the resources required for the membership
 - Payment methodology scores for performance and improvement
 - Adult and Child CAHPS scores are used in the methodology
 - Payment is not earned for poor performance
 - More allocated funds are converted to incentive payments

Medi-Cal P4V Clinical Measures

2016 Measurement Year Measures

Adult Measures	Child Measures
Adult Access to Preventive Care Services	Children's Access to Primary Care Physicians
Breast Cancer Screening	Well Child Visits 3-6 Years
Cervical Cancer Screening	Adolescent Well Care Visits
Diabetes Care: A1C Testing	Childhood Immunizations (Combo 10)
Diabetes Care: Retinal Eye Exams	Appropriate Testing for Children with Pharyngitis
Medication Management for People with Asthma	Appropriate Treatment for Children with URI
	Medication Management for People with Asthma

MediCal P4V CAHPS Measures

2016 Measurement Year Measures

Child and Adult Measures

Getting Appointment with a Specialist

Timely Care & Service

Rating of PCP

Rating of all HealthCare

Introducing Display Measures

- Display Measures are new measures that may be included in future pay for value programs. These measures are not eligible for payment for 2016 measurement year performance.
- CalOptima will include these measures on the monthly HN HEDIS incentive measures rate reports for monitoring purposes.
- Proposed Measures:
 - Ambulatory Care (Outpatient and ER visits)
 - Readmissions
 - IHA completion rates

Payment Methodology

Population Included:

Total # of Adults in Health Network

Total # of Children in Health Network

Apply Acuity Score (SPD Weight 4X, TANF Weight 1X)

Proposed Scoring for Measure Performance:

A relative point system by measure, based on:

- NCQA National HEDIS Percentiles (clinical measures)
- NCQA National CAHPS Percentiles (satisfaction measures)
 - Percent Improvement year over year

Final score for each measure is determined by weight and acuity

Clinical Measures = 60% of the Total

CAHPS Measures = 40% of the Total

2016 MY OneCare P4P Clinical Measures

(Retire Program for MY2016)

Breast Cancer Screening	Diabetes Care: A1 Screening
Colorectal Cancer Screening	Diabetes Care: A1C Good control (<8%)
Adults' Access to Preventive/Ambulatory Health services	Diabetes Care: Retinal Eye Exams
	Diabetes Care: Nephropathy Screening

OneCare Connect P4V Clinical Measures

2016 Measurement Year Measures – OneCare Connect

1. Plan All Cause Readmissions
2. Behavioral Health:
 - Antidepressant Medication Management
3. Blood Pressure Control
4. Part D Medication Adherence for Diabetes

OneCare Connect P4V: Windstone Behavioral Health

2016 Measurement Year Measures – Windstone

1. Follow-up After Hospitalization for Mental Illness:
 - Follow-up Visit after 7 days
 - Follow-up Visit after 30 days
2. Reduction in Emergency Department use for Seriously Mentally Ill and Substance Use Disorders (per CMS-defined standards)

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken on April 7, 2016 **Regular Meeting of the CalOptima Board of Directors**

Consent Calendar

8. Authorize a Mock Audit of the OneCare Connect Program; Authorize a Budget Reallocation to Fund This Mock Audit

Contact

Silver Ho, Executive Director, Compliance, (714) 246-8400

Recommended Actions

1. Authorize the Chief Executive Officer to contract with a consultant to conduct a mock audit of CalOptima's OneCare Connect program in preparation for an anticipated 2016 audit by the Centers for Medicare & Medicaid Services (CMS); and
2. Repurpose up to \$300,000 in unspent funds from the ICD-10 Conversion Program to cover the cost of the mock audit.

Background

On February 12, 2015, CMS issued the 2015 Program Audit Protocols for the Medicare Advantage (MA) and Prescription Drug (Part D) programs. On October 20, 2015, CMS updated the 2015 audit protocols. CMS will be making no additional changes to the protocols for 2016. Consequently, the revised protocols will function as the 2015 and 2016 MA and Part D program audit protocols. The audit protocols define the audit purpose, universe and sample selection processes, the evidence required for review and submission, and the compliance standards tested during the audit. Specifically, CMS will utilize the audit protocols to measure outcomes in the following areas:

- Part D Formulary and Benefit Administration
- Part D Coverage Determinations, Appeals, and Grievances
- Part C Organization Determinations, Appeals, and Grievances
- Special Needs Plans– Model of Care
- Part C and Part D Compliance Program Effectiveness

CMS expects plan sponsors to utilize the audit protocols to ensure readiness for a program audit in Calendar Year (CY) 2016.

Discussion

Given that CalOptima recently transitioned to a new pharmacy benefit manager (PBM) effective January 1, 2016, for all lines of business and that the OneCare Connect program has not undergone a regulatory audit since its launch in July 2015, CalOptima management anticipates that it is likely that CMS may select the OneCare Connect program for a program audit in CY 2016. As such, CalOptima management plans to conduct a mock audit of all aforementioned audit areas for the OneCare Connect program in the second quarter of 2016 to identify any potential issues of non-compliance and remediate them prior to potential selection by CMS for an audit.

Consistent with the Board-approved procurement policy, CalOptima staff initiated a Request for Proposal (RFP) in February 2016 for a consultant to conduct the mock audit. RFP responses were due on March 9, 2016. Selection of a vendor and award of a contract are contingent on approval of a budget reallocation by the Board. Subject to this approval, the mock audit is scheduled to start the week of April 25, 2016, and conclude by the end of May 2016, with a final report due to CalOptima in June 2016. As proposed, the mock audit will cover technical assistance for preparation of universe files, file reviews of sample selections, mock interviews of staff and delegates, drafting of an audit report, and any necessary trainings.

Fiscal Impact

Funding for a consultant to conduct the mock audit was not included in the CalOptima FY 2015-16 Operating Budget. However, management proposes to repurpose \$300,000 in unused funds which had been budgeted for the ICD-10 Conversion Program to fund consulting services related to the OneCare Connect mock audit. The ICD-10 Conversion Program was completed with its successful transition on October 1, 2015, but expenses for this project came in below the approved funding limit, thereby making these unspent funds available for reallocation.

Rationale for Recommendation

The reallocation of funds in the FY 2015-16 budget to support mock audit activities is intended to ensure that CalOptima is fully prepared to undergo a CMS program audit by identifying and remediating any issues of non-compliance prior to the selection for an audit by CMS. Audit readiness will mitigate issues of non-compliance, which may lead to regulatory enforcement actions including, but may not be limited to, requests for corrective action plans, sanctions, penalties, and/or termination of CalOptima's contract with CMS.

Concurrence

Gary Crockett, Chief Counsel

Attachments

None

/s/ Michael Schrader
Authorized Signature

04/01/2016
Date

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 7, 2016

Regular Meeting of the CalOptima Board of Directors

Consent Calendar

9. Ratify Amendment A-06 to the Secondary Agreement with the California Department of Health Care Services (DHCS)

Contact

Chet Uma, Chief Financial Officer, (714) 246-8400

Recommended Action

Ratify Amendment A-06 to the Secondary Agreement between DHCS and CalOptima.

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 new five (5) year Primary and Secondary agreements with DHCS. Amendments to these agreements are summarized in the attached appendix, including Amendment A-06 to the Secondary Agreement, which extends term of the agreement through December 31, 2016. The agreement also contains revised capitation rates that CalOptima receives from DHCS to provide health care services.

At the May 7, 2015 meeting of the CalOptima Board of Directors, the Chairman was authorized and directed to sign an extension of the term of the Secondary Agreement to December 31, 2016.

Discussion

In February 2016, CalOptima received the anticipated Amendment A-06 to the Secondary Agreement. The amendment included the extension of the term of the agreement through December 31, 2016, but also included revised capitation rates, which was not expected. As previously noted, the CalOptima Board of Directors had previously authorized and directed the Chairman to execute an amendment that would extend the term of the Secondary Agreement. The CalOptima Board of Directors had not, however, considered any adjustment to the capitation rates contained within the Secondary Agreement.

The amendment incorporated capitation rates are for the period commencing July 1, 2015, and only pertain to services covered under the scope of the Secondary Agreement. The capitation rates for this period were raised for the “Family” aid group and the “Adult” aid group, and were lowered for the “Adult Expansion” aid group. The net impact of these capitation rate revisions amounts to a rate increase.

DHCS officially requested that Amendment A-06 be signed and returned “as soon as possible,” so CalOptima staff procured the Chairman’s signature and returned the signed Amendment A-06 to DHCS in accordance with the request. At this time, CalOptima staff requests the CalOptima Board of Directors’ ratification of Amendment A-06 to the Secondary Agreement.

Fiscal Impact

The Secondary rates listed in Amendment A-06 result in an approximate 14.8% increase from those executed in Amendment A-05. The changes made in Amendment A-06 are expected to have a small, but positive fiscal impact on CalOptima's Medi-Cal line of business.

Rationale for Recommendation

The execution of Amendment A-06 to the Secondary Agreement was necessary to ensure CalOptima's continued responsiveness to and compliance with DHCS' requirements and expectations.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Appendix summary of amendments to Secondary Agreement with DHCS

/s/ Michael Schrader
Authorized Signature

04/01/2016
Date

APPENDIX TO AGENDA ITEM 9

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

Amendments to Secondary Agreement	Board Approval
A-01 implemented rate amendments to conform to rate amendments contained in the Primary Agreement with DHCS (08-85214).	July 8, 2010
A-02 implemented rate adjustments to reflect a decrease in the statewide average cost for Sensitive Services for the rate period July 1, 2010 through June 30, 2011.	August 4, 2011
A-03 extended the term of the Secondary Agreement to December 31, 2014.	June 6, 2013
A-04 incorporates rates for the periods July 1, 2011 through June 30, 2012, and July 1, 2012 through June 30, 2013 as well as extends the current term of the Secondary Agreement to December 31, 2015	January 5, 2012 (FY 11-12 and FY 12-13 rates) May 1, 2014 (term extension)
A-05 incorporates rates for the periods July 1, 2013 through June 30, 2014, and July 1, 2014 through June 30, 2015. For the period July 1, 2014 through June 30, 2015, Amendment A-05 also adds funding for the Medi-Cal expansion population for services provided through the Secondary Agreement.	December 4, 2014
A-06 incorporates rates for the period July 1, 2015 onward. A-06 also extends the term of the Secondary Agreement to December 31, 2016.	May 7, 2015 (term extension) Ratification of rates requested April 7, 2016

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 7, 2016 **Regular Meeting of the CalOptima Board of Directors**

Report Item

10. Consider Selection of Taxi Vendor and Authorize Contract for Taxi Services Effective July 1, 2016

Contact

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

Recommended Action

Authorize the Chief Executive Officer, with the assistance of legal counsel, to enter into an agreement with American Logistics to serve as CalOptima's Taxi Vendor for OneCare Connect, OneCare, and Medi-Cal EPSDT members effective July 1, 2016, for a two (2) year term with three (3) additional one-year extension options, each exercisable at CalOptima's sole discretion.

Background

The current taxi services contract for CalOptima's Medicare programs has been in place since January 1, 2008. It was awarded to American Logistics through a competitive procurement process. The agreement expires on June 30, 2016.

On September 3, 2015, the CalOptima Board of Directors authorized CalOptima staff to issue a Request for Proposal (RFP) for Taxi services for the contract period commencing July 1, 2016.

Following CalOptima's standard RFP process, an RFP was issued and a total of three responses were received.

Discussion

The responses to the RFP were reviewed by CalOptima's evaluation team consisting of the Senior Program Manager for Medicare, Customer Service Director, Customer Service Manager, Executive Director Medical Operations, Contracts Manager, and representatives from the following departments: Finance, Compliance, and Information Services. All vendors were provided a Scope of Work document and the CalOptima base contract at the time of the RFP.

The evaluation team's final weighted scoring for the RFP is as follows:

Vendor	Score
American Logistics	3.96
Access2Care	3.66
Veyo	3.19

Based upon the weighted scores each vendor received, American Logistics finished with the highest score at 3.96 out of a possible 5.0 of the evaluation. Access2Care finished second with a score of 3.66.

American Logistics was the only bidder who proved to have an established transportation network in the Orange County service area.

Fiscal Impact

Under the terms of the proposed contract, consolidated taxi expenses are projected to decrease 4.9% in the next fiscal year. Management will include expenses associated with the proposed contract in the CalOptima FY 2016-17 operating budgets.

Rationale for Recommendation

CalOptima staff believes that contracting with the highest scoring taxi vendor, American Logistics, will meet the goal of continuing to ensure that CalOptima members receive safe, reliable transportation services in a cost-effective manner. CalOptima staff reviewed qualified taxi vendor responses and identified the candidate believed to best meet CalOptima's needs for safe, reliable, regulatory compliance, technological advances, administrative simplification, as well as overall cost savings. Accordingly, staff recommends that the Board authorize the CEO to contract with the existing taxi vendor as a result of completion of the RFP process authorized by the Board in September, 2015.

Concurrence

Gary Crockett, Chief Counsel

Attachments

None

/s/ Michael Schrader
Authorized Signature

04/01/2016
Date

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 7, 2016 **Regular Meeting of the CalOptima Board of Directors**

Report Item

11. Consider Selection of Vision Vendor and Authorize Contract for Vision Services Effective July 1, 2016

Contact

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

Recommended Action

Authorize the Chief Executive Officer, with the assistance of legal counsel, to enter into an agreement with VSP to serve as CalOptima's Vision Vendor for Medi-Cal, OneCare Connect, OneCare and PACE members effective July 1, 2016 through June 30, 2019, with two additional one-year extension options, each exercisable at CalOptima's sole discretion.

Background

The current vision services contract for CalOptima's Medi-Cal and Medicare programs has been in place since January 1, 2007. It was awarded to VSP through a competitive procurement process. The agreement expires on June 30, 2016.

On September 3, 2015, the CalOptima Board of Directors authorized CalOptima staff to issue a Request for Proposal (RFP) for vision services for the contract period commencing July 1, 2016.

Following CalOptima's standard RFP process, an RFP was issued and one response was received.

Discussion

The response to the RFP was reviewed by CalOptima's evaluation team consisting of the Senior Program Manager for Medicare, Customer Service Director, Customer Service Manager, Executive Director Medical Operations, Contracting Manager, and representatives from the following departments: Finance, Compliance, and Information Services. All potential RFP responders were provided a Scope of Work document and the CalOptima base contract at the time of the RFP.

Since only one response was received, the evaluation team reviewed VSP's proposal and recommends awarding the contract to VSP.

Fiscal Impact

Under the terms of the proposed agreement, CalOptima's consolidated vision expenses are projected to decrease by 5.0% in Fiscal Year (FY) 2016-17. Management will include expenses associated with the vision services contract in the CalOptima FY 2016-17 Operating Budget.

Rationale for Recommendation

CalOptima staff believes that contracting with the recommended vision services vendor, VSP, will meet the goal of continuing to ensure that CalOptima members receive quality vision services in a cost-effective manner. CalOptima staff reviewed the vendor's response to the RFP and believes it can meet CalOptima's need for a qualified, reliable, cost effective vision vendor. Accordingly, staff recommends

that the Board authorize the CEO to contract with the existing vision vendor as a result of completion of the RFP process authorized by the Board in September, 2015.

Concurrence

Gary Crockett, Chief Counsel

Attachments

None

/s/ Michael Schrader
Authorized Signature

04/01/2016
Date

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 7, 2016

Regular Meeting of the CalOptima Board of Directors

Report Item

12. Consider Recommended Expenditure Categories for Intergovernmental Transfer (IGT) 5 and Recommended Expenditure Plan for IGT 4

Contact

Cheryl Meronk, Director, Strategic Development, (714) 246-8400

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

Richard Helmer, MD, Chief Medical Officer, (714) 246-8400

Recommended Actions

1. Approve recommended expenditure categories for IGT 5; and
2. ~~Approve recommended expenditure plan for IGT 4, including investments in Personal Care Coordinators (PCCs) and provider incentives to support Adult Mental Health and Children's Mental Health services and support for IGT program administration, authorizing \$6,111,087 in IGT 4 funds to support these projects.~~

Background/Discussion

To date, CalOptima has partnered with the University of California, Irvine (UCI) Medical Center on a total of four Intergovernmental Transfer (IGT) transactions covering funding years 2010-11 (IGT 1), 2011-12 (IGT 2), 2012-13 (IGT 3), and 2013-14 (IGT 4). These IGTs have generated funds for enhanced benefits for existing CalOptima Medi-Cal members. A fifth IGT with four additional new funding partners is pending and is projected to generate an additional \$15 million in funds. As with the prior IGTs, the funds are available to provide enhanced benefits to existing Medi-Cal beneficiaries, with the funding contingent in part on state approval of the proposed IGT 5 funding categories. As part of this recommended action, staff is requesting Board approval of the recommended expenditure categories for IGT 5, as well as the expenditure plan for IGT 4.

IGT 5 Proposed Funding Categories

Staff recommends the following funding categories for the benefit of CalOptima Medi-Cal members, consistent with funding categories approved by the Board on March 5, 2015 to guide CalOptima's community health investments:

- Adult Mental Health
- Childhood Obesity
- Children's Mental Health
- Improving Children's Health
- Strengthening the Safety Net
- Pilot Program Planning and Implementation

Staff will return to the Board at a later date with recommendations for an IGT 5 expenditure plan after the IGT 5 transaction has been approved by DHCS and CMS and the funding amount has been confirmed.

IGT 4 Expenditure Plan

Staff recommends the use of \$6,111,087 in IGT 4 funds to support the following funding categories for the benefit of CalOptima Medi-Cal beneficiaries. Staff will return to the Board for approval of the specific details on these initiatives, projects and incentives:

Category	Funding Amount
Adult Mental Health	\$3.1M
Children's Mental Health	\$1.0M
Improving Children's Health	\$1.85M
IGT Project Administration	\$161K
Total IGT 4 Funds	<u>\$6.11M</u>

Specific projects within these categories are broken down as follows:

Adult Mental Health

- \$1,100,000 to support enhanced care coordination and management for mentally ill members. This proposed action will expand the Personal Care Coordinator program to include homeless members in the Medi-Cal program for the period July 1, 2016 to June 30, 2017.
- \$2,000,000 to support performance improvement incentives for health networks to address issues surrounding adult mental health. The program will offer incentives for provider groups who achieve high performance in measures for mental health care coordination and depression screening.

Children's Mental Health

- \$1,000,000 to support performance improvement incentives for health networks to address issues surrounding children's mental health. The program will offer incentives for primary care providers who achieve high performance in measures for autism screenings and depression screenings for adolescents above current required levels.

Improving Children's Health

- \$1,850,000 to support enhanced care coordination and management focused on children with high acuity needs. This proposed action will expand the Personal Care Coordinator program to include CalOptima members served by California Children's Services and the Regional Center of Orange County in the Medi-Cal program for the period July 1, 2016 to June 30, 2017.

IGT Project Administration

- \$161,087 to support a full-time staff person and related costs to provide IGT project administration and oversight through FY 2017-18.

Additional IGT 4 Funds Received: \$855,120

On March 31, 2016, it was determined that CalOptima received additional funds from DHCS related to the IGT 4 transaction with UCI Medical Center. As a result of a recalculation of the FY 2013-14 rate to include the Medi-Cal Expansion population, CalOptima's share of the total IGT 4 funds has increased by approximately \$855,000. Staff will return to the Board at a later date with recommendations for an expenditure plan for the additional funds.

Fiscal Impact

The recommended action to approve the expenditure plan of \$6,111,087 for the IGT 4 is budget neutral. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima Medi-Cal members, and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

Staff recommends approval of the proposed funding categories for IGT 5 and proposed expenditure plan for IGT 4 in order to continue critical funding support of projects that benefit CalOptima Medi-Cal members by addressing unmet needs. Approval will help ensure the success of ongoing and future IGT projects.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. PowerPoint Presentation: IGT 5 Update and IGT 4 Expenditure Recommendations
2. March 5, 2015 CalOptima Board Action Agenda Referral, Report Item VII.C. Approve the Community Health Needs Assessment as the Framework to Guide CalOptima's Community Health Investments for the Benefit of CalOptima Members

/s/ Michael Schrader
Authorized Signature

04/01/2016
Date



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IGT 5 Update and IGT 4 Expenditure Recommendations

**Board of Directors Meeting
April 7, 2016**

**Cheryl Meronk
Director, Strategic Development**

IGT 5 Next Steps

Obtain Board approval to proceed with funding entities – March 3



DHCS sends application notice and headroom amount – March 8



Submit proposal to DHCS – due 21 days from DHCS Notice – March 29



Obtain Board authorization for agreements with all funding entities – April 7



Internal decision on proposed uses of funds – April 7



Notification of rate amendment and administration of funds

IGT 5 – Funding Recommendations

Continue IGT 4 funding categories:

Adult Mental Health

Children's Mental Health

Childhood Obesity

Strengthening the Safety Net

Improving Children's Health

Pilot Programming Planning & Implementation



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Recommended IGT 4 Expenditure Categories

IGT Investment Framework

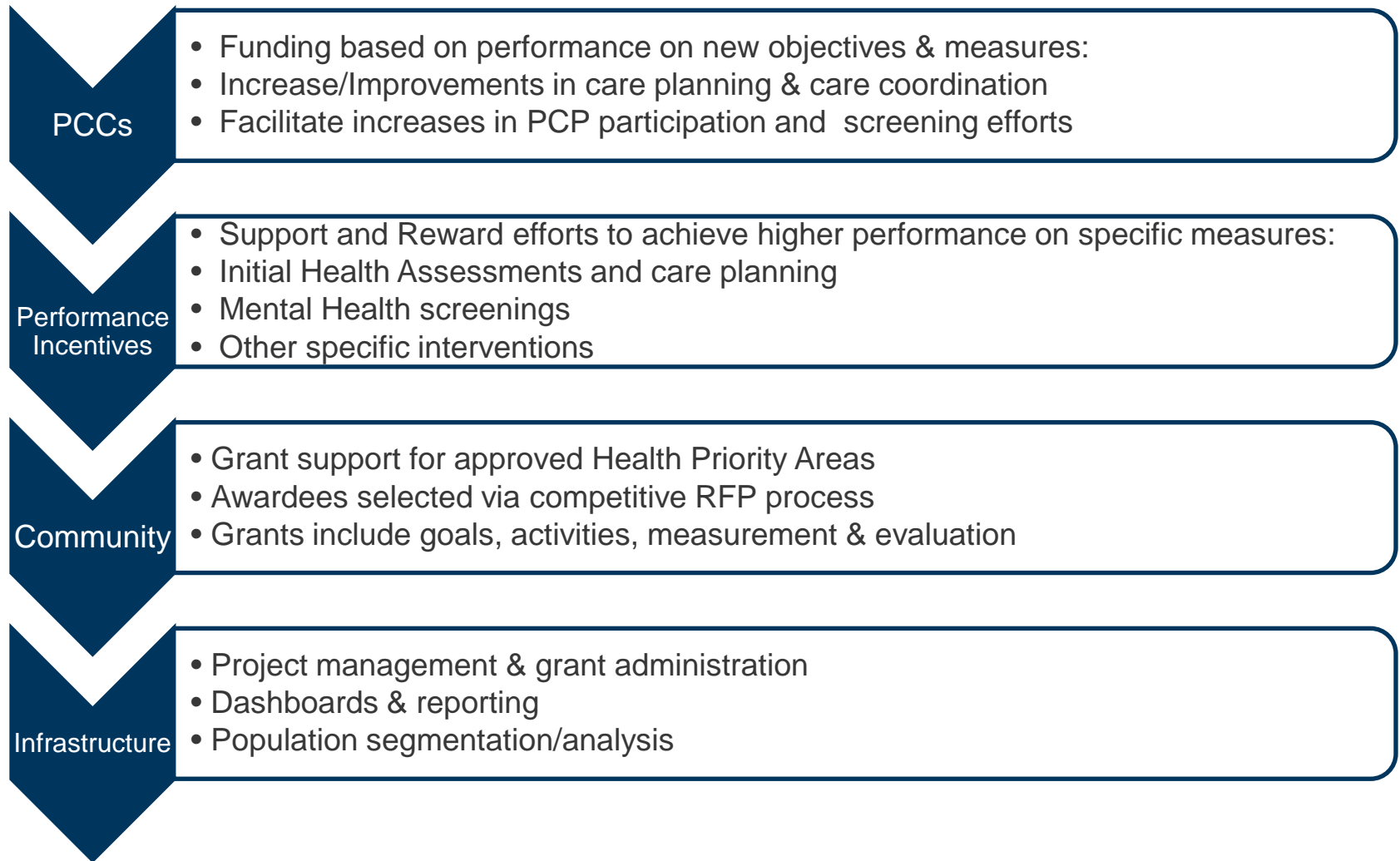
- Our Goals

- Support coordinated care across board-approved priority funding areas
- Collaborative approach to dealing with difficult health issues
- Simplify administration

- Framework Funding Mechanisms

- Support Personal Care Coordinators
- Performance Improvement Incentives
- Community Investment
- Strengthen Infrastructure

Framework Funding Mechanisms



IGT 4 Investments

Funding Category	Funding Mechanism	Impact
Adult Mental Health	PCC Support Performance Incentives	-Improved care coordination -Increased quality scores
Children's Mental Health	PCC Support Performance Incentives	PCC Support -Increased quality scores
Improving Children's Health	PCC Support	-PCC Support
n/a	Infrastructure – IGT Project Administration	-Improved IGT administration and reporting

IGT 4 – Adult Mental Health

Funding Mechanism	Activities	IGT 4 Amount
Personal Care Coordinators	<ul style="list-style-type: none">• Expand PCC program to serve Homeless members	\$1.1 M
Performance Incentives	<ul style="list-style-type: none">• Health Networks adjustment for PCP & PCC performance<ul style="list-style-type: none">• Completion of Initial Health Assessment and Integrated Care Plan• Inclusion of PCPs & BH provider in Interdisciplinary Care Team• Depression Screening• Screening, Brief Intervention and Referral to Treatment for alcohol/substance abuse	\$2M

IGT 4 – Children’s Mental Health

Funding Mechanism	Activities	IGT 4 Amount
Performance Incentives	<ul style="list-style-type: none">• Health Networks adjustment for PCP & PCC performance<ul style="list-style-type: none">• Completion of Initial Health Assessment and Integrated Care Plan• Inclusion of PCPs & BH provider in Interdisciplinary Care Team• Depression Screening	\$1M

IGT 4 – Improving Children’s Health

Funding Mechanism	Activities	IGT 4 Amount
Personal Care Coordinators	<ul style="list-style-type: none">Expand PCC program to members served by CCS and RCOC	\$1.85 M

IGT 4 – IGT Project Administration

Funding Mechanism	Activities	IGT 4 Amount
n/a	<ul style="list-style-type: none">• Support staffing and related costs for administration and management of IGT-funded projects and grants	\$161 K

IGT 4 – Newly Received Funds

Funding Mechanism	Activities	IGT 4 Amount
TBD	<ul style="list-style-type: none">• TBD<ul style="list-style-type: none">• Received notice of Additional IGT 4 Funds on 3/31/16• Additional funds based on DHCS recalculation	\$855 K

IGT 4 Recommended Expenditure Plan

Categories	Funding Amount
Adult Mental Health	\$3.1M
Children's Mental Health	\$1M
Improving Children's Health	\$1.85M
IGT Project Administration	\$161K
Total IGT 4 Funds	<u>\$6.11M</u>

Note: Recommendation for expenditure plan for \$855,120 in newly received IGT 4 funds will be made at a later date.

IGT 5 Investments

Funding Category	Funding Mechanism	Impact
Adult Mental Health	PCC Support Performance Incentives Infrastructure	-Improve care coordination -Increase quality scores -Improve reporting/analysis
Children's Mental Health	PCC Support Performance Incentives Infrastructure	-Improve care coordination -Increase quality scores
Childhood Obesity	Community Investment	-Increase collaborative efforts and broaden access to interventions
Strengthen Safety Net	Community Investment	-Increase access
Improving Children's Health	Performance Incentives Community Investment Infrastructure	-Increase quality scores -Increase access
Pilot Program Planning	Infrastructure	-Preparation for pilot program reporting and analysis

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 5, 2015 **Regular Meeting of the CalOptima Board of Directors**

Report Item

VII C. Approve the Community Health Needs Assessment as the Framework to Guide CalOptima's Community Health Investments for the Benefit of CalOptima Members

Contact

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

Recommended Actions

1. Receive the Community Health Needs Assessment for 2015; and
2. Approve the following five priority areas to guide CalOptima's community health investments for the benefit of CalOptima members:
 1. Adult Mental Health
 2. Children's Mental Health
 3. Childhood Obesity and Diabetes
 4. Strengthening the Safety Net
 5. Improving Children's Health

Background and Discussion

CalOptima has traditionally enjoyed a strong presence in the Orange County community, actively participating in a wide-range of activities that include health access events, collaborative community programs, and forums. During CalOptima's 2013 Strategic Planning, the Board of Directors recognized that CalOptima is also well-positioned to provide resources to address gaps in care in the community which impact the health of our members. Thus, the Board-approved 2013-16 Strategic Plan outlines an enhanced role for CalOptima to invest in the community.

To help identify areas of unmet need for CalOptima members in the community, staff convened an advisory workgroup, comprised of volunteers from CalOptima's Member Advisory Committee (MAC) and Provider Advisory Committee (PAC), and conducted a Community Health Needs Assessment (CHNA).

The Workgroup reviewed a wide-range of data regarding the health status of CalOptima members, including needs assessments conducted by local non-profit hospitals and community-based organizations. Staff also engaged CalOptima's Quality Assurance Committee (QAC) for recommendations.

Based on their review, the following five health needs were ultimately identified: adult mental health, children's mental health, childhood obesity and diabetes, strengthening the safety net and improving children's health. These unmet community health needs represent the input and recommendations of CalOptima's internal and external stakeholders as to the areas of greatest concern to CalOptima members in the community.

As noted in the attachment, these priority needs will guide the community health investments funded by Intergovernmental Transfer (IGT) revenue or the CalOptima Foundation.

Fiscal Impact

There will be no immediate financial impacts related to this action. Any future funding of unmet community health needs will be provided from IGT or Foundation funding allocations based on future action by the CalOptima Board of Directors and the CalOptima Foundation Board of Directors, respectively.

Rationale for Recommendation

Staff recommends approval of the five proposed priority health needs as it will guide the allocation of IGT and Foundation resources to address service gaps experienced by CalOptima members in the community, consistent with the Board-approved 2013-16 Strategic Plan.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Presentation: Community Health Needs Assessment, Identifying Unmet Community Needs

/s/ Michael Schrader
Authorized Signature

2/27/2015
Date



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Community Health Needs Assessment (CHNA)

Identifying Unmet Community Needs

Board of Directors Meeting
March 5, 2015

Michael Ruane
Chief, Strategy & Public Affairs

[Back to Agenda](#)

Community Health Needs Assessment (CHNA)

- CHNA conducted to identify unmet health needs that may guide IGT investments and support the Foundation's work as it expands its presence in the community
 - CHNA Workgroup comprised of MAC/PAC volunteers as well as CalOptima subject matter experts
 - Included CalOptima staff from the following departments:
 - Medical Data Management
 - Health Education
 - Community Relations

CHNA Process

- Workgroup reviewed wide range of data on the health status of CalOptima members and larger community
 - Orange County 2014 Community Indicators Report and other countywide reports
 - CHNA reports from 11 non-profit hospitals in Orange County, including:
 - Children's Hospital of Orange County (CHOC)
 - St. Joseph Hospital
 - Kaiser
 - UC Irvine Medical Center
 - CalOptima HEDIS data

CHNA Process, Cont.

- Facilitated discussion generated a preliminary list
- Final selection was based on the following criteria:
 - Limited to items directly linked to CalOptima's mission
 - CalOptima's ability to affect change for this health need
 - The magnitude and severity of the problem
 - Extent to which the health need contributes to health disparities in the community
 - The risk of the problem becoming exacerbated if not addressed
 - The resources needed to effectively address the problem
 - The need to address the health need given the current climate (i.e. sense of urgency)

Health Needs Prioritized by CHNA

- Workgroup ultimately identified the following (3) health needs as those of greatest impact to CalOptima members
 - 1) Adult Mental Health
 - Rationale:
 - O.C. is currently facing a shortage of psychiatric beds, which causes patients to linger in the E.R. before receiving treatment
 - Medi-Cal members may encounter barriers to care stemming from lack of mental health providers
 - 2) Children's Mental Health
 - Rationale:
 - Children have access to even fewer beds than the adult population
 - Addressing mental health concerns in adolescents is an important preventative measures against mental illness later
 - 3) Childhood Obesity and Diabetes
 - Rationale:
 - O.C. is experiencing high obesity rates in children and obesity can lead to onset of diabetes

Overarching Priorities

- In addition to the specific needs identified by the CHNA process, the Quality Assurance Committee has identified two overarching priorities:
 - 1) Strengthening the health care safety net
 - IGT funding is allocated to increasing the amount of FQHC's in Orange County and increasing the capacity of health centers to initiate the FQHC process
 - 2) Improving children's health
 - In addition to childhood obesity prevention, the restructuring of CalOptima's Disease Management Program will address children's health outcomes
 - Additional opportunities exist to improve children's health outcomes through collaborative community partnerships

Proposed Priority Areas

- As result of the CHNA process, the following five identified health needs are proposed as priorities for IGT community funding and the Foundation's work plan
 - Adult Mental Health
 - Children's Mental Health
 - Childhood Obesity and Diabetes
 - Strengthening the Health Care Safety Net
 - Improving Children's Health
- Funding Considerations
 - IGT funds are restricted to: 1) services that are not currently covered benefits and 2) Medi-Cal members
 - In addition, the Foundation will not receive future funding or loans from the CalOptima health plan

Addressing Priority Areas-Potential Roles

	<u>Priority Area</u> Children's Mental Health	<u>Priority Area</u> Adult Mental Health	<u>Priority Area</u> Childhood Obesity	<u>Priority Area</u> Safety Net Clinics	<u>Priority Area</u> Children's Health
Potential CalOptima Programs	<ul style="list-style-type: none"> •System of Care for Children •Additional Beds •Developmental Screening 	<ul style="list-style-type: none"> •Recuperative Care •Innovative programs to improve community capacity (e.g. PES) 	<ul style="list-style-type: none"> •Childhood Obesity Prevention and Treatment Program 	<ul style="list-style-type: none"> •FQHC Grants •Capacity Building 	<ul style="list-style-type: none"> •New Model of Care for Children
Potential CalOptima Role	<ul style="list-style-type: none"> •Collaborative Partner 	<ul style="list-style-type: none"> •Collaborative Partner 	<ul style="list-style-type: none"> •Funder •Collaborative Partner 	<ul style="list-style-type: none"> •Funder 	<ul style="list-style-type: none"> •Funder •Convener
Potential Funding Source	<ul style="list-style-type: none"> •Funding TBD •IGT (Potential Start-up Funding) 	<ul style="list-style-type: none"> •Funding TBD •IGT (Potential Start-up Funding) 	<ul style="list-style-type: none"> •CalOptima for health plan components •IGT for community initiatives & matching funds 	<ul style="list-style-type: none"> •IGT •Foundation (Receive Matching Funds) 	<ul style="list-style-type: none"> •CalOptima •IGT (PCC Start-up) •Foundation (Receive Matching Funds)

Next Steps

1. Develop a strategic framework detailing the plans to address each priority area
2. Present progress report on current IGT funding allocations at April Board meeting
3. Continue to develop collaborative partnerships with funders and community stakeholders for each priority area

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 7, 2016

Regular Meeting of the CalOptima Board of Directors

Report Item

13. Adopt Resolution Approving CalOptima's Updated Human Resources Policies and Employee Handbook

Contact

Ron Santos, Executive Director, Human Resources, (714) 246-8400

Recommended Action

Adopt Resolution No. 16-0407, approving CalOptima's updated Human Resources Policies and Employee Handbook.

Background/Discussion

On November 1, 1994, the Board of Directors delegated authority to the Chief Executive Officer to promulgate employee policies and procedures, and to amend these policies from time to time, subject to annual presentation of the policies and procedures, with specific emphasis on any changes thereto, to the Board of Directors or a committee appointed by the Board of Directors for that purpose. On December 6, 1994, the Board adopted CalOptima's Bylaws, which requires, pursuant to section 13.1, that the Board of Directors adopt by resolution, and from time to time amend, procedures, practices and policies for, among other things, hiring employees and managing personnel.

The Human Resources Department conducted a review of existing processes and current policies and procedures, and has updated policies to reflect changes in employment law, procedural changes and process improvements and/or general employment practices to recruit and retain top talent. Updates at this time include revisions to two Human Resources Policies and the CalOptima Employee Handbook (see pages 9, 32, and 36).

The following table lists the existing Human Resources policies that have been updated and are presented for review and approval:

	Policy No./Name	Summary of Changes	Reason for Change
1.	GA. 8056: Paid Holidays	<ul style="list-style-type: none">Specifies that employees are only eligible to receive a maximum of eight (8) hours, prorated based on scheduled work hours, for a flex holidaySets forth the ability to carry unused flex holiday hours into subsequent years, but limits the amount of flex holiday hours in an employee's flex holiday	<ul style="list-style-type: none">- To align the treatment of flex holiday hours with state law, which prohibits forfeiture of vested vacation hours.-To change the restriction from not allowing unused flex hours to be carried over to the next calendar year to instead allow the ability to accrue unused

	Policy No./Name	Summary of Changes	Reason for Change
		<p>account to a maximum of twelve (12) hours, prorated based on the employee's scheduled work hours.</p> <ul style="list-style-type: none"> Specifies that flex holiday hours are not eligible for annual cash outs applicable to PTO hours; however, upon separation, an employee is entitled to be paid out for unused flex holiday hours 	<p>hours subject to a maximum limit of twelve (12) accrued hours.</p>
2.	GA.8057: Compensation Program	<ul style="list-style-type: none"> Changes the eligibility requirement for merit increases for newly hired employees in the Compensation Guidelines from six (6) months service prior to the annual pay adjustment date to now require that the employee have started work on or before March 31st to be eligible for merit increase in July of the same year. The merit pay adjustment is proposed to be changed from a percentage of base pay (using an employee's base pay in effect at the time the adjustment is made) to a prorated adjustment based on the number of actual months of service divided by the twelve (12) months of the full merit review cycle and in proportion to the salary earned during those months. Changes are illustrated in Attachment 3: 12-Month Evaluation Cycle Chart. 	<p>-In the current process, newly hired employees are not eligible to receive a merit increase for as much as eighteen (18) months, depending on their start date. This has the effect of unfairly withholding reward for what otherwise would be performance worthy of a merit increase.</p> <p>-To establish a clear cut-off date for eligibility.</p> <p>-To create a formula for proportional merit increase based on months of service and salary earned to ensure equity in base pay increases, promote employee engagement, and facilitate retention.</p>

Fiscal Impact

The recommended action to revise CalOptima Policies GA.8056: Paid Holidays regarding unused flex hours and GA.8057: Compensation Program regarding implementation of a new proration methodology for merit increases for newly hired employees is budget neutral.

Rationale for Recommendation

Approval is recommended of the updated Human Resources Policy to ensure that CalOptima meets its ongoing obligation to provide structure and clarity on employment matters, consistent with applicable federal, state, and local laws and regulations. The recommended changes address the need to maintain CalOptima's competitiveness in a challenging labor market by incentivizing good performance and supporting a positive work-life balance environment for employees.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Resolution No. 16-0407, A Resolution Approving CalOptima's Updated Human Resources Policies and Employee Handbook
2. Revised CalOptima's Policy:
 - a. GA.8056: Paid Holidays – (redlined and clean copies)
 - b. GA.8057: Compensation Program – (redlined and clean copies) with revised Attachment
3. 12-Month Evaluation Cycle Chart
4. Updated Employee Handbook

/s/ Michael Schrader
Authorized Signature

04/01/2016
Date

RESOLUTION NO. 16-0407

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

APPROVE UPDATED HUMAN RESOURCES POLICIES AND EMPLOYEE HANDBOOK

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, among other things, 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.

NOW, THEREFORE, BE IT RESOLVED:

Section 1. That the Board of Directors hereby approves and adopts the attached updated Human Resources Policies and Employee Handbook.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a., CalOptima this 7th day of April, 2016.

AYES:

NOES:

ABSENT:

ABSTAIN:

/s/_____

Title: Chair, Board of Directors

Printed Name and Title: Mark A. Refowitz, Chair, CalOptima Board of Directors

Attest:

/s/_____

Suzanne Turf, Clerk of the Board

Policy #: GA.8056
Title: **Paid Holidays**
Department: Human Resources
Section: Not Applicable

CEO Approval: Michael Schrader

Effective Date: 04/01/14

Last Review Date: 04/07/16

Last Revised Date: 04/07/16

I. PURPOSE

To establish the paid holiday schedule for CalOptima employees.

II. DEFINITIONS

Not ~~A~~pplicable-

III. POLICY

1. The following holidays shall be observed by CalOptima:

A. New Year's Day

B. Martin Luther King Jr. Day

C. Presidents' Day

D. Memorial Day

E. Independence Day

F. Labor Day

G. Veteran's Day

H. Thanksgiving Day and the Friday after Thanksgiving

I. Christmas Day

J. One Flex Holiday (credited on January 1)

2. A holiday that falls on a Saturday or Sunday can be observed on the preceding Friday or the following Monday. Holiday observances will be noted on the annual payroll schedule. Employees will be provided notice of any changes to the published schedule.

3. Regular full-time, regular part-time and limited-term employees who are regularly scheduled to work twenty (20) or more hours per week are eligible to receive a maximum of one (1) Flex Holiday (maximum of eight (8) hours, prorated based on scheduled work hours) each calendar year on January 1st. Limits are imposed on the number of Flex Holiday hours that can be maintained in an employee's Flex Holiday account. A maximum of twelve (12) hours, prorated based on

scheduled work hours, may be maintained in an employee's Flex Holiday account as of January 1st of each year. In the event that available Flex Holiday hours are not used by the last pay period of the calendar year, employees may carry unused Flex Holiday hours into subsequent years and may accrue additional hours up to the maximum of eight (8) hours, prorated based on scheduled work hours. If an employee reached the maximum amount of twelve (12) hours on January 1st, prorated based on scheduled work hours, the employee will stop accruing Flex Holiday hours. Flex Holiday hours are not eligible for annual cash out applicable to PTO hours. The Chief Executive Officer may assign a specific date for the Flex Holiday for business reasons and/or needs. -Assignment of the Flex Holiday will be announced in advance. -Otherwise, employees may take the Flex Holiday on any day elected by the employee, subject to approval by the employee's manager. If an employee separates from CalOptima and has unused Flex Holiday hours, the unused Flex Holiday hours will be paid out at the same time and in the same manner as unused PTO hours upon termination.

4. Regular full-time, regular part-time, and Limited Term employees shall be paid his or her regular rate of pay for the holidays specified in this Policy.

5. CalOptima may, in its discretion, amend the list of paid holidays and/or require an employee to work on one or more of the observed holidays.

~~5.~~

IV. PROCEDURE

1. CalOptima will note holiday observances annually on its payroll schedule. In the event of a change to the published schedule, CalOptima will provide prompt notice to all employees.
2. When a holiday falls on a regular nine (9) hour work day for a full-time non-exempt employee on a 9/80 schedule pursuant to CalOptima Policy GA.-8020: 9/80 Work Schedule, the employee has the option of using one (1) hour of accrued Paid Time Off (PTO) or making up the time if approved by his or her supervisor. For employees on the 9/80 Work Schedule, should a holiday fall on an employee's scheduled day off, the employee will be permitted to take another day off in the same workweek.
3. If a non-exempt employee is required to work a scheduled holiday, he or she will receive his or her regular rate of pay for the holiday, in addition to his or her regular compensation for the hours of actual work performed.

V. ATTACHMENTS

Not Applicable-

VI. REFERENCES

Not Applicable-

VII. REGULATORY APPROVALS OR

None to Date

~~VII.~~ VIII. BOARD ACTION

Policy #: GA.8056
Title: Paid Holidays

~~Effective~~ 4/1/144/7/16
Revised Date:

A. 04/07/16: Regular Meeting of the CalOptima Board of Directors

~~A.B. 05/01/14: Regular Meeting of the CalOptima Board of Directors Meeting~~

~~VIII.~~IX. **REVIEW/REVISION HISTORY**

~~Not Applicable:~~

<u>Version</u>	<u>Version Date</u>	<u>Policy Number</u>	<u>Policy Title</u>
<u>Original Date</u>	<u>04/01/2014</u>	<u>GA.8056</u>	<u>Paid Holidays</u>
<u>Revision Date 1</u>	<u>04/07/2016</u>	<u>GA.8056</u>	<u>Paid Holidays</u>

~~IX.~~ **KEYWORDS**

Policy #: GA.8056
Title: **Paid Holidays**
Department: Human Resources
Section: Not Applicable

CEO Approval: Michael Schrader _____

Effective Date: 04/01/14

Last Review Date: 04/07/16

Last Revised Date: 04/07/16

I. PURPOSE

To establish the paid holiday schedule for CalOptima employees.

II. DEFINITIONS

Not Applicable

III. POLICY

1. The following holidays shall be observed by CalOptima:

A. New Year's Day

B. Martin Luther King Jr. Day

C. Presidents' Day

D. Memorial Day

E. Independence Day

F. Labor Day

G. Veteran's Day

H. Thanksgiving Day and the Friday after Thanksgiving

I. Christmas Day

J. One Flex Holiday (credited on January 1)

2. A holiday that falls on a Saturday or Sunday can be observed on the preceding Friday or the following Monday. Holiday observances will be noted on the annual payroll schedule. Employees will be provided notice of any changes to the published schedule.

3. Regular full-time, regular part-time and limited-term employees who are regularly scheduled to work twenty (20) or more hours per week are eligible to receive a maximum of one (1) Flex Holiday (maximum of eight (8) hours, prorated based on scheduled work hours) each calendar year on January 1st. Limits are imposed on the number of Flex Holiday hours that can be maintained in an employee's Flex Holiday account. A maximum of twelve (12) hours, prorated based on

scheduled work hours, may be maintained in an employee's Flex Holiday account as of January 1st of each year. In the event that available Flex Holiday hours are not used by the last pay period of the calendar year, employees may carry unused Flex Holiday hours into subsequent years and may accrue additional hours up to the maximum of eight (8) hours, prorated based on scheduled work hours. If an employee reached the maximum amount of twelve (12) hours on January 1st, prorated based on scheduled work hours, the employee will stop accruing Flex Holiday hours. Flex Holiday hours are not eligible for annual cash out applicable to PTO hours. The Chief Executive Officer may assign a specific date for the Flex Holiday for business reasons and/or needs. Assignment of the Flex Holiday will be announced in advance. Otherwise, employees may take the Flex Holiday on any day elected by the employee, subject to approval by the employee's manager. If an employee separates from CalOptima and has unused Flex Holiday hours, the unused Flex Holiday hours will be paid out at the same time and in the same manner as unused PTO hours upon termination.

4. Regular full-time, regular part-time, and Limited Term employees shall be paid his or her regular rate of pay for the holidays specified in this Policy.
5. CalOptima may, in its discretion, amend the list of paid holidays and/or require an employee to work on one or more of the observed holidays.

IV. PROCEDURE

1. CalOptima will note holiday observances annually on its payroll schedule. In the event of a change to the published schedule, CalOptima will provide prompt notice to all employees.
2. When a holiday falls on a regular nine (9) hour work day for a full-time non-exempt employee on a 9/80 schedule pursuant to CalOptima Policy GA.8020: 9/80 Work Schedule, the employee has the option of using one (1) hour of accrued Paid Time Off (PTO) or making up the time if approved by his or her supervisor. For employees on the 9/80 Work Schedule, should a holiday fall on an employee's scheduled day off, the employee will be permitted to take another day off in the same workweek.
3. If a non-exempt employee is required to work a scheduled holiday, he or she will receive his or her regular rate of pay for the holiday, in addition to his or her regular compensation for the hours of actual work performed.

V. ATTACHMENTS

Not Applicable

VI. REFERENCES

Not Applicable

VII. REGULATORY APPROVALS

None to Date

VIII. BOARD ACTION

- A. 04/07/16: Regular Meeting of the CalOptima Board of Directors

B. 05/01/14: Regular Meeting of the CalOptima Board of Directors

IX. REVIEW/REVISION HISTORY

Version	Version Date	Policy Number	Policy Title
Original Date	04/01/2014	GA.8056	Paid Holidays
Revision Date 1	04/07/2016	GA.8056	Paid Holidays

Policy #: GA.8057
 Title: **Compensation Program**
 Department: Human Resources
 Section: Not Applicable
 CEO Approval: Michael Schrader _____
 Effective Date: 5/1/14
 Last Review Date: ~~64/47/15~~ **16**
 Last Revised Date: 6/4/15

Board Approved Policy

I. PURPOSE

To establish a compensation program for CalOptima job classifications within clearly defined guidelines that promote consistent, competitive and equitable pay practices.

II. DEFINITIONS

Not Applicable

III. POLICY

A. CalOptima's compensation program is intended to:

1. Provide fair compensation based on organization and individual performance;
2. Attract, retain, and motivate employees;
3. Balance internal equity and market competitiveness to recruit and retain qualified employees; and
4. Be mindful of CalOptima's status as a public agency.

B. The Chief Executive Officer (CEO), in conjunction with the Executive Director of Human Resources, is directed to administer the compensation program consistent with the attached Compensation Administration Guidelines, which is a document that defines the principles upon which CalOptima's compensation practices will be managed, procedural aspects of how compensation administration procedures will be administered, and how the overall compensation administration function will respond to changing market conditions and business demands. Some of these guidelines include, but are not limited to:

1. Establishing pay rates based on the market 50th percentile.
2. Determining appropriate pay rates within the pay range for a position by assessing an employee's or applicant's knowledge, skills, experience, and current pay level, as well as pay rates currently being paid to similarly situated incumbents. Employees may be paid anywhere within the pay range based on proficiency levels. The following criteria shall be considered:

Minimum (Min)	The rate paid to an individual possessing the minimum job qualifications & meeting minimum job performance expectations
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Midpoint (Mid) aka: 50th percentile	The rate paid to individuals that are fully proficient in all aspects of the job's requirements & performance expectations
Maximum (Max)	The maximum rate paid to individuals who possess qualifications significantly above market norms & consistently deliver superior performance

3. All new hires and employees should have a pay rate equal to or greater than the pay range minimum, unless the minimum job requirements are not met, then a training rate equal to ten percent (10%) below the salary grade minimum may be used for six (6) months.
4. Base pay for all employees shall be capped at the pay range maximum, and once an employee reaches the base pay maximum, the employee will not be eligible for future base pay increases. However, in lieu of future base pay increases, these employees may be eligible for merit pay delivered as a lump sum bonus provided that the employee's performance warrants this additional compensation.

C. The Chief Executive Officer (CEO) is authorized and directed to take all steps necessary and proper to implement the CalOptima compensation program and the Compensation Administration Guidelines not inconsistent therewith.

IV. PROCEDURE

Not Applicable

V. ATTACHMENTS

A. Compensation Administration Guidelines

VI. REFERENCES

Not Applicable

VII. REGULATORY APPROVALS

Not Applicable

VIII. BOARD ACTION

A. 4/7/16: Regular Meeting of the CalOptima Board of Directors

A.B. 6/4/15: Regular Meeting of the CalOptima Board of Directors

B.C. 3/5/15: Regular Meeting of the CalOptima Board of Directors

C.D. 12/4/14: Regular Meeting of the CalOptima Board of Directors

D.E. 11/6/14: Regular Meeting of the CalOptima Board of Directors

E.F. 8/7/14: Regular Meeting of the CalOptima Board of Directors

F.G. 5/1/14: Regular Meeting of the CalOptima Board of Directors

IX. REVIEW/REVISION HISTORY

Version	Version Date	Policy Number	Policy Title
Original Date	5/1/14	GA.8057	Compensation Program and Salary Schedule

Policy #: GA.8057
Title: Compensation Program

Revised Date: 6/4/15

Version	Version Date	Policy Number	Policy Title
Revision Date 1	8/7/14	GA.8057	Compensation Program and Salary Schedule
Revision Date 2	11/6/14	GA.8057	Compensation Program and Salary Schedule
Revision Date 3	12/4/14	GA.8057	Compensation Program and Salary Schedule
Revision Date 4	3/5/15	GA.8057	Compensation Program and Salary Schedule
Revision Date 5	6/4/15	GA.8057	Compensation Program
<u>Review Date</u>	<u>4/7/16</u>	<u>GA.8057</u>	<u>Compensation Program</u>

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Policy #: GA.8057
 Title: **Compensation Program**
 Department: Human Resources
 Section: Not Applicable
 CEO Approval: Michael Schrader _____
 Effective Date: 5/1/14
 Last Review Date: 4/7/16
 Last Revised Date: 6/4/15

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- C. The Chief Executive Officer (CEO) is authorized and directed to take all steps necessary and proper to implement the CalOptima compensation program and the Compensation Administration Guidelines not inconsistent therewith.

IV. PROCEDURE

Not Applicable

V. ATTACHMENTS

- A. Compensation Administration Guidelines

VI. REFERENCES

Not Applicable

VII. REGULATORY APPROVALS

Not Applicable

VIII. BOARD ACTION

- A. 4/7/16: Regular Meeting of the CalOptima Board of Directors
B. 6/4/15: Regular Meeting of the CalOptima Board of Directors
C. 3/5/15: Regular Meeting of the CalOptima Board of Directors
D. 12/4/14: Regular Meeting of the CalOptima Board of Directors
E. 11/6/14: Regular Meeting of the CalOptima Board of Directors
F. 8/7/14: Regular Meeting of the CalOptima Board of Directors
G. 5/1/14: Regular Meeting of the CalOptima Board of Directors

IX. REVIEW/REVISION HISTORY

Version	Version Date	Policy Number	Policy Title
Original Date	5/1/14	GA.8057	Compensation Program and Salary Schedule

Policy #: GA.8057
Title: Compensation Program

Revised Date: 6/4/15

Version	Version Date	Policy Number	Policy Title
Revision Date 1	8/7/14	GA.8057	Compensation Program and Salary Schedule
Revision Date 2	11/6/14	GA.8057	Compensation Program and Salary Schedule
Revision Date 3	12/4/14	GA.8057	Compensation Program and Salary Schedule
Revision Date 4	3/5/15	GA.8057	Compensation Program and Salary Schedule
Revision Date 5	6/4/15	GA.8057	Compensation Program
Review Date	4/7/16	GA.8057	Compensation Program

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Compensation Administration Guidelines

Pay administration guidelines

Common pay administration guidelines for CalOptima are detailed in this section. These guidelines:

- Help maintain the integrity of the base pay program by introducing a common set of standards
- Assist managers in ongoing compensation program administration
- CEO compensation will be established by the Board of Directors
- Chief and Executive Director compensation will be established by the CEO within proposed guidelines
- The Board will be informed of all Chief and Executive Director hires and compensation changes

Proposed Pay Administration Guidelines

Pay ranges and pay levels

- Pay range targets
- Range minimums and maximums
- Pay above range maximums
- Pay range thirds
- Pay range halves
- Compa-ratio

Annual pay adjustments/increases

- Market adjustment
- Merit pay
- Step increase

Special one-time pay considerations

- Recruitment incentive

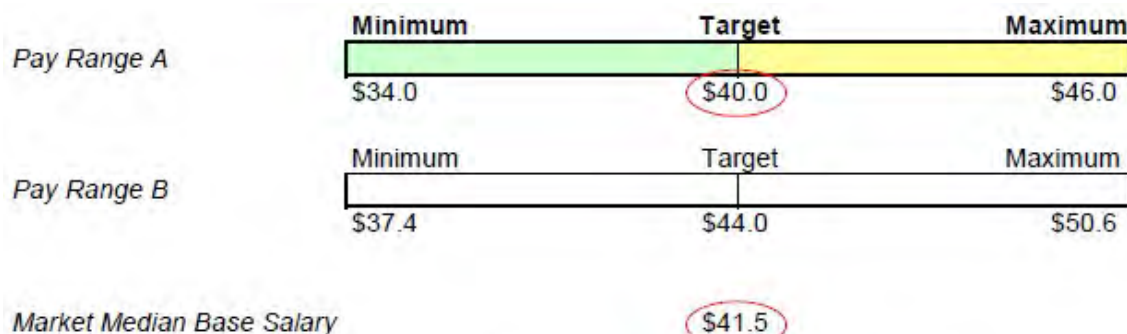
Periodic pay adjustments/increases

- New hire/Rehire
- Promotion
- Lateral transfer
- Demotion
- Temporary assignment
- Secondary job
- Job Re-evaluation
- Appeal Process
- Register/Certified status
- Base pay program maintenance
 - Salary structure adjustment
 - Annual competitive assessment
 - Market sensitive jobs

Pay Ranges and Pay Levels

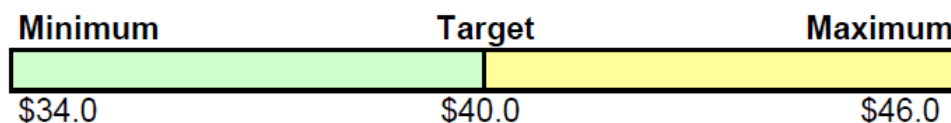
Range Target: internal “going market rate” for the job (50th percentile); represents the rate paid to individuals that are fully proficient in all aspects of the job’s requirements and performance expectations

- For benchmark jobs, the pay range (i.e. pay grade) is determined based on the comparability of values between market median base pay rates and the pay range targets



Range Target \$40.0 is Closest to Market Median of \$41.5; job is assigned to Pay Range A

- For non-benchmark jobs, the pay range is determined based on comparability of the job to benchmark jobs within the same job family or other internal positions in terms of knowledge, skills, complexity and organizational impact



Range Minimum: represents the rate paid to individuals possessing the minimum job qualifications and meeting minimum job performance expectations

- All employees should have a pay rate equal to or greater than the pay range minimum
- If the minimum job requirements are not met, a training rate equal to 10% below the salary grade minimum may be used for six months while a new incumbent is learning the skills to become proficient in the new role

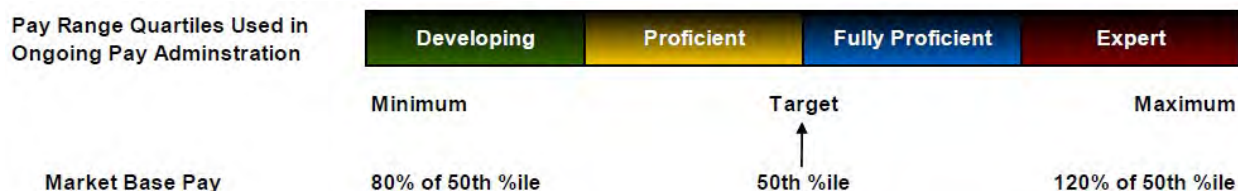
Range Maximum: represents the maximum rate paid to individuals who possess qualifications significantly above market norms and consistently deliver superior performance

- Base pay growth is capped at the pay range maximum

Pay Above Range Maximum: as a rule, employees are not to be paid above the range maximum

- Employees paid above the pay range maximum will have their base pay frozen and will not be eligible for future base pay increases
- In lieu of future base pay increases, these individuals may be eligible for merit pay delivered as a lump sum bonus providing their performance warrants this additional compensation
- As the pay structures and pay ranges move (every 12 – 36 months or as necessary), the employees paid above the pay range maximum will eventually be paid below the pay range maximum and will then be eligible to receive base pay increases, as appropriate

Pay Range: Employees may be paid anywhere within the open pay range; the pay range is divided into equal quartiles to assist in achieving competitive, equitable and appropriate pay levels



- Developing Area – Below market pay; this area is used for employees possessing minimum job requirements and/or for those having significant learning curves to become fully proficient in the job's duties, responsibilities and performance expectations
- Proficient/Fully Proficient Area – Market competitive pay; this area is used for employees possessing preferred job requirements and consistently demonstrate 100% proficiency in all aspects of the job's duties, responsibilities and performance expectations
- Expert Area – Above market pay; this area is used for employees possessing unique knowledge, skills or abilities that far surpass the market's typical requirements and consistently demonstrate superior performance in all aspects of the job's duties, responsibilities and performance expectations

Compa-Ratio: In addition to pay range quartiles, this is a metric also used to communicate pay competitiveness

- Compa-Ratio: A compa-ratio is calculated by taking the employee's base pay divided by his/her pay range target
- Compa-Ratio of 100%: This ratio indicates the employee's base pay equals the pay range target, or the market rate

- Compa-Ratio <100%: This ratio indicates the employee's base pay is less than the pay range target
- Compa-Ratio >100%: This ratio indicates the employee's base pay is greater than the pay range target

Illustrative Range Shown Below:

Note: Range minimums and maximums will be based on the developed salary range spreads

	Minimum	Target	Maximum
<i>Compa-Ratio RNs</i>	87.5%	100.0%	117.0%
<i>Compa-Ratio Non-Exempt</i>	88.0%	100.0%	117.0%
<i>Compa-Ratio Exempt</i>	83.0%	100.0%	118.0%

Annual Pay Adjustments/Increases

Market Adjustment: A market adjustment is an increase or decrease to pay range rates based on market pay practices

- A market adjustment results in base pay increases for full-time, part-time, and some as-needed and limited term staff paid at or below the pay range target (there is no base pay increase between target and maximum for non-market sensitive jobs unless compression exists at the target)
 - For some market-sensitive jobs, a market adjustment may also be granted to full-time, part-time, and some as-needed and limited term staff paid above the pay range target but below the pay range maximum to maintain competitiveness and minimize pay compression
- A market adjustment may result in a base pay increase to some staff to ensure employees are paid a base pay rate at least equal to the new pay range minimum
 - If a market adjustment is made, employees paid below the new range minimum receive an increase to their base pay to ensure it is at least equal to the pay range minimum before any merit pay is awarded (cap at 10%)

Market Adjustment:

- The appropriateness of a market adjustment is determined based on:
 1. A competitive assessment of the pay range target versus market base pay practices;
 2. Market trends and practices relative to average base pay and pay range increases; and
 3. Current recruiting and retention issues
- Market adjustments are made prior to determining merit pay

- Newly hired employees will be eligible for any market adjustments granted at the annual pay increase date if the employee is paid at or below the pay range target

Base Pay Adjustment: All employees who achieve a satisfactory level of performance will be eligible for a merit pay adjustment

- Merit Pay: Merit pay is variable pay that typically affects individuals' base pay; it recognizes individuals' job proficiency and performance of job duties
 - Merit pay is applicable to full-time and part-time employees paid below, at, or above the pay range target; Per diem employees are not eligible for merit pay
 - To be eligible for merit pay, the employee must have started work on or before March 31st to be eligible for a merit increase in July of the same year at least six months of service prior to the annual pay adjustment date and have successfully completed of the introductory period (3 months for transfers and, 6 months for new hires) prior to the annual pay adjustment date
 - Merit pay will typically be an increase to base pay; however, it may also be delivered as a onetime lump sum bonus for individuals paid above the pay range maximum
 - The budgeted amount for merit pay, if any, is based on: 1) the organization's financial status; 2) market trends relative to average base pay increases; 3) competitiveness of current base pay practices; and, 4) recruiting and retention issues

Merit Pay – Staff Paid At and Above Pay Range Target

- The combination of an individual's performance rating, and the position of his/her pay within the pay range, the number of months he/she has been working, and the salary earned during those months determines the individual's merit pay opportunity
 - Merit pay is typically calculated as a percent of base pay, prorated to reflect the number of months an employee worked and the salary earned during those months
 - Managers s have the discretion to determine the actual increase amount within the published guidelines; the appropriate merit pay amount will reflect the manager's internal equity, pay competitiveness, and performance recognition objectives
 - Adjustments to employees' base pay are capped at the pay range maximums; therefore, some employees may receive a portion of their merit pay as a base pay increase up to the pay range maximum and also receive a lump sum amount for the remaining portion of the merit pay. Employees paid over the pay range maximum may be eligible to receive merit pay as a lump sum payment paid out in 2 incremental amounts- the first half when merit pay is normally distributed; and the second half 6 months later
 - Merit pay may be held altogether or delayed for 90 days if employees do not achieve a satisfactory level of performance or if a written warning or suspension/final written warning is active in their record
 - Merit pay is typically awarded once a year at a specific time
 - Full-time and part-time employees may receive both a market adjustment and a

merit pay adjustment at the same time

- Executive Directors and Chief's must approve all areas they are responsible for before submitting to HR
- HR has final approval of all merit increases

A Merit Pay Grid similar to the one shown below (assumes a 3% merit increase budget) is often used to provide managers with a guideline as to what merit pay increase may be appropriate based upon performance and to reflect:**

1. The organization's financial status;
2. Market trends relative to average base pay increases;
3. Competitiveness of current base practices; and,
4. Recruiting and retention issues

	Pay Range Position					
Performance Rating	1 st Quartile	2 nd Quartile	3 rd Quartile	4 th Quartile	Above Max	Above Max = Lump Sum Bonus
Highly Effective	6% - 5%	5% - 4%	4% - 3%	3% - 2%	3% - 2%	
Effective	5% - 4%	4% - 3%	3% - 2%	3% - 2%	0%	
Needs Improvement	0%	0%	0%	0%	0%	

** The Merit Pay Grid is a sample only. Actual merit increase percentages will depend upon the salary distribution across the salary structure.

- Employees who do not achieve a satisfactory level of performance at the time of their annual pay increase will not receive any type of pay increase – market adjustment, or merit pay
- The increase may be held all together or delayed 90 days until the written performance improvement plan is complete and performance is judged to be acceptable by the manager; the pay increase will be effective at the time performance is judged to be acceptable (beginning of applicable pay period) and will not be retro-active; the manager is responsible for informing the employee in this situation and is responsible for notifying HR to initiate the increase
- Employees on any type of leave of absence who are eligible for a market adjustment, and/or merit pay, may receive these adjustments upon their return to active status with a completed performance appraisal that is competent or above

Special One-time Pay Considerations

Recruitment Incentive

- Recruitment incentives up to 15% of an employee's base pay may be provided on an exception basis to entice an employee to join CalOptima
 - Recruitment incentives require the approval of the CEO
 - Board approval is required for recruitment incentives offered to Executive Director and above positions
 - Incentives are provided with a "pay-back" provision if the employee terminates within 24 months of hire

New Hires/Rehires

- A new hire's pay level should correspond to the appropriate pay range but typically should not exceed the pay range target; offers above the pay range target require the approval of the Compensation Analyst in consultation with the Executive Director of Human Resources, and the CEO when necessary
- Factors to be considered in determining an appropriate pay level for a new hire include:
 - Job-related experience: what is the estimated learning curve given the individual's prior work experience?
 - Market conditions: what is the going rate of pay in the external market for the individual's skills and knowledge?
 - Internal equity: is the proposed pay level lower, higher or in line with the pay levels of current employees having comparable skill and experience levels?
- At hire, external service is typically valued comparable to internal service
 - For example, an RN having three years of prior job experience is viewed comparably to an RN having three years of job experience at CalOptima
- Internal equity (how this position and compensation compares relative to existing employees) must be considered when making hiring decisions

Process for Determining a New Hire Starting Pay Rate

HR determines applicable pay rate:

- Starting pay rate is at or near the minimum of the pay range for a candidate who only meets the job's minimum qualifications
- Starting pay rate cannot be below the minimum of the pay range (unless it is viewed as a training rate)
- Determine appropriate pay rate by assessing candidate's knowledge, skills and experience, current pay level, as well as pay rates currently being paid to similarly situated incumbents
- Candidates with superior knowledge, skills and experience can be paid above the pay range midpoint; starting pay rates above the pay range midpoint must have the appropriate Compensation Analyst, Executive Director of Human Resources, and CEO approval when necessary
- There are certain positions that will usually be placed near the salary grade minimum (all entry level service and clerical)
- Pay rates for all management positions must be reviewed with the Compensation Analyst before an offer is made. The Compensation Analyst will review internal equity across the system to ensure that the appropriate offer is made

- Any questions or concerns about new hire offers should be directed to the Compensation Analyst or Executive Director of Human Resources. The Compensation Analyst will review any concerns with the Executive Director of Human Resources as necessary
- Rehires to the same position should be paid at least the same amount they earned prior to termination with adjustments and/or credit for recent additional career experience or education earned while away from CalOptima
- The above policy applies to the current organization structure
- Additional positions at the level of Chief or Executive Director require Board approval

Promotion

Promotion: An employee receives a promotion when he/she applies for and is selected for a job with a higher pay range target

- An employee will receive a promotional increase to at least the pay range minimum of his/her new pay range.
- The amount of a promotional increase will vary and the actual amount will be determined based on the incumbent's qualifications, performance and the internal pay practices of other similarly-situated employees. The typical promotional increase is 4% to 5% of base pay for one grade increase.
- Typically, the promotional increase should not exceed the pay range target.
- When an employee moves from non-exempt to exempt, the loss of overtime pay will be considered. However, the realization that overtime is not guaranteed must also be considered.
- The pay rate adjustment will be effective on the first day of the pay period in which the job change takes effect.
- The next merit pay adjustment after a promotion may be pro-rated based on the amount of time the employee has spent in the job.

Lateral Transfer

Lateral transfer: It is considered a lateral transfer if an employee moves to a job having the same pay range target

- Lateral job changes will not typically result in a base pay increase or adjustment unless otherwise approved by the Compensation Analyst and Executive Director of Human Resources

Demotion

Demotion: An employee is classified as having been demoted if he/she moves to a job with a lower pay range target

- An employee demoted due to an organizational restructure, no pay decrease will be given unless the employee is above the maximum on the new pay range; if so, the employee will be reduced to the maximum of the new pay range.
 - An involuntary demotion due to performance will follow the guidelines below for reducing base pay
 - A voluntary demotion based on an application for an open position will typically result in a pay decrease between 0 – 4% for each salary grade demoted
 - The demoted employee's base pay will be reduced to the next lower pay grade. Target, or pay grade maximum, whichever is appropriate using the 0 – 4% guideline above
- The pay rate adjustment will be effective on the first day of the pay period in which the job change takes effect
- Future merit increases and market adjustments will not be affected by a demotion unless competent performance is not achieved.

Temporary Assignment

Temporary assignment: An employee who is asked to assume a full-time temporary assignment in a job having a *higher* pay range target is eligible for a temporary base pay increase. The employee must assume some or all of the responsibilities of the new job to qualify for a temporary assignment increase

- The employee's base pay rate prior to the assignment will be maintained and the higher temporary assignment rate will be added as a secondary job title and pay rate
- This increased secondary pay rate is eliminated when the temporary assignment ends
- The amount of the temporary assignment increase should be consistent with the promotion policy

Job Re-Evaluations

Job Re-Evaluations: Job re-evaluations will be reviewed in the following priority order:

1. New Positions
2. Change of 35% or more of duties (any change in responsibilities less than 35% will not be considered)
 - Enhancements must require a higher level of skills, abilities, scope of authority, autonomy, and/or education to qualify for a re-classification

- Additional duties that do not require the above will not be considered for reclassification
- All requests for job re-classification must be documented, signed by the department manager and submitted to the Compensation Analyst
- In the case of management positions being re-classified, the appropriate Chief must sign the documentation
- The request must include the incumbent's current job description and revised job description with enhancements highlighted.
- The request must also include justification that the re-classification supports a business need

If the job is determined to be a priority, the Compensation Analyst will analyze the job according to:

- The job's scope against other jobs in the same discipline
 - Available market data
 - Appropriate title identification. The Compensation Analyst will determine if the title fits within the hierarchy; if not, a benchmark title will be recommended
 - Job family
 - FLSA status
 - Appropriate pay grade – the job will be fit into one of the pay grades that currently exists- there will be no new pay grades created
 - A pay rate will be determined
 - A recommendation will be made to the Executive Director of Human Resources for approval, and the decision will be communicated to the appropriate manager
-
- If a job is reassigned to a higher grade, the change will be effective on the first day of the pay period following the evaluation. The pay increase is not retroactive to any earlier date
 - The manager will be informed of the decision to move the job to a higher pay grade by the Compensation Analyst
 - The amount of the pay increase should follow the guidelines in the promotion section
 - If the upgrade and a pay change occurs less than six months before the annual pay increase date, the employee's next merit pay adjustment may be pro-rated
 - If the job is not reassigned to a higher pay grade, the manager will be notified. If dissatisfied with the decision, the manager may file an appeal with the Executive Director of Human Resources
-
- If a job is reassigned to a lower pay grade as a result of a job re-evaluation due to available market data, without a change in job responsibilities, the involuntary demotion due to organizational restructuring protocol will be followed
 - If a job is reassigned to a lower pay grade due to a job evaluation and change in job responsibilities, the voluntary demotion protocol will be followed

- Job evaluations and re-evaluations will occur throughout the year; all priority jobs will be evaluated within one month of the request
- If a job is not a priority or does not meet the guidelines, the manager will be notified

Base Pay Program Maintenance

Salary Structure Adjustment

- The salary structure should be reviewed on a regular basis either annually or every other year to continue to reflect market competitiveness
- The salary structure updates are designed to relieve any upward pressure on range minimums, midpoints and maximums that may impede the ability to attract, motivate and retain the workforce
- The salary structure is dynamic; it needs to be revised at regular intervals based upon market conditions to maintain market competitiveness. The goal is to keep the structure's market rates on track with market data
- Market adjustments will be applied to the salary schedule as needed at least every two years, using surveyed salary structure adjustment percentages
- The salary structure adjustment approval process includes:
 - The Executive Director of Human Resources makes a recommendation to the CEO for approval
 - CEO takes the recommendation to the Board for final approval

Annual Competitive Assessment

- On an annual basis, HR will identify the current competitiveness of CalOptima's pay practices by comparing: 1) current pay levels to market practices; 2) current pay levels to pay range targets; and, 3) current pay range targets to market practices
 - CalOptima will annually spot check benchmark jobs to determine market fluctuations in benchmark jobs' pay rates
 - Based on market findings, the pay grade and ranges will be updated
 - Any jobs in which reasonable benchmark data is not available can be slotted into the salary structure based on internal equity considerations
- The results of these analyses, along with CalOptima's current financial performance and economic situation will determine the appropriate market adjustments (i.e., pay range adjustments) and merit pay budgets
- The following criteria is typically used to determine which jobs to market price each year:
 - Review job-level turnover statistics for jobs with above-average separation rates to identify jobs with potential retention issues;
 - Review the time-to-fill metrics for jobs requiring above-average recruiting efforts and expenses to identify jobs with potential recruiting issues;
 - Review the applicant tracking reports (if available) for jobs with a high level of initial/ subsequent offer rejections to identify additional potential recruiting issues;

- Review jobs with pay-to-pay range target compa-ratios in excess of 110% or below 90%
- Review jobs with market-to-pay range target compa-ratios in excess of 110% or below 90%
- Review all market-sensitive jobs and those on the “watch list”
- Review top 10 highest populated jobs on an annual basis
- Jobs are ranked by degree of severity for each of the preceding criteria; the jobs that are most frequently identified across all criteria are typically market priced
- It is recommended that at least two jobs be selected from every pay range

Market Adjustments (Structure and Pay Range Adjustments): Market adjustments to specific pay ranges or the entire pay structure may be made on an annual or as needed basis to reflect current competitiveness or market trends

- Each year the pay range targets are compared to the external market base pay practices and necessary adjustments are made to ensure alignment including job grade changes and range rate adjustments
- Employees falling below the range minimum of the adjusted structures are typically brought to the pay range minimum, assuming the employee has a satisfactory level of performance; any pay compression resulting from structure adjustments should be addressed as part of the annual pay increase process
 - Adjustments to pay range minimums occur prior to merit pay calculations

Process for Making Market Adjustments

- HR performs an annual review of compensation surveys to calculate the average market adjustment to pay structures; HR also analyzes the competitiveness of the current pay range targets to market practices for benchmarked jobs
- HR reviews CalOptima’s financial operating conditions and quantifies any recruiting/retention issues
- HR determines if an adjustment is appropriate (minor variations in the market may be recognized in the following year) and recommends the amount
- HR multiplies the current pay range target of each grade by the necessary adjustment percentage; then HR recalculates the pay range minimum and maximum based on the existing structure design (i.e., pay range minimums = 80% of the new pay range target; pay range maximums = 120% of the new pay range target, etc.)
- HR identifies the cost implications for the market adjustment by identifying the difference between: 1) current pay rates and new pay range minimums, and, 2) current pay rates.
- The market adjustment approval process will work as follows:
 - The Executive Director of Human Resources recommends an adjustment to the CEO for approval
 - If the CEO agrees, the CEO will seek Board approval

Market-Sensitive Jobs: Market sensitive jobs are those for which market conditions make recruiting and retention challenging

- Premium pay is built into the pay targets for these jobs
 - Prospectively, the pay range and grade selected for these jobs will reflect the desired market target rate (i.e., 60th or 75th percentile of base pay practices) based on business need
 - The desired market target rate is established on a job-by-job basis to reflect specific market conditions
- Criteria used to determine if a job is classified as market-sensitive typically includes two or more of the following:
 - Time to fill the position – statistics will suggest the average amount of time required to fill a requisition for a market-sensitive position will be significantly higher than the historical norm for this position or similar positions
 - Job offer rejections – statistics will illustrate an increase in the number of employment offers rejected due to low starting rates
 - Turnover – statistics will suggest a higher than typical amount of turnover for the position within the last 3 to 6 months; turnover for the job will be compared to historical results for the same job and to other similarly-situated jobs
 - Market Changes – market-sensitive jobs may experience an excessively large increase in competitive pay rates over the previous year's results; specifically, jobs considered to be market-sensitive may have:
 - a year-to-year increase significantly greater than the average year-to-year increase for other jobs analyzed,
 - a competitive market rate significantly higher (approximately 10%) than its current pay range target, or
 - a competitive market rate with significantly higher pay practices (approximately 10%) in the labor market than the average of current internal pay practices.
- When a job is classified as market-sensitive, typically some form of adjustment is made to employees' base pay rates and is typically referred to as a market adjustment and the pay increase policies noted under the market adjustment section apply.
- Jobs classified as market-sensitive are reviewed annually to determine if this status still applies
 - Once a job is classified as market-sensitive, it typically remains as such until the recruiting and retention challenges subside and/or the market pay rates adjust themselves – typically not less than one year
 - When a job is no longer considered market-sensitive, the job's pay range and grade is reassigned to reflect a market median base pay rate target; no changes are typically made to the employees' base pay rates at this time
- Throughout the year, jobs that are not yet considered market sensitive but are showing signs of becoming so are placed on a "watch list" and monitored


- If necessary, these jobs will be moved to the market-sensitive category and handled accordingly

Attachment 3

SCENARIO A No Proration		CURRENT 12-MONTH EVALUATION CYCLE											
		2015									2016		
		APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
A-1	Existing Emp No Off-cycle Increase	\$10,000											
A-2	Existing Emp Off-cycle Increase	\$10,000						\$11,000					
A-3	New Emp No Off-cycle Increase							\$10,000					
A-4	New Emp Off-cycle Increase			\$10,000				\$11,000					
A-5	New Emp Hired After DEC										\$10,000		
		<div>→ End of Merit Eligibility</div>											

→ End of Merit Eligibility

Merit Eligibility	Salary Basis for Merit Increase
YES	\$10,000 12
YES	\$11,000 12
YES	\$10,000 12
YES	\$11,000 12
NO	\$0


2016			
APR	MAY	JUN	JUL
			

SCENARIO B Proration		PROPOSED 12-MONTH EVALUATION CYCLE											
		2016									2017		
		APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
B-1	Existing Emp No Off-cycle Increase	\$10,000											
B-2	Existing Emp Off-cycle Increase	\$10,000							\$11,000				
B-3	New Emp No Off-cycle Increase								\$10,000				
B-4	New Emp Off-cycle Increase			\$10,000				\$11,000					
B-5	New Emp Hired After DEC										\$10,000		

End of Merit Eligibility →

→ End of Merit Eligibility

Merit Eligibility	Salary Basis for Merit Increase
YES	\$10,000 12
YES	6: \$10,000 6: \$11,000
YES	\$10,000 6
YES	4: \$10,000 6: \$11,000
YES	\$10,000 3

2017			
APR	MAY	JUN	JUL
			

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CalOptima

Better. Together.

*****REPLACE COVER PAGE WITH NEW ONE*****

Employee Handbook

Revised ~~April~~December 3, 201556

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Welcome Letter

Thank you for choosing CalOptima as your employer. The dedication of our employees is critical to CalOptima's ability to fulfill its mission and deliver access to quality, compassionate care to all members. Although we have evolved into a multi-faceted organization, we are grateful that our employees remain fully committed to ensuring that all programs, initiatives and services are centered on meeting the health care needs of our members.

We at CalOptima understand that excellence in service to our members could not happen without our most valued resource, our dedicated and caring employees. Our diverse and mission-driven staff works tirelessly to meet our members' health care needs. I am exceptionally proud of our employees and am fully committed to maintaining the employee-focused culture in which our employees thrive.

With the support of CalOptima's Board of Directors and the Member and Provider Advisory Committees, our strong network of physicians and hospitals, and the dedication and drive of our employees, CalOptima looks forward to fully engaging in new opportunities that will improve the delivery of health care services to our members and the Orange County community.

On behalf of the administrative staff and the Board of Directors, welcome to CalOptima.

Sincerely,

Michael Schrader
Chief Executive Officer

Mark Refowitz
Chairman, CalOptima Board of Directors

Required Policies

Welcome to CalOptima

Welcome to CalOptima, a public agency and health plan that serves Orange County members of Medi-Cal, OneCare (Medicare Advantage Special Needs Plan), OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) and PACE (Program of All-Inclusive Care for the Elderly). We believe you will find CalOptima an exciting organization with an important mission that is fulfilled through the collective efforts of our employees. You are joining our staff of dedicated and talented professionals, and we are confident that your skills and experience will assist us in achieving our mission.

Our Personal Challenge

CalOptima's success is a direct result of the important contributions our employees make every day. We challenge all employees to keep our members front and center in all that they do. Our commitment to our members goes beyond the customer service department, and we recognize that we would be unable to implement our important mission without our providers. We also recognize we need to serve all of our customers which include members, health networks, pharmacies, ancillary providers, physicians and their staff, and CalOptima employees.

But more than just meeting our members' needs, we strive to anticipate what they need and recommend it before they ask. We strive to be good stewards of public funds and honor our accountability to the community by working together to keep administrative costs as low as possible while improving the quality of care for our members and the effectiveness of our providers.

To do this, we must continually evaluate and reinvent the way we do business. Identifying opportunities for improving efficiency and effectiveness is the responsibility of all CalOptima team members. With your help, we will continue to build a team-oriented environment where innovation and flexibility are the standards for achieving our mission.

Mission Statement

The Mission of CalOptima is to provide members with access to quality health care services delivered in a cost-effective and compassionate manner.

About This Handbook

This handbook is provided for your use as a reference and as a summary of CalOptima's mission, history, employment practices, key employee policies, procedures and benefits. Because CalOptima is a dynamic and changing organization, at times it may be necessary to change or improve the policies and practices presented in this handbook. As CalOptima deems appropriate in its sole and absolute discretion, CalOptima reserves the right to amend, supplement or rescind this handbook, or any portion(s) herein, other than CalOptima's employment-at-will provisions. This handbook is not a contract, either express or implied, of continued employment.

Employees are encouraged and expected to read and familiarize themselves with the contents of this handbook, and should consult with their manager and/or Human Resources to obtain clarification or detailed information regarding any policy, procedure or practice outlined in this handbook.

CalOptima is constantly striving to improve its policies, procedures and services. We encourage employees to bring suggestions for improvements to their managers. By working together, we hope to share with all of our employees a sincere pride in our workplace and the services we are all here to provide.

This handbook supersedes all previously issued handbooks but does not supersede applicable federal, state or local laws. Your manager or the Human Resources department will be happy to answer any questions you may have.

Right to Revise

This employee handbook summarizes some of the employment policies and practices of CalOptima in effect at the time of publication. A full list of policies may be found on the CalOptima InfoNet. All previously issued handbooks and any inconsistent policy statements or memoranda in effect prior to the effective date of publication are hereby superseded to the extent it conflicts with this handbook.

CalOptima reserves the rights to revise, modify, delete, or add to any and/or all policies, procedures, work rules or benefits stated in this handbook or in any other document, except for the policy of at-will employment.

Any written changes to this handbook will be made available to all employees via CalOptima's InfoNet and/or via email communication so that employees will be aware of the new policies or procedures. No oral statements or representations can in any way alter the provisions of this handbook.

Nothing in this employee handbook or in any other personnel document, including benefit plan descriptions, creates or is intended to create a promise or representation of continued employment for any employee.

The History of CalOptima

CalOptima was established as a result of a longstanding community effort to improve access to health services for the county's low-income populations. The Orange County Board of Supervisors established CalOptima in 1993 as a county organized health system (COHS), which is a public agency. It is one of six COHS authorized by federal and state law to administer Medi-Cal benefits in California. This model of delivering health care services allows decision making at the local level and ensures the plan is community-driven and sensitive to local needs. CalOptima's goal is to provide Orange County's Medi-Cal population with streamlined access to quality care through the efficient use of state and federal funds.

In 1998, CalOptima launched the Healthy Families Program (HFP) to provide health care coverage for children up to the age of 19 who reside in Orange County and met eligibility requirements. In 2013, HFP members were transitioned into CalOptima's Medi-Cal plan, based on direction provided by the State of California.

In October 2005, CalOptima launched OneCare, our Medicare Advantage Special Needs Plan (SNP). OneCare was created through a contract with the Centers for Medicare & Medicaid Services to offer enhanced care coordination and streamlined health care delivery by combining the Medicare and Medi-Cal benefit packages into a single plan.

In 2013, CalOptima launched a Program of All-Inclusive Care for the Elderly (PACE), which is a community-based Medicare and Medi-Cal program that provides coordinated and integrated health care services to frail elderly members to help these members continue living independently in the community.

In 2014, CalOptima earned our highest quality honor to date, being named the top-ranked health plan in California by the National Committee for Quality Assurance (NCQA). In the NCQA's Medicaid Health Insurance Plan Rankings 2014–2015, CalOptima was ranked first in the state and 29th nationwide among the 136 Medicaid plans that were ranked.

In 2015, CalOptima launched OneCare Connect, a new health plan designed to simplify and improve health care for seniors and people with disabilities who have Medicare and Medi-Cal coverage. The plan combines Medicare and Medi-Cal benefits, adds supplemental benefits and offers personalized support.

Since commencing operations on October 1, 1995, CalOptima continues to fulfill its mission of providing access to quality health care for members through a unique health care delivery system that relies on private health care networks, including more than 1,600 primary care providers and nearly 6,000 specialists. CalOptima is proud to administer our programs in a cost-effective manner and is consistently recognized as having one of the lowest administrative cost ratios of all Medi-Cal managed care plans in California.

At-Will Employment Status

CalOptima employees are at-will employees with no guarantee of employment for any specified term. CalOptima recognizes that relationships are not always mutually satisfactory. To protect both parties' rights, the employment relationship at CalOptima is terminable at-will, at the option of the employee or CalOptima. An employee or CalOptima may terminate employment at any time, with or without cause, and with or without notice.

CalOptima reserves the right to change the conditions of an employee's employment including, but not limited to, compensation, duties, assignments, responsibilities and location at any time, with or without cause. There are no written, oral or implied promises of permanent or continuing employment. This policy supersedes any such agreements to the extent that any may exist.

| ~~See Human Resources Policy GA.8028: At-Will Employment~~

Equal Employment Opportunity

CalOptima is an equal employment opportunity employer and makes all employment decisions on the basis of merit. CalOptima wants to have qualified employees in every job position. CalOptima prohibits unlawful discrimination based on race, religion/religious creed, color, national origin, ancestry, physical disability/handicap, mental disability/handicap, medical condition, genetic information, marital status, sex, gender, gender identity, gender expression, age, sexual orientation, status as a disabled veteran or veteran of the Vietnam era, or any other consideration made unlawful by federal, state or local laws. CalOptima also prohibits unlawful discrimination based on the perception that anyone has any of those characteristics or is associated with a person who has or is perceived as having any of those characteristics.

Equal employment opportunity will be extended to all persons in all aspects of the employer-employee relationship, including recruitment or recruitment advertising, hiring, training, promotion, rates of pay or other forms of compensation, benefits, transfer, discipline, layoff or termination, career development opportunities, and social and recreational programs.

It is the responsibility of every manager and employee to conscientiously adhere to this policy.

See Human Resources Policy GA.8025: Equal Employment Opportunity

Unlawful Harassment and Discrimination

CalOptima is committed to providing a work environment that is free of harassment and discrimination. Harassment and/or discrimination based on race, sex, gender, gender identity, gender expression, age, national origin, mental or physical disability, sexual orientation, religion, exercise of rights under Family and Medical Leave Act (FMLA), marital status, veteran status or any other protected characteristic is a violation of state and

federal law and is strictly prohibited by CalOptima. Any person who commits such a violation may be subject to personal liability as well as disciplinary action, up to and including termination of employment.

CalOptima encourages reporting of all perceived or actual incidents of discrimination or harassment. An employee who believes he or she is being, or has been, harassed in any way, should report the facts of the incident or incidents immediately to his or her supervisor, manager or, if he or she prefers, to the Human Resources department. Supervisors and managers must report incidents or claims of harassment immediately to the Human Resources department. A Human Resources representative will investigate any and all complaints and take appropriate preventive and/or corrective action, including disciplinary action, when it is warranted. Every reported complaint of harassment will be investigated thoroughly, promptly and in a confidential manner.

CalOptima will not tolerate retaliation against an employee for reporting harassment and/or discrimination, for cooperating in an investigation, for making compliance complaints or for making any other complaint to the Human Resources department. Employees engaging in any actions which are retaliatory against another employee will be subjected to disciplinary action, up to and including termination of employment

See Human Resources Policy GA.8027: Unlawful Harassment

Recruitment and Hiring

Job Posting

CalOptima supports the development and advancement of employees from within the organization, and that belief is supported by CalOptima's job posting process. Employees are responsible for taking ownership of their own career and checking new and current job postings for growth and advancement opportunities. CalOptima encourages employees to apply for promotions or transfers to open positions for which they meet the qualifications and minimum requirements.

Upon completion of the Request To Fill (RTF) process, positions will normally be posted internally and/or externally. Open positions must be posted internally for five full business days before an offer can be made. On rare occasions, there may be situations where a position is not posted due to a sensitive business need. The exceptions from posting must be approved by the Chief Executive Officer.

Employees are not eligible to apply for posted jobs until they have completed at least six months' service in their current position. Employees must possess the necessary education, skills and experience for the job position, complete an Internal Job Application (including an updated résumé) and be in good standing to apply for open positions. As a courtesy, it is recommended that employees notify their managers upon applying.

See Human Resources Policy GA.8019: Promotions and Transfers

Background Checks

CalOptima believes that hiring qualified individuals to fill positions contributes to our overall strategic success. Background checks serve as an important part of the selection process. CalOptima employees have access to confidential, private and protected health information. Through comprehensive background checks, CalOptima can obtain additional applicant-related information that helps determine the applicant's overall employability and ensures the protection of the people, property and information of the organization.

CalOptima uses a third party agency to conduct the background checks. The type of information that can be collected by this agency includes, but is not limited to, information pertaining to an individual's past employment, criminal background, education, character, credit record, Department of Motor Vehicles (DMV) record and reputation. Background checks are held confidentially in compliance with all federal and state statutes, such as the California Investigative Consumer Reporting Act and the Fair Credit Reporting Act.

CalOptima conducts background checks on job applicants prior to commencement of employment. For promotions or transfers of employees to certain positions, a post-employment background check may also be required. Falsification of information on the employment application or providing false information for the purpose of hiring may result in disciplinary action up to and including termination of employment.

CalOptima also conducts exclusion monitoring through the Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE) and the General Services Administration's (GSA) System for Award Management (SAM) website. Any applicant found on the LEIE and/or SAM website and verified according to the Human Resources procedures cannot be hired with CalOptima. Similarly, any existing CalOptima employee found on the LEIE and/or SAM website and verified according to the Human Resources procedures will be immediately terminated. Employees shall notify the Human Resources department upon hire or immediately any time thereafter if the employee knows or has reason to know that the employee is excluded from a federally funded health care program and/or may be listed on the LEIE and/or SAM Website.

See Human Resources Policy GA.8030: Background Checks

Proof of Right to Work

In accordance with federal law, all new hires will need to produce original documentation establishing their identity and authorization to be legally employed in the United States. In addition, each new hire is required to complete an INS Form I-9 swearing that they are legally employable in the United States. This verification must be completed as soon as possible after an offer of employment is made and in no event more than three business days after an individual is hired. All offers of employment and continued employment for positions in the United States are conditioned on furnishing satisfactory evidence of identity and legal authority to work in the United States.

Job Duties

In order to run a cost-effective program at CalOptima, it's important that employees are flexible and do what needs to be done to best serve the needs of our members and customers. During the employee's initial orientation and during the initial performance review, management will explain job responsibilities and the performance standards expected of their employees. Be aware that job responsibilities may evolve and/or change at any time during the employment relationship. From time to time, employees may be asked to work on special projects, and/or to assist with other work necessary or important to the operation of their department or CalOptima. Cooperation and assistance in performing such additional work is expected.

CalOptima reserves the right, at any time, with or without notice, to alter or change job responsibilities, reassign or transfer job positions, or assign additional job responsibilities.

Employment Classifications

CalOptima uses the following specific classifications to describe the responsibilities and benefits of employment:

Full-Time: Employees who are regularly scheduled to work 60 to 80 hours a pay period and are eligible for all employer-provided health care and retirement benefits.

Part-Time: Employees who are regularly scheduled to work less than 59 hours per pay period. Regular part-time employees are eligible for benefits and must pay an additional premium for health care benefits. PTO and flex holiday hours accrue on a prorated basis according to an employee's prorated work schedule.

Limited-Term: Employees who are hired to work a full-time or part-time schedule on special assignments that last a period of less than six months. Limited-term employees do not become regular employees as a result of the passage of time. Limited-term employees are eligible for employer-provided health care and retirement benefits at a rate dependent on their full-time or part-time status.

As-Needed: Employees called to work sporadically on an as-needed basis. As-needed employees are employed for an indefinite duration and must work less than 1,000 hours per fiscal year. These employees may not have regularly scheduled hours and do not earn any benefits but may become eligible for paid sick leave

Temporary Agency Workers: Workers who have been hired by and are paid by a temporary agency for an assignment generally not expected to last more than 1,000 hours per fiscal year. Temporary agency workers are not eligible for CalOptima benefits.

Salaried (Exempt): These employees are exempt from the overtime provisions of the federal Fair Labor Standards Act (FLSA) and state regulations governing wages and salaries, where applicable. Exempt status is determined by the duties and responsibilities of the position and is defined by Human Resources for each position.

Hourly (Non-Exempt): Includes all employees who are not identified as exempt. Non-exempt employees are paid on an hourly basis and are eligible for overtime compensation as required by federal wage and hour laws.

Interns: Paid interns are considered as-needed employees and should be concurrently enrolled in college or graduate courses.

CalOptima may change the employment classification/category of any employee at any time based on the nature of the employment assignment and to ensure compliance with applicable state and federal laws.

Employment of Relatives

Management will exercise appropriate discretion in each case in the hiring and employment of relatives of current employees. “Relatives” are defined as any persons related by birth, marriage, domestic partner status, or legal guardianship including, but not limited to, the following relationships: spouse, child, step-child, parent, step-parent, grandparent, grandchild, brother, sister, half-brother, half-sister, aunt, uncle, niece, nephew, parent-in-law, daughter-in-law, son-in-law, brother-in-law and sister-in-law. If an employee knows or has reason to know that CalOptima is considering a relative of the employee for employment, that employee should make that fact known to the Human Resources department.

Relatives of present employees may be hired by CalOptima only if:

- The applicant will not work directly for or directly supervising an existing employee; and
- A determination can be made that a potential for adverse impact on supervision, security, safety or employee morale does not exist.

If the relationship is established after the employee’s employment with CalOptima, i.e. two existing employees marry, become related by marriage, or become housemates, and a determination has been made that the potential for adverse impact does exist, the department head in conjunction with the Human Resources director, shall make reasonable efforts to minimize problems of supervision, or safety, security or morale, through reassignment of duties, relocation, or transfer to another position for which he or she is qualified, if such position is available. If CalOptima is unable to make an acceptable accommodation, then the employee and his or her relative and/or housemate shall be given an opportunity to decide which one person shall be transferred, if possible, or terminated from employment. If the employees do not make a decision within 30 business days, CalOptima shall automatically reassign one of the employees, if possible, or terminate one of the employees from employment. The decision as to which employee will leave will be at the discretion of CalOptima with consideration of CalOptima’s business needs.

See Human Resources Policy GA.8051: Hiring of Relatives

Employee Performance and Responsibilities

Introduction to Employee Performance and Responsibilities

CalOptima strives to create an environment and culture where our employees can bring their skills and talents to the forefront. We will treat our employees with respect and provide opportunities to be successful. CalOptima expects that each employee will strive to do his or her best as a CalOptima employee and that each employee will hold him or herself accountable for excellent performance, service and results.

Performance Evaluations

Evaluation of employees is a continuing process that takes place both formally and informally. Formal evaluations of performance and competence of regular employees shall take place following 90 days of employment, based on the date of hire, transfer or promotion, and one time per year thereafter as part of the annual review process.

Initial Performance Review

CalOptima strives to hire qualified employees for the job. In order to ensure both the employee and CalOptima are meeting their respective expectations, an initial performance review is conducted following 90 days of employment, based on the date of hire, transfer or promotion, assuming the employee's employment has not otherwise been terminated. The manager will evaluate the employee's capabilities, work habits, compatibility with the job, interest in the job and will discuss individual, department and organizational expectations and performance. As an at-will employee, either party may terminate the employee's employment at any time, with or without cause, and with or without notice.

Job Performance, Conduct and Progressive Discipline

CalOptima employees are bound to one another and our organization by the following shared values: integrity, teamwork, mutual respect and personal responsibility. Our reputation is fundamental to our continued success. Each of us has a personal responsibility to ensure that our conduct is true to that objective.

Employees are expected to abide by CalOptima's Code of Conduct and conduct themselves in an intelligent, mature and responsible manner and in accordance with applicable laws, regulations, policies and generally accepted work behaviors. Appropriate conduct is expected at all times while employees are on duty and/or on CalOptima property. Any violation of CalOptima policies or any act or incident of improper behavior or conduct may warrant disciplinary action, up to and including termination. In this regard, CalOptima has outlined some examples of undesirable behavior and/or performance issues that may result in disciplinary action, up to and including termination, which include, but are not limited to:

- Unsatisfactory work quality or quantity
- Failure to meet performance standards
- Behavioral-based problems that impact productivity, quality, service or teamwork
- Excessive absenteeism, tardiness, or abuse of break and lunch privileges
- Failure to follow instructions, policies, regulations, laws or CalOptima policies and procedures
- Failure to follow established safety regulations

CalOptima strives to assist employees in understanding their performance expectations and in improving and preventing recurrence of undesirable behavior and/or performance issues. Employees are responsible for taking ownership in correcting their performance/behavior and in meeting their performance expectations.

CalOptima may, at its sole and complete discretion, apply a progressive discipline process, where appropriate, in an effort to correct undesirable behavior and/or performance issues. Progressive discipline does not apply to all performance issues or undesirable behaviors and will be employed on a case by case basis. The severity of the discipline will depend on the nature of the offense, taking into consideration an employee's past performance and disciplinary record, where applicable. Discipline should be assessed in a fair and consistent manner.

As an at-will employee, CalOptima employees may be disciplined, up to and including termination, at any time, without advance notice. Employees are not guaranteed a right to progressive discipline prior to termination. CalOptima may skip one or more steps, repeat certain steps or skip the entire progressive discipline process altogether at CalOptima's sole and complete discretion. An employee may be terminated immediately within his or her initial 90 days of employment, transfer or promotion without applying progressive discipline. Serious performance or behavioral problems may result in immediate termination without resorting to any of these progressive disciplinary actions.

The progressive discipline process, when applied, is intended to give employees advance notice of problems with their conduct or performance in order to provide the employee with an opportunity to correct these problems. When used, the progressive actions may include:

- Documented Counseling Memo
- Written Warning;
- Final Warning with a Written Action Plan
- Termination

Management may also place an employee on administrative leave pending an HR investigation. CalOptima may also suspend an employee without pay after an initial HR investigation. The Human Resources department shall work with management to address disciplinary issues and management actions.

See Human Resources Policy GA.8022: Progressive Discipline

Training

CalOptima values the talent of its employees and encourages employees to continually develop their skills to enhance their job responsibilities and prepare for future opportunities within the organization. CalOptima provides mandatory trainings, as designated by CalOptima leadership, Human Resources, Compliance and departmental staff, as well as other optional training and personal development opportunities.

All mandatory trainings must be completed within a specified time frame and may require documentation that the employee passed the associated exam in order to be deemed completed. Mandatory trainings include, but are not limited to, compliance and regulatory requirements and information, which may be administered in person, online and/or through other means of communication. Employees failing to complete the mandatory training and/or pass the associated exam within the stated time frame may be disciplined, up to and including termination of employment.

Open Door

CalOptima has an open door approach that encourages employee participation in decisions affecting them and their daily responsibilities at CalOptima and/or the organizational operations. Employees who have work-related concerns or complaints, or have suggestions to improve operations, are encouraged to discuss these matters in an informal and professional manner with their immediate supervisor and/or any other management representative with responsibility for their department. If such concern or complaint arises from any particular incident,

employees should report these issues to their immediate supervisor or another management representative with responsibility for their department as soon as possible after the event or incident that caused the concern.

If the employee feels he or she cannot resolve his or her concern or complaint with management within his or her department, then the employee should contact Human Resources. CalOptima believes that employee concerns are best addressed through open communication and that the majority of misunderstandings can be resolved through open dialogue. Employees are encouraged to pursue discussion of their work-related concerns until the matter is fully resolved.

Although CalOptima cannot guarantee that employees will be satisfied with the result, CalOptima will attempt in each instance to explain the result or resolution to the employee if the employee is not satisfied. CalOptima will also attempt to keep all such expressions of concern, the results of the investigation and the terms of the resolution confidential. However, in the course of investigating and resolving the matter, some dissemination of information to others may be appropriate and/or necessary. No employee will be disciplined or otherwise penalized for raising a good-faith work-related concern in keeping with the open door approach.

Employees who conclude their work-related concerns should be brought to the attention of CalOptima by written complaint and formal review may refer to the Internal Complaint Review process set forth in this handbook.

Internal Complaint Review

CalOptima strives to maintain a safe, positive and pleasant environment for our employees. Employees who encounter work-related problems are encouraged to follow the steps outlined below to resolve their issues.

Step One: Immediate Supervisor

Should an employee have a problem or complaint, he or she should try to resolve this issue with his or her immediate supervisor. In most instances, a friendly talk with a supervisor can quickly resolve a problem. The supervisor will evaluate the matter and work to provide a timely solution.

Step Two: Department Head

If the problem is not resolved in Step One, an employee can refer the problem in writing to his or her department head. The department head should schedule a meeting to discuss the issue with the employee and, in turn, provide a timely solution, where applicable.

Step Three: Human Resources Department

If, for any reason, an employee is dissatisfied with the decision of the department head, the employee can file a written complaint with the Human Resources department. A representative from the Human Resources department will investigate the complaint, meeting separately with the employee and with others who are either named in the complaint or who may have knowledge of the facts set forth in the complaint. CalOptima will attempt to treat all internal complaints and their investigation as confidential, recognizing, however, that in the course of investigating and resolving internal complaints, some dissemination of information to others may be necessary. On completion of the investigation, the Human Resources department will discuss any actions or resolutions with the employee.

Step Four: Appeal

If the complaint is not resolved to the employee's satisfaction, the employee may submit a written request for review of the complaint to CalOptima's executive director of Human Resources. On completion of the appeal review, the employee should receive an oral or written explanation of the conclusion reached and the reasons for that conclusion. Decisions resulting from appeal reviews by CalOptima's executive director of Human Resources will be final.

No employee will be retaliated or discriminated against in any way because he or she made a complaint in compliance with this process. Nothing in this Internal Complaint Review is intended to or alters the at-will nature of employment.

Attendance, Tardiness and Reporting Absences

CalOptima counts on each employee's attendance and punctuality to provide efficient and consistent service to our members. We expect employees to report to work on time, observe the time limits for break and meal periods, and not leave work earlier without prior approval from their immediate supervisor.

If an employee is going to be absent or tardy, he or she must provide timely notice to his or her supervisor *before* his or her scheduled shift time. If the supervisor cannot be reached, the employee is expected to leave a message on the supervisor's voicemail and notify the department head or other designated department contact. Employees must provide the reason for the absence and the expected date of return. Employees must call in each day they will be absent or tardy, unless they are on a lengthier, pre-approved medical leave. Frequent tardiness or absenteeism will result in disciplinary action, up to and including termination. If an employee is absent for 3 consecutive days or more of personal sick time, a doctor's note is required on the first day back.

Authorized Absence

An authorized absence occurs when all four of the following conditions are met:

1. The employee provides sufficient notice to his or her supervisor (employee personally contacts his or her immediate supervisor prior the commencement of his or her shift).
2. The employee provides an acceptable reason to his or her supervisor.
3. Such absence request is approved by his or her supervisor.
4. The employee has sufficient accrued PTO to cover such absence or the supervisor waives this requirement because the employee has not yet accrued sufficient PTO.

The employee's immediate supervisor may waive the notice requirement when it is warranted by the particular circumstances involved; for example, when an employee is unexpectedly taken ill and cannot call. Failure to meet these requirements may result in discipline up to and including termination, depending on the surrounding circumstances.

Unauthorized Absence

An employee is considered to be on an unauthorized absence when one or more of the four conditions mentioned above are not met.

Unauthorized absences may result in disciplinary action, up to and including termination, depending on the surrounding circumstances. In addition, an employee is considered to have resigned when the employee fails to report to work without giving notice to and/or receiving authorization from his or her immediate supervisor for three consecutive days. In rare circumstances, the employee will be reinstated when it is warranted by the particular circumstances involved.

Frequent or Prolonged Absenteeism or Tardiness

Frequent or prolonged absenteeism or repeated tardiness, even when authorized, may result in disciplinary action, up to and including termination. Absences from work that qualify and are approved under CalOptima's leave of absence policy will not count toward excessive absenteeism.

Drug-Free and Alcohol-Free Workplace

CalOptima strives to maintain a workplace that is free of drugs and alcohol and discourages drug and alcohol

abuse by its employees. CalOptima has a vital interest in maintaining a safe and productive work environment for its employees, members and those who come into contact with CalOptima. Substance abuse is incompatible with the mission and interest of CalOptima. Employees who are under the influence of drugs and/or alcohol in the workplace can compromise CalOptima's interests, endanger their own health and safety and the health and safety of others, and can cause a loss of efficiency, productivity, or a disruptive working environment.

The following rules and standards of conduct apply to all employees either on CalOptima's property or on CalOptima business. Behavior that violates CalOptima policy includes:

- The unlawful manufacture, distribution, dispensing, possession or use of a controlled substance
- Possession or use of an illegal or controlled substance, or being under the influence of an illegal or controlled substance while on the job, except where the controlled substance is lawfully prescribed and used consistent with a doctor's authorization
- Abuse of a legal drug or the purchase, sale, manufacture, distribution, dispensation or any legal prescription drug in a manner inconsistent with law
- Driving a CalOptima owned or leased vehicle while under the influence of alcohol, illegal drugs or controlled substance
- Distribution, sale, or purchase of an illegal or controlled substance while on the job

Violation of these rules and standards of conduct will not be tolerated, and CalOptima shall take appropriate actions including, but not limited to, employee discipline, up to and including termination. CalOptima also may bring the matter to the attention of appropriate law enforcement authorities and/or professional licensing authority.

CalOptima reserves the right to conduct searches of CalOptima property or employees and/or their personal property, and to implement other measures necessary to deter and detect abuse of this policy. CalOptima asserts its legal right and prerogative to test certain employees for substance abuse. These employees may be asked to submit a medical examination and/or to submit to urine testing for illegal drugs, controlled substances or alcohol under the following circumstances:

- Employees in certain positions are required to pass a pre-employment urine drug test.
- Employees in certain positions may be subject to random drug testing.
- If the CalOptima employee is involved in a traffic accident and there is reasonable suspicion of the involvement of drugs and/or alcohol
- If an employee's supervisor suspects an employee is under the influence of drugs and/or alcohol and observes one or more symptoms

Employee acceptance of medical examinations and testing, when requested by CalOptima for one of the reasons set forth above, is a mandatory condition of employment. Refusal to submit to such medical examinations and tests constitutes a violation of CalOptima's policy and is grounds for disciplinary action, up to and including immediate termination of employment.

Any employee who is using prescription or over-the-counter drugs that may impair the employee's ability to safely perform the job, or affect the safety or well-being of others, must notify a supervisor of such use immediately before starting or resuming work. Any prescription medication, which must be taken while at work, should be kept in the original prescription container and used in accordance with the prescribing physician's instructions. CalOptima reserves the right to require written medical certification of the employee's ability to perform his or her duties while taking any prescribed medication.

All CalOptima employees who provide health care services and personal care services to CalOptima members may be subject to random drug testing. This shall include any employee who operates a CalOptima owned or

leased motor vehicle.

All CalOptima employees that have face-to-face interaction in the residence of a member or prospective member and provide health care services or personal care services, such as nurses in the field, may be subject to random drug testing.

Employees are required to report any drug and/or alcohol related convictions occurring in the workplace to CalOptima within five days of such conviction. This information may subject the employee to disciplinary action, random testing requirements, referral to the EAP, and/or may be reported to the appropriate licensing authority.

See Human Resources Policy GA.8052: Drug-Free and Alcohol-Free Workplace

Employee Access to Personnel Records

Employees of CalOptima, in certain instances, are given permission to have access to information in their own personnel files. Employees may request access to this information at a reasonable time and place by appointment, usually during business hours in the Human Resources department, unless another time or place is mutually agreed upon. CalOptima reserves the right to monitor the inspection of the file to ensure that nothing is removed, destroyed or altered, and that it is returned to its proper location. The right to inspection does not include certain records including, but not limited to, records relating to investigations, letters of reference, and/or records obtained prior to the employee's employment or were obtained in connection with a promotion or transfer.

Change of Employee Personal Information

Each employee is required to report promptly any change in his/her status and/or personal information to the Human Resources department as soon as it occurs. Such changes include name, address, marital status, telephone number, number of dependents, person(s) to be notified in case of emergency, physical limitations, beneficiary, etc. This information affects deductions, health coverage and many other aspects of employment.

It is vitally important to notify the Human Resources department within 30 days of a status change such as marriage, divorce, birth or adoption. Status changes may be made through the Employee Self-Service module on the CalOptima InfoNet. Failure to notify Human Resources of these qualifying events may preclude or delay changes in eligibility for insurance.

Confidential Information

CalOptima property includes not only tangible property, like desks, file cabinets and computers, but also intangible property such as information. CalOptima has a particular interest in protecting its proprietary, private and/or confidential information. Proprietary information includes all information obtained by CalOptima employees during the course of their work including, but not limited to, intellectual property, computer software, and provider identification numbers. Private information includes, but is not limited to, any information related to a person's health, employment application, residence address, testing scores, personnel review or social security number. Confidential information is any CalOptima information that is not known generally to the public including, but not limited to, Protected Health Information (PHI), personnel files, provider rates, DHCS reimbursements, and any other information that may exist in contracts, administrative files, personnel records, computer records, computer programs, and financial data.

CalOptima employees or agents may not reveal or disclose, divulge, or make accessible, proprietary, private, and/or confidential information belonging to, or obtained through, the employee's affiliation with CalOptima to

any person, including relatives, friends, and business and professional associates, other than persons who have a legitimate business need for such information and to whom CalOptima has authorized disclosure. Employees may not disclose or use proprietary or confidential information, except as their jobs require. Inappropriate use or disclosure of confidential, private or proprietary CalOptima information obtained through the employee's affiliation with CalOptima will subject an employee to discipline, up to and including termination and possible legal recourse.

Confidentiality and the Health Insurance Portability and Accountability Act (HIPAA)

CalOptima is committed to protecting the confidential, sensitive and proprietary health information of our members. HIPAA addresses our need to protect and safeguard our members' information. This includes making sure electronic health information is secure, taking precautions to safeguard member files, and following all other HIPAA regulations regarding Protected Health Information (PHI). Please contact our HIPAA Officer for more information. Failure to follow HIPAA regulations and CalOptima policies concerning protection of member files and information may subject an employee to discipline, up to and including termination and possible legal recourse.

See Human Resources Policy GA.8050: Confidentiality and Disclosure

Compliance Program

CalOptima maintains a comprehensive Compliance Program, part of which is a plan to detect, investigate and report fraud, waste and abuse in any and all of the CalOptima programs. CalOptima employees are required to report any and all suspected or actual cases of fraud, waste and abuse to the CalOptima Office of Compliance. An employee can file a report anonymously by contacting the CalOptima Compliance and Ethics Hotline at 1-877-837-4417. Employees can also file a Fraud and Abuse Referral form with the Office of Compliance, which is available on the CalOptima InfoNet. In addition, employees are always welcome to speak with their supervisor or the Compliance director at any time with any concerns they may have. CalOptima maintains a strict policy of non-retaliation and non-retribution toward employees who make such reports in good faith. Employees are protected from retaliation under 31 U.S.C. § 3730(h) for False Claims Act complaints, as well as any other anti-retaliation protections.

The CalOptima Code of Conduct provides that CalOptima employees are expected and required to promptly report suspected violations of any statute, regulation or guideline applicable to any CalOptima program, its policies and procedures and its Compliance program. Failure to comply with the Compliance program, including CalOptima's Code of Conduct, may lead to disciplinary action. Discipline, at CalOptima's discretion, may include progressive discipline or may lead to direct termination in accordance with CalOptima policies. In addition, failure to comply with CalOptima's Compliance program and Code of Conduct may result in the imposition of civil, criminal, or administrative fines on the employee and/or CalOptima, which may include exclusion from participation in federal and/or state health care programs.

Code of Conduct

CalOptima maintains a strict Code of Conduct governing employee conduct, as well as ethical behavior related to and/or concerning work-related decisions. CalOptima expects all employees to follow this code and to report situations in which they become aware of circumstances and/or behaviors which do not live up to CalOptima's standard. In order to discourage inappropriate conduct and/or illegal activities and to protect member confidentiality, CalOptima maintains the CalOptima Compliance and Ethics Hotline at 1-877-837-4417 to provide an opportunity for all employees to report unethical conduct. CalOptima maintains a strict policy of non-retaliation and non-retribution toward employees who make such reports in good faith. Employees are protected from retaliation under 31 U.S.C. § 3730(h) for False Claims Act complaints, as well as any other anti-retaliation

protections.

The CalOptima Code of Conduct provides that CalOptima employees are encouraged to speak up and report any instance in which unethical behavior occurs as outlined in the Code of Conduct policy. Failure to comply with the Code of Conduct may lead to disciplinary action, up to and including termination.

See CalOptima's Code of Conduct

Dress Code

CalOptima has adopted a Business Casual Attire Dress policy as the standard attire from Monday through Thursday. Employees must choose business casual clothing that communicates professionalism. Business casual includes CalOptima logo attire.

There may be times that management may require employees to dress in customary business professional attire including, but not limited to, when presenting to the Board of Directors, meeting with members of the business community or representing the organization at an outside community function.

The following dress guideline outlines the general workplace standard that must be followed by CalOptima employees. Management within each department shall have the discretion to determine appropriate attire and grooming requirements for employees based upon job duties.

Business Casual: Business casual attire includes suits, dress pants, dress shirts, dress sandals, sweaters, dresses and skirts. Ties may be worn but are not required. All clothing should be clean, pressed and in good repair. The height of heels should be suitable to the individual to prevent safety hazards. In all cases, management within each respective department will define "appropriate" business casual attire. We ask that employees not wear jeans (or any type of denim or any color jeans), spaghetti strap shirts, see-through clothing, short skirts, any type of shorts (at or above the knee), casual sandals (such as flip flops or beach attire), tennis shoes, capri pants (unless part of a professional dress suit or two-piece business outfit), leggings or stretch pants, clothing displaying any written words or symbols (with the exception of CalOptima logo attire or brand names or symbols), clothing that reveals undergarments or parts of the body incompatible with a professional setting, or any type of hat, unless the employee obtains prior approval from Human Resources.

CalOptima Logo Attire (Monday–Friday): CalOptima logo attire includes dress shirts, polo shirts or other shirts purchased through the Human Resources department with CalOptima's logo displayed. Logo attire from any CalOptima program is allowed. These shirts must be partnered with dress pants or khaki pants in good condition. Logo attire is allowed Monday through Friday. CalOptima logo attire may not be worn with jeans, shorts or capri pants from Monday through Thursday.

Casual Attire (Friday): Casual attire is a benefit permitted only on Fridays, unless otherwise specified. As with business casual attire, casual attire should be neat in appearance and in good repair, with no tears or holes. Casual attire includes jeans, capri pants (loose and below the knee), casual sandals (no flip flops), tennis shoes or other casual clothing in good condition. Leggings or stretch slacks are acceptable only when worn with a dress or long shirt that falls at least below the mid-thigh level. We ask that employees not wear any type of jogging or sweat suits/sweatpants, halter tops, spaghetti strap shirts, see-through clothing, ripped jeans, shorts (at or above the knee), clothing that reveals undergarments or other parts of the body incompatible with a professional environment, clothing displaying any written words or symbols (with the exception of CalOptima logo attire, brand names or symbols, sports teams, or university/school/club names or logos), or any type of hat unless the employee obtains prior approval from Human Resources.

As a benefit, employees may dress in casual attire every Friday and every year during the following times, unless otherwise specified:

- The week of Thanksgiving
- The period between Christmas and New Years Day
- The period between Memorial Day and Labor Day
- National Customer Service Week (First week of October)

Employees may be subject to disciplinary action, up to and including termination, for violations of CalOptima's dress code policy.

See Human Resources Policy GA.8032: Employee Dress Code

Conflict of Interest

Employees are expected to devote their best efforts and attention to the full-time performance of their jobs. Employees are expected to use good judgment, to adhere to high ethical standards, and to avoid situations that create an actual or potential conflict or the appearance of a conflict between the employee's personal interests and the interests of CalOptima. It is CalOptima's view that both the actual and appearance of a conflict of interest must be avoided.

Employees unsure as to whether a certain personal or non-CalOptima transaction, activity or relationship constitutes a conflict of interest should discuss it with their immediate supervisor or the Human Resources department for clarification. Any exceptions to this guideline must be approved in writing by CalOptima's Chief Executive Officer (CEO).

While it is not feasible to describe all possible conflicts of interest that could develop, some of the more common actual or potential conflicts, which employees should avoid, include the following:

1. Accepting personal gifts or entertainment from current or potential providers, members or suppliers that is more than twenty-five dollars (\$25) in a calendar year from any single source
2. Working for a current or potential provider, contractor, vendor, member or supplier, association of contractors, vendors, providers, or other organizations with which CalOptima does business or which seek to do business with CalOptima, except when it is determined that the nature of the job does not create a conflict
3. Engaging in self-employment in competition with CalOptima
4. Using proprietary or confidential CalOptima information for personal gain, or the gain of others, or CalOptima's detriment
5. Having a direct or indirect financial interest in or relationship with a current or potential provider, supplier or member; except when it is determined that the nature or financial interest does not create a conflict
6. Using CalOptima assets or labor for personal use
7. Acquiring any interest in property or assets of any kind for the purpose of selling or leasing it to CalOptima
8. Committing CalOptima to give its financial or other support to any outside activity or organization

If an employee or someone with whom an employee has a close relationship (a family member or close companion) has a financial or employment relationship with a current or potential provider, contractor, vendor, supplier or member, the employee must disclose this fact in writing to the Human Resources department. Employees should be aware that if they enter into a personal relationship with an employee of a current or potential provider, supplier or member, a conflict of interest might exist, which requires full disclosure to CalOptima.

All CalOptima employees are required to promptly report any and all non-CalOptima job positions, positions held on non-profit/charitable organizations, and/or their affiliations or interests in job-related businesses or organizations to the Human Resources department.

In addition to these provisions, designated employees are also subject to the provisions of the Conflict of Interest Code adopted by the CalOptima Board of Directors in compliance with the California Government Code. Designated employees must complete a Form 700 and a CalOptima Supplemental Form upon hire, annually and upon termination of employment. The Human Resources Department coordinates this activity with the Clerk of the CalOptima Board.

Failure to adhere to this guideline, including failure to disclose any conflicts or to seek an exception, may result in discipline, up to and including termination of employment and/or criminal, civil or administrative action.

See Human Resources Policy GA.8012: Conflicts of Interest

Guests

Due to the confidential nature of CalOptima's operations, employees are discouraged from having visitors at work, unless necessary or related to performance of job duties. Children of employees are not allowed on the premises during working hours unless attending a formal CalOptima sponsored function. All guests must register at the reception desk in the lobby and obtain a guest badge. Guests shall not be permitted to walk around CalOptima's secured areas unaccompanied.

Benefits

Introduction

CalOptima is proud of the comprehensive benefits package we provide to our employees. This section of the handbook is designed to acquaint employees with some of the more significant features of CalOptima's employee benefits. It is important to remember that more detailed information is set forth in the official plan documents, summary plans descriptions and/or group policy contracts that govern the plans. Accordingly, if there is any real or apparent conflict between the brief summaries contained in this manual and the terms, conditions, limitations or exclusions of the official plan documents, the provisions of the official plan documents will control over these brief summaries. Employees are welcome and encouraged to review the official plan documents, available in the Human Resources department, for further information.

Workers' Compensation

CalOptima, in accordance with state law, provides insurance coverage for employees in case of work-related injuries. The cost of this insurance is completely paid for by CalOptima. The Workers' Compensation benefits provided to injured employees may include:

- Medical, surgical and hospital treatment
- Partial payment for lost earnings that result from work-related injuries
- Rehabilitation services to help injured employees return to a suitable employment

Employees are required to report all on-the-job injuries to their supervisor and Human Resources immediately, regardless of how minor the injury may be. CalOptima is legally required to report serious injuries or illnesses, including the death of an employee, within eight hours of the incident and/or accident.

See Human Resources Policy GA.8041: Workers' Compensation Leave of Absence

Paid Time Off and Workers' Compensation

Workers' Compensation does not usually cover absences for medical treatment, follow-up doctor's appointments, physical therapy appointments, and/or other appointments related to a Workers' Compensation claim or injury. When an employee reports a work-related illness or injury, he or she will be sent to CalOptima's designated clinic if medical treatment is necessary. Employees may have the option of seeing their own doctor if their doctor has previously been designated as the treating physician and this authorization has been submitted to Human Resources. CalOptima generally participates in a Medical Provider Network (MPN), through which all treatments are provided to the employee. All appointments related to treatment must be coordinated through the Workers' Compensation insurance company and the Human Resources department.

Any further medical treatment will be under the direction of the employee's primary treating physician. Employees returning to work or who are still working after a work-related injury or illness under the Workers' Compensation Act are required to coordinate with their supervisor to use accrued PTO or make up time away from work, consistent with CalOptima's time-keeping requirements, for follow-up medical appointments. Employees who do not have sufficient PTO accruals may take unpaid time off for follow-up medical appointments. Appointments should be scheduled in a manner that provides the least disruption to the employee's normal work schedule.

Core Health Benefits

The benefits CalOptima offers its employees are an important part of a total compensation package. Such benefits, like health and life insurance, would be significantly more expensive if employees had to purchase them privately. CalOptima's benefits are regularly reviewed to ensure that they are competitive with those offered by other public agencies and organizations in Southern California.

All regular full-time, regular part-time and limited term employees and, if elected, their eligible family members, are eligible for health insurance benefits beginning the first day of the month following the employee's date of hire. However, if the date of hire is on the first of the month, health insurance benefits begin effective on the hire date. Eligible family members include: spouses, registered domestic partners and dependent children. Documentation certifying eligibility is required. Coverage will commence on the first of the month following the employee's date of hire.

Employment eligibility requirements and enrollment change information is available in the individual Summary of Benefits and Coverage (SBC), Summary Plan Descriptions (SPD) and other benefits booklets. Questions regarding any of CalOptima's benefits should be directed to the Human Resources department.

Once enrolled, the employee's elections will remain in effect for the entire or remaining plan year (January 1 through December 31) unless the employee has a qualifying event. Many of the deductions taken on CalOptima employee health benefits are taken on a pre-tax basis since CalOptima participates in a Flexible Benefits Plan (Cafeteria Section 125 Plan). For this reason, changes to medical, dental, vision, health or dependent care flexible spending accounts (FSA) may only be made with the submission of supporting documentation that provides substantiation of the qualifying event. Some examples of qualifying events include, but are not limited to: marriage, divorce, birth/adoption of child, over-age dependent and change of spouse's employment. If one of these events occurs, the Human Resources department must be contacted within 30 days to make a change. Otherwise, employees are required to wait until the next annual open enrollment period, usually held in October of each year, to make any changes to their elections. The effective date for qualifying event changes can only be made prospectively, not retroactively.

When health benefits coverage terminates due to an extended personal leave of absence or termination of employment with CalOptima, employees may be eligible under COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) to continue enrollment for a period of time. Additional information is mailed to terminated employees from a third party COBRA administrator following the last day of employment.

Upon an employee's separation from CalOptima, health insurance benefits continue through the end of the month that he or she terminates in. The employee is responsible for his or her share of the costs for health insurance benefits for the entire month, and appropriate deductions will be included in the employee's final paycheck.

Below is list of core benefits available to eligible full-time and part-time regular employees, as well as limited term employees. The employee premiums, deductions from payroll for these benefits, vary depending on the employee's employment classification and annual modifications based on changes in premiums from our carriers. CalOptima reserves the rights to modify, change, eliminate or add to the following list of benefits at its sole discretion:

Health — CalOptima provides different options for affordable HMO and PPO health plans that include a broad network of medical groups and hospital access with a very reasonable co-pay structure for office visits and pharmacy benefits. A High Deduction Health Plan (HDHP), inclusive of employer contributions, and a Health Savings Account (HSA) are available at the employee's election.

Dental — Comprehensive dental plans that include preventive dental care visits at no charge, as well as orthodontia benefits, are available to CalOptima employees.

Vision — CalOptima's vision plan design allows for eye examinations, glasses and contact lenses.

Life and AD&D — Full-time regular employees receive a \$50,000 life and accidental death and dismemberment (AD&D) insurance policy, or one times the employee's basic annual earnings, whichever is higher, with a maximum amount of \$325,000. Part-time regular employees receive a \$25,000 life and AD&D insurance policy, or one times their basic annual earnings, whichever is higher.

Short-Term Disability — An employee with a qualifying disability/condition may receive short-term disability benefits, which pays 60 percent of an employee's regular wages for a period of time following a waiting period. This benefit is a substitute for state disability benefits as CalOptima does not participate with the State Disability Insurance (SDI) program. CalOptima provides this benefit free to eligible employees.

Long-Term Disability — An eligible employee with a qualifying disability/condition may receive long-term disability benefits, which pays 60 percent of regular wages until normal retirement age, as long as the employee meets the definition of disability. This benefit is used in lieu of state disability benefits since CalOptima does not participate with the State Disability Insurance (SDI) program. CalOptima provides this benefit free to eligible employees.

Employee Assistance Program (EAP) — This free and confidential resource provides easy and accessible services to employees (and some extended family members) for behavioral health issues such as: counseling for relationship issues, emotional well-being, legal and financial assistance, substance abuse, as well as workplace challenges.

CalOptima also offers additional voluntary benefits to eligible employees. These voluntary optional benefits may include benefits such as: additional voluntary life and AD&D insurance, whole life and critical illness insurance plans, legal plans and flexible spending accounts (FSA). All voluntary benefit premiums are 100 percent paid for by the employee.

Retirement Benefits

CalPERS (California Public Employees Retirement System) Defined Benefit Plan — CalOptima has contracted with CalPERS instead of participating in Social Security. Regular full-time, regular part-time and limited term employees are automatically enrolled into the CalPERS plan upon date of eligibility, which is usually the employee's date of hire. To be eligible for service retirement with CalPERS, employees must be at least age 50 and have a minimum of five years credited service. For new employees hired on or after December 1, 2013, who do not have reciprocal rights, the minimum retirement age for new hires has been increased to 52; however, the years of credited service remains five. Classic CalPERS members (those that established membership prior to January 1, 2013) are enrolled in the 2 percent @ 60 benefit formula. New members (those that established membership on or after January 1, 2013) are enrolled in the 2 percent @ 62 formula. Basic CalPERS plan information is provided to employees during their first month of employment.

PARS (Public Agency Retirement Services) Defined Contribution Plan — This supplemental retirement plan is a 401(a) tax-qualified multiple employer trust. All regular full-time, regular part-time and limited term employees are automatically enrolled and a contribution is made by CalOptima. There is a vesting requirement based on quarters of service. Contributions are automatically invested into a life-cycle mutual fund and professionally managed; however, employees have the option to self-direct fund investments in their account. Basic plan information is provided to employees during their first month of employment.

457b Deferred Compensation Plan — A 457b voluntary plan is also offered as a way to save for retirement. All deposits to this plan are made by the employee. The annual IRS regulated contribution limit generally increases each year and catch-up contribution provisions are available for those who are age 50 and above. The employee

determines his or her contribution amount as well as his or her investment allocation. A licensed financial advisor will provide plan related information, usually within the first month of employment.

Social Security Retirement — CalOptima does not participate in Social Security. All regular full-time and regular part-time employees are considered Social Security tax exempt and pay into CalPERS instead of Social Security. Upon hire, Human Resources will explain how CalPERS and Social Security work together. The Human Resources department will inform employees about two important Social Security provisions: Government Pension Offset and Windfall Elimination Provision. As-needed employees are not eligible for CalPERS membership, therefore, by default, they are the exception to this rule and will see a FICA/Social Security deduction taken from their payroll, and subsequently are only authorized to work up to 1,000 hours per fiscal year on a general basis.

Medicare — The employee and CalOptima each contribute their proportionate share to Medicare.

Paid Time Off (PTO)

CalOptima provides paid time off (PTO) benefits to all eligible employees to enable them to take time off for rest and recreation and to recover from illness. CalOptima believes this time is valuable for employees in order to enhance productivity and to make the work experience more personally satisfying. CalOptima provides long-service employees with additional PTO benefits as years of service are accumulated.

Full-time, part-time and limited-term employees who are regularly scheduled to work more than 20 hours per week are eligible to accrue PTO. An eligible employee may use PTO hours for vacation, preventive health or dental care or care of an existing health condition of the employee or the employee's family member, short-term illness, family illness, emergencies, religious observances, personal business, or for specified purposes if the employee is a victim of domestic violence, sexual assault or stalking. CalOptima encourages all employees to maintain a work-life balance by utilizing PTO benefits for rest and recreation throughout the year.

The maximum amount permitted in an employee's PTO account is equal to two (2) times the employee's annual PTO accrual rate. When an employee reaches his or her maximum PTO accrual amount, the employee will stop accruing PTO. PTO accruals will only accrue in conjunction with CalOptima payroll and will be prorated based on hours earned.

Eligible employees accrue PTO based on their classification as exempt or non-exempt, hours paid (excluding overtime) each pay period (non-exempt employees), and years of continuous services in accordance with the following accrual schedule below. PTO begins accruing from the date of hire.

Annual Paid Time Off Benefits Accrual Schedule

Non-Exempt Employees:

Years of Continuous Service	Hours of PTO Earned (Biweekly pay period)	Hours Accrued per Year	Days Accrued per Year
0–3	5.54	144	18
4–10	7.08	184	23
11 +	8.62	224	28

Exempt Employees:

Years of Continuous Service	Hours of PTO Earned (Biweekly pay period)	Hours Accrued per Year	Days Accrued per Year
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0–3	7.08	184	23
4–10	8.62	224	28
11 +	10.15	264	33

See Human Resources Policy GA.8018: Paid Time Off (PTO)

Paid Sick Leave

CalOptima provides employees who are eligible to accrue PTO a sufficient amount of PTO that can be used for sick leave that satisfies the accrual, carryover and use requirements under the Healthy Workplaces, Healthy Families Act of 2014 (Act). For all other employees who are not eligible to accrue PTO, effective July 1, 2015, as-needed, per diem, or temporary employees may become eligible for paid sick leave if the employee works 30 or more days within one year from the start of their date of employment. Twenty-four hours or three days, whichever is greater, of paid sick leave is provided only to eligible employees who do not accrue PTO.

Upon satisfying a 90-day employment period, employees may use accrued sick leave for preventative care or diagnosis, care or treatment of an existing health condition of the employee or the employee's family member, or for specified purposes if the employee is a victim of domestic violence, sexual assault or stalking.

Upon termination, resignation, retirement or other separation from employment, CalOptima will not pay out employees for unused paid sick leave time accrued under the Act. If an employee separates and is then rehired by CalOptima within one year from the date of separation, the previously accrued and unused paid sick leave time will be reinstated. An employee rehired within one year from the date of separation may not be subject to the Act's 90-day waiting period, if such condition was previously satisfied, and may use their paid sick leave time immediately upon rehire, if eligible.

See Human Resources Policy GA. 8018: Paid Time Off (PTO)

Holidays

CalOptima generally observes the following holidays:

- New Year's Day
- Martin Luther King Jr. Day
- Presidents' Day
- Memorial Day
- Independence Day
- Labor Day
- Veteran's Day
- Thanksgiving Day and the Friday after Thanksgiving
- Christmas Day
- One Flex Day (accrues on January 1st)

A holiday that falls on a Saturday or Sunday is usually observed on the preceding Friday or the following Monday. Holiday observances will be announced in advance. CalOptima may, in its discretion, require an employee to work on scheduled holidays. If a non-exempt employee is required to work a scheduled holiday, he or she will receive his or her regular rate of pay for the holiday pay in addition to his or her regular compensation for the hours of actual work performed.

Flex Holidays

Employees will receive a maximum of one flex holiday (maximum of eight (8) hours, prorated based on scheduled work hours) on January 1st ~~of each year~~; however, CalOptima reserves the right to assign a specific date for the flex holiday for business reasons and/or needs. Limits are imposed on the number of flex holiday hours that can be maintained in the employee's flex holiday account. A maximum of twelve (12) hours, prorated based on scheduled work hours, may be maintained in an employee's flex holiday account as of January 1st of each year. In the event that available flex holiday hours are not used by the last pay period of the calendar year, employees may carry unused flex holiday hours into subsequent years and may accrue additional hours up to the maximum of eight (8) hours, prorated based on the scheduled work hours. If an employee reaches the maximum amount of twelve (12) hours on January 1st, prorated based on the scheduled work hours, the employee will stop accruing flex holiday hours. Flex holiday hours are not eligible for annual cash out applicable to PTO hours. Employees must use the flex holiday in the same calendar year that it is accrued and by the last pay period of that year. If an employee fails to use his or her accrued flex holiday in the same calendar year it is accrued, the employee will lose the flex holiday and it will not carry over to the next calendar year. In addition, flex holiday hours are not eligible for cash out. Employees will accrue a flex holiday the following calendar year. However, if an employee separates from CalOptima and has unused flex holiday hours, the unused flex holiday hours for that calendar year will be paid out at the same time and in the same manner as unused PTO hours upon termination.

Eligibility

Regular full-time, regular part-time and limited-term employees who are regularly scheduled to work 20 or more hours per week are eligible for holiday benefits and flex holiday accrual hours, but will be prorated based on their scheduled work hours at the time of the holiday. To receive holiday pay, employees must work or be paid for the regularly scheduled workdays preceding and following the CalOptima holiday. ~~If an employee calls in sick on the scheduled workday immediately before or after a holiday, management has the right to ask for a doctor's note to verify the absence. Failure to provide verification may result in loss of holiday pay.~~

Education Reimbursement

CalOptima believes in the development and growth of its employees. In order to encourage developmental progression, CalOptima provides an Education Reimbursement Program to offer repayment of reasonable educational and professional development expenses for work-related courses and/or programs, including professional licensure requirements, to all eligible regular full-time or part-time employees who have completed their initial 180 days of employment.

Courses eligible for tuition reimbursement must be either part of an accredited college degree program, certifications awarded by state or national professional organizations, or individual local courses provided by credible institutions that meet one the following conditions:

1. Educate the employee in new concepts and methods in their present assignment.
2. Help prepare the employee for advancement to positions of greater responsibility available within CalOptima.

Attendance at outside education courses and/or programs, whether required by CalOptima or requested by individual employees, requires prior written management and Human Resources approval. Details of the program and how to apply for reimbursement are available in the Human Resources department. The Human Resources department shall be responsible for developing, administering and maintaining the program. In order to be reimbursed, eligible employees must satisfactorily complete a work-related course or program or complete a professional certification offered by an accredited school, community college, college, university or other

recognized professional organization or learning institution. Miscellaneous expenses such as parking, books and supplies are not covered and shall not be reimbursed.

Seminars, conferences or business meetings that do not result in certification are not covered under Education Reimbursement.

See Human Resources Policy GA.8036: Education Reimbursement

Unemployment Insurance

CalOptima contributes to the California Unemployment Insurance Fund on behalf of its employees in the event employees become unemployed through no fault of their own. Eligibility for Unemployment Insurance is determined solely by the Employment Development Department (EDD) of the State of California.

COBRA

CalOptima complies with the provisions and requirements of both the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Both Acts provide for continued coverage of an employee's, his or her spouse's, and his or her dependents' health benefit coverage in the event that the employee is no longer eligible for CalOptima's group health coverage. Please see the Human Resources department for additional information.

CalOptima Property

Employer Property

Cubicles, desks, computers, vehicles and other CalOptima owned or leased items are considered CalOptima property and must be maintained according to CalOptima's policies, rules and regulations. CalOptima property must be kept clean and in good condition. Decorations in an employee's work space should fit with the overall professional business atmosphere CalOptima projects and should take into consideration the needs and sensitivities of our members, providers, fellow employees and the public.

Posters, calendars, personal affects, etc. are not allowed to be taped or tacked to shared areas such as filing cabinets, corridors, walls or doors. In addition, the placing of items outside of a work station panel is prohibited. If an employee has any items that need to be mounted on a wall within his or her workstation or office, he or she should request assistance from the Facilities department. CalOptima reserves the right to inspect all CalOptima property to ensure compliance with its policies, rules and regulations, without notice to the employee and at any time, not necessarily in the employee's presence.

Employees are asked to minimize personal phone calls and messages from personal callers to avoid interruption of work. CalOptima understands that, from time-to-time, personal or family calls or messages are necessary; however, employees are expected to use good judgment and, whenever possible, to limit these calls to meal and break times. CalOptima reserves the right to monitor voice mail messages and email messages to ensure compliance with this rule, without notice to the employee and at any time, not necessarily in the employee's presence. Employees should be aware that as a public agency, all documents, including email messages, are public records and may be subject to disclosure. Employees should not have any expectation of privacy concerning email messages sent and received from CalOptima email.

Prior authorization must be obtained before any CalOptima property may be removed from the premises. For security reasons, employees should not leave personal belongings of value in the workplace or in plain view. Employees are solely responsible for their own personal belongings, and CalOptima shall not be liable for any lost, stolen or misplaced personal belongings. Personal items in and on CalOptima property are subject to reasonable inspection and search.

Terminated employees must remove any personal items at the time they leave CalOptima or make arrangements with Human Resources to remove these items. Personal items left in the workplace are subject to disposal if arrangements are not made at the time of an employee's termination. CalOptima shall not be responsible for any lost or discarded personal items left behind. Terminated employees who have CalOptima property at their home must make arrangements with Human Resources to have these items picked up within a week of their termination date.

Housekeeping

All employees are expected to keep their work areas clean and organized. The use of personal floor or desktop heaters, coffee makers and mini-refrigerators is not permitted in the cubicles.

People using common areas such as lunch rooms, locker rooms, conference rooms and restrooms are expected to use appropriate and courteous etiquette including keeping the common areas sanitary and in a clean state for the next person to use. Employees should clean up immediately after meals and dispose of trash properly. CalOptima encourages good health habits to prevent the spread of germs, colds, the flu and other illnesses.

Off-Duty Use of Facilities

Employees are prohibited from remaining on CalOptima premises or making personal use of CalOptima facilities while not on duty without prior permission from the Human Resources department.

Cell Phones

Driving with Cell Phones:

In the interest of the safety of our employees and other drivers, and in compliance with state laws, CalOptima employees are prohibited from using cell phones without a hands-free device and prohibited from text messaging and/or searching the internet while driving on CalOptima business and/or driving during CalOptima time. If an employee's job requires that he or she keep his or her cell phone turned on while he or she is driving, he or she must use a hands-free device and operate the vehicle safely. Cell phones may not be used under any circumstances or in any manner that would distract an employee from the duty to drive in a safe and non-negligent manner.

Cell Phone Etiquette:

We ask that employees are considerate of others when using a cell phone during work hours and while on duty. Appropriate phone etiquette includes putting phones on silent or vibrate mode to minimize disruptions, and minimizing text messaging and internet surfing during meetings. Employees should refrain from excessive use of personal hand-held devices during work hours and while on duty for non-job related duties. Employees are asked to minimize personal cell phone calls and text messages or personal emails unrelated to CalOptima business on hand-held devices to avoid interruption of work. Employees are asked to refrain from using cell phones in restrooms. Employees are expected to use good judgment and, whenever possible, to limit these personal cell phone calls or use of hand-held devices to meal and break times.

~~See Human Resources Policy GA.8017: Cellular Telephone Program~~

Restrictions on Smoking and Unregulated Nicotine Products

As a public agency providing access to quality health care services, CalOptima endeavors to maintain a safe and healthful environment for its employees, members and visitors to CalOptima property. In keeping with this philosophy, it is important that the workplace and office environment reflect CalOptima's concern for good health. Therefore, smoking, inclusive of electronic smoking devices, and the use of unregulated nicotine products is strictly prohibited inside the building, and is allowed only in designated outside smoking areas at least 25 feet away from any CalOptima owned or leased building. Employees who wish to smoke, inclusive of electronic smoking devices, or use unregulated nicotine products, must limit their smoking or use of unregulated nicotine products to break and meal periods in areas outside of work premises and only in designated smoking areas.

See Human Resources Policy GA.8048: Restrictions on Smoking and Unregulated Nicotine Products

Computer, Email and Internet Usage

CalOptima recognizes that use of the Internet has many benefits for CalOptima and its employees. The Internet and email make communication more efficient and effective. Therefore, employees are encouraged to use and access the Internet appropriately. Unacceptable use of the Internet and email can place CalOptima and others at risk. As a public agency, we must be mindful that our written communications, stored data and internet searches could constitute a public record. Therefore, all communications, including emails, and internet usage should be business appropriate.

The following guidelines have been established for using the Internet and email in an appropriate, ethical and professional manner:

- CalOptima's Internet and email access may not be used for transmitting, retrieving or storing of any communications of a defamatory, discriminatory or harassing nature or materials that are obscene, sexually suggestive or explicit.
- No messages with derogatory or inflammatory remarks about an individual's race, age, disability, religion, national origin, physical attributes or sexual preference shall be transmitted. Harassment and discrimination of any kind or form is strictly prohibited.
- Disparaging, abusive, profane, discriminatory or offensive language and any illegal activities are forbidden. The posting, uploading or downloading of pornographic or vulgar messages, photos, images, sound files, text files, video files, newsletters or related materials is strictly prohibited.
- Each employee is responsible for the content of all text, audio or images that he/she places or sends over CalOptima's Internet and email system. No email or other electronic communications may be sent that hides the identity of the sender or represents the sender as someone else.
- CalOptima recognizes that at times employees may receive personal emails related to doctor's visits, school information, etc. CalOptima employees should minimize the personal use of e-mail or the Internet and try to restrict personal email and Internet use to break periods. Employees are encouraged to use personal Internet email accounts to communicate regarding non-work-related matters and to keep this to a minimum.
- Users shall have no expectation or assumption of confidentiality or privacy of any kind related to the use of emails and the Internet. CalOptima has the right, with or without cause or notice, to access, examine, monitor and regulate all electronic communications, including email messages, directories and files, as well as Internet usage. Also, the Internet is not secure, so employees should not assume that others cannot read or possibly alter messages.
- Internal and external email messages are considered business records and may be subject to discovery in the event of litigation or disclosure in the event of a public records request. Be aware of this possibility when sending email within and outside CalOptima.
- Users shall ensure the security of Protected Health Information (PHI) in accordance with CalOptima's HIPAA policies.
- Users shall be responsible for using the Internet, email, InfoNet and internal office communicator in an appropriate manner. CalOptima shall block access to categories of websites deemed inappropriate (illegal, pornographic, etc.) or unnecessary (entertainment, games, etc.).

All CalOptima-supplied technology, including computer systems and CalOptima-related work records, belong to CalOptima and not the employee. CalOptima may routinely monitor usage patterns for its email and Internet communications. Since all the computer systems and software, as well as the email and Internet connection, are CalOptima owned, all CalOptima policies are in effect at all times during usage. Any employee who abuses the privilege of access to email and/or the Internet may be denied access to the Internet and, if appropriate, be subject to disciplinary action up to and including termination.

CalOptima may periodically need to assign and/or change passwords and personal codes for voice mail, email or computer login. CalOptima reserves the right to keep a record of all passwords and codes used for CalOptima business and/or may be able to override any such password system.

CalOptima has separate agreements with wireless providers. As a result, CalOptima employees may be eligible for discounts with these providers. Please check with Human Resources for more information.

See Administrative Policy GA.5005b: E-mail and Internet Use

Solicitation, Distribution and Bulletin Boards

CalOptima is an employer that values families and nonprofit organizations, and we want to support our employees with their fundraising activities. Employees should reserve fundraising activities for non-work time (breaks and lunch or after hours) and in non-work areas (break rooms). Solicitations should be discrete, courteous and carried out in a manner that does not interfere with CalOptima's operations. Please make sure that any solicitation involves requests that are professional and in good taste.

An employee may distribute or circulate non-CalOptima written materials to other employees only during non-working time and only in non-work areas. If an employee is unclear whether an area is a work or non-work area, he or she should consult his or her immediate supervisor or the Human Resources department for clarification.

Solicitation or distribution in any way connected with the sale of any goods or services for profit is strictly prohibited anywhere on CalOptima property at any time, unless otherwise approved by management. Similarly, solicitation or distribution of literature for any purpose by non-employees is strictly prohibited on CalOptima's property at any time.

CalOptima has a bulletin board located on each floor for the purpose of communicating with its employees. Postings on these boards are limited to CalOptima related material including statutory and legal notices, safety and work-related rules, CalOptima policies, memos of general interest relating to CalOptima and other items. All postings require the prior approval of the Human Resources director or designee.

Unauthorized posting of literature on CalOptima property (including bulletin boards, walls and the outside of cubicles) is strictly prohibited.

Photo-Identification Badges

Employees of CalOptima are required to wear their photo-identification badges while at CalOptima and, when appropriate, while conducting CalOptima business. Photo identification badges must be visible at all times while working on site. In addition, an employee's photo-identification badge also serves as a key to allow an employee access to his or her department, restrooms, break/lunch room and other permitted areas within the building.

Photo-identification badges and/or key cards are not transferable to other CalOptima employees, vendors or family members.

The employee's photo-identification badge is the property of CalOptima and must be returned when employment is terminated for any reason.

We also encourage employees to be aware of people in our work areas to make sure they are wearing a badge and are either CalOptima employees or escorted by CalOptima employees. If an employee notices someone who is not wearing a badge they are expected to report them to the Facilities department.

Wages and Work Schedules

Work Schedules

CalOptima's normal hours of operation are between the hours of 8 a.m. and 5 p.m., Monday through Friday, and our reception area is open during these hours. You and your supervisor will work out your individual work schedule, meal period and break times. All employees are expected to be at their desks or work stations at the start of their scheduled shifts, ready to work. CalOptima reserves the right to modify employees' starting and ending times and the number of hours worked.

Time-keeping Requirements

All hourly (non-exempt) employees are required to accurately record time worked for payroll purposes. Employees must record their own time at the start and at the end of each work day, including before and after unpaid lunch breaks. Except for scheduled break times, non-exempt employees also must record their time away from CalOptima premises whenever they leave the building for any reason other than CalOptima business. At the end of each pay period, each hourly (non-exempt) employee shall verify and approve this schedule through CalOptima's time-keeping system and submit it to his or her supervisor for approval. Any errors on an employee's timecard should be reported immediately to his or her immediate supervisor.

Supervisors will determine and notify employees of their regular work schedule/shift. Due to possible changes in work force and CalOptima's needs, CalOptima retains the right to change an employee's work schedule or the number of hours worked in a day, subject to all applicable wage and hour laws.

Exempt employees are not required to complete timecards and are not eligible for overtime. However, as a public agency employer, CalOptima has expectations of employees that are established pursuant to principles of public accountability. Exempt employees are expected to work a regular work schedule based on CalOptima's core business hours and should notify their supervisors in advance and accurately record any exceptions to their regular work schedule including, but not limited to, hours used for PTO, jury duty, bereavement leave, etc. CalOptima looks to exempt employees to demonstrate the level of commitment and conscientiousness that is appropriate to their status. Exempt employees work a minimum of forty (40) hours per week (for full-time employees) and may need to work additional hours to complete projects and tasks. It is common for exempt employees to work more than a 40 hour work week. As a result, subject to prior supervisor approval, occasional short-term absences (for example, two hours for a doctor's appointment) would not require the use of PTO accruals if the employee otherwise makes up the time away from work in the same pay period. Exempt employees are still required to be respectful and request this time off in advance from their supervisor. Supervisors will monitor an employee's time away from work and make up time to ensure accountability. Should an exempt employee work less than a full work day, and the employee does not otherwise make up the time off within the same pay period, the employee must request approval for PTO because this is lost time to the organization.

Workweek and Workday

The workweek on which weekly overtime calculations will be based begins each Sunday at midnight (12:01 a.m.) and ends the following Sunday at midnight. The work week will differ for employees working an alternative schedule such as 9/80 (see section regarding Alternative Work Schedules).

Payment and Wages

Normal paydays are every other Friday. Please consult CalOptima's pay schedule available through the Human Resources department.

Each paycheck will include base earnings for all reported hours performed through the end of the payroll period. The payroll period ends the Sunday prior to pay day at 12 a.m. In the event that a regularly scheduled payday falls on a holiday, employees will receive their pay on the last day of the workweek preceding the day off. All employees will receive an itemized statement of wages each payday.

Payment on Resignation or Termination

According to California Labor Code Section 220 (b), as a public agency, CalOptima is not required to pay wages immediately upon termination. If an employee resigns or is terminated, his or her final paycheck will be available on CalOptima's next regularly scheduled payday. The employee's final paycheck will include payment for all wages due and not previously paid and for accrued but unused PTO, minus authorized deductions.

Overtime

Hourly (Non-Exempt) Employees

Periodically, a need for overtime arises, either before or after the regular workday or on weekends. As a public agency, we follow federal wage and hour laws. Overtime will be provided for all **hours worked** in excess of 40 hours in any one work week at the rate of 1½ times the non-exempt employee's regular rate of pay. Overtime must be approved in advance by management.

Salaried (Exempt) Employees

Exempt employees are not covered by the overtime provisions and do not receive overtime pay.

Meal and Rest Periods

CalOptima recognizes how important it is to have a break during the work day. As a result, CalOptima encourages employees who work for a period of more than five hours to take an unpaid meal period of at least 30 minutes. CalOptima also recommends a paid rest period of no more than 15 minutes to be taken approximately halfway through any work period of 3½ hours or more. For example, employees should receive one 15-minute rest period in the first half of an 8-hour shift, and one 15-minute rest period in the second half of an 8-hour shift. Employees may not combine their breaks and lunch to alter their normal work hours.

Holiday Pay

Employees are paid their regular straight-time wages for CalOptima paid holidays as set forth in the Holidays section under Benefits in this handbook.

Make Up Time

CalOptima allows the use of makeup time when employees need time off to tend to personal obligations. For example, an employee might request makeup time in advance for the following situations:

- An employee needs to leave one hour early for a doctor's appointment on Monday and asks to make up that time on Tuesday by working an hour later.
- An employee on a 9/80 workweek will receive eight hours of holiday pay on a nine hour day and he or she asks in advance to make up the additional hour rather than take it from his or her PTO accruals.

Make up time worked will not be paid at an overtime rate and the work week in which the makeup time occurs cannot exceed 40 hours. Employees may take time off and then make up the time later in the same work week or

may work extra hours earlier in the work week to make up for time that will be taken off later in the work week.

Non-exempt employees should submit make up time requests **in advance** to their supervisor through CalOptima's time-keeping system and document their revised schedule into their timecard. Requests will be considered for approval based on the legitimate business needs of the department at the time the request is submitted. A separate written request is required for each occasion the employee requests make up time.

An employee's use of make-up time is completely voluntary. CalOptima does not encourage, discourage or solicit the use of make-up time.

Supplemental Compensation

In certain instances, CalOptima offers supplemental compensation, in addition to an employee's regular base pay, to compensate for business needs. Supplemental compensation includes, but is not limited to, compensation for:

- **Overtime:** Non-exempt employees will be paid overtime pay at a rate of 1.5 times the employee's base hourly rate of pay for all hours worked in excess of 40 in any one workweek. Exempt employees are not covered by the overtime provisions and do not receive overtime pay.
- **Night Shift:** A non-exempt employee who works an assigned night shift shall, in addition to his or her regular base pay, be paid a supplemental night shift pay for each hour actually worked on the assigned night shift.
- **Bilingual Pay:** A supplemental bilingual pay may be paid to a qualified exempt and non-exempt employee holding a position requiring bilingual proficiency in a specific language as designated by the department director.
- **Call Back Pay:** In certain departments, non-exempt employees are eligible for call back pay should they be asked to return to work by their supervisor.
- **On Call Pay:** On occasion, employees may be asked to be on call. On call pay is compensation provided to employees who must remain accessible after hours and/or on the weekends via pager or mobile phone, and be available to work via phone, fix problems or report to work, if necessary.
- **Certified Case Manager (CCM) Pay:** Supplemental pay may be paid to an RN who holds an active CCM certification.
- **Translation Pay:** The Cultural and Linguistic Services Program may compensate CalOptima employees outside of their department for translation work.

See Human Resources Policy GA.8042: Supplemental Compensation and Human Resources and Policy GA.8035: Translation Rates

Severance Pay

The Chief Executive Officer (CEO), in his sole and complete discretion, may authorize severance pay upon an employee's separation from service when it is deemed appropriate due to special circumstances; e.g., separations due to changing needs of CalOptima, a reorganization of functions or staffing, lack of work and/or changes in the technology or methods used for a specific position.

See Human Resources Policy GA.8047: Reduction in Force

Merit Pay

The annual performance review period established by the Chief Executive Officer is typically April 1–March 31,

with the annual salary review date occurring in July. In the event a performance review date is delayed for an employee and a positive performance review is given for the covered period that results in a recommended salary increase, CalOptima may make salary adjustments retroactive to the original performance review date with the approval of the Human Resources department and subject to the guidelines set by the Human Resources department.

Unemployment Compensation

CalOptima pays into Unemployment Compensation on behalf of the employee. This insurance provides income in the event an employee loses his or her job through no fault of his or her own. Qualified employees should register at their nearest Employment Development Department in order to receive benefits. The amount of unemployment insurance payments varies according to income level.

Short-Term Disability

CalOptima does not participate in the State of California Disability Insurance Plan. Instead, CalOptima operates under an approved private plan of disability insurance. This plan provides for loss of income resulting from non-work related illness or injury, paying 60 percent of regular income for up to a maximum of 12 weeks for all benefit-eligible employees. There is a 14-day waiting/elimination period on illness-related and accident-related disabilities. CalOptima provides this benefit free of charge to employees.

Long-Term Disability

CalOptima provides a rich long-term disability program. Regular full-time, and part-time and limited term employees are eligible to receive long-term disability coverage, following a 90-day waiting period, during which short-term disability is provided the first month following 90 days of employment. Regular Part-Time/Benefit, Regular Part-Time/Non-Benefit, Per Diem, and Temporary employees are not eligible for long-term disability benefits. All benefit eligible employees are automatically enrolled into this benefit.

Alternative Work Schedules (9/80)

CalOptima has established an alternative workweek schedule as another way for employees to manage work/life balance and provide CalOptima the opportunity to maintain productivity through different work schedules. Employees will be considered for alternative workweek scheduling on a case-by-case basis. The department director/manager is responsible for identifying if an alternative work week is practical and effective for their department by evaluating both the productivity and quality impacts of the schedule to the department and the needs of the department to ensure service goals can be consistently achieved.

The 9/80 alternate work schedule consists of eight business days of nine work hours per day and one business day of eight work hours for a total of 80 hours during two consecutive workweeks. The eight-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 schedule, one calendar week will consist of 44 hours (four 9-hour days and one 8-hour day) and the alternating calendar week will consist of 36 hours (four 9-hour days and one day off). However, each work week will only consist of 40 hours, in accordance with the 9/80 Federal Labor Standards Act (FLSA) workweek.

Not every position at CalOptima is eligible for alternative work scheduling. Employees who are interested should discuss this with their supervisor. Employees must receive approval from their supervisor and Human Resources to participate in the 9/80 work schedule. Employees not meeting job standards or expectations and/or who are on a performance improvement plan may not participate in the compressed work schedule until performance standards are met. Managers will review such exceptions with Human Resources before denying the option.

Transitioning to the new work week can result in either fewer or more than 80 hours in a pay period. Human Resources will work with management to minimize incurring overtime during the transitional period.

Paid time off (PTO) accrual will remain the same for participating employees. When an employee takes a day off under the PTO policy, the accrual will be depleted by the number of scheduled hours for that day. For example, if an employee takes a PTO day on one of their 9-hour days, 9 hours of PTO time will be removed from their total available PTO hours. Holiday pay shall remain at eight (8) hours. When a holiday falls on a regular nine-hour workday, the employee has the option of using one hour of accrued PTO or working one hour of make-up time. Should a holiday fall on an employee's scheduled day off, the employee will be permitted to take another day off in the same work week.

Employees are expected to continue to provide the same level of excellent service expected of them. Department managers, at their discretion, may discontinue an individual's, group's or department's participation in the 9/80 work schedule based on business needs. As a condition of participating in the 9/80 work schedule, employees must agree to work on a scheduled day off for an urgent situation or as compelled by business needs as determined by the employee's manager .

The 9/80 alternate work schedule is an optional program. CalOptima reserves the right to discontinue the entire program or an individual employee's participation in the program at any time for any reason at management discretion.

See Human Resources Policy GA.8020: 9/80 Work Schedule

Telecommuting

CalOptima is committed to providing a work environment that assists employees to achieve a proper balance between their work, home and family obligations. In some cases, this balance can best be achieved by allowing employees to perform some or all of their work from their homes when they can do so without compromising their work quality, efficiency or productivity. Telework is not a universal employee benefit or entitlement, but an alternative method of meeting the work needs of the organization through an innovative and flexible work structure. Telecommuting must be pre-approved by an employee's supervisor, director, Environmental Health & Safety manager, and Human Resources. A Telecommuting Agreement must be completed before an employee may begin telecommuting.

CalOptima retains the right, in its sole discretion, to designate positions that are appropriate for telecommuting and approve employees for telecommuting. Telecommuting does not change the conditions of employment or required compliance with all CalOptima policies and procedures. CalOptima reserves the right to change or terminate the Telecommuting Agreement at any time, with or without cause or advance notice. An employee's ability to work under a Telecommuting Agreement rests in the sole discretion of CalOptima. Telecommuting is a privilege and may not be appropriate for all employees and/or all positions. Any employee wishing to telework must first discuss this option with his or her supervisor and Human Resources.

For exempt employees not in a teleworking position, an employee's manager has the discretion to allow an exempt employee, who is required to be present at his or her home for an unusual and reasonable purpose, to work from home on an occasional basis. 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 home. A Telecommuting Agreement, along with the Teleworker Home Inspection Checklists, must be completed and submitted before an employee may work from home.

See Human Resources Policy GA.8044: Telework Program

Leaves of Absence

Leaves of Absence Overview

CalOptima will grant a leave of absence (LOA) to eligible employees in accordance with CalOptima's respective policies and procedures and all applicable laws. An employee's manager may approve up to five business days of excused absences for an illness or pre-planned surgery; however, absences of more than 5 days for illnesses or pre-planned surgery must be submitted to and approved by HR. Use of PTO time for pre-planned vacations does not require HR approval.

If the LOA is granted, the start date of the LOA will be the first day of the requested, substantiated and approved LOA. Requests for an LOA must be made through the Human Resources department.

Employees who satisfy the eligibility requirements set out in CalOptima's respective policies and applicable laws will receive the following types of LOAs. These leaves include:

- a. Pregnancy Disability Leave
- b. Family Medical Leave
- c. California Family Rights Leave
- d. Military Family Leave
- e. Military Service Leave
- f. Military Spouse Leave
- g. Workers' Compensation Leave
- h. Jury or Witness Duty Leave
- i. Parental School Attendance
- j. Voting Leave
- k. Victims of Domestic Violence, Sexual Assault or Stalking Leave
- l. Victims of Crime Leave
- m. Volunteer Civil Service Leave
- n. Civil Air Patrol Leave
- o. Bereavement Leave
- p. Personal Leave

Employees taking any LOA must use their full balance of PTO before moving to unpaid leave, unless deemed otherwise by law (i.e. Pregnancy Disability Leave, etc.).

See Human Resource Policy GA.8037: Leave of Absence, GA.8038: Personal Leave of Absence, GA.8039: Pregnancy Disability Leave, GA.8040: Family and Medical Leave Act and California Family Rights Act Leave, GA.8041: Workers' Compensation Leave

Types of Leaves:

Pregnancy Disability Leave

Pursuant to the California Fair Employment and Housing Act (FEHA), Pregnancy Disability Leave (PDL) is available to eligible female employees who are temporarily disabled by pregnancy, childbirth or a related medical condition. PDL is available for up to four months, including intermittent periods.

An employee may request to use accumulated PTO during the PDL and is eligible for disability benefits. If PDL is foreseeable, and when practicable, a 30-day advance notice is required. Health benefits and other insurances will continue during the leave period, and the employee is required to pay her portion of coverage at the active

employee rate, either by the usual payroll deduction if the employee is still receiving a paycheck, or by making other payment arrangements with the CalOptima Human Resources department.

See Human Resources Policy GA.8039: Pregnancy Disability Leave of Absence

Family Medical Leave Act and California Family Rights Act Leave

State and federal family and medical leave laws provide up to 12 workweeks of unpaid family/medical leave within a 12-month period. Full-time and part-time employees must meet the following conditions:

- The employee must have a total of at least 12 months of service at CalOptima.
- The employee must have worked at least 1,250 hours during the previous 12-month period before the need for leave.

An eligible employee may take an unpaid leave of absence under the federal Family and Medical Leave Act (FMLA) and the California Family Rights Act (CFRA) for the following reasons:

- To care for the employee's newborn child, or placement of a child with an employee for adoption or foster care
- To care for the employee's spouse, registered domestic partner, child or parent who has a serious health condition
- For the employee's own serious health condition that makes the employee unable to work at all or unable to perform the functions of his or her job (While an employee disabled by pregnancy, childbirth or related medical condition may qualify for a LOA under FMLA, such conditions do not qualify the employee for a LOA under CFRA.)
- To care for a spouse, child or parent who is a covered military service member on active duty or has been notified of an impending call or order to active duty
- To care for a covered military service member with a qualifying serious injury or illness if the employee is the spouse, child, parent or next of kin of the military service member. Under FMLA, an eligible employee may take up to 26 weeks, during a single 12-month period, of unpaid leave to care for a covered service member with a qualifying serious injury or illness.

An employee is required to use accumulated PTO during FMLA and/or CFRA LOA, unless deemed otherwise by law and may be eligible for disability benefits if the LOA is due to his or her own illness. If FMLA/CFRA is foreseeable, and when practicable, a 30-day advance notice is required. Health benefits and other insurances will continue during the leave period and the employee is required to pay his or her portion of coverage at the active employee rate.

See Human Resources Policy GA.8040: Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA) Leave of Absence

Coordination of PDL with FMLA and/or CFRA

If an employee takes PDL and is eligible for a LOA under FMLA and/or CFRA, CalOptima will continue to make payments towards group health insurance coverage during the period of the PDL, FMLA and/or CFRA, subject to the employee's timely payment of his or her portion of coverage at the active employee rate. For any leave taken under PDL, FMLA runs concurrently with PDL, and may run concurrently with CFRA if less than 12 weeks of PDL are taken.

If an employee is ineligible under FMLA and CFRA for a LOA, CalOptima will continue to pay the employer's portion of payments to group health insurance coverage during the period of the PDL, subject to the employee's timely payment of his or her portion of coverage at the active employee rate. In some instances, CalOptima may recover premiums it paid to maintain health coverage for an employee if the employee fails to return to work following PDL.

If an employee exhausts her PDL, and the employee is granted a Personal LOA, the employee may elect to continue health insurance coverage through CalOptima in conjunction with federal COBRA guidelines by making timely monthly payments to CalOptima.

See Human Resources Policy GA.8040: Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA) Leaves of Absence

Military Service Leave

CalOptima employees who are members of "uniformed services" (e.g., Army, Navy, Air Force, Marine Corps, Coast Guard, and the reserves of each of those branches: Army National Guard, Air National Guard or similar branches) will be granted, upon request, a cumulative of five years of leave of absence (with certain exceptions) without pay for both inactive and active duty (e.g., military training, drills, encampments, cruises, special exercises or similar activities). All regular full-time and part-time employees are eligible for Military Service Leave.

In certain circumstances employees on a Military Service Leave may be entitled to up to 30 days' salary and benefits continuation in any one fiscal year.

Upon the exhaustion of pay and benefits for the first 30 calendar days, an employee called to active duty or active training duty with the U.S. Armed Forces or National Guard as a result of the National Emergency arising from the War on Terror, may receive supplemental compensation and continuation of benefits during the Military Service Leave.

Employees will be required to complete a Leave of Absence Request form and provide a copy of all military orders to the Human Resources department.

An employee who returns from a Military Service Leave will be reinstated to the same position or a position of like seniority, status and pay in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) and Section 395.1 of the California Military and Veteran's Code.

See Human Resources Policy GA.8037: Leave of Absence

Military Spouse Leave

In addition, employees who are regularly scheduled to work an average of 20 or more hours per week and who are spouses of qualified military service members, are eligible to take up to 10 days of unpaid leave when their spouses are on leave from active duty in the U.S. armed forces, reserves or National Guard. Employees may use accrued PTO if sufficient PTO is accrued or may take this time as unpaid. Employees must give a minimum of two days' notice of their need for leave and provide appropriate written documentation to the Human Resources department.

See Human Resources Policy GA.8037: Leave of Absence

Workers' Compensation Leave

Employees who sustain a work-related injury will be granted a leave of absence as required by law. Subject to any limitations permitted by law, time off for work-related injuries shall be extended to the employee for the duration of the injury.

See Human Resources Policy GA.8041: Workers' Compensation Leave

Jury or Witness Duty Leave

CalOptima will grant a LOA with regular pay for those hours that coincide with the employee's regularly-scheduled working hours for the purpose of jury service, appearance as a witness in court (other than as a litigant, or to respond to an official order from another governmental jurisdiction for reasons not brought about through the connivance or misconduct of the employee.) Employees are required to provide reasonable advance notice of any need for such leave. On days employees are not required to report to court, or on days when the court either dismisses the employee early or requests that the employee report at a later time, whenever practical, the employee must report to work to perform regular duties prior to or after completing jury duty or appearing as a witness, unless the employee's manager approves that the remaining work time is less than reasonable travel time to court and work location. Employees are expected to work with and coordinate with their manager to ensure that their time away from work does not adversely impact business needs, their coworkers, or CalOptima's members. Employees seeking an official Jury Duty Leave should submit to their immediate supervisor a memo for absence accompanied by a copy of the official order not less than 10 days prior to the beginning of the date of the leave. The employee must submit to the Human Resources Department the payment received for the jury service, excluding payments for mileage.

See Human Resources Policy GA.8037: Leave of Absence

Parental School Attendance

Pursuant to Labor Code section 230.8, employees can take time off up to eight hours in one month or 40 hours each year to participate in school activities of their children, subject to conditions. Pursuant to Labor Code section 230.7, employees can take time off to appear in the school pursuant to a request made under Education Code section 48900.1 (suspension of pupil), subject to conditions. Employee may use accrued paid time off (PTO) if sufficient PTO is accrued or may take this time as unpaid.

Bereavement Leave

With approval of an employee's manager, an employee may take up to three scheduled workdays off with pay (maximum of 24 hours) in the event of a death of an employee's: current spouse; registered domestic partner; biological, adopted, step or foster child; biological, adopted, step or foster parent; legal guardian; brother; sister; grandparent; grandchild; parents-in-law; siblings-in-law; or child-in-law. The employee's manager may approve additional time off of up to five business days to be taken as either PTO or unpaid time off. An employee must submit an LOA request form to HR and request a Personal LOA pursuant to Human Resources Policy GA. 8038: Personal Leave of Absence, if the employee plans to take additional unpaid time off exceeding five days.

Time Off for Voting

CalOptima encourages employees to fulfill their civic responsibilities by voting. Employees who are unable to vote before or after work should request time off to vote from their supervisor at least two working days prior to election day so that the necessary time off can be scheduled at the beginning or end of the work day, whichever provides the least disruption to the normal work schedule.

See California Elections Code 14000

Victims of Domestic Violence, Sexual Assault or Stalking Leave

Subject to the requirements under Labor Code sections 230 and 230.1, an employee who is a victim of domestic violence, sexual assault or stalking may, with reasonable advance notice, unless the advance notice is not feasible, request an LOA. Employees may elect to use accrued PTO, if available, when an LOA is granted; however, the PTO cannot be used to adjust the start date and will count as part of the LOA. This LOA is limited to 12 weeks in a 12-month period. After an employee exhausts his or her PTO accruals, if elected, the remaining time off will be unpaid.

See Human Resources Policy GA.8037: Leave of Absence

Victims of Crime Leave

An employee who is a victim of a crime or whose immediate family member(s) is/are a crime victim may take time off to attend judicial proceedings related to that crime, subject to the procedural conditions imposed pursuant to Labor Code section 230.2.

The absence from work must be in order to attend judicial proceedings related to a crime. To the extent feasible, before an employee is absent from work for such a reason, the employee must provide documentation of the scheduled proceeding. Such notice is typically given to the victim of the crime by a court or government agency setting the hearing, an attorney related to the case, or victim/witness office. Any absence from work to attend judicial proceedings will be unpaid, unless employee chooses to use PTO.

See Human Resources Policy GA.8037: Leave of Absence

Volunteer Civil Service Leave

A Civil Service LOA may be granted for employees who are required to perform emergency duty (reserve peace officers, volunteer firefighter and emergency rescue personnel). There are no limitations to the amount of time an employee can use for volunteer civil service leave.

An employee who performs duty as a volunteer firefighter, a reserve peace officer, or as emergency rescue personnel is also permitted to take an LOA not to exceed an aggregate of 14 days per calendar year, for the purpose of fire, law enforcement or emergency rescue training.

Any Volunteer Civil Service Leave can be taken unpaid, unless employee chooses to use accrued PTO. However, an employee cannot use PTO to adjust the start date of the required leave period and the time covered by PTO will still count as part of this leave.

Certification from emergency personnel office or civil air authority will be required to verify the employee's eligibility for leave requested.

See Human Resources Policy GA.8037: Leave of Absence

Civil Air Patrol Leave

Employees who have been employed for at least 90 days may request a maximum total of 10 days per calendar year (three days maximum for a single emergency operational mission, unless otherwise authorized by HR) for Civil Air Patrol duty.

See Human Resources Policy GA.8037: Leave of Absence

Extended Disability Leave

Reasonable accommodations for a leave of absence will be granted for a recognized disability, including pregnancy disability and other serious medical conditions that prevent the employee from working. Human Resources will engage in the “interactive process” with the employee and his or her manager to help determine whether a reasonable accommodation is available in order to grant such leave request.

Employees are required to use PTO during the leave of absence. Group health insurance plans (health, dental and vision) will generally be made available via COBRA.

Personal Leave

All full-time and part-time employees are eligible to request a Personal Leave of Absence.

A Personal Leave of Absence, without pay, may be granted, in CalOptima's sole discretion, for a reasonable period of time of up to a total of 90 days per 12-month period. Personal LOAs are entirely dependent on CalOptima's discretion and are only approved when it is determined that granting the LOA will not unduly interfere with CalOptima's operations.

Any accumulated PTO must be used during Personal LOA. However, the use of such PTO will not adjust the start date of the leave; i.e., time covered by PTO will still count as part of the Personal Leave.

CalOptima does not guarantee that an employee's position will remain vacant while the employee is on an approved Personal LOA. CalOptima may fill the employee's position for business reasons.

If an employee's position is filled while he or she is off on an approved Personal LOA, the employee may, at the conclusion of his or her scheduled leave, apply for any open position for which he or she is qualified at CalOptima. However, if no such position is available, the employee's employment will be terminated. If the employee fails to return to work at the agreed date, the employee will be treated as having voluntarily resigned his or her employment.

See Human Resources Policy GA.8038: Personal Leave of Absence

Kin Care

Employees may use up to one-half of their annual PTO accrual to attend to a child, parent, spouse, domestic partner, or domestic partner's child who is ill. Leave for this purpose may not be taken until the PTO has actually accrued.

For purposes of PTO use, a “child” is defined as a biological, foster, or adopted child; stepchild; or a legal ward.

A “child” also may be someone for whom an employee has accepted the duties and responsibilities of raising, even if he or she is not their legal child.

A “parent” is an employee’s biological, foster, or adoptive parent; stepparent; or legal guardian.

A “spouse” is an employee’s legal spouse according to the laws of California, which do not recognize “common law” spouses (a union that has not been certified by a civil or religious ceremony). All conditions and restrictions placed on an employee’s use of PTO apply also to PTO used for care of a child, parent or spouse.

A “registered domestic partner” is another adult with whom an employee has chosen to share his or her life in an intimate and committed relationship of mutual caring, and with whom they have filed a Declaration of Domestic Partnership with the Secretary of State of California (or another state that allows for such).

A “registered domestic partner’s child” is the biological, foster or adopted child, stepchild or legal ward of an employee’s domestic partner. A “domestic partner’s child” also may be someone for whom an employee’s domestic partner has accepted the duties and responsibilities of raising, even if he or she is not the domestic partner’s legal child.

Safety and Security

Safety

CalOptima is committed to providing and maintaining a healthy and safe work environment for all employees. CalOptima believes that the establishment and maintenance of a safe work environment is the shared responsibility of CalOptima and employees at all levels of the organization. CalOptima will attempt to establish a safe environment in compliance with federal, state and local safety regulations.

Accordingly, CalOptima has instituted an Injury and Illness Prevention Program designed to protect the health and safety of all personnel. A complete copy of the Injury and Illness Prevention Program is kept in the Facilities department and is available for employees' review.

Every employee is required to know and comply with CalOptima's general safety rules and to follow safe and healthy work practices at all times. Employees may be subject to discipline, up to and including termination, for engaging in any unsafe or unhealthy work practice or for violation of established safety rules. Each employee is also required to report to his or her supervisor any potential health or safety hazards and all injuries or accidents.

First aid supplies are located in each lunch/copy room. Please report any work-related injuries or illnesses immediately to the manager of Environmental Health and Safety and/or Human Resources department. If an employee witnesses or discovers an accident in which a CalOptima visitor or employee is injured, they are expected to assist the visitor or employee as much as possible, and if the situation is an emergency, to call 911. If the situation is not an emergency, employees should contact the manager of Environmental Health and Safety and/or Human Resources department for further direction.

See Human Resources Policy GA.8016: Unusual Occurrence, Threats and Danger

Security

The security of employees, employee property and CalOptima property is of vital importance. All employees share responsibility to ensure that proper security is maintained. Any breach of security should be reported promptly to the CalOptima security guard, manager or director of Facilities and the Human Resources department. Employees may call upon the CalOptima security guard for assistance by dialing zero and having the receptionist page him/her. For immediate emergencies, dial 911.

The building security guard is stationed in the main lobby of the building. The building security guard hours are 24 hours daily, Monday through Friday and all Friday night until 6 a.m. Saturday morning p.m. If an employee is working late and requires an escort to his or her vehicle, the employee may call the building guard, number located on the InfoNet.. If an employee experiences a problem while working on the weekend or after regular working hours, he or she should call the building after hours emergency number located on the Infonet.

Security Cameras

CalOptima takes the safety and security of its employees, members and CalOptima guests very seriously. Proper video surveillance, where deemed appropriate and necessary, is one of the most effective means of helping to keep CalOptima facilities and properties operating in a safe and secure manner. Therefore, please be aware CalOptima has and monitors video surveillance cameras in common areas throughout its buildings and surrounding property for safety and security reasons. The use of video surveillance is solely for the purpose of controlling theft, ensuring the safety of CalOptima employees and members, and facilitating the identification of individuals who behave in a disruptive manner, cause damage to CalOptima property or are otherwise in contravention of CalOptima's policies, procedures and Code of Conduct.

Workplace Violence

CalOptima has a strong commitment to its employees and its members to provide a safe, healthy and secure work environment. CalOptima has zero tolerance for acts of violence, threats, intimidation or harassment, whether occurring on CalOptima property or off CalOptima property but while conducting CalOptima business. All such acts and threats, even those made in apparent jest, will be taken seriously, and will lead to disciplinary action, up to and including termination.

It is every employee's responsibility to assist in establishing and maintaining a violence-free and safe work environment. Therefore, employees are expected and encouraged to report any incident which may be threatening to them or their co-workers or any event which they reasonably believe is threatening, intimidating or violent. Employees may report an incident to any supervisor or manager.

A threat includes, but is not limited to, a statement (verbal, written or physical) which is intended to intimidate by expressing the intent to either harass, hurt, take the love of another person or damage or destroy property. This includes threats made in jest or as a joke, but which others could perceive as serious.

See Human Resources Policy GA.8053: Workplace Violence

Ergonomics

CalOptima is subject to Cal/OSHA ergonomics standards for minimizing workplace repetitive motion injuries. CalOptima will make necessary adjustments to reduce exposure to ergonomic hazards through modifications to equipment and processes and employee training. CalOptima encourages safe and proper work procedures and requires all employees to follow safety instructions and guidelines.

CalOptima believes that reduction of ergonomic risk is instrumental in maintaining an environment of personal safety and well-being, and is essential to our business. We intend to provide appropriate resources to create a risk-free environment. For more information, contact the Facilities department.

Inspections, Searches and Monitoring of CalOptima Premises

CalOptima believes that it is important to the efficient and safe conduct of its business to assure access at all times to any property, equipment, records, documents, and/or files, etc. on its premises. CalOptima also believes that maintaining a workplace that is free of drugs, alcohol, firearms, explosives and other harmful and improper materials is vital to the health and safety of its employees and to the success of the organization. CalOptima also intends to protect against the unauthorized removal of its property from the premises. Accordingly, CalOptima reserves the right to access, inspect and search CalOptima property and premises at any time according to this policy.

Prohibited materials, including weapons, explosives, alcohol and non-prescribed drugs or medications, may not be placed or stored in employees' work spaces or desks. If such prohibited items are found, they will be confiscated by CalOptima and delivered to the proper authorities. In addition, CalOptima reserves the right to inspect personal belongings including, but not limited to, any package, container, bag, briefcase, etc. carried in or out of CalOptima by any employee, volunteer or visitor when deemed appropriate by management and/or CalOptima's security guards. Employees who fail to cooperate in any inspection will be subject to disciplinary action, up to and including termination.

CalOptima is not responsible for any personal belongings or items placed or stored in a work space or desk that is lost, damaged, destroyed or stolen. Employees have an obligation to cooperate fully with all inspections,

investigations and searches conducted in accordance with this Section; failure to do so may result in disciplinary action, up to and including termination.

Termination

Employee References

All requests for references must be directed to the Human Resources department. No other manager, supervisor or employee is authorized to release references for current or former employees. By policy, CalOptima discloses only the dates of employment and the title of the last position held of former employees. If an employee authorizes the disclosure in writing, CalOptima will also inform prospective employers of the amount of salary or wage the employee last earned.

Exit Interviews

At time of separation, employees will be scheduled for an exit interview with the Human Resources department. This interview allows employees to communicate their views on their work with CalOptima, as well as provide input regarding the requirements, operations and training needs of their former position. It also provides employees an opportunity to discuss issues concerning benefits and insurance. At the time of the interview, employees must return all CalOptima-furnished property, e.g., uniforms, tools, equipment, I.D. cards, keys (electronic and regular), laptops, cell phones and CalOptima-related documents. Arrangements for clearing any outstanding debts with CalOptima and for receiving final pay will also be made at this time.

Termination

We hope employees will enjoy a long and mutually rewarding employment relationship with CalOptima. Sometimes, however, an employee may find it desirable or necessary to resign and take employment elsewhere, or CalOptima may need to discharge an employee. In either case, it is important that employees who resign or are terminated are treated with mutual respect to achieve a professional, orderly transition.

An employee is considered to have voluntarily terminated his or her employment with CalOptima when the employee:

- Resigns from CalOptima
- Fails to return from vacation or from an approved leave of absence at the scheduled time
- Fails to report to work without notice or authorization for three consecutive days

Employees who elect to resign are asked to provide CalOptima with at least two week's notice prior to their final day of work.

From time-to-time, CalOptima may reduce the size of the work force by terminating employees for business, operational or economic reasons (such as lack of work, restructuring the workforce, reorganizing a department, or job elimination). Should CalOptima consider such terminations necessary, CalOptima will attempt to provide all affected employees with advance notice when practical. Employees affected by such reductions in force are considered to have been laid-off.

Confirmation of Receipt

Confirmation of Receipt

I have received my copy of CalOptima's Employee Handbook. I understand and agree that it is my responsibility to read and familiarize myself with the policies and procedures contained in the handbook.

I understand that except for employment at-will status, any and all policies or practices can be changed at any time by CalOptima. CalOptima reserves the right to change my hours, wages, benefits and/or working conditions at any time. I understand and agree that other than the Board and CEO of CalOptima, no manager, supervisor or representative of CalOptima has authority to enter into any agreement, express or implied, for employment for any specific period of time, or to make any agreement for employment other than at-will. I understand that if there is a conflict between a relevant law and this handbook, the law will supersede the handbook.

I understand and agree that nothing in the Employee Handbook creates or is intended to create a promise or representation of continued employment and that employment at CalOptima is employment at-will; employment may be terminated at the will of either CalOptima or me. My signature certifies that I understand that the foregoing agreement on my at-will status is the sole and entire agreement between CalOptima and me concerning the duration of my employment and the circumstances under which my employment may be terminated. It supersedes all prior agreements, understandings and representations concerning my employment with CalOptima.

Employee's Name (Printed): _____

Department: _____

Employee's Signature: _____ Date: _____

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 7, 2016

Regular Meeting of the CalOptima Board of Directors

Report Item

14. Consider Adoption of Position on Senate Bill (SB) 1273, Legislation that Clarifies Counties' Ability to use Mental Health Services Act (MHSA) Funds to Provide Crisis Stabilization Services, and on SB 1308, that Imposes New Restrictions on County Organized Health System (COHS) Plans Including CalOptima

Contact

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

Recommended Actions

1. Adopt a CalOptima 'support' position for SB 1273 - Crisis Stabilization Units; ~~and~~
2. ~~Adopt a CalOptima 'oppose' position for SB 1308 - Medi-Cal county organized health systems.~~

Background/ Discussion

SB 1273 (Moorlach):

The Mental Health Services Act, an initiative enacted by California voters as Proposition 63 in November 2004, establishes the Mental Health Services Fund (MHSF). The MHSF is continuously appropriated to and provides funding for specified county mental health programs. SB 1273, was introduced on February 18, 2016 by State Senator John Moorlach and amended on March 28, 2016. The bill would clarify that counties may use MHSF funds to provide crisis stabilization services, specifically in circumstances in which law enforcement officials have in custody individuals exhibiting behavior that warrants a mental health evaluation, otherwise known as a "5150 hold."

Currently, Orange County has one ten-bed emergency facility to care for individuals requiring this type of care. This has lead to a situation where law enforcement agencies have to transport individuals exhibiting behavior that warrants a mental health evaluation to hospital emergency rooms to receive care. As such, these institutions incur great cost in caring for individuals under 5150 holds.

SB 1273 would ease some of the financial burden on these institutions by clarifying that MHSA funds can be used by counties to fund outpatient care. Specifically, this bill will clarify that when a peace officer or other designated person determines that an individual requires a 5150 hold, that person will be eligible for outpatient services funded by MHSA.

SB 1308 (Nguyen)

SB 1308, was introduced on February 19, 2016 and was recently amended on March 28, 2016. This bill would impose new restrictions on County Organized Health Systems (COHS). Specifically, the bill as amended would restrict certain types of community outreach efforts by COHS that feature elected officials and would prohibit COHS from using administrative or operational funds intended for staff retreats, promotional giveaways and excessive executive compensation.

Rationale for Recommendation

SB 1273 (Moorlach) - Support

While MHSF funds do not directly impact CalOptima, CalOptima members would likely benefit from the improvement in the mental health service delivery and availability that SB 1273 clarifies for MHSF funds. The MHSA was adopted by the voters of California to help provide mental health services and this clarification assists in MHSF dollars reach a particularly vulnerable population, specifically individuals in need of immediate crisis stabilization. This bill will benefit overall public health in Orange County by helping to extend appropriate and necessary support to vulnerable members of our community.

SB 1308 (Nguyen) - Oppose

For twenty years CalOptima's mission—to provide members with access to quality health care services delivered in a cost-effective and compassionate manner—has remained the same and has focused the agency's work on member service and fiscal responsibility. CalOptima spends more than 96 cents of every dollar on member care. CalOptima's administrative loss ratio (ALR) of 3.98%, the amount of revenue used for administrative expenses, is the lowest among all county organized health system plans and is the third lowest out of 15 public plans in California and lowest among the commercial health plans within the Medi-Cal managed care program. Further, the agency's focus on the quality of member care is evidenced by the fact that for the second year in a row CalOptima was recognized for top quality care by the National Committee for Quality Assurance (NCQA). CalOptima received an overall rating of four out of five on NCQA's Medicaid Health Insurance Plan Ratings for 2015–2016. This is the highest rating among California Medi-Cal plans that reported full data to NCQA.

CalOptima's community engagement efforts ensure member access to services and crucial communications are conducted through community outreach and marketing. Circumscribing CalOptima's ability to reach our members in the manner proposed by SB 1308 will damage the agency's capability to engage with our members and will hinder efforts to improve access to health care, one of SB 1308's stated goals.

The COHS model was established to provide local jurisdictions to more efficiently serve the needs of their area's Medi-Cal populations. This local oriented governance for COHS plans is emphasized with a local/community-oriented represented board of directors. This allows COHS plans to be responsive to local needs and concerns.

Finally, existing regulations provide all COHS, including CalOptima, with effective guidance and parameters of operation. CalOptima has been and will continue to be a responsible steward of public funds as well as an organization that operates in the best interest of its members and the community.

Fiscal Impact

There is no fiscal impact related to the two actions proposed to the Board.

CalOptima Board Action Agenda Referral
Consider Adoption of Position on SB 1273, Legislation that Clarifies Counties’
Ability to use MHSA Funds to Provide Crisis Stabilization Services, and on
SB 1308, that Imposes New Restrictions on COHS Plans Including CalOptima
Page 3

Concurrence

Gary Crockett, Chief Counsel

Attachments

SB 1273

SB 1308

/s/ Michael Schrader
Authorized Signature

04/01/2016
Date

AMENDED IN SENATE MARCH 28, 2016

SENATE BILL

No. 1273

Introduced by Senator Moorlach

February 18, 2016

An act to amend Section 5813.5 of the Welfare and Institutions Code, relating to mental health.

LEGISLATIVE COUNSEL'S DIGEST

SB 1273, as amended, Moorlach. Crisis stabilization units: funding.

Existing law contains provisions governing the operation and financing of community mental health services for the mentally disordered in every county through locally administered and locally controlled community mental health programs. Existing law, the Mental Health Services Act, an initiative measure enacted by the voters as Proposition 63 at the November 2, 2004, statewide general election, funds a system of county mental health plans for the provision of mental health services, as specified.

The act establishes the Mental Health Services Fund, continuously appropriated to and administered by the State Department of Health Care Services, to fund specified county mental health programs, including programs funded under the Adult and Older Adult Mental Health System of Care Act. Existing law prohibits these funds from being used to pay for persons incarcerated in state prison or parolees from state prisons.

This bill would clarify that the counties may use Mental Health Services Fund moneys to provide *outpatient* crisis stabilization services, including ~~temporary commitment~~ *crisis intervention and stabilization for a person suffering acute symptoms or distress, crisis residential treatment, rehabilitative mental health services, and mobile crisis*

support teams. Because the bill would clarify the procedures and terms of Proposition 63, it would require a majority vote of the Legislature.

Vote: majority. Appropriation: no. Fiscal committee: no.
State-mandated local program: no.

The people of the State of California do enact as follows:

1 *SECTION 1. (a) The Legislature finds and declares all of the*
2 *following:*

3 *(1) There is an urgent and crucial need for mental health crisis*
4 *stabilization services in California.*

5 *(2) In 2013, the California Legislature enacted Senate Bill 82*
6 *(Chapter 34 of the Statutes of 2013) to dedicate money for the*
7 *General Fund to support crisis stabilization services.*

8 *(3) In 2004, the California electorate approved Proposition 63,*
9 *the Mental Health Services Act, to address serious mental illness*
10 *among adults, children, and seniors involving prevention and early*
11 *intervention and supportive medical care.*

12 *(4) Currently there are counties using Mental Health Services*
13 *Act money for crisis stabilization services, and other counties that*
14 *are not.*

15 *(b) The Legislature finds and declares that this act clarifies that*
16 *counties may use funds provided under the Mental Health Services*
17 *Act to provide services to individuals who are being temporarily*
18 *evaluated for mental health reasons.*

19 ~~SECTION 1.~~

20 *SEC. 2. Section 5813.5 of the Welfare and Institutions Code*
21 *is amended to read:*

22 5813.5. Subject to the availability of funds from the Mental
23 Health Services Fund, the state shall distribute funds for the
24 provision of services under Sections 5801, 5802, and 5806 to
25 county mental health programs. Services shall be available to adults
26 and seniors with severe illnesses who meet the eligibility criteria
27 in subdivisions (b) and (c) of Section 5600.3. For purposes of this
28 act, “seniors” means older adult persons identified in Part 3
29 (commencing with Section 5800) of this division.

30 (a) Funding shall be provided at sufficient levels to ensure that
31 counties can provide each adult and senior served pursuant to this
32 part with the medically necessary mental health services,

1 medications, and supportive services set forth in the applicable
2 treatment plan.

3 (b) The funding shall only cover the portions of those costs of
4 services that cannot be paid for with other funds including other
5 mental health funds, public and private insurance, and other local,
6 state, and federal funds.

7 (c) Each county mental health program's plan shall provide for
8 services in accordance with the system of care for adults and
9 seniors who meet the eligibility criteria in subdivisions (b) and (c)
10 of Section 5600.3.

11 (d) Planning for services shall be consistent with the philosophy,
12 principles, and practices of the Recovery Vision for mental health
13 consumers:

14 (1) To promote concepts key to the recovery for individuals
15 who have mental illness: hope, personal empowerment, respect,
16 social connections, self-responsibility, and self-determination.

17 (2) To promote consumer-operated services as a way to support
18 recovery.

19 (3) To reflect the cultural, ethnic, and racial diversity of mental
20 health consumers.

21 (4) To plan for each consumer's individual needs.

22 (e) The plan for each county mental health program shall
23 indicate, subject to the availability of funds as determined by Part
24 4.5 (commencing with Section 5890), and other funds available
25 for mental health services, adults and seniors with a severe mental
26 illness being served by this program are either receiving services
27 from this program or have a mental illness that is not sufficiently
28 severe to require the level of services required of this program.

29 (f) Each county plan and annual update pursuant to Section
30 5847 shall consider ways to provide services similar to those
31 established pursuant to the Mentally Ill Offender Crime Reduction
32 Grant Program. Funds shall not be used to pay for persons
33 incarcerated in state prison or parolees from state prisons.

34 (1) When included in county plans pursuant to Section 5847,
35 funds may be used for the provision of mental health services under
36 Sections 5347 and 5348 in counties that elect to participate in the
37 Assisted Outpatient Treatment Demonstration Project Act of 2002
38 (Article 9 (commencing with Section 5345) of Chapter 2 of Part
39 1).

(2) When included in county plans pursuant to Section 5847, funds may be used for the provision of *outpatient* crisis stabilization services, including ~~temporary commitment pursuant to Section 5150:~~ *crisis intervention and stabilization for a person suffering acute symptoms or distress, crisis residential treatment, as defined in Section 5671, rehabilitative mental health services, and mobile crisis support teams, including personnel and the purchase or lease of equipment such as vehicles.*

(g) The department shall contract for services with county mental health programs pursuant to Section 5897. After the effective date of this section, the term grants referred to in Sections 5814 and 5814.5 shall refer to such contracts.

~~SEC. 2. The Legislature finds and declares that this act clarifies that counties may use funds provided under the Mental Health Services Act to provide services to individuals who are being temporarily evaluated for mental health reasons.~~

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AMENDED IN SENATE MARCH 28, 2016

SENATE BILL

No. 1308

Introduced by Senator Nguyen

February 19, 2016

An act to amend Section ~~14087.8~~ of 14087.6 of, and to add Section 14087.65 to, the Welfare and Institutions Code, relating to Medi-Cal.

LEGISLATIVE COUNSEL'S DIGEST

SB 1308, as amended, Nguyen. Medi-Cal: county *organized* health systems.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid Program provisions. Existing law authorizes the department to negotiate exclusive contracts with any county ~~which~~ *that* seeks to provide, or arrange for the provision ~~of~~ *of*, the Medi-Cal services to Medi-Cal beneficiaries, as specified. Existing law ~~requires that when the department has entered into a contract with a county, that the department, at a minimum, monitor the level and quality of services provided in the county and the county's expenditures pursuant to the contract, as specified.~~ *authorizes a county that has contracted for the provision of services to arrange for any or all of the services to be provided by subcontracting with primary care providers, health maintenance organizations, insurance carriers, or other entities or individuals.*

~~This bill would require the department to additionally report to the Legislature annually on the level and quality of services provided in the county and the county's expenditures pursuant to the contract.~~

prohibit a county organized health system that has contracted with the department as described above from utilizing funds intended for administrative and operational expenses for staff retreats, promotional giveaways, excessive executive compensation, or promotion of federal or state legislative or regulatory modifications. The bill would prohibit a media campaign or paid advertising purchased by the county organized health system from featuring the image or voice of an elected public official or candidate for elected office, or directly represent the views of an official or candidate. The bill would permit the media campaign or paid advertising to reference an official or candidate if the name appears in a roster listing containing the names of all officers of the purchasing agency, as specified. The bill would make related legislative findings and declarations.

Vote: majority. Appropriation: no. Fiscal committee: yes.
State-mandated local program: no.

The people of the State of California do enact as follows:

- 1 *SECTION 1. The Legislature finds and declares all of the*
- 2 *following:*
- 3 *(a) County organized health systems together serve 2.2 million*
- 4 *enrollees in the Medi-Cal program.*
- 5 *(b) Recent increases in enrollment in the Medi-Cal program*
- 6 *have stretched available resources and have the potential to limit*
- 7 *access to vital medical care.*
- 8 *(c) County organized health system resources should be directed*
- 9 *to providing direct care to the maximum extent possible.*
- 10 *(d) The California Health Benefit Exchange has operated with*
- 11 *limitations on how taxpayer funding can be used in an effort to*
- 12 *direct more resources into direct patient services.*
- 13 *(e) All advertisement and promotional material produced by*
- 14 *county organized health systems should be used to promote access*
- 15 *to health care and not to promote board members.*
- 16 *(f) County organized health systems are responsible for*
- 17 *billion-dollar annual contracts, which potentially creates perceived*
- 18 *or real conflicts of interest.*
- 19 *SEC. 2. Section 14087.6 of the Welfare and Institutions Code*
- 20 *is amended to read:*
- 21 14087.6. (a) A county that has contracted for the provision
- 22 of services pursuant to this article may provide the services directly

1 to recipients, or arrange for any or all of the services to be provided
2 by subcontracting with primary care providers, health maintenance
3 organizations, insurance carriers, or other entities or individuals.
4 The subcontracts may utilize a prospectively negotiated
5 reimbursement rate, fee-for-service, retainer, capitation, or other
6 basis for payment. The rate of payment established under the
7 contract shall not exceed the total per capita amount that the
8 department estimates would be payable for all services and
9 requirements covered under the contract if all these services and
10 requirements were to be furnished to Medi-Cal beneficiaries under
11 the Medi-Cal fee-for-service program.

12 ~~Counties~~

13 (b) *Counties* that are responsible for providing health care under
14 this chapter shall make efforts to utilize existing health service
15 resources if these resources can be estimated by the county to result
16 in lower total long-term costs and accessible quality care to persons
17 served under this chapter. The granting of a certificate of need
18 pursuant to the criteria set forth in Section 127200 of the Health
19 and Safety Code or a certificate of exemption pursuant to the
20 criteria set forth in Section 127175 of the Health and Safety Code
21 shall satisfy the intent of this provision.

22 (c) *A county organized health system that has contracted for*
23 *the provision of services pursuant to this article shall not utilize*
24 *any funds intended for administrative and operational expenses*
25 *for staff retreats, promotional giveaways, excessive executive*
26 *compensation, or promotion of federal or state legislative or*
27 *regulatory modifications.*

28 SEC. 3. Section 14087.65 is added to the Welfare and
29 Institutions Code, to read:

30 14087.65. (a) *A media campaign or paid advertising purchased*
31 *by a county organized health system that contracts for the provision*
32 *of services pursuant to this article shall not feature in any manner*
33 *the image or voice of an elected public official or candidate for*
34 *elected office, or directly represent the views of an elected public*
35 *official or candidate for elected office.*

36 (b) *A media campaign or paid advertising purchased by a county*
37 *organized health system that contracts for the provision of services*
38 *pursuant to this article may include a reference to an elected public*
39 *official or candidate for elected office if the name appears in a*
40 *roster listing containing the names of all officers of the purchasing*

1 agency and all names in the roster appear in the same type size,
2 typeface, type color, and location.

3 ~~SECTION 1. Section 14087.8 of the Welfare and Institutions~~
4 ~~Code is amended to read:~~

5 ~~14087.8. When the department has entered into a contract with~~
6 ~~a county pursuant to this article, the department shall, at a~~
7 ~~minimum, through a method independent of any agency of the~~
8 ~~county, monitor and report to the Legislature annually on the level~~
9 ~~and quality of services provided in a county, as well as a county's~~
10 ~~expenditures pursuant to the contract, and shall ensure conformity~~
11 ~~with federal law.~~

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Board of Directors Meeting April 7, 2016

Member Advisory Committee Update

A quorum was not reached at the March 10, 2016 Member Advisory Committee (MAC) meeting, so no actions were taken by the committee.

The MAC reported on its strategies for outreach to the autism population at the December 3, 2015 CalOptima Board of Directors' meeting. The following strategies are complete:

- The MAC developed a comprehensive list of autism resources for use when working with members and this list is posted on the CalOptima website under the Resources page.
- The MAC requested placement of autism articles in CalOptima newsletters. An article on *“How to Access Services for Autism Spectrum Disorder”* was published in the February Medi-Cal newsletter and the March Community Connections newsletter.
- The MAC recommended inviting presenters, such as advocates, community professionals and/or parents, to MAC meetings to increase awareness and understanding of this population.
 - The Regional Center of Orange County presented at the November 2015 MAC meeting on developmental disabilities and autism.
 - The MAC and Provider Advisory Committee convened a Special Joint meeting in January 2016 to discuss the growing need for coordinated mental/behavioral health care services.
 - Additional presentations are proposed for upcoming meetings.

The MAC continues its recruitment until April 1, 2016 for candidates to fill the seven seats expiring on June 30, 2016, including Children, Consumer, Foster Children, Long-Term Care, Medically Indigent Persons, Persons with Mental Illness and Persons with Special Needs. As reported previously, notification methods include placing advertisements in local newspapers in Threshold languages, running articles in the Community Connections E-newsletter and the winter issue of the Medi-Cal newsletter, notifying the CalOptima Board of impending vacancies, outreaching to community stakeholders and community-based organizations and posting recruitment notices on the CalOptima website. The MAC anticipates qualified candidates to apply.

The MAC appreciates the opportunity to provide the CalOptima Board with input and updates on the MAC's activities.

Board of Directors Meeting April 7, 2016

Provider Advisory Committee (PAC) Update

March 10, 2016 PAC Meeting

Ten (10) PAC members were in attendance at the March 10, 2016 meeting.

PAC members received information from staff on the Medi-Cal Expansion (MCE) rate reduction of approximately 40% with an effective date of July 1, 2016 to CalOptima providers. CalOptima staff clarified that all providers were aware of these MCE rates reduction as per their contractual amendment which is set to expire on June 30, 2016. Staff also notified the PAC that letters are being formulated and will be sent out to all health networks, hospitals and specialists notifying them of this reduction.

PAC members received information on the Pay for Value 2016 (P4V:2016) proposed changes. Dr. Richard Bock, Deputy Chief Medical Officer discussed the current Pay for Performance and the goals of the new program and methodology behind the P4V:2016. As a result of this presentation, PAC would like to reconvene their CAHPS Survey Ad Hoc Committee.

PAC received a follow-up update from Dr. Donald Sharps, Medical Director, on Behavioral Health Utilization Data.

PAC members received a verbal update on the status of IGT 4 funds and the upcoming IGT 5.

PAC received the following updates from CalOptima executive staff at the March 10, 2016 PAC meeting: CEO Update, CFO Update, CMO Update, CNO Update, COO Update, State Budget Update, Behavioral Health Utilization Data and an IGT Update.

Once again, the PAC appreciates and thanks the CalOptima Board for the opportunity to present input and updates on the PAC's activities.



Board of Directors Meeting April 7, 2016

OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) Member Advisory Committee Update

February 25, 2016 OneCare Connect Member Advisory Committee (OCC MAC) Meeting

The OCC MAC members welcomed two new OneCare Connect Family Member representatives, Josefina Diaz and Susie Gordee.

OCC MAC is recruiting for a third OneCare Connect Member or Family Member representative as one of the Board appointed Family Member representatives encountered eligibility issues. Recruitment efforts coincide with the recruitment to fill the four OCC MAC seats expiring on June 30, 2016, including Community-Based Adult Services provider representative, Home- and Community-Based Services (HCBS) representative serving seniors, Long-Term Care facility representative and the Member advocate representative. The deadline for interested candidates is April 1, 2016.

Member Sara Lee presented a Quarterly Ombudsman Update explaining the role of the Ombudsman in assisting OneCare Connect clients navigate the health care system, resolve eligibility issues and assist with any service barriers.

March 24, 2016 OCC MAC Meeting

OCC MAC members received a presentation on *Homeless CalOptima Membership* that provided a comprehensive look at CalOptima's homeless population by condition and relevant member demographics. In addition, the presentation included CalOptima's interventions to manage this population. OCC MAC members appreciated the information and requested additional follow up at a future meeting.

Member Gio Corzo presented an overview of his agency SeniorServ, including its mission, programs and services.

The OCC MAC appreciates the opportunity to provide the CalOptima Board with input and updates on the OCC MAC activities.



CalOptima

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Financial Summary

February 2016

Board of Directors Meeting
April 7, 2016

Chet Uma
Chief Financial Officer

FY 2015-16: Consolidated Enrollment

- February 2016 MTD:
 - Overall enrollment reached 782,411 member months
 - Actual lower than budget by 6,881 or 0.9%
 - Medi-Cal: favorable variance of 979 members
 - Medi-Cal Expansion growth higher than budget
 - SPD enrollment higher than budget due to less than anticipated dual eligible members transferring to OneCare Connect
 - Offset by lower than budget TANF enrollment
 - OneCare Connect: unfavorable variance of 7,775 members
 - 0.4% increase from prior month
 - OneCare Connect: increase of 3,460
 - 7.0% or 51,275 increase in enrollment from prior year

FY 2015-16: Consolidated Enrollment (Cont.)

- February 2016 YTD:
 - Overall enrollment reached 6,220,364 member months
 - Actual lower than budget by 73,665 or 1.2%
 - Medi-Cal: unfavorable variance of 36,081
 - TANF enrollment lower than budget
 - Offset by higher than budget enrollment in Medi-Cal Expansion and SPD categories
 - OneCare Connect: unfavorable variance of 35,043

FY 2015-16: Consolidated Revenues

- February 2016 MTD:

- Actual lower than budget by \$17.9 million or 6.5%
 - OneCare Connect: unfavorable variance of \$18.1 million due to lower enrollment
 - Medi-Cal revenue is in line with budget
 - Favorable price variance due to actual member mix
 - Offset by prior period adjustments of \$3.7 million related to lower Hepatitis C reimbursement from DHCS

- February 2016 YTD:

- Actual lower than budget by \$85.1 million, or 4.1%
 - OneCare Connect: unfavorable variance of \$71.1 million due to lower actual enrollment than budget
 - Medi-Cal: lower than budget by \$8.5 million
 - Mainly due to lower actual enrollment in TANF population
 - Prior year revenue adjustment of \$1.7 million

FY 2015-16: Consolidated Medical Expenses

- February 2016 MTD:

- Actual lower than budget by \$13.7 million or 5.3%
 - OneCare Connect: favorable variance of \$14.2 million due to lower actual enrollment than budget
 - Offset by unfavorable variance of \$1.1 million in Medi-Cal
 - Higher claims related expenses
 - Offset by savings in capitation expense categories

- February 2016 YTD:

- Actual lower than budget by \$80.8 million or 4.0%
 - OneCare Connect: favorable variance of \$65.2 million due to lower actual enrollment than budget
 - Medi-Cal: favorable variance of \$11.0 million due to actual utilization and cost variances than budget

- Medical Loss Ratio (MLR):

- February 2016 MTD: Actual: 95.7% Budget: 94.5%
- February 2016 YTD: Actual: 96.0% Budget: 96.0%

FY 2015-16: Consolidated Administrative Expenses

- February 2016 MTD:
 - Actual lower than budget by \$3.6 million or 27.8%
 - Salaries and Benefits: favorable variance of \$1.4 million
 - Other categories: favorable variance of \$2.1 million
- February 2016 YTD:
 - Actual lower than budget by \$32.5 million or 32.1%
 - Salaries and Benefits: favorable variance of \$14.2 million
 - Professional Fees and Purchased services: favorable variance of \$7.1 million (\$2.8 million and \$4.3 million, respectively)
 - Printing and Postage: favorable variance of \$3.8 million
- Administrative Loss Ratio (ALR):
 - February 2016 MTD: Actual: 3.6% Budget: 4.7%
 - February 2016 YTD: Actual: 3.4% Budget: 4.8%

FY 2015-16: Change in Net Assets

- February 2016 MTD:

- \$4.4 million surplus
- \$1.8 million favorable to budget
 - Attributable to:
 - Savings in medical expenses of \$13.7 million
 - Savings in administrative expenses of \$3.6 million
 - Investment income of \$2.7 million
 - Offset by lower than budgeted revenue of \$17.9 million

- February 2016 YTD:

- \$15.9 million surplus
- \$31.5 million favorable to budget
 - Attributable to:
 - Savings in medical expenses of \$80.8 million
 - Savings in administrative expenses of \$32.5 million
 - Investment income of \$4.8 million
 - Offset by lower than budgeted revenue of \$85.1 million

FY 2015-16: Change in Net Assets (cont.)

- February 2016 YTD variance attributable to:
 - Medi-Cal: \$17.2 million surplus; \$25.6 million favorable to budget
 - Savings in medical expenses of \$11.0 million
 - Savings in administrative expenses of \$23.1 million
 - Offset by lower than budgeted revenue of \$8.5 million
 - OneCare: \$1.9 million surplus; \$0.4 million unfavorable to budget
 - Favorable medical expenses of \$4.9 million
 - Favorable administrative expenses of \$0.7 million
 - Offset by lower than budgeted revenue of \$6.0 million
 - PACE: \$1.5 million deficit; \$0.3 million favorable to budget
 - Unfavorable medical expenses of \$405,928
 - Favorable administrative expenses of \$186,075
 - Favorable revenue of \$505,100
 - OneCare Connect: \$6.4 million deficit; \$2.5 million favorable to budget
 - Favorable medical expenses of \$65.2 million
 - Favorable administrative expenses of \$8.5 million
 - Offset by lower than budgeted revenue of \$71.1 million

Enrollment Summary: February 2016

Month-to-Date				Enrollment (By Aid Category)	Year-to-Date			
Actual	Budget	Variance	%		Actual	Budget	Variance	%
56,013	50,186	5,827	11.6%	Aged	492,685	466,449	26,236	5.6%
654	737	(83)	(11.3%)	BCCTP	5,437	5,892	(455)	(7.7%)
49,258	50,691	(1,433)	(2.8%)	Disabled	425,173	431,655	(6,482)	(1.5%)
3,347	2,653	694	26.2%	LTC	29,001	27,359	1,642	6.0%
219,583	200,832	18,751	9.3%	MCE	1,675,762	1,587,189	88,573	5.6%
436,120	458,876	(22,756)	(5.0%)	TANF	3,469,617	3,615,073	(145,456)	(4.0%)
764,975	763,975	1,000	0.1%	Medi-Cal	6,097,675	6,133,617	(35,942)	(0.6%)
458	479	(21)	(4.4%)	MSSP	3,693	3,832	(139)	(3.6%)
765,433	764,454	979	0.1%	Total Medi-Cal	6,101,368	6,137,449	(36,081)	(0.6%)
15,550	23,325	(7,775)	(33.3%)	OneCare Connect	40,384	75,427	(35,043)	(46.5%)
140	134	6	4.5%	PACE	985	932	53	5.7%
1,288	1,379	(91)	(6.6%)	OneCare	77,627	80,221	(2,594)	(3.2%)
782,411	789,292	(6,881)	(0.9%)	CalOptima Total	6,220,364	6,294,029	(73,665)	(1.2%)

Financial Highlights: February 2016

Month-to-Date

Actual	Budget	\$ Variance	% Variance
782,411	789,292	(6,881)	(0.9%)
257,125,387	274,993,971	(17,868,585)	(6.5%)
246,151,389	259,828,972	13,677,583	5.3%
9,251,838	12,807,120	3,555,282	27.8%
1,722,159	2,357,879	(635,720)	(0)
2,659,383	202,596	2,456,787	1212.7%
4,381,542	2,560,475	1,821,067	71.1%

95.7%	94.5%	(1.2%)
3.6%	4.7%	1.1%
<u>0.7%</u>	<u>0.9%</u>	<u>(0.2%)</u>
100.0%	100.0%	0.0%

Year-to-Date

Actual	Budget	\$ Variance	% Variance
6,220,364	6,294,029	(73,665)	(1.2%)
2,007,435,323	2,092,522,973	(85,087,651)	(4.1%)
1,927,418,051	2,008,229,613	80,811,562	4.0%
68,773,320	101,226,696	32,453,377	32.1%
11,243,952	(16,933,336)	28,177,288	2
4,704,409	1,356,481	3,347,927	246.8%
15,948,361	(15,576,855)	31,525,216	202.4%

Medical Loss Ratio	96.0%	96.0%	(0.0%)
Administrative Loss Ratio	3.4%	4.8%	1.4%
Operating Margin Ratio	<u>0.6%</u>	<u>(0.8%)</u>	<u>1.4%</u>
Total Operating	100.0%	100.0%	0.0%

Consolidated Performance Actual vs. Budget: February 2016 (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>
2.5	3.5	(1.0)	Medi-Cal	17.2	(8.5)	25.6
(0.8)	(0.4)	(0.4)	OneCare	1.9	2.2	(0.4)
0.1	(0.6)	0.7	OCC	(6.4)	(9.0)	2.5
0.0	0.0	0.0	ASO	0.1	0.0	0.1
(0.2)	(0.2)	0.0	PACE	(1.5)	(1.8)	0.3
1.7	2.4	(0.6)	Operating	11.2	(16.9)	28.2
<u>2.7</u>	<u>0.2</u>	<u>2.5</u>	Inv./Rental Inc, MCO tax	<u>4.7</u>	<u>1.4</u>	<u>3.3</u>
2.7	0.2	2.5	Non-Operating	4.7	1.4	3.3
4.4	2.6	1.8	TOTAL	15.9	(15.6)	31.5

Consolidated Revenue & Expense:

February 2016 MTD

	Medi-Cal	OneCare	OneCare Connect	PACE	Behavioral Health ASO	Consolidated
Member Months	765,433	1,288	15,550	140	-	782,411
REVENUES						
Capitation revenue	\$ 229,429,398	\$ 1,105,352	\$ 25,735,386	\$ 855,251	\$ -	\$ 257,125,387
Other Income	-	-	-	-	-	-
Total Operating Revenues	<u>229,429,398</u>	<u>1,105,352</u>	<u>25,735,386</u>	<u>855,251</u>	<u>-</u>	<u>257,125,387</u>
MEDICAL EXPENSES						
Provider capitation	77,069,364	239,062	7,636,407	-	-	84,944,832
Facility inpatient	35,358,674	449,514	16,213,463	-	-	52,021,651
Ancillary	-	93,710	824,612	-	-	918,321
Skilled Nursing	-	(5,469)	(3,407,917)	-	-	(3,413,386)
Facility outpatient	5,821,637	-	-	212,887	-	6,034,524
Professional Claims	10,003,819	-	-	185,250	-	10,189,069
Prescription drugs	33,589,285	192,348	5,184,588	79,112	-	39,045,333
Long-term care facility payments	42,440,480	-	-	-	-	42,440,480
Contingencies	8,968,329	-	-	-	-	8,968,329
Medical management	2,850,802	137,871	800,197	-	-	3,788,871
Reinsurance & other	536,949	6,753	236,952	433,927	(1,217)	1,213,364
Total Medical Expenses	<u>216,639,340</u>	<u>1,113,789</u>	<u>27,488,301</u>	<u>911,176</u>	<u>(1,217)</u>	<u>246,151,389</u>
GROSS MARGIN	12,790,058	(8,437)	(1,752,915)	(55,926)	1,217	10,973,998
ADMINISTRATIVE EXPENSES						
Salaries, wages & employee benefits	4,813,794	89,686	726,356	85,770	-	5,715,606
Professional fees	430,945	(6,993)	-	1,443	-	425,396
Purchased Services	404,691	(89,502)	124,737	113	-	440,039
Printing and Postage	697,147	(28,160)	115,201	413	0	784,601
Depreciation and Amortization	338,377	-	-	1,995	-	340,372
Other Expenses	1,290,011	36,300	(492)	12,631	-	1,338,450
Indirect cost allocation, Occupancy Expense	2,269,539	772,245	(2,838,992)	4,583	-	207,374
Total Administrative Expenses	<u>10,244,504</u>	<u>773,576</u>	<u>(1,873,190)</u>	<u>106,948</u>	<u>0</u>	<u>9,251,838</u>
INCOME (LOSS) FROM OPERATIONS	2,545,555	(782,013)	120,275	(162,874)	1,217	1,722,159
INVESTMENT INCOME	-	-	-	-	-	2,674,608
NET RENTAL INCOME	-	-	-	-	-	(15,270)
NET GRANT INCOME	-	-	-	-	-	-
OTHER INCOME	45	-	-	-	-	45
CHANGE IN NET ASSETS	<u>\$ 2,545,600</u>	<u>\$ (782,013)</u>	<u>\$ 120,275</u>	<u>\$ (162,874)</u>	<u>\$ 1,217</u>	<u>\$ 4,381,542</u>
BUDGETED CHANGE IN ASSETS	3,502,338	(408,955)	(557,885)	(177,618)	-	2,560,475
VARIANCE TO BUDGET - FAV (UNFAV)	<u>(956,738)</u>	<u>(373,058)</u>	<u>678,160</u>	<u>14,744</u>	<u>1,217</u>	<u>1,821,067</u>

Consolidated Revenue & Expense:

February 2016 YTD

	Medi-Cal	OneCare	OneCare Connect	PACE	Behavioral Health ASO	Consolidated
Member Months	6,101,368	77,627	40,384	985	-	6,220,364
REVENUES						
Capitation revenue	\$ 1,849,801,307	\$ 80,955,133	\$ 70,542,568	\$ 6,136,314	\$ -	\$ 2,007,435,323
Other Income	-	-	-	-	-	-
Total Operating Revenues	<u>1,849,801,307</u>	<u>80,955,133</u>	<u>70,542,568</u>	<u>6,136,314</u>	<u>-</u>	<u>2,007,435,323</u>
MEDICAL EXPENSES						
Provider capitation	621,578,948	28,784,281	19,628,987	-	-	669,992,216
Facility inpatient	391,583,674	28,761,529	25,644,879	-	-	445,990,081
Ancillary		2,286,173	2,483,506	-	-	4,769,679
Skilled Nursing		2,212,344	3,502,592	-	-	5,714,936
Facility outpatient	63,534,309	-	-	1,551,844	-	65,086,152
Professional Claims	91,636,408	-	-	1,442,375	-	93,078,783
Prescription drugs	257,228,948	6,475,006	14,722,103	596,787	-	279,022,844
Quality Incentives		899,979	-	-	-	899,979
Long-term care facility payments	343,269,035	-	-	-	-	343,269,035
Contingencies	(16,717,923)	-	-	-	-	(16,717,923)
Medical management	20,576,999	3,122,792	4,157,182	-	-	27,856,973
Reinsurance & other	4,413,273	606,171	302,129	3,207,968	(74,245)	8,455,295
Total Medical Expenses	<u>1,777,103,670</u>	<u>73,148,275</u>	<u>70,441,377</u>	<u>6,798,974</u>	<u>(74,245)</u>	<u>1,927,418,051</u>
GROSS MARGIN	72,697,637	7,806,859	101,191	(662,660)	74,245	80,017,272
ADMINISTRATIVE EXPENSES						
Salaries, wages & employee benefits	35,952,073	3,260,616	3,546,752	657,973	-	43,417,414
Professional fees	1,996,212	167,928	-	25,955	-	2,190,095
Purchased Services	5,334,371	385,864	566,722	7,344	-	6,294,300
Printing and Postage	2,434,924	88,862	967,807	18,254	(405)	3,509,442
Depreciation and Amortization	1,990,567	-	-	19,624	-	2,010,192
Other Expenses	8,472,567	297,248	14,640	55,838	13	8,840,307
Indirect cost allocation, Occupancy Expense	(657,013)	1,736,415	1,414,244	17,925	-	2,511,571
Total Administrative Expenses	<u>55,523,701</u>	<u>5,936,932</u>	<u>6,510,164</u>	<u>802,913</u>	<u>(392)</u>	<u>68,773,320</u>
INCOME (LOSS) FROM OPERATIONS	17,173,936	1,869,926	(6,408,974)	(1,465,573)	74,637	11,243,952
INVESTMENT INCOME	-	-	-	-	-	4,839,090
NET RENTAL INCOME	-	-	-	-	-	(135,388)
NET GRANT INCOME	(154)	-	-	-	-	(154)
OTHER INCOME	861	-	-	-	-	861
CHANGE IN NET ASSETS	<u>\$ 17,174,643</u>	<u>\$ 1,869,926</u>	<u>\$ (6,408,974)</u>	<u>\$ (1,465,573)</u>	<u>\$ 74,637</u>	<u>\$ 15,948,361</u>
BUDGETED CHANGE IN ASSETS	(8,465,225)	2,233,325	(8,950,617)	(1,750,820)	-	(15,576,855)
VARIANCE TO BUDGET - FAV (UNFAV)	<u>25,639,868</u>	<u>(363,398)</u>	<u>2,541,643</u>	<u>285,246</u>	<u>74,637</u>	<u>31,525,216</u>

Balance Sheet:

As of February 2016

ASSETS

Current Assets

Operating Cash	\$477,215,571
Catastrophic Reserves	11,312,408
Investments	1,004,926,750
Capitation receivable	133,821,064
Receivables - Other	11,774,994
Prepaid Expenses	5,668,822

Total Current Assets	<u>1,644,719,609</u>
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Capital Assets

Furniture and equipment	27,720,290
Leasehold improvements	9,495,402
505 City Parkway West	46,682,460
	<u>83,898,152</u>
Less: accumulated depreciation	<u>(30,108,421)</u>
Capital assets, net	<u>53,789,731</u>

Other Assets

Restricted deposit & Other	268,819
Board-designated assets	
Cash and cash equivalents	30,116,099
Short term investments	-
Long term investments	441,316,173
Total Board-designated Assets	<u>471,432,272</u>
Total Other Assets	<u>471,701,092</u>

Deferred outflows of Resources	3,787,544
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TOTAL ASSETS & OUTFLOWS	<u>2,173,997,976</u>
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LIABILITIES & FUND BALANCES

Current Liabilities

Accounts payable	\$150,253
Medical claims liability	534,658,040
Accrued payroll liabilities	8,728,049
Deferred revenue	564,676,793
Deferred revenue - CMS	0
Deferred lease obligations	298,864
Capitation and withholds	388,190,513
Accrued insurance costs	0

Total Current Liabilities	<u>1,496,702,512</u>
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Other (than pensions) post employment benefits liability	27,584,126
Net Pension Liabilities	989,603
Long Term Liabilities	150,000

TOTAL LIABILITIES	<u>1,525,426,242</u>
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Deferred inflows of Resources	5,580,552
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Tangible net equity (TNE)	83,856,380
Funds in excess of TNE	<u>559,134,802</u>

Net Assets	<u>642,991,182</u>
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TOTAL LIABILITIES, INFLOWS & FUND BALANCES	<u>2,173,997,976</u>
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CalOptima
Better. Together.

UNAUDITED FINANCIAL STATEMENTS

February 2016

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CalOptima - Consolidated
Financial Highlights
For the Eight Months Ended February 29, 2016

Month-to-Date					Year-to-Date			
Actual	Budget	\$ Variance	% Variance		Actual	Budget	\$ Variance	% Variance
782,411	789,292	(6,881)	(0.9%)	Member Months	6,220,364	6,294,029	(73,665)	(1.2%)
257,125,387	274,993,971	(17,868,585)	(6.5%)	Revenues	2,007,435,323	2,092,522,973	(85,087,651)	(4.1%)
246,151,389	259,828,972	13,677,583	5.3%	Medical Expenses	1,927,418,051	2,008,229,613	80,811,562	4.0%
9,251,838	12,807,120	3,555,282	27.8%	Administrative Expenses	68,773,320	101,226,696	32,453,377	32.1%
1,722,159	2,357,879	(635,720)	(0)	Operating Margin	11,243,952	(16,933,336)	28,177,288	2
2,659,383	202,596	2,456,787	1212.7%	Non Operating Income (Loss)	4,704,409	1,356,481	3,347,927	246.8%
4,381,542	2,560,475	1,821,067	71.1%	Change in Net Assets	15,948,361	(15,576,855)	31,525,216	202.4%
95.7%	94.5%	(1.2%)		Medical Loss Ratio	96.0%	96.0%	(0.0%)	
3.6%	4.7%	1.1%		Administrative Loss Ratio	3.4%	4.8%	1.4%	
<u>0.7%</u>	<u>0.9%</u>	<u>(0.2%)</u>		Operating Margin Ratio	<u>0.6%</u>	<u>(0.8%)</u>	<u>1.4%</u>	
100.0%	100.0%	0.0%		Total Operating	100.0%	100.0%	0.0%	

CalOptima
Financial Dashboard
For the Eight Months Ended February 29, 2016

MONTH

Enrollment				
	Actual	Budget	Fav / (Unfav)	
Medi-Cal	764,975	763,975	↑	1,000 (0.1%)
OneCare	1,288	1,379	↓	(91) (6.6%)
OneCare Connect	15,550	23,325	↓	(7,775) (33.3%)
PACE	140	134	↑	6 4.5%
MSSP	458	479	↓	(21) (4.4%)
Total	782,411	789,292	↓	(6,881) (0.9%)

Change in Net Assets (\$000)				
	Actual	Budget	Fav / (Unfav)	
Medi-Cal (w/ MSSP)	\$ 2,546	\$ 3,502	↓	\$ (957) (27.3%)
OneCare	(782)	(409)	↓	(373) (91.2%)
OneCare Connect	120	(558)	↑	678 121.6%
PACE	(163)	(178)	↑	15 8.3%
ASO	1	-	↑	1 100.0%
505 Bldg.	(15)	(6)	↓	(10) (166.2%)
Investment Income & Other	2,675	208	↑	2,466 1183.8%
Total	\$ 4,382	\$ 2,560	↑	\$ 1,821 71.1%

MLR			
	Actual	Budget	% Point Var
Medi-Cal (w/ MSSP)	94.4%	94.2%	↓ (0.3)
OneCare	100.8%	117.0%	↑ 16.2
OneCare Connect	106.8%	95.2%	↓ (11.6)

Administrative Cost (\$000)				
	Actual	Budget	Fav / (Unfav)	
Medi-Cal (w/ MSSP)	\$ 10,245	\$ 9,858	↓	\$ (387) (3.9%)
OneCare	774	159	↓	(615) (387.6%)
OneCare Connect	(1,873)	2,670	↑	4,543 170.2%
PACE	107	121	↑	14 11.3%
Total	\$ 9,252	\$ 12,807	↑	\$ 3,555 27.8%

Total FTE's Month			
	Actual	Budget	Fav / (Unfav)
Medi-Cal	753	879	126
OneCare	57	-	(57)
OneCare Connect	177	291	114
PACE	35	44	9
MSSP	16	18	1
Total	1,038	1,231	193

MM per FTE			
	Actual	Budget	Fav / (Unfav)
Medi-Cal	1,016	869	147
OneCare	23	-	-
OneCare Connect	88	80	8
PACE	4	3	1
MSSP	28	27	1
Total	1,159	979	157

YEAR - TO - DATE

Year To Date Enrollment				
	Actual	Budget	Fav / (Unfav)	
Medi-Cal	6,097,675	6,133,617	↓	(35,942) (0.6%)
OneCare	77,627	80,221	↓	(2,594) (3.2%)
OneCare Connect	40,384	75,427	↓	(35,043) (46.5%)
PACE	985	932	↑	53 5.7%
MSSP	3,693	3,832	↓	(139) (3.6%)
Total	6,220,364	6,294,029	↓	(73,665) (1.2%)

Change in Net Assets (\$000)				
	Actual	Budget	Fav / (Unfav)	
Medi-Cal (w/ MSSP)	\$ 17,175	\$ (8,465)	↑	\$ 25,640 302.9%
OneCare	1,870	2,233	↓	(363) (16.3%)
OneCare Connect	(6,409)	(8,951)	↑	2,542 28.4%
PACE	(1,466)	(1,751)	↑	285 16.3%
ASO	75	-	↑	75 100.0%
505 Bldg.	(135)	(310)	↑	175 56.4%
Investment Income &	4,840	1,667	↑	3,173 190.4%
Total	\$ 15,949	\$ (15,577)	↑	\$ 31,526 202.4%

MLR			
	Actual	Budget	% Point Var
Medi-Cal (w/ MSSP)	96.1%	96.2%	↑ 0.2
OneCare	90.4%	89.8%	↓ (0.5)
OneCare Connect	99.9%	95.7%	↓ (4.1)

Administrative Cost (\$000)				
	Actual	Budget	Fav / (Unfav)	
Medi-Cal (w/ MSSP)	\$ 55,524	\$ 78,617	↑	\$ 23,093 29.4%
OneCare	5,937	6,617	↑	680 10.3%
OneCare Connect	6,510	15,004	↑	8,494 56.6%
PACE	803	989	↑	186 18.8%
Total	\$ 68,774	\$ 101,227	↑	\$ 32,453 32.1%

Total FTE's YTD			
	Actual	Budget	Fav / (Unfav)
Medi-Cal	5,826	6,969	1,143
OneCare	801	947	145
OneCare Connect	965	1,368	402
PACE	275	339	64
MSSP	142	142	0
Total	8,009	9,764	1,755

MM per FTE			
	Actual	Budget	Fav / (Unfav)
Medi-Cal	1,047	880	167
OneCare	97	85	12
OneCare Connect	42	55	(13)
PACE	4	3	1
MSSP	26	27	(1)
Total	1,215	1,050	165

**CalOptima - Consolidated
Statement of Revenue and Expenses
For the One Month Ended February 29, 2016**

	Actual		Month Budget		Variance	
	\$	PMPM*	\$	PMPM*	\$	PMPM
Member Months**	782,411		789,292		(6,881)	
Revenues						
Medi-Cal	\$ 229,429,398	\$ 299.74	\$ 228,901,776	\$ 299.43	\$ 527,622	\$ 0.31
OneCare	1,105,352	858.19	1,472,488	1,067.79	(367,136)	(209.60)
OneCare Connect	25,735,386	1,655.01	43,808,582	1,878.18	(18,073,196)	(223.17)
PACE	855,251	6,108.93	811,125	6,053.17	44,126	55.76
Total Operating Revenue	<u>257,125,387</u>	<u>328.63</u>	<u>274,993,971</u>	<u>348.41</u>	<u>(17,868,585)</u>	<u>(19.77)</u>
Medical Expenses						
Medi-Cal	216,639,340	283.03	215,541,687	281.96	(1,097,653)	(1.07)
OneCare	1,113,789	864.74	1,722,777	1,249.29	608,988	384.55
OneCare Connect	27,488,301	1,767.74	41,696,302	1,787.62	14,208,001	19.89
PACE	911,176	6,508.40	868,206	6,479.15	(42,971)	(29.26)
ASO for Specialty Mental Health Svcs	(1,217)	-	-	-	1,217	-
Total Medical Expenses	<u>246,151,389</u>	<u>314.61</u>	<u>259,828,972</u>	<u>329.19</u>	<u>13,677,583</u>	<u>14.59</u>
Gross Margin	10,973,998	14.03	15,164,999	19.21	(4,191,002)	(5.19)
Administrative Expenses						
Salaries and benefits	5,715,606	7.31	7,162,300	9.07	1,446,694	1.77
Professional fees	425,396	0.54	627,034	0.79	201,638	0.25
Purchased services	440,039	0.56	1,555,289	1.97	1,115,250	1.41
Printing and Postage	784,601	1.00	910,100	1.15	125,499	0.15
Depreciation and amortization	340,372	0.44	460,712	0.58	120,340	0.15
Other	1,338,450	1.71	1,689,706	2.14	351,256	0.43
Indirect Cost Allocation, Occupancy Expense	207,374	0.27	401,980	0.51	194,606	0.24
Total Administrative Expenses	<u>9,251,838</u>	<u>11.82</u>	<u>12,807,120</u>	<u>16.23</u>	<u>3,555,282</u>	<u>4.40</u>
Income (Loss) From Operations	1,722,159	2.20	2,357,879	2.99	(635,720)	(0.79)
Investment income						
Interest income	974,835	1.25	208,333	0.26	766,503	0.98
Realized gain/(loss) on investments	108,409	0.14	-	-	108,409	0.14
Unrealized gain/(loss) on investments	1,591,364	2.03	-	-	1,591,364	2.03
Total Investment Income	<u>2,674,608</u>	<u>3.42</u>	<u>208,333</u>	<u>0.26</u>	<u>2,466,275</u>	<u>3.15</u>
Net Rental Income	(15,270)	(0.02)	(5,737)	(0.01)	(9,533)	(0.01)
Total Net Operating Tax	-	-	-	-	-	-
Total Net Grant Income	-	-	-	-	-	-
QAF/IGT	-	-	-	-	-	-
Other Income	45	0.00	-	-	45	0.00
Change In Net Assets	<u>4,381,542</u>	<u>5.60</u>	<u>2,560,475</u>	<u>3.24</u>	<u>1,821,067</u>	<u>2.36</u>
Medical Loss Ratio	95.7%		94.5%		(1.2%)	
Administrative Loss Ratio	3.6%		4.7%		1.1%	

* PMPMs for Revenues and Medical Expenses are calculated using line of business enrollment

** Includes MSSP

**CalOptima - Consolidated - Year to Date
Statement of Revenue and Expenses
For the Eight Months Ended February 29, 2016**

	Actual		Year to Date Budget		Variance	
	\$	PMPM*	\$	PMPM*	\$	PMPM
Member Months**	6,220,364		6,294,029		(73,665)	
Revenues						
Medi-Cal	\$ 1,849,801,307	\$ 303.18	\$ 1,858,294,325	\$ 302.78	\$ (8,493,018)	\$ 0.40
OneCare	80,955,133	1,042.87	86,932,179	1,083.66	(5,977,046)	(40.79)
OneCare Connect	70,542,568	1,746.79	141,665,254	1,878.18	(71,122,686)	(131.38)
PACE	6,136,314	6,229.76	5,631,215	6,042.08	505,100	187.68
Total Operating Revenue	<u>2,007,435,323</u>	<u>322.72</u>	<u>2,092,522,973</u>	<u>332.46</u>	<u>(85,087,651)</u>	<u>(9.74)</u>
Medical Expenses						
Medi-Cal	1,777,103,670	291.26	1,788,142,986	291.35	11,039,316	0.09
OneCare	73,148,275	942.30	78,081,614	973.33	4,933,339	31.03
OneCare Connect	70,441,377	1,744.29	135,611,967	1,797.92	65,170,590	53.63
PACE	6,798,974	6,902.51	6,393,046	6,859.49	(405,928)	(43.02)
ASO for Specialty Mental Health Svcs	(74,245)	-	-	-	74,245	-
Total Medical Expenses	<u>1,927,418,051</u>	<u>309.86</u>	<u>2,008,229,613</u>	<u>319.07</u>	<u>80,811,562</u>	<u>9.21</u>
Gross Margin	80,017,272	12.86	84,293,360	13.39	(4,276,088)	(0.53)
Administrative Expenses						
Salaries and benefits	43,417,414	6.98	57,605,667	9.15	14,188,254	2.17
Professional fees	2,190,095	0.35	4,953,731	0.79	2,763,636	0.43
Purchased services	6,294,300	1.01	10,599,680	1.68	4,305,381	0.67
Printing and Postage	3,509,442	0.56	7,318,303	1.16	3,808,861	0.60
Depreciation and amortization	2,010,192	0.32	3,685,698	0.59	1,675,506	0.26
Other	8,840,307	1.42	13,848,579	2.20	5,008,272	0.78
Indirect cost allocation, Occupancy Expense	2,511,571	0.40	3,215,038	0.51	703,467	0.11
Total Administrative Expenses	<u>68,773,320</u>	<u>11.06</u>	<u>101,226,696</u>	<u>16.08</u>	<u>32,453,377</u>	<u>5.03</u>
Income (Loss) From Operations	11,243,952	1.81	(16,933,336)	(2.69)	28,177,288	4.50
Investment income						
Interest income	5,819,942	0.94	1,666,661	0.26	4,153,282	0.67
Realized gain/(loss) on investments	212,315	0.03	-	-	212,315	0.03
Unrealized gain/(loss) on investments	(1,193,168)	(0.19)	-	-	(1,193,168)	(0.19)
Total Investment Income	<u>4,839,090</u>	<u>0.78</u>	<u>1,666,661</u>	<u>0.26</u>	<u>3,172,429</u>	<u>0.51</u>
Net Rental Income	(135,388)	(0.02)	(310,179)	(0.05)	174,791	0.03
Total Net Operating Tax	-	-	-	-	-	-
Total Net Grant Income	(154)	(0)	-	-	(154)	(0)
QAF/IGT	-	-	-	-	-	-
Other Income	861	0	-	-	861	0
Change In Net Assets	<u>15,948,361</u>	<u>2.56</u>	<u>(15,576,855)</u>	<u>(2.47)</u>	<u>31,525,216</u>	<u>5.04</u>
Medical Loss Ratio	96.0%		96.0%		(0.0%)	
Administrative Loss Ratio	3.4%		4.8%		1.4%	

* PMPMs for Revenues and Medical Expenses are calculated using line of business enrollment

** Includes MSSP

**CalOptima - Consolidated - Month to Date
Statement of Revenues and Expenses by LOB
For the One Month Ended February 29, 2016**

	<u>Medi-Cal</u>	<u>OneCare</u>	<u>OneCare Connect</u>	<u>PACE</u>	<u>Behavioral Health ASO</u>	<u>Consolidated</u>
Member Months	765,433	1,288	15,550	140	-	782,411
REVENUES						
Capitation revenue	\$ 229,429,398	\$ 1,105,352	\$ 25,735,386	\$ 855,251	\$ -	\$ 257,125,387
Other Income	-	-	-	-	-	-
Total Operating Revenues	<u>229,429,398</u>	<u>1,105,352</u>	<u>25,735,386</u>	<u>855,251</u>	<u>-</u>	<u>257,125,387</u>
MEDICAL EXPENSES						
Provider capitation	77,069,364	239,062	7,636,407	-	-	84,944,832
Facility inpatient	35,358,674	449,514	16,213,463	-	-	52,021,651
Ancillary	-	93,710	824,612	-	-	918,321
Skilled Nursing	-	(5,469)	(3,407,917)	-	-	(3,413,386)
Facility outpatient	5,821,637	-	-	212,887	-	6,034,524
Professional Claims	10,003,819	-	-	185,250	-	10,189,069
Prescription drugs	33,589,285	192,348	5,184,588	79,112	-	39,045,333
Long-term care facility payments	42,440,480	-	-	-	-	42,440,480
Contingencies	8,968,329	-	-	-	-	8,968,329
Medical management	2,850,802	137,871	800,197	-	-	3,788,871
Reinsurance & other	536,949	6,753	236,952	433,927	(1,217)	1,213,364
Total Medical Expenses	<u>216,639,340</u>	<u>1,113,789</u>	<u>27,488,301</u>	<u>911,176</u>	<u>(1,217)</u>	<u>246,151,389</u>
GROSS MARGIN	12,790,058	(8,437)	(1,752,915)	(55,926)	1,217	10,973,998
ADMINISTRATIVE EXPENSES						
Salaries, wages & employee benefits	4,813,794	89,686	726,356	85,770	-	5,715,606
Professional fees	430,945	(6,993)	-	1,443	-	425,396
Purchased Services	404,691	(89,502)	124,737	113	-	440,039
Printing and Postage	697,147	(28,160)	115,201	413	0	784,601
Depreciation and Amortization	338,377	-	-	1,995	-	340,372
Other Expenses	1,290,011	36,300	(492)	12,631	-	1,338,450
Indirect cost allocation, Occupancy Expense	2,269,539	772,245	(2,838,992)	4,583	-	207,374
Total Administrative Expenses	<u>10,244,504</u>	<u>773,576</u>	<u>(1,873,190)</u>	<u>106,948</u>	<u>0</u>	<u>9,251,838</u>
INCOME (LOSS) FROM OPERATIONS	2,545,555	(782,013)	120,275	(162,874)	1,217	1,722,159
INVESTMENT INCOME	-	-	-	-	-	2,674,608
NET RENTAL INCOME	-	-	-	-	-	(15,270)
NET GRANT INCOME	-	-	-	-	-	-
OTHER INCOME	45	-	-	-	-	45
CHANGE IN NET ASSETS	<u>\$ 2,545,600</u>	<u>\$ (782,013)</u>	<u>\$ 120,275</u>	<u>\$ (162,874)</u>	<u>\$ 1,217</u>	<u>\$ 4,381,542</u>
BUDGETED CHANGE IN ASSETS	3,502,338	(408,955)	(557,885)	(177,618)	-	2,560,475
VARIANCE TO BUDGET - FAV (UNFAV)	<u>(956,738)</u>	<u>(373,058)</u>	<u>678,160</u>	<u>14,744</u>	<u>1,217</u>	<u>1,821,067</u>

CalOptima - Consolidated - Year to Date
Statement of Revenues and Expenses by LOB
For the Eight Months Ended February 29, 2016

	Medi-Cal	OneCare	OneCare Connect	PACE	Behavioral Health ASO	Consolidated
Member Months	6,101,368	77,627	40,384	985	-	6,220,364
REVENUES						
Capitation revenue	\$ 1,849,801,307	\$ 80,955,133	\$ 70,542,568	\$ 6,136,314	\$ -	\$ 2,007,435,323
Other Income	-	-	-	-	-	-
Total Operating Revenues	<u>1,849,801,307</u>	<u>80,955,133</u>	<u>70,542,568</u>	<u>6,136,314</u>	<u>-</u>	<u>2,007,435,323</u>
MEDICAL EXPENSES						
Provider capitation	621,578,948	28,784,281	19,628,987	-	-	669,992,216
Facility inpatient	391,583,674	28,761,529	25,644,879	-	-	445,990,081
Ancillary		2,286,173	2,483,506	-	-	4,769,679
Skilled Nursing		2,212,344	3,502,592	-	-	5,714,936
Facility outpatient	63,534,309	-	-	1,551,844	-	65,086,152
Professional Claims	91,636,408	-	-	1,442,375	-	93,078,783
Prescription drugs	257,228,948	6,475,006	14,722,103	596,787	-	279,022,844
Quality Incentives		899,979	-	-	-	899,979
Long-term care facility payments	343,269,035	-	-	-	-	343,269,035
Contingencies	(16,717,923)	-	-	-	-	(16,717,923)
Medical management	20,576,999	3,122,792	4,157,182	-	-	27,856,973
Reinsurance & other	4,413,273	606,171	302,129	3,207,968	(74,245)	8,455,295
Total Medical Expenses	<u>1,777,103,670</u>	<u>73,148,275</u>	<u>70,441,377</u>	<u>6,798,974</u>	<u>(74,245)</u>	<u>1,927,418,051</u>
GROSS MARGIN	72,697,637	7,806,859	101,191	(662,660)	74,245	80,017,272
ADMINISTRATIVE EXPENSES						
Salaries, wages & employee benefits	35,952,073	3,260,616	3,546,752	657,973	-	43,417,414
Professional fees	1,996,212	167,928	-	25,955	-	2,190,095
Purchased Services	5,334,371	385,864	566,722	7,344	-	6,294,300
Printing and Postage	2,434,924	88,862	967,807	18,254	(405)	3,509,442
Depreciation and Amortization	1,990,567	-	-	19,624	-	2,010,192
Other Expenses	8,472,567	297,248	14,640	55,838	13	8,840,307
Indirect cost allocation, Occupancy Expense	(657,013)	1,736,415	1,414,244	17,925	-	2,511,571
Total Administrative Expenses	<u>55,523,701</u>	<u>5,936,932</u>	<u>6,510,164</u>	<u>802,913</u>	<u>(392)</u>	<u>68,773,320</u>
INCOME (LOSS) FROM OPERATIONS	17,173,936	1,869,926	(6,408,974)	(1,465,573)	74,637	11,243,952
INVESTMENT INCOME	-	-	-	-	-	4,839,090
NET RENTAL INCOME	-	-	-	-	-	(135,388)
NET GRANT INCOME	(154)	-	-	-	-	(154)
OTHER INCOME	861	-	-	-	-	861
CHANGE IN NET ASSETS	<u>\$ 17,174,643</u>	<u>\$ 1,869,926</u>	<u>\$ (6,408,974)</u>	<u>\$ (1,465,573)</u>	<u>\$ 74,637</u>	<u>\$ 15,948,361</u>
BUDGETED CHANGE IN ASSETS	(8,465,225)	2,233,325	(8,950,617)	(1,750,820)	-	(15,576,855)
VARIANCE TO BUDGET - FAV (UNFAV)	<u>25,639,868</u>	<u>(363,398)</u>	<u>2,541,643</u>	<u>285,246</u>	<u>74,637</u>	<u>31,525,216</u>

February 29, 2016 Unaudited Financial Statements

SUMMARY

MONTHLY RESULTS:

- Change in Net Assets is \$4.4 million, \$1.8 million favorable to budget
- Operating surplus is \$1.7 million with a surplus in non-operating of \$2.7 million

YTD RESULTS:

- Change in Net Assets is \$15.9 million, \$31.5 million favorable to budget
- Operating surplus is \$11.2 million, and non-operating surplus is \$4.7 million

Change in Net Assets by 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>
2.5	3.5	(1.0)	Medi-Cal	17.2	(8.5)	25.6
(0.8)	(0.4)	(0.4)	OneCare	1.9	2.2	(0.4)
0.1	(0.6)	0.7	OCC	(6.4)	(9.0)	2.5
0.0	0.0	0.0	ASO	0.1	0.0	0.1
(0.2)	(0.2)	0.0	PACE	(1.5)	(1.8)	0.3
1.7	2.4	(0.6)	Operating	11.2	(16.9)	28.2
<u>2.7</u>	<u>0.2</u>	<u>2.5</u>	Inv./Rental Inc, MCO tax	<u>4.7</u>	<u>1.4</u>	<u>3.3</u>
2.7	0.2	2.5	Non-Operating	4.7	1.4	3.3
4.4	2.6	1.8	TOTAL	15.9	(15.6)	31.5

CalOptima
Enrollment Summary
For the Eight Months Ended February 29, 2016

Month-to-Date				Enrollment (By Aid Category)	Year-to-Date			
Actual	Budget	Variance	%		Actual	Budget	Variance	%
56,013	50,186	5,827	11.6%	Aged	492,685	466,449	26,236	5.6%
654	737	(83)	(11.3%)	BCCTP	5,437	5,892	(455)	(7.7%)
49,258	50,691	(1,433)	(2.8%)	Disabled	425,173	431,655	(6,482)	(1.5%)
3,347	2,653	694	26.2%	LTC	29,001	27,359	1,642	6.0%
219,583	200,832	18,751	9.3%	MCE	1,675,762	1,587,189	88,573	5.6%
436,120	458,876	(22,756)	(5.0%)	TANF	3,469,617	3,615,073	(145,456)	(4.0%)
764,975	763,975	1,000	0.1%	Medi-Cal	6,097,675	6,133,617	(35,942)	(0.6%)
458	479	(21)	(4.4%)	MSSP	3,693	3,832	(139)	(3.6%)
765,433	764,454	979	0.1%	Total Medi-Cal	6,101,368	6,137,449	(36,081)	(0.6%)
15,550	23,325	(7,775)	(33.3%)	OneCare Connect	40,384	75,427	(35,043)	(46.5%)
140	134	6	4.5%	PACE	985	932	53	5.7%
1,288	1,379	(91)	(6.6%)	OneCare	77,627	80,221	(2,594)	(3.2%)
782,411	789,292	(6,881)	(0.9%)	CalOptima Total	6,220,364	6,294,029	(73,665)	(1.2%)
Enrollment (By Network)								
44,420	44,130	290	0.7%	HMO	343,440	346,560	(3,120)	(0.9%)
225,924	236,498	(10,574)	(4.5%)	PHC	1,798,920	1,866,052	(67,132)	(3.6%)
340,552	355,750	(15,198)	(4.3%)	Shared Risk Group	2,734,499	2,808,475	(73,976)	(2.6%)
154,079	127,597	26,482	20.8%	Fee for Service	1,220,816	1,112,530	108,286	9.7%
764,975	763,975	1,000	0.1%	Medi-Cal	6,097,675	6,133,617	(35,942)	(0.6%)
458	479	(21)	(4.4%)	MSSP	3,693	3,832	(139)	(3.6%)
765,433	764,454	979	0.1%	Total Medi-Cal	6,101,368	6,137,449	(36,081)	(0.6%)
15,550	23,325	(7,775)	(33.3%)	OneCare Connect	40,384	75,427	(35,043)	(46.5%)
140	134	6	4.5%	PACE	985	932	53	5.7%
1,288	1,379	(91)	(6.6%)	OneCare	77,627	80,221	(2,594)	(3.2%)
782,411	789,292	(6,881)	(0.9%)	CalOptima Total	6,220,364	6,294,029	(73,665)	(1.2%)

CalOptima
Enrollment Trend by Network Type
Fiscal Year 2016

Network Type	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	MMs
HMO													
Aged	275	274	276	268	271	266	278	279	-	-	-	-	2,187
BCCTP	-	-	-	-	2	4	3	8	-	-	-	-	17
Disabled	1,705	1,709	1,719	1,715	1,731	1,719	1,730	1,762	-	-	-	-	13,790
MCX	9,194	9,431	9,678	9,990	10,203	10,411	10,388	10,966	-	-	-	-	80,261
TANF	30,496	30,681	30,806	31,011	30,829	31,059	30,898	31,405	-	-	-	-	247,185
	41,670	42,095	42,479	42,984	43,036	43,459	43,297	44,420	-	-	-	-	343,440
PHC													
Aged	1,209	1,265	1,286	1,264	1,316	1,355	1,342	1,368	-	-	-	-	10,405
BCCTP	-	-	-	-	-	-	-	-	-	-	-	-	-
Disabled	8,147	8,148	8,139	8,080	8,141	8,031	7,995	7,989	-	-	-	-	64,670
MCX	31,591	32,558	33,426	34,638	35,529	36,352	35,625	35,756	-	-	-	-	275,475
TANF	179,126	179,848	180,626	181,957	182,035	182,975	180,992	180,811	-	-	-	-	1,448,370
	220,073	221,819	223,477	225,939	227,021	228,713	225,954	225,924	-	-	-	-	1,798,920
Shared Risk Group													
Aged	7,127	7,221	7,326	7,156	7,377	7,406	7,401	7,456	-	-	-	-	58,470
BCCTP	-	-	-	-	-	-	-	-	-	-	-	-	-
Disabled	15,565	15,485	15,439	15,178	15,245	15,067	14,906	14,838	-	-	-	-	121,723
MCX	125,793	127,941	130,404	133,133	135,550	138,081	133,138	133,838	-	-	-	-	1,057,878
TANF	186,142	186,379	186,841	188,949	188,873	188,378	185,442	184,420	-	-	-	-	1,496,424
	334,627	337,026	340,010	344,416	347,045	349,932	340,887	340,552	-	-	-	-	2,734,495
Fee for Service (Dual)													
Aged	52,530	52,110	51,992	51,739	51,522	51,041	43,625	43,676	-	-	-	-	398,235
BCCTP	35	35	34	33	36	47	35	32	-	-	-	-	287
Disabled	25,713	25,495	25,271	25,063	24,900	24,467	20,344	20,231	-	-	-	-	191,484
LTC	3,391	3,395	3,337	3,347	3,311	3,228	3,089	2,993	-	-	-	-	26,091
MCX	2,904	2,965	2,934	3,034	3,007	3,152	3,023	3,084	-	-	-	-	24,103
TANF	1,358	1,383	1,381	1,361	1,346	1,387	1,169	1,195	-	-	-	-	10,580
	85,931	85,383	84,949	84,577	84,122	83,322	71,285	71,211	-	-	-	-	650,780
Fee for Service (Non-Dual)													
Aged	2,401	2,671	1,925	3,122	3,136	3,318	3,581	3,234	-	-	-	-	23,388
BCCTP	629	620	594	693	683	652	648	614	-	-	-	-	5,133
Disabled	3,962	4,076	3,598	4,454	4,222	4,283	4,473	4,438	-	-	-	-	33,506
LTC	406	389	255	388	380	371	367	354	-	-	-	-	2,910
MCX	25,032	26,395	24,324	29,312	30,062	31,335	35,646	35,939	-	-	-	-	238,045
TANF	28,959	29,852	31,084	32,224	33,662	34,021	38,963	38,289	-	-	-	-	267,054
	61,389	64,003	61,780	70,193	72,145	73,980	83,678	82,868	-	-	-	-	570,036
MEDI-CAL TOTAL													
Aged	63,542	63,541	62,805	63,549	63,622	63,386	56,227	56,013	-	-	-	-	492,685
BCCTP	664	655	628	726	721	703	686	654	-	-	-	-	5,437
Disabled	55,092	54,913	54,166	54,490	54,239	53,567	49,448	49,258	-	-	-	-	425,173
LTC	3,797	3,784	3,592	3,735	3,691	3,599	3,456	3,347	-	-	-	-	29,001
MCX	194,514	199,290	200,766	210,107	214,351	219,331	217,820	219,583	-	-	-	-	1,675,762
TANF	426,081	428,143	430,738	435,502	436,745	438,824	437,464	436,120	-	-	-	-	3,469,617
	743,690	750,326	752,695	768,109	773,369	779,410	765,101	764,975	-	-	-	-	6,097,675
PACE	101	114	119	123	124	129	135	140	-	-	-	-	985
OneCare	13,021	12,803	12,628	12,455	12,166	11,891	1,375	1,288	-	-	-	-	77,627
OneCare Connect	2	954	1,666	2,496	3,189	4,437	12,090	15,550	-	-	-	-	40,384
MSSP	455	458	466	466	465	464	461	458	-	-	-	-	3,693
TOTAL	757,269	764,655	767,574	783,649	789,313	796,331	779,162	782,411	-	-	-	-	6,220,364

ENROLLMENT

Overall enrollment was 782,411

- Increased 3,249 or 0.4% from prior month
- Increased 51,275 or 7.0% from prior year (February 2015)
- Unfavorable to budget by (6,881)

Medi-Cal enrollment was 764,975

- Decreased (126) from prior month and reflective of the dual member movement to OneCare Connect
- Favorable to budget by 1,000 primarily driven by:
 - TANF unfavorable by (22,756)
 - Offset with Medi-Cal Expansion favorable by 18,751 and aged by 5,827

OneCare enrollment was 1,288

- Decreased (87) from prior month due to shift to OneCare Connect program
- Unfavorable to budget by (91)

OneCare Connect enrollment was 15,550

- Increased 3,460 from prior month due to shift from OneCare program
- Unfavorable to budget by (7,775)
- Enrollment without retroactivity is 16,910

PACE enrollment was 140

- Increased 5 from prior month
- Favorable to budget by 6

**CalOptima - MediCal Total
Statement of Revenues and Expenses
For the Eight Months Ended February 29, 2016**

Month			
Actual	Budget	\$ Variance	% Variance
765,433	764,454	979	0.13%
229,429,398	228,901,776	527,622	0.23%
0	0	0	0.00%
229,429,398	228,901,776	527,622	0.23%
77,069,364	82,350,692	5,281,329	6.41%
35,358,674	42,318,434	6,959,759	16.45%
5,821,637	9,729,910	3,908,273	40.17%
10,003,819	18,663,086	8,659,267	46.40%
33,589,285	30,682,341	(2,906,943)	-9.47%
42,440,480	32,284,069	(10,156,412)	-31.46%
8,968,329	(4,729,014)	(13,697,343)	-289.64%
2,850,802	3,694,964	844,162	22.85%
536,949	547,205	10,256	1.87%
216,639,340	215,541,687	(1,097,653)	-0.51%
12,790,058	13,360,089	(570,031)	-4.27%
4,813,794	5,844,934	1,031,140	17.64%
430,945	570,833	139,888	24.51%
404,691	1,113,238	708,547	63.65%
697,147	661,833	(35,314)	-5.34%
0	0	0	0.00%
338,377	458,456	120,079	26.19%
1,290,011	1,614,656	324,645	20.11%
2,269,539	(406,199)	(2,675,738)	-658.73%
10,244,504	9,857,752	(386,752)	-3.92%
8,969,711	11,434,344	2,464,633	21.55%
0	11,434,344	11,434,344	100.00%
8,969,711	0	(8,969,711)	0.00%
0	0	0	0.00%
0	617,857	(617,857)	-100.00%
0	525,179	525,179	100.00%
0	92,679	92,679	100.00%
0	0	0	0.00%
0	0	0	0.00%
45	0	45	0.00%
2,545,600	3,502,338	(956,738)	-27.32%
94.4%	94.2%	-0.3%	-0.3%
4.5%	4.3%	-0.2%	-3.7%

	Year - To - Date			
	Actual	Budget	\$ Variance	% Variance
Member Months	6,101,368	6,137,449	(36,081)	-0.59%
Revenues				
Capitation revenue	1,849,801,307	1,858,294,325	(8,493,018)	-0.46%
Grant & other income	0	0	0	0.00%
Total Operating Revenues	1,849,801,307	1,858,294,325	(8,493,018)	-0.46%
Medical Expenses				
Provider capitation	621,578,948	667,914,321	46,335,373	6.94%
Facility inpatient	391,583,674	338,878,478	(52,705,196)	-15.55%
Facility outpatient	63,534,309	82,915,025	19,380,716	23.37%
Professional Claims	91,636,408	144,106,620	52,470,212	36.41%
Prescription drugs	257,228,948	247,681,539	(9,547,409)	-3.85%
Long-term care facility payments	343,269,035	310,499,555	(32,769,480)	-10.55%
Contingencies	(16,717,923)	(37,832,113)	(21,114,190)	-55.81%
Medical Management	20,576,999	29,612,328	9,035,329	30.51%
Reinsurance & other	4,413,273	4,367,233	(46,040)	-1.05%
Total Medical Expenses	1,777,103,670	1,788,142,986	11,039,316	0.62%
Gross Margin	72,697,637	70,151,339	2,546,298	3.63%
Administrative Expenses				
Salaries, wages & employee benefits	35,952,073	46,958,916	11,006,843	23.44%
Professional fees	1,996,212	4,496,035	2,499,822	55.60%
Purchased services	5,334,371	8,243,775	2,909,404	35.29%
Printing and postage	2,434,924	5,302,733	2,867,809	54.08%
Occupancy expenses	0	0	0	0.00%
Depreciation & amortization	1,990,567	3,667,650	1,677,082	45.73%
Other operating expenses	8,472,567	13,197,162	4,724,595	35.80%
Indirect cost allocation	(657,013)	(3,249,707)	(2,592,694)	-79.78%
Total Administrative Expenses	55,523,701	78,616,564	23,092,862	29.37%
Operating Tax				
Tax Revenue	73,146,823	92,330,191	19,183,368	20.78%
Premium tax expense	0	92,330,191	92,330,191	100.00%
Sales tax expense	73,146,823	0	(73,146,823)	0.00%
Total Net Operating Tax	0	0	0	0.00%
Grant Income				
Grant Revenue	0	1,853,571	(1,853,571)	-100.00%
Grant expense - Service Partner	0	1,575,536	1,575,536	100.00%
Grant expense - Adminisitrative	154	278,036	277,882	99.94%
Total Net Grant Income	(154)	0	(154)	0.00%
QAF and IGT - Net	0	0	0	0.00%
Other income	861	0	861	0.00%
Change in Net Assets	17,174,643	(8,465,225)	25,639,868	302.88%
Medical Loss Ratio	96.1%	96.2%	0.2%	0.2%
Admin Loss Ratio	3.0%	4.2%	1.2%	29.0%

MEDI-CAL INCOME STATEMENT – FEBRUARY MONTH

REVENUES of \$229.4 million are favorable to budget by \$0.5 million, driven by:

- Price related variance of: \$0.2 million relates to aid code mix
- Volume related variance of: \$0.3 million due to the higher enrollment

MEDICAL EXPENSES: Overall \$216.6 million, unfavorable to budget by (\$1.1) million due to:

- **Capitation** is favorable to budget \$5.3 million due to:
 - Price related variance of: \$5.4 million
 - Volume related variance of: (\$0.1) million
- **Total Claim Payments** are favorable to budget \$6.5 million due to:
 - Price related variance of: \$6.6 million
 - Favorable prior period adjustment for Medi-Cal Expansion IBNR methodology
 - Volume related variance of: (\$0.1) million
- **Contingencies** are unfavorable to budget (\$13.7) million driven by:
 - Prior period adjustment for Medi-Cal Expansion IBNR methodology
 - Expense offset for risk corridor recovery to bring MLR to 95% per DHCS contract

ADMINISTRATION EXPENSES are \$10.2 million, unfavorable to budget (\$0.4) million, driven by:

- Salary & Benefits: \$1.0 million favorable to budget
- Non-Salary: (\$1.4) million unfavorable to budget across most categories

CHANGE IN NET ASSETS is \$2.5 million for the month, unfavorable to budget by \$1.0 million

CalOptima - OneCare
Statement of Revenues and Expenses
For the Eight Months Ended February 29, 2016

Month					Year - To - Date			
Actual	Budget	\$ Variance	% Variance		Actual	Budget	\$ Variance	% Variance
1,288	1,379	(91)	-6.60%	Member Months	77,627	80,221	(2,594)	-3.23%
				Revenues				
1,105,352	1,472,488	(367,136)	-24.93%	Capitation revenue	80,955,133	86,932,179	(5,977,046)	-6.88%
1,105,352	1,472,488	(367,136)	-24.93%	Total Operating Revenue	80,955,133	86,932,179	(5,977,046)	-6.88%
				Medical Expenses				
239,062	496,657	257,595	51.87%	Provider capitation	28,784,281	29,291,532	507,251	1.73%
449,514	511,933	62,419	12.19%	Inpatient	28,761,529	31,111,402	2,349,873	7.55%
93,710	55,112	(38,598)	-70.04%	Ancillary	2,286,173	3,297,238	1,011,066	30.66%
(5,469)	48,490	53,959	111.28%	Skilled nursing facilities	2,212,344	2,975,967	763,623	25.66%
192,348	286,076	93,728	32.76%	Prescription drugs	6,475,006	4,068,423	(2,406,583)	-59.15%
0	18,382	18,382	100.00%	Quality incentives	899,979	1,069,335	169,356	15.84%
137,871	875	(136,996)	-15656.69%	Medical management	3,122,792	4,120,883	998,091	24.22%
6,753	305,253	298,500	97.79%	Other medical expenses	606,171	2,146,834	1,540,663	71.76%
1,113,789	1,722,777	608,988	35.35%	Total Medical Expenses	73,148,275	78,081,614	4,933,339	6.32%
(8,437)	(250,289)	241,852	96.63%	Gross Margin	7,806,859	8,850,565	(1,043,706)	-11.79%
				Administrative Expenses				
89,686	(108)	(89,795)	-83020.15%	Salaries, wages & employee benefits	3,260,616	3,976,055	715,439	17.99%
(6,993)	36,833	43,826	118.98%	Professional fees	167,928	303,666	135,739	44.70%
(89,502)	37,865	127,367	336.37%	Purchased services	385,864	641,983	256,119	39.90%
(28,160)	42,503	70,663	166.25%	Printing and postage	88,862	339,275	250,413	73.81%
36,300	41,573	5,273	12.68%	Other operating expenses	297,248	339,076	41,827	12.34%
772,245	0	(772,245)	0.00%	Indirect cost allocation, Occupancy Expense	1,736,415	1,017,186	(719,229)	-70.71%
773,576	158,666	(614,910)	-387.55%	Total Administrative Expenses	5,936,932	6,617,240	680,308	10.28%
(782,013)	(408,955)	(373,058)	-91.22%	Change in Net Assets	1,869,926	2,233,325	(363,398)	-16.27%
=====	=====	=====	=====		=====	=====	=====	=====
100.8%	117.0%	16.2%	13.9%	Medical Loss Ratio	90.4%	89.8%	-0.5%	-0.6%
70.0%	10.8%	-59.2%	-549.5%	Admin Loss Ratio	7.3%	7.6%	0.3%	3.7%

ONECARE INCOME STATEMENT – FEBRUARY MONTH

REVENUES of \$1.1 million are unfavorable to budget by (\$0.4) million

MEDICAL EXPENSES are favorable to budget \$0.6 million due to:

- Across most categories relative to enrollment and the shift to OneCare Connect

ADMINISTRATIVE EXPENSES are unfavorable to budget by (\$0.6) million

- July – December 2015 indirect allocation true-up

CHANGE IN NET ASSETS is (\$0.8) million, unfavorable to budget by (\$0.4) million

**CalOptima - OneCare Connect
Statement of Revenues and Expenses
For the Eight Months Ended February 29, 2016**

Month					Year - To - Date			
Actual	Budget	\$ Variance	% Variance		Actual	Budget	\$ Variance	% Variance
15,550	23,325	(7,775)	-33.33%	Member Months	40,384	75,427	(35,043)	-46.46%
25,735,386	43,808,582	(18,073,196)	-41.25%	Revenues	70,542,568	141,665,254	(71,122,686)	-50.20%
25,735,386	43,808,582	(18,073,196)	-41.25%	Capitation revenue	70,542,568	141,665,254	(71,122,686)	-50.20%
				Total Operating Revenue	70,542,568	141,665,254	(71,122,686)	-50.20%
				Medical Expenses				
7,636,407	12,750,191	5,113,785	40.11%	Provider capitation	19,628,987	41,230,713	21,601,726	52.39%
16,213,463	6,230,446	(9,983,017)	-160.23%	Inpatient	25,644,879	20,479,437	(5,165,442)	-25.22%
824,612	2,440,845	1,616,233	66.22%	Ancillary	2,483,506	7,951,576	5,468,070	68.77%
(3,407,917)	12,595,290	16,003,207	127.06%	Skilled nursing facilities	3,502,592	40,817,522	37,314,931	91.42%
5,184,588	5,251,432	66,845	1.27%	Prescription drugs	14,722,103	15,358,174	636,071	4.14%
0	388,133	388,133	100.00%	Quality incentives	0	1,255,120	1,255,120	100.00%
800,197	1,282,706	482,508	37.62%	Medical management	4,157,182	6,070,652	1,913,470	31.52%
236,952	757,259	520,307	68.71%	Other medical expenses	302,129	2,448,772	2,146,643	87.66%
27,488,301	41,696,302	14,208,001	34.07%	Total Medical Expenses	70,441,377	135,611,967	65,170,590	48.06%
(1,752,915)	2,112,280	(3,865,195)	-182.99%	Gross Margin	101,191	6,053,287	(5,952,096)	-98.33%
726,356	1,231,253	504,897	41.01%	Administrative Expenses	3,546,752	5,973,388	2,426,636	40.62%
0	8,367	8,367	100.00%	Salaries, wages & employee benefits	0	66,030	66,030	100.00%
124,737	394,655	269,918	68.39%	Professional fees	566,722	1,637,673	1,070,952	65.39%
115,201	201,598	86,397	42.86%	Purchased services	967,807	1,642,962	675,155	41.09%
(492)	28,091	28,583	101.75%	Printing and postage	14,640	251,428	236,788	94.18%
(2,838,992)	806,201	3,645,193	452.14%	Other operating expenses	1,414,244	5,432,422	4,018,179	73.97%
(1,873,190)	2,670,165	4,543,355	170.15%	Indirect cost allocation, Occupancy Expense				
128,277	0	128,277	0.00%	Total Administrative Expenses	6,510,164	15,003,904	8,493,740	56.61%
128,277	0	(128,277)	0.00%	Operating Tax				
0	0	0	0.00%	Tax Revenue	429,147	0	429,147	0.00%
				Sales tax expense	429,147	0	(429,147)	0.00%
				Total Net Operating Tax	0	0	0	0.00%
120,275	(557,885)	678,160	121.56%	Change in Net Assets	(6,408,974)	(8,950,617)	2,541,643	28.40%
106.8%	95.2%	-11.6%	-12.2%	Medical Loss Ratio	99.9%	95.7%	-4.1%	-4.3%
-7.3%	6.1%	13.4%	219.4%	Admin Loss Ratio	9.2%	10.6%	1.4%	12.9%

CalOptima - PACE
Statement of Revenues and Expenses
For the Eight Months Ended February 29, 2016

Month					Year - To - Date			
Actual	Budget	\$ Variance	% Variance		Actual	Budget	\$ Variance	% Variance
140	134	6	4.48%	Member Months	985	932	53	5.69%
				Revenues				
599,937	537,077	62,860	11.70%	Medi-Cal capitation revenue	4,186,701	3,729,271	457,431	12.27%
255,313	274,048	(18,735)	-6.84%	MediCare capitation revenue	1,939,959	1,901,944	38,016	2.00%
0	0	0	0.00%	MediCare Part D Revenue	9,654	0	9,654	0.00%
855,251	811,125	44,126	5.44%	Total Operating Revenues	6,136,314	5,631,215	505,100	8.97%
				Medical Expenses				
195,449	243,700	48,251	19.80%	Clinical salaries & benefits	1,715,065	1,900,970	185,905	9.78%
0	0	0	0.00%	Pace Center Support salaries & benefits	0	0	0	0.00%
0	0	0	0.00%	Provider capitation	0	0	0	0.00%
212,887	112,024	(100,863)	-90.04%	Claims payments to hospitals	1,551,844	779,152	(772,692)	-99.17%
185,250	214,580	29,330	13.67%	Professional Claims	1,442,375	1,492,452	50,077	3.36%
79,112	72,360	(6,752)	-9.33%	Prescription drugs	596,787	503,280	(93,507)	-18.58%
0	6,600	6,600	100.00%	Long-term care facility payments	0	12,953	12,953	100.00%
47,658	87,100	39,442	45.28%	Patient Transportation	391,417	605,800	214,384	35.39%
47,885	54,141	6,257	11.56%	Depreciation & amortization	470,986	433,131	(37,855)	-8.74%
37,655	38,370	715	1.86%	Occupancy expenses	301,239	300,150	(1,089)	-0.36%
16,346	12,263	(4,083)	-33.29%	Utilities & Facilities Expense	108,950	120,971	12,021	9.94%
75	2,329	2,254	96.78%	Purchased Services	1,359	18,823	17,464	92.78%
72,343	9,085	(63,257)	-696.25%	Indirect Allocation	128,980	63,194	(65,786)	-104.10%
0	0	0	0.00%	Reinsurance	0	0	0	0.00%
16,517	15,653	(864)	-5.52%	Other Expenses	89,973	162,171	72,198	44.52%
911,176	868,206	(42,971)	-4.95%	Total Medical Expenses	6,798,974	6,393,046	(405,928)	-6.35%
(55,926)	(57,080)	1,155	2.02%	Gross Margin	(662,660)	(761,832)	99,172	13.02%
				Administrative Expenses				
85,770	86,221	451	0.52%	Salaries, wages & employee benefits	657,973	697,308	39,335	5.64%
1,443	11,000	9,557	86.88%	Professional fees	25,955	88,000	62,045	70.51%
113	9,530	9,417	98.81%	Purchased services	7,344	76,249	68,905	90.37%
413	4,167	3,753	90.08%	Printing and postage	18,254	33,333	15,080	45.24%
1,995	2,256	261	11.56%	Depreciation & amortization	19,624	18,048	(1,576)	-8.73%
12,631	5,386	(7,245)	-134.50%	Other operating expenses	55,838	60,912	5,074	8.33%
4,583	1,978	(2,605)	-131.73%	Indirect cost allocation, Occupancy Expense	17,925	15,137	(2,788)	-18.42%
106,948	120,538	13,589	11.27%	Total Administrative Expenses	802,913	988,988	186,075	18.81%
(162,874)	(177,618)	14,744	8.30%	Change in Net Assets	(1,465,573)	(1,750,820)	285,246	16.29%
=====	=====	=====	=====		=====	=====	=====	=====
106.5%	107.0%	0.5%	0.5%	Medical Loss Ratio	110.8%	113.5%	2.7%	2.4%
12.5%	14.9%	2.4%	15.9%	Admin Loss Ratio	13.1%	17.6%	4.5%	25.5%

CalOptima - Behavioral Health ASO
Statement of Revenues and Expenses
For the Eight Months Ended February 29, 2016

	Month			
Actual	Budget	\$ Variance	% Variance	
0	0	0	0.00%	
0	0	0	0.00%	
(1,217)	0	1,217	0.00%	
0	0	0	0.00%	
(1,217)	0	1,217	0.00%	
1,217	0	1,217	0.00%	
0	0	0	0.00%	
0	0	0	0.00%	
0	0	0	0.00%	
0	0	0	0.00%	
0	0	0	0.00%	
0	0	0	0.00%	
0	0	0	0.00%	
0	0	0	0.00%	
0	0	0	0.00%	
1,217	0	1,217	0.00%	
0.0%	0.0%	0.0%	0.0%	
0.0%	0.0%	0.0%	0.0%	

Revenues
Other Income

Total Operating Revenues

Medical Expenses
Other Medical
Medical management

Total Medical Expenses

Gross Margin

Administrative Expenses
Salaries, wages & employee benefits
Professional fees
Purchased services
Printing and postage
Depreciation & amortization
Other operating expenses
Indirect cost allocation, Occupancy Expense

Total Administrative Expenses

Change in Net Assets

Medical Loss Ratio
Admin Loss Ratio

Actual	Budget	\$ Variance	% Variance	
0	0	0	0.00%	
0	0	0	0.00%	
(74,245)	0	74,245	0.00%	
0	0	0	0.00%	
(74,245)	0	74,245	0.00%	
74,245	0	74,245	0.00%	
0	0	0	0.00%	
0	0	0	0.00%	
0	0	0	0.00%	
(405)	0	405	0.00%	
0	0	0	0.00%	
13	0	(13)	0.00%	
0	0	0	0.00%	
(392)	0	392	0.00%	
74,637	0	74,637	0.00%	
0.0%	0.0%	0.0%	0.0%	
0.0%	0.0%	0.0%	0.0%	

**CalOptima - Building 505 City Parkway
Statement of Revenues and Expenses
For the Eight Months Ended February 29, 2016**

Actual	Month		% Variance
	Budget	\$ Variance	
24,056	20,473	3,583	17.50%
-----	-----	-----	-----
24,056	20,473	3,583	17.50%
-----	-----	-----	-----
1,235	2,085	850	40.79%
27,372	22,912	(4,460)	-19.46%
139,121	136,086	(3,035)	-2.23%
14,549	15,110	561	3.72%
76,136	161,923	85,787	52.98%
26,480	0	(26,480)	0.00%
(245,566)	(311,907)	(66,341)	-21.27%
-----	-----	-----	-----
39,327	26,210	(13,117)	-50.04%
-----	-----	-----	-----
(15,270)	(5,737)	(9,533)	-166.18%
=====	=====	=====	=====

Revenues

Rental income

Total Operating Revenue

Actual	Year - To - Date		% Variance
	Budget	\$ Variance	
279,523	163,786	115,737	70.66%
-----	-----	-----	-----
279,523	163,786	115,737	70.66%
-----	-----	-----	-----
9,803	16,680	6,877	41.23%
197,862	183,299	(14,563)	-7.94%
1,148,160	1,088,690	(59,469)	-5.46%
116,391	120,882	4,492	3.72%
876,776	1,295,385	418,609	32.32%
446,854	0	(446,854)	0.00%
(2,380,934)	(2,230,971)	149,963	6.72%
-----	-----	-----	-----
414,911	473,965	59,054	12.46%
-----	-----	-----	-----
(135,388)	(310,179)	174,791	56.35%
=====	=====	=====	=====

Administrative Expenses

Professional fees

Purchase services

Depreciation & amortization

Insurance expense

Repair and maintenance

Other Operating Expense

Indirect allocation, Occupancy Expense

Total Administrative Expenses

Change in Net Assets

OTHER STATEMENTS – FEBRUARY MONTH:

ONECARE CONNECT INCOME STATEMENT

- **Change in Net Assets** is \$120.3 thousand, \$678.2 thousand favorable to budget
- **REVENUES** of \$25.7 million are unfavorable to budget by (\$18.1) million
 - Relative to enrollment and cohort
- **Medical Expenses** are \$14.2 million favorable to budget across most categories due to lower enrollment and delayed transition of long-term care members
- **Administration Expenses** are (\$1.9) million, \$4.5 million favorable to budget
 - \$3.1 million favorable true-up adjustment for July- December 2015 indirect allocation
 - Across all other categories relative to enrollment

PACE INCOME STATEMENT

- **Change in Net Assets** for the month is (\$162.9) thousand, which is operating favorable to budget by \$14.7 thousand

505 CITY PARKWAY BUILDING INCOME STATEMENT

- **Change in Net Assets** for the month is (\$15.3) thousand which is unfavorable to budget \$9.5 thousand
 - Unfavorable true-up adjustment for July- December 2015 indirect allocation

CalOptima
BALANCE SHEET
February 29, 2016

ASSETS

Current Assets

Operating Cash	\$477,215,571
Catastrophic Reserves	11,312,408
Investments	1,004,926,750
Capitation receivable	133,821,064
Receivables - Other	11,774,994
Prepaid Expenses	5,668,822

Total Current Assets	<u>1,644,719,609</u>
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Capital Assets

Furniture and equipment	27,720,290
Leasehold improvements	9,495,402
505 City Parkway West	46,682,460
	<u>83,898,152</u>
Less: accumulated depreciation	(30,108,421)
Capital assets, net	<u>53,789,731</u>

Other Assets

Restricted deposit & Other	268,819
Board-designated assets	
Cash and cash equivalents	30,116,099
Short term investments	-
Long term investments	441,316,173
Total Board-designated Assets	<u>471,432,272</u>

Total Other Assets	<u>471,701,092</u>
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Deferred outflows of Resources	3,787,544
--------------------------------	------------------

TOTAL ASSETS & OUTFLOWS	<u>2,173,997,976</u>
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LIABILITIES & FUND BALANCES

Current Liabilities

Accounts payable	\$150,253
Medical claims liability	534,658,040
Accrued payroll liabilities	8,728,049
Deferred revenue	564,676,793
Deferred revenue - CMS	0
Deferred lease obligations	298,864
Capitation and withholds	388,190,513
Accrued insurance costs	0

Total Current Liabilities	<u>1,496,702,512</u>
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Other (than pensions) post

employment benefits liability	27,584,126
Net Pension Liabilities	989,603
Long Term Liabilities	150,000

TOTAL LIABILITIES	<u>1,525,426,242</u>
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Deferred inflows of Resources	5,580,552
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Tangible net equity (TNE)	83,856,380
Funds in excess of TNE	<u>559,134,802</u>

Net Assets	<u>642,991,182</u>
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TOTAL LIABILITIES, INFLOWS & FUND BALANCES	<u>2,173,997,976</u>
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CalOptima
Statement of Cash Flows
February 29, 2016

	<u>Month Ended</u>	<u>Year-To-Date</u>
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets	4,381,542	15,948,361
Adjustments to reconcile change in net assets to net cash provided by operating activities	-	-
Depreciation and amortization	479,493	3,158,351
Changes in assets and liabilities:		
Prepaid expenses and other	566,992	(5,668,822)
Catastrophic reserves	-	-
Capitation receivable	14,844,779	433,769,553
Medical claims liability	4,692,117	(135,675,260)
Deferred revenue	(29,125,888)	353,665,747
Payable to providers	(10,726,265)	97,557,601
Accounts payable	(3,638,202)	(24,683,687)
Other accrued liabilities	736,110	654,514
Net cash provided by/(used in) operating activities	<u>(17,789,323)</u>	<u>738,726,359</u>
GASB 68 CalPERS Adjustments	-	1,163,367
CASH FLOWS FROM INVESTING ACTIVITIES		
Purchase of Investments	(32,286,987)	(259,134,142)
Purchase of property and equipment	(648,698)	(3,598,695)
Change in Board designated reserves	<u>(2,427,808)</u>	<u>(11,146,966)</u>
Net cash provided by/(used in) investing activities	<u>(35,363,493)</u>	<u>(273,879,802)</u>
NET INCREASE/(DECREASE) IN CASH & CASH EQUIVALENTS	(53,152,816)	466,009,924
CASH AND CASH EQUIVALENTS, beginning of period	<u>\$541,680,795</u>	<u>22,518,055</u>
CASH AND CASH EQUIVALENTS, end of period	<u>\$ 488,527,979</u>	<u>\$ 488,527,979</u>

BALANCE SHEET

ASSETS decreased (\$33.7) million from January

- **Cash and Cash Equivalents** decreased by (\$53.1) million from January and includes the impact of a state recoupment for Medi-Cal Expansion of \$68.3 million
- **Capitation Receivables** decreased (\$16.0) million and reflects timing of state deposits
- **Investments** increased \$32.3 million due to month-end cut-off and cash funding requirements

LIABILITIES decreased (\$38.1) million from January

- **Deferred Revenue** decreased by (\$29.1) million from January due to:
 - Medi-Cal Expansion: \$35.6 million for overpayments related to the rate change effective January 1, 2015 to be recouped by DHCS
- **Incentives and Risk Pool** decreased (\$6.8) million based upon timing of pool estimates, recalculations and payouts

NET ASSETS are \$643.0 million

CalOptima Foundation
Statement of Revenues and Expenses
For the Eight Months Ended February 29, 2016
Consolidated

Month					Year - To - Date				
		\$	%				\$	%	
Actual	Budget	Variance		Variance	Actual	Budget	Variance		Variance
					Revenues				
27,449	0	27,449		0.00%	Income - Grant	158,849	331,766	(172,917)	-52.12%
32,456	0	32,456		0.00%	In Kind Revenue - HITEC Grant	205,736	0	205,736	0.00%
0	0	0		0.00%	In Kind Revenue - Foundation Corporate	123	0	123	0.00%
59,904	0	59,904		0.00%	Total Operating Revenue	364,708	331,766	32,942	9.93%
					Operating Expenditures				
19,964	7,373	(12,590)		-170.75%	Personnel	147,206	58,987	(88,219)	-149.56%
10,746	3,559	(7,187)		-201.95%	Taxes and Benefits	70,266	28,472	(41,794)	-146.79%
0	0	0		0.00%	Travel	345	0	(345)	0.00%
217	0	(217)		0.00%	Supplies	1,279	0	(1,279)	0.00%
25,000	0	(25,000)		0.00%	Contractual	140,698	310,766	170,068	54.73%
3,977	231,282	227,305		98.28%	Other	12,173	1,871,255	1,859,083	99.35%
59,904	242,214	182,310		75.27%	Total Operating Expenditures	371,967	2,269,480	1,897,513	83.61%
0	0	0		0.00%	Investment Income	0	0	0	0.00%
0	(242,214)	(242,214)		-100.00%	Program Income	(7,259)	(1,937,714)	(1,930,455)	-99.63%
=====	=====	=====		=====	=====	=====	=====		=====

**CalOptima Foundation
Balance Sheet
February 29, 2016**

<u>ASSETS</u>		<u>LIABILITIES & NET ASSETS</u>	
Operating cash	2,899,345	Accounts payable-Current	44,591
Grants receivable	44,591	Deferred Revenue	0
Prepaid expenses	0	Payable to CalOptima	0
Total Current Assets	<u>2,943,935</u>	Grants-Foundation	0
		Total Current Liabilities	<u>44,591</u>
		Total Liabilities	44,591
		Net Assets	2,899,345
TOTAL ASSETS	<u><u>2,943,935</u></u>	TOTAL LIABILITIES & NET ASSETS	<u><u>2,943,935</u></u>

CALOPTIMA FOUNDATION INCOME STATEMENT

- For February, expenses are equal to revenue
- YTD expenses are \$7.3 thousand higher than revenue due to non-grant expenses from the Foundation reserve

Budget Allocation Changes
Reporting changes for February 2016

Transfer Month	Line of Business	From	To	Amount	Expense Description	Fiscal Year
July	MediCal	Human Resources Professional Fees	Human Resources Professional Fees	\$19,428	Re-purpose funds for CareerBuilder Professional Searches & Software	2016
July	Capital	Facilities - Car Charging Station	PACE - Blinds	\$13,000	Re-purpose FY15 unspent Board approved budget to purchase blinds for PACE	2016
July	Capital	Facilities - Board Breakout Room 104 & 105	PACE - Water Softener	\$40,000	Re-purpose FY15 unspent Board approved budget to purchase water softener for PACE	2016
July	Capital	Facilities - Car Charging Station	Facilities - Beacon Space Re-Wiring	\$26,000	Re-purpose FY15 unspent Board approved budget to re-wire the 7th floor space previously occupied by Beacon	2016
August	MediCal	Executive - Other Pay	Compliance - Professional	\$99,000	Funds needed for Susan Miller Consulting for DHCS/DHMC	2016
August	OneCare	Compliance - Professional	Executive - Other Pay	\$99,000	Re-allocate funds from department for DHCS/DMHC consulting services	2016
August	OneCare Connect	Community Relations - Public Activities; Printing	Community Relations - Professional Fees	\$10,000	Consulting services to address opt-out rate for OneCare Connect specifically in the Vietnamese community	2016
September	MediCal	IGT - Security Audit Remediation	IGT - Case Management	\$99,000	Re-allocate funds from IGT Security Audit Remediation to fund services done by Altruista	2016
September	MediCal	Human Resources - Professional Fees - Sal & Comp Research; Executive Coaching	Human Resources - Professional Fees	\$29,000	Re-purpose additional funds needed to cover SageView, CalOptima's 457b Plan Reviewer	2016
September	MediCal	Government/Legislative Affairs - Membership	Government/Legislative Affairs - Professional Fees	\$42,612	Re-allocate funds from Membership for consultation services that strengthen relationship between CalOptima & local Vietnamese providers	2016
September	MediCal	IS Application Development - Professional Fees	IS Application Development - Maintenance HW/SW	\$18,400	Re-allocate funds for add-on service by Ceridian for ACA reporting requirement, which is annual filing of ACA forms required by the Taxing Authority	2016
October	MediCal	IS Application Mgmt - Professional Fees	Quality Analytics - Purchased Services - Member Satisfaction Surveys	\$75,000	Transfer of funds budgeted in IS Application Mgmt to Quality Analytics for Member Experience Survey	2016
October	MediCal	Quality Analytics - Incentives	Quality Analytics - Purchased Services - Access & Avail Study	\$80,000	Funds needed for the Timely Access Survey for 2016	2016
October	OneCare	Health Network Provider Relations - In Home Assessments	Health Network Provider Relations - RADV Plan Audit	\$25,000	Additional funds needed for the RADV Plan Audit	2016
October	MediCal	Human Resources - Purchased Services	Human Resources - Professional Fees - Sal & Comp Research	\$18,500	Funds needed for Pearl Meyer Salary Structure review and Senior Management benchmarking	2016
November	MediCal	Cultural & Linguistic - Member Communications	Grievances & Appeals Resolution Office - Purchased Services & Office Supplies	\$40,000	Funds needed to cover office supplies & services from ImageNet	2016
November	MediCal	eBusiness - Purchased Services	eBusiness - Purchased Services	\$11,648	Re-purpose funds from FY16 AMA Royalty to pay for SAAS License Fee	2016
November	OneCare	Quality Analytics - Member Communications - QIP Activities	Quality Analytics - Purchased Services - Member Satisfaction Surveys	\$20,000	Funds needed to cover OC Group Level CAHPS (member experience) survey	2016
November	MediCal	Process Excellence - Professional Fees	Executive - Other Pay	\$50,000	Funds needed to cover RADV Plan Audit Chart Administrative Fee	2016
November	OneCare	Executive Office - Other Pay	Health Network Provider Relations - RADV Plan Audit	\$50,000	Funds needed to cover RADV Plan Audit Chart Administrative Fee	2016
December	PACE	PACE - DME	PACE - Recreation Therapy Supplies	\$10,000	Funds needed for member recreation therapy supplies	2016
December	MediCal	Compliance - Professional Fees	Audit & Oversight - Professional Fees	\$12,500	Re-allocate funds from Compliance to Audit & Oversight for review of audit tools and protocols for A&O audit processes	2016
December	MediCal	IS-Infrastructure - Minor Equipment & Supplies	IS-Infrastructure - Software Maintenance	\$29,000	Funds needed for maintenance expense relating to the HPCA e-mail archiving system	2016
January	MediCal	Facilities - Repairs & Maintenance - Building	Facilities - Comp Supply/Minor Equipment	\$75,000	Funds needed for signage, furniture, adds move and change and other additional FF&E	2016
January	MediCal	CIP - 10th Floor Renovation - Common Corridor	CIP - 505 Building Tiles	\$11,500	Funds needed for purchased of floor tiles as part of upcoming remodel of common area restroom throughout the building	2016
January	MediCal	Executive Office - Professional Fees	Executive Office - Purchased Services	\$15,000	Re-purpose \$15,000 specified for Prof Fees - Legal to be used for an armed security officer at all board of directors meeting	2016
January	MediCal	CIP - Board Dias/Table	CIP - PACE Water Softener	\$36,000	Re-purposed unspent board approved budget of \$36,000 specified for Board Dias/Table to be used for PACE Water Softener	2016
January	MediCal	CIP - Board Dias/Table	CIP - Sound Recording System	\$46,000	Re-purposed unspent board approved budget of \$46,000 specified for Board Dias/Table to be used for Sound Recording System	2016
February	MediCal	Community Relations - Public Activities	Community Relations - Professional Fees	\$17,000	Re-allocate funds from Public Activities to Professional Fees to cover community liaison consultants to assist with community relation functions.	2016
February	MediCal	CIP - Altruista Provider Portal Network	CIP - Claims Editor	\$31,700	Re-allocate capital funds to cover full cost of the claim editor program	2016
February	MediCal	Audit & Oversight - Professional Fees	Compliance - Professional Fees	\$75,000	Re-allocate professional fees funds from Audit & Oversight to Compliance to cover Deloitte audit expenses	2016

**Board of Directors' Meeting
April 7, 2016**

Monthly Compliance Report

The purpose of this report is to provide compliance updates to CalOptima's Board of Directors, including but may not be limited to, updates on internal and external audits, regulatory audits, privacy updates, fraud, waste, and abuse (FWA) updates, and any notices of non-compliance received from a regulator.

A. Updates on Regulatory Audits

1. OneCare

- **OneCare Validation Audit:** CMS' re-audit of CalOptima's OneCare program took place from January 12 - 26, 2015. CalOptima received the final audit report from CMS on March 10, 2015, which identified four (4) corrective actions required (CARs) and two (2) immediate corrective actions required (ICARs). The validation audit will take place from March 29 -30, 2016.
- **OneCare Financial Audit:** On March 23, 2015, CalOptima received official notification that CMS selected its OneCare program for a financial audit of records for contract year 2013. CMS has contracted with Bland & Associates to conduct this financial audit. The audit will include a review of records and supporting documentation for, but not limited to, the following items --- claims data, solvency, enrollment, base year entries on the bids, medical and/or drug expenses, related party transactions, general administrative expenses, and Direct and Indirect Remuneration (DIR). The onsite audit took place on January 19, 2016, and consisted of a desktop review of all documents requested. Auditors continued to request additional documentation and information since the onsite audit, but expect to conclude all requests by the end of March 2016.
- **Medicare Part C Contract-Level Risk Adjustment Data Validation (RADV) Audit:** On September 14, 2015, CalOptima received notification from CMS of CalOptima's selection for the CY2012 Medicare Part C Contract-Level Risk Adjustment Data Validation (RADV) audit. CMS will be conducting a medical records review to validate the accuracy of the CY 2012 Medicare Part C risk adjustment data and payments. CalOptima has contracted with Optum to retrieve the medical records requested by CMS. CalOptima must submit all requested medical records to the CMS contractor by May 10, 2016.
- **Medicare Part C National Risk Adjustment Data Validation (RADV) Audit:** On January 27, 2016, CMS notified CalOptima that it was selected for the CY 2014 Medicare Part C National Risk Adjustment Data Validation (RADV) audit. CalOptima must submit all requested medical records to the CMS contractor by June 20, 2016.

2. OneCare Connect

- CY 2016 Quality Withhold Performance Measure Validation: On November 12, 2015, CalOptima received notice that CMS' contractor, Health Services Advisory Group (HSAG), will be conducting a Quality Withhold Performance Measure Validation (PMV) for OneCare Connect for CY 2016. CalOptima submitted a pre-audit questionnaire to HSAG on January 20, 2016. The validation will be performed via webex on April 5, 2016.

3. PACE

- The CMS/DHCS onsite audit took place from November 2-5, 2015. CMS/DHCS reviewed nineteen (19) audit elements. On December 5, 2015, CMS/DHCS issued a final audit report with the following findings:
 - Nine (9) Elements: Met
 - Three (3) Elements: Not Met
 - Seven (7) Elements: Met with Notes
- On December 31, 2015, CalOptima submitted a corrective action plan (CAP) for these findings. Subsequently, CMS/DHCS auditors requested additional information from CalOptima prior to accepting its CAP responses. CMS will provide a response as to its final acceptance once all CAP activities are completed. The last expected completion date for all CAPs is April 1, 2016.

4. Medi-Cal

- 2015 DHCS Medical Audit: Up to thirteen (13) auditors from DHCS were onsite from February 8 – 19, 2016 conducting an annual audit of CalOptima's Medi-Cal program. The review period was from February 1, 2015 through November 30, 2015. The DHCS Medi-Cal audit consisted of an evaluation of CalOptima's compliance with its contract and regulations in the areas of utilization management, case management and care coordination, access and availability, member rights and responsibilities, quality improvement system, organization and administration of CalOptima, facility site reviews, and medical records review. The DHCS held a preliminary exit conference on February 17, 2016. Although detailed findings were not discussed, DHCS auditors noted significant overall improvement from last year's audit. CalOptima may expect a draft report by April 5, 2016, with a final report by May 7, 2016. The exit conference has been scheduled for April 7, 2016.

B. Updates on Internal /External Audits

1. Pharmacy Audits – OneCare (January 2016)

- **Formulary Rejected Claims Review**

Month	% Claims Rejected in Error (Member Impact)
January 2016	0%

- No claims rejected in error due to formulary restrictions.

- **Coverage Determination Timeliness Review**

Month	Non-Compliant Cases	% of Timeliness
January 2016	0	100%

- For the past twelve (12) months, timeliness for coverage determinations has been 100% compliant.

- **Monthly Direct Member Reimbursement (DMR) Review**

Month	% of DMR Case Compliance
January 2016	100%

- For the past twelve (12) months, pharmaceutical direct member reimbursement (DMR) has been above 95% compliant, with 100% compliance the last two (2) months.

- **Coverage Determination Clinical Decision Making (CDM) Review**

Week	Protected Drug Cases	Unprotected Drug Cases	Overall Compliance
January 2016 Summary	1	15	100%

- For the past four (4) months, coverage determination clinical decision making (CDM) has been above 95% compliant, with 100% compliance this month.

2. Delegation Oversight: Utilization Management (UM) and Claims

- Medi-Cal Utilization Management (UM) – Summary of Findings (January 2016)

	Timeliness for Urgents	CDM for Urgents	Letter Score for Urgents	Timeliness For Routine	Timeliness For Denials	CDM For Denials	Letter Score for Denials	Timeliness For Modifieds	CDM for Modifieds	Letter Score for Modifieds	Timeliness for Deferrals	CDM for Deferrals	Letter Score for Deferrals
January 2016	90%	NA	NA	86%	87%	95%	96%	86%	100%	93%	90%	100%	87%

- The lower scores for timeliness, clinical decision making (CDM), and letters were due to the following reasons:

- Timeliness:

- Failure to meet timeframe for decision
 - Failure to meet timeframe for member notification
 - Failure to meet timeframe for provider initial notification
 - Failure to meet timeframe for provider written notification

- CDM:

- Failure to cite the criteria utilized to make the decision

- Letters:

- Failure to provide description of services in lay language

- Medi-Cal Claims – Summary of Findings: Misclassified Claims (January 2016)

	Misclassified Paid Claims	Misclassified Denied Claims
January 2016	96%	95%

- The compliance rate for misclassified paid claims has remained above 95% for the past six (6) months.
 - The compliance rate for misclassified denied claims has increased by 3% from the previous month.

- Medi-Cal Claims – Summary of Findings: Professional Claims (January 2016)

	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
January 2016	96%	95%	95%	97%

- For the past eight (8) months, the compliance rate for paid and denied claims accuracy and timeliness remains stable at or above 95%.
- The compliance rate for denied claims accuracy has remained at 97% for the past two (2) months.

- Medi-Cal Claims – Summary of Findings: Misclassified Hospital Claims (January 2016)

	Misclassified Paid Claims	Misclassified Denied Claims
January 2016	100%	100%

- The compliance rate for misclassified paid hospital claims and misclassified denied hospital claims has remained at 100% for the past two (2) months.

- Medi-Cal Claims – Summary of Findings: Hospital Claims (January 2016)

	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
January 2016	93%	99%	100%	100%

- The compliance rate for paid claims timeliness and accuracy has decreased from the previous month due to a delegate's failure to submit timely data.
- The compliance rate for denied claims timeliness and accuracy has remained at 100% for the past two (2) months.

- OneCare Utilization Management (UM) – Summary of Findings (January 2016)

	Timeliness for EIOD ^{a\}	Letter Score for EIOD	Timeliness for SOD ^{b\}	Letter Score for SOD	Timelines for Denials	CDM for Denials ^{c\}	Letter Score for Denials
January 2016	97%	90%	100%	98%	100%	97%	100%

- The compliance rate for EIOD letter score decreased by 8% due to the following reasons:
 - Failure to use approved CMS letter template
 - Failure to provide description of services in lay language
- The compliance rate for SOD letter score has remained above 96% for the past four (4) months.
- The compliance rates for denial timeliness and letter score have increased to 100% from the previous month.
- The compliance rate for CDM has remained stable above 95% the last two (2) months.

^{a\} EIOD = expedited initial organization determination

^{b\} SOD = standard organization determination

^{c\} CDM = clinical decision making

- OneCare Claims – Summary of Findings: Misclassified Claims (January 2016)

	Misclassified Paid Claims	Misclassified Denied Claims
January 2016	97%	96%

- The compliance rate for misclassified paid claims has been above 95% during the last seven (7) months.
- The compliance rate for misclassified denied claims has been above 96% for the past three (3) months.

- OneCare Claims (Professional) – Summary of Findings (January 2016)

	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
January 2016	100%	100%	100%	78%

- The compliance rate for paid claims timeliness and accuracy has remained steady above 95% for the past (2) months.
- The compliance rate for denied claims timeliness has been at 100% for the past two (2) months.
- The compliance rate for paid claims accuracy has increased by 1% from the previous month.
- The compliance rate for denied claims accuracy has decreased by 22% from the previous month due to the following reasons:
 - Failure to provide denial letter in lay language.
 - Interest amount incorrectly added to billed amount.

- OneCare Connect Utilization Management (UM) – Summary of Findings (January 2016)

	Timeliness for Urgents	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	Timeliness for Deferrals	CDM for Deferrals	Letter Score for Deferrals
January 2016	100%	NA	81%	85%	77%	72%	100%	91% ^{HCP}	100%	100%	89%	NA	NA	NA

- The low scores for urgent and routine letter scores were due to the following reasons:
 - Failure to provide letter in member's primary language.
 - Failure to provide language assistance program (LAP) insert with approved threshold languages.
- The low scores for routine and denial timeliness were due to the following reasons:
 - Failure to meet time frame for decision.
 - Failure to meet time frame for provider written notification.
- The low scores for modified letter scores were due to the following reasons:
 - Failure to provide LAP insert with approved threshold languages.

- OneCare Connect Claims (Professional) – Summary of Findings (January 2016)

	Misclassified Paid Claims	Misclassified Denied Claims
January 2016	99%	100%

- The compliance rate for misclassified paid claims has been above 95% for the past six (6) months.
- The compliance rate for misclassified denied claims has been at 100% for the past two (2) months.

- OneCare Connect Claims– Summary of Findings: Professional Claims (January 2016)

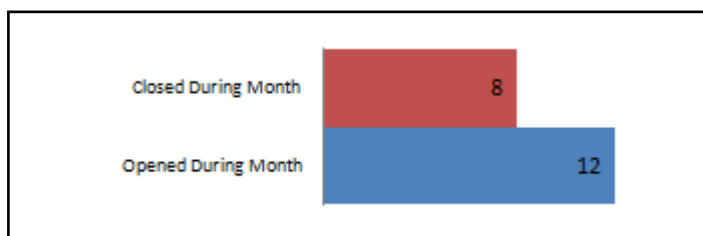
	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
January 2016	96%	99%	90%	72%

- The compliance rate for paid claims accuracy and timeliness has been at or above 90% for the past six (6) months.
- The compliance rate for denied claims timeliness has decreased by 10% from the previous month due to untimely submission of denied claims.
- The compliance rate for denied claims accuracy has decreased by 18% due to the following reasons:
 - Claims interest incorrectly added to billed amount.
 - Failure to provide denied claim letter in lay language.

3. Special Investigations Unit (SIU) / Fraud, Waste & Abuse (FWA) Investigations (February 2016)

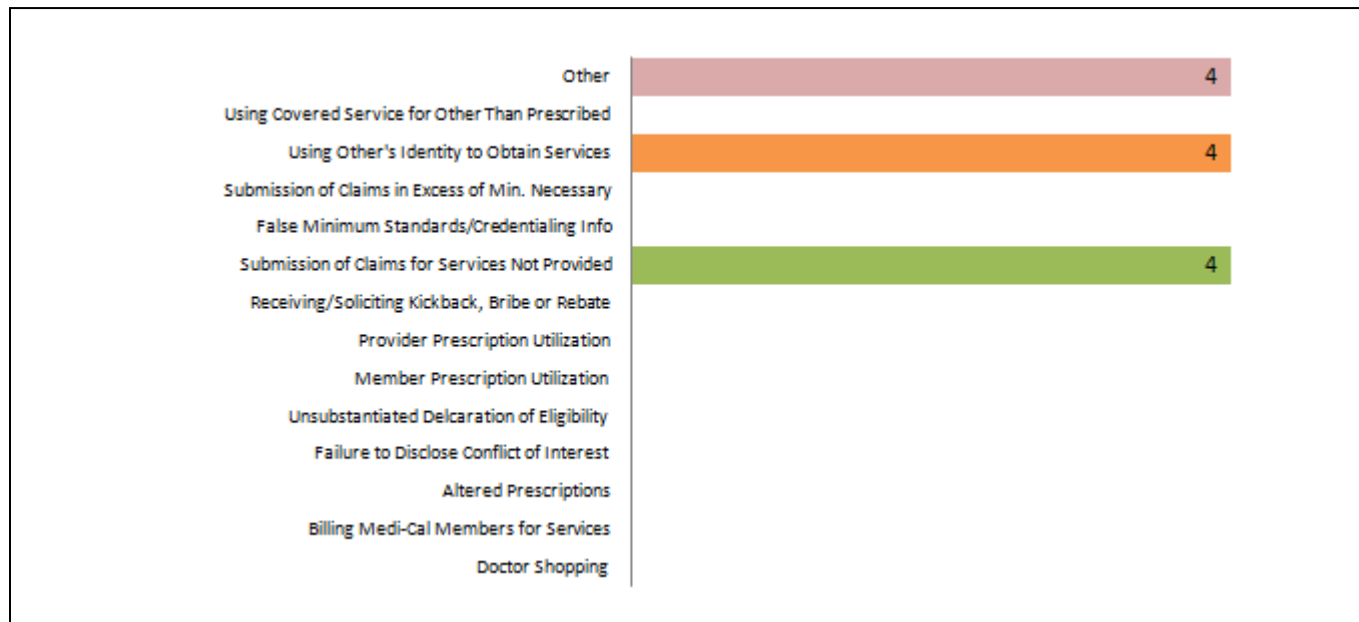
Case Status

Case status at the end of February 2016



Note: Cases that are referred to DHCS or the MEDIC are not “closed” until CalOptima receives notification of case closure from the applicable government agency.

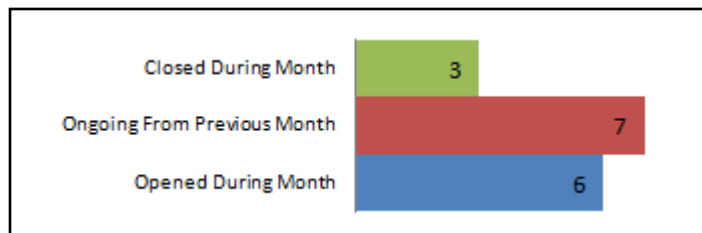
Types of FWA Cases:
 (Received in February 2016)



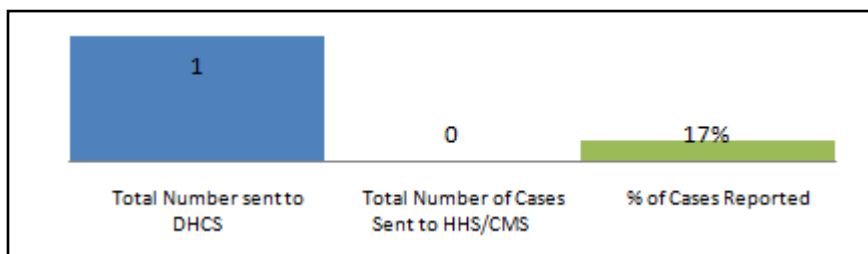
4. Privacy Cases (February 2016)

Case Status

Case status at the end of February 2016
 (Case status may change throughout the month)



Privacy Statistics
 (February 2016)





CalOptima
Better. Together.

Federal & State Legislative Advocate Reports

Board of Directors Meeting
April 7, 2016

James McConnell / Edelstein Gilbert Robson & Smith

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CalOptima
Washington Report
March 22, 2016

The House of Representatives is facing a stalemate within the Republican Caucus over adoption of a Fiscal Year 2017 budget resolution. Last year's Bipartisan Budget Act (P.L. 114-74) established top line spending for FY 17 of \$1.07 trillion for discretionary programs, both domestic and defense.

The House Freedom Caucus is insisting that the top line number be reduced by \$30 billion, all from the domestic discretionary side of the ledger as the price for their support of the budget resolution. House Speaker Paul Ryan (R-WI) continued to negotiate with the Freedom Caucus this week in hope of securing their support a budget resolution capped at \$1.07 trillion.

It is not required that Congress pass a budget resolution, and the resolution is only an internal working document. It does not require the signature of the President. The chief purpose of the budget resolution is to give guidance to the Appropriations Committees of each House as to the top line for the 12 annual spending bills funding the government. If House and Senate appropriators are working with the same set of figures, it makes for an easier conference between the two Houses on the eventual final appropriations bills.

Unfortunately, over the past decade the Appropriations Committees have been unable to bring individual appropriations bills to their respective floors for debate and passage. As a result Congress has had to resort to massive, all-encompassing Omnibus bills to fund the government, or the even more unwieldy device of a series of Continuing Resolutions.

The Congressional Budget Act of 1974 calls for Congress to adopt an annual budget resolution by April 15 of each year, though there is no penalty for failure to do so. If no resolution has been agreed to by May 15 of each year, the Appropriations Committees are free to begin marking up their 12 individual bills.

Senate Majority Leader Mitch McConnell (R-KY) had promised this year to return to "regular order," i.e., the passage of the 12 individual appropriations bills. He says that remains his intention. However without cooperation from the House Freedom Caucus, the Senate effort to achieve regular order may be a one-sided event.

On March 2, the House passed H.R. 3716, "Ensuring Terminated Providers are Removed from Medicaid and CHIP Act" by a vote of 406-0. The legislation would codify and expand requirements that states share information when they terminate the participation of health-care providers in Medicaid and the Children's Health Insurance Program (CHIP) as well as requiring state Medicaid agencies to establish databases with information about fee-for-service and other providers.

The bill would create additional requirements for Medicaid and CHIP, like data reporting, to ensure that states have all information necessary to enforce certain requirements of the Affordable Care Act (ACA), and would require that states pay back the federal portion of Medicaid and CHIP payments made to terminated providers for services performed more than sixty days after a provider's termination. The ACA contained a provision that prohibited providers terminated "for cause" relating to quality, integrity, or fraud, in one state's Medicaid program from participating in another state's program.

The legislation also contains the language from the "Medicaid Directory of Caregivers (DOC) Act," (H.R. 3821) which increases the efficiency of the Medicaid program by creating a searchable database that is more patient friendly and would provide beneficiaries served under the Medicaid fee-for-service or primary care case management programs with a directory of physicians participating in the program so those patients can receive the most up to date information and are able to find doctors who accept Medicaid more quickly and efficiently.

The Obama Administration is supportive of H.R. 3716, saying it "improves program integrity" for Medicaid and CHIP.

On March 14, the House Energy and Commerce Committee marked up H.R. 4725, "Common Sense Savings Act of 2016." Unlike H.R.3716, this bill was approved on a strict party line vote of 28 to 19 by the committee.

The bill would reduce federal spending by approximately \$25 billion over 10 years, largely from Medicaid. The changes to Medicaid include the following:

- Eliminate Medicaid eligibility for lottery jackpot winners;
- Eliminate the Affordable Care Act's enhanced FMAP for prisoners in states that expanded eligibility;
- Reduce the Medicaid provider tax threshold to 5.5 percent; and
- Eliminate the ACA's enhanced matching rate for CHIP.

The legislation would also eliminate the ACA's Prevention and Public Health Fund (PPHF).

The bill was crafted to help satisfy conservative Republican Members' demands for cuts to entitlement spending in exchange for \$30 billion in increased discretionary

spending in the proposed FY 2017 budget resolution. Whether the House will proceed to debate the bill remains unclear.

On March 16, Senate Health, Education, Labor and Pensions Committee approved an amended version of S. 2680, the “Mental Health Reform Act of 2016”. The bipartisan bill was chiefly crafted by Chairman Lamar Alexander (R-TN) and ranking Senator Patty Murray (D-WA) but also takes language from S. 1945, the “Mental Health Reform Act”, sponsored last summer by Senators Chris Murphy (D-CT) and Bill Cassidy (R-LA) that will not be marked up.

S. 2680 authorizes funding for the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Community and Mental Health Services (CMHS) and Substance Abuse Prevention and Treatment (SAPT) block grants. It also does the following:

- formalizes a partnership between SAMHSA and the Department of Health and Human Services (HHS) Assistant Secretary for Planning and Evaluation (ASPE) and creates a Chief Medical Officer position within SAMHSA
- directs HHS to clarify the Health Insurance Portability and Accountability Act (HIPAA) for providers, patients and their families
- promotes better enforcement of the Mental Health Parity and Addiction Equity Act to help increase patients’ access to mental health care
- authorizes a wide array of critically important initiatives including Grants for Jail Diversion, Grants for Treatment and Recovery for Homeless Individuals, Primary Care Behavioral Health Integration (PBCHI) Grants, and the HRSA-SAMHSA Mental and Behavioral Health Training Program

An amendment to the bill was approved that would award grants to develop, maintain, or enhance infant and early childhood mental health prevention, intervention and treatment programs.

The bill will head to the Senate floor, but not until after the lengthy Easter recess now underway. Congress returns to Washington on April 11.



CalOptima Legislative Report

By Don Gilbert and Trent Smith

March 23, 2016

Committee hearings will be in full swing when the Legislature returns from their Spring Recess on March 28. This is the time of year when the Legislature begins reviewing hundreds of new bills introduced in the first few months of the Legislative Session. Several bills will be heard in policy committees in the next six weeks that are of interest to CalOptima.

Many bills introduced this year propose mandating health plans to provide new services. For example, AB 2207 (Wood) would require Medi-Cal managed care plans to provide dental health screenings for eligible beneficiaries and refer them to the appropriate Medi-Cal dental provider. The author, Assemblyman Wood, is the newly appointed Chair of the Assembly Health Committee and a dentist.

Another bill by Assemblyman Wood, AB 2084, would make comprehensive medication management (CMM) services a covered Medi-Cal benefit. The core element of a CMM is a written medication treatment plan designed to resolve and prevent medication therapy problems. The goals of a CMM is to improve quality outcomes for beneficiaries and to lower overall health care costs by optimizing appropriate medication while avoiding counteractive medications.

AB 2394 (Garcia) proposes to add nonmedical transportation to the schedule of benefits covered under Medi-Cal. Utilization controls and permissible time and distance standards would be applicable.

Assemblywoman Eggman is authoring AB 2810, which requires Medi-Cal to provide coverage with state only funds for aid in dying drugs for beneficiaries requesting the prescription who meet the qualifications of the End of Life Option Act. This bill will likely be controversial, as opponents of the End of Life Option Act will object to using state funds for aid in dying drugs.

Other bills of interest include, AB 2670 (R. Hernandez) requiring DHCS to annually administer the Consumer Assessment of Health Care Providers and Systems (CAHPS) Health Plan surveys for all Medi-Cal managed care plans. The survey results would be used to evaluate and compare health care outcomes and patient satisfaction among Medi-Cal enrollees.

Meanwhile, AB 2077 (Burke) establishes procedures to ensure that eligible recipients of insurance affordability programs move between the Medi-Cal program and other insurance affordability programs without any breaks in coverage. The bill would require

an individual's case to be run through the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS). Furthermore, the bill would generally prohibit Medi-Cal benefits from being terminated until at least 30 days after the county sends the notice of action terminating Medi-Cal eligibility. AB 2077 will increase the responsibilities of counties in the administration of the Medi-Cal program.

AB 1831 (Low) requires all health plans to allow for early refill of covered topical ophthalmic products at 70 percent of the predicted days of use. The author argues that the special early refill policy proposed in AB 1831 is necessary because eye drop medications are difficult to administer and some portion of the medication is wasted in failed attempts to place drops in the patient's eye.

Senator Hernandez, Chairman of the Senate Health Committee, is authoring several health related bills, including SB 960. This measure adds reproductive health care to the services already allowed to be conducted via telehealth.

Another bill author by Chairman Hernandez, SB 999, would require health plans to authorize pharmacies to dispense a 12-month supply of FDA approved self-administered hormonal contraceptives.

Senator Hernandez is also authoring SB 1010, which requires a pharmaceutical manufacturer to notify state purchasers at least 60 days prior to the planned effective date, if it intends to increase the wholesale acquisition cost of a prescription drug by more than 10 percent for brand name drugs and 25 percent for generic drugs.

The bill also requires health plans, including Medi-Cal managed care plans, to annually report to DMHC various data regarding prescription drug prices and utilization, as well as the aggregate costs of prescription drugs as a percentage of overall healthcare costs for each plan.

The Legislature would be required to hold an annual hearing to review and debate this reported data, as well as the notifications provided by manufacturers related to drug price increases. The Chairman believes the provisions of SB 1010 will help bring some clarity regarding factors driving increases to health care costs. However, as currently drafted, the bill requires health plans, like CalOptima, to annually compile and analyze huge amounts of data and submit a report to the state.

Another bill we are watching closely is SB 1308 (Nguyen). While this bill appears to be just a spot bill – placeholder language without significant policy implications – we understand that amendments are pending that could be of interest to CalOptima.

In addition to the various bills outlined above, there is a budget proposal that we have been focused on for CalOptima. In 2015, the Administration proposed moving the California Children Services (CCS) program into managed care. Late in last year's Legislative Session the Administration put forth a plan to place the CCS population into managed care only in COHS counties. The plan was named the CCS Whole Child Model. This proposal was rejected by the Legislature because there was not enough time to fully develop the proposal and meet the concerns of various stakeholders. Instead, a bill was passed to continue excluding the CCS population from managed care for one more year.

Early this year the Governor's office placed the Whole Child proposal into budget trailer bill language. On March 14 this language was debated in the Assembly Budget Subcommittee on Health and Human Services. There was a lot of debate and public testimony. Eventually, the committee voted to reject the budget trailer bill language, recommending that the issue be debated in a policy bill.

The Senate Budget Subcommittee will hear the trailer bill language in the coming weeks, but we suspect they will take similar action. Eventually, if it appears that the interested parties can reach a compromise, the Whole Child proposal will be placed in a bill. If this happens, the likely author of the bill will be Senator Hernandez, Chair of the Senate Health Committee.

CCS families and providers remain skeptical over placing the vulnerable CCS population into managed care, even in COHS counties that have a long history of success caring for other vulnerable populations like seniors and persons with disabilities.

In addition, labor unions who represent the county workers who provide enrollment services and case management have voiced concerns over the future employment opportunities for their members under the Whole Child proposal.

There are many complicated matters that need to be resolved before the various stakeholders feel comfortable supporting the Whole Child proposal. However, we have learned that many of the concerned parties have a greater comfort working with COHS plans, but are fearful that the program will eventually move forward in other counties, like Los Angeles, where they would be very concerned.

We have been meeting with legislators, staff, and stakeholders to share information and learn more about their concerns and will continue to work closely with CalOptima staff in these efforts.

Board of Directors Meeting April 7, 2016

CalOptima Community Outreach Summary – March 2016

Background

CalOptima participates in public activities that meet at least one of the following criteria:

- Member interaction/enrollment – The event/activity attracts a significant number of CalOptima members and/or potential members who could be enrolled in any of CalOptima's programs.
- Branding – The event/activity promotes awareness of CalOptima in the general 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.

Requests for sponsorship 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.

In addition to participating in community events, CalOptima is active on several committees/coalitions focused on community health, with an emphasis on improving health care access, reducing health disparities, strengthening the safety net system and promoting a healthier Orange County.

OneCare Connect Program Outreach Update

Community Forums

CalOptima Community Relations department continues to collaborate with community partners to host community forums to provide accurate information about OneCare Connect, understand the benefits of the program, explain the difference between CalOptima offered programs, and answer any question the attendees have about the OneCare Connect program.

In March, two community forums were hosted. The first community forum was hosted in partnership with Lakeview Senior Center which was focused on the Farsi speaking community. Approximately 50 seniors attended the event. The second community forum was hosted on March 22 in partnership with Santa Ana Senior Center. The community forum was focused on the Spanish community. Approximately 15 seniors who participate in activities at the senior center attended the presentation.

Community Relations will continue to schedule the presentations throughout the year. Community Relations will continue to partner with community-based organizations to host the forums and outreach to the different ethnic communities including the Farsi, Korean and Spanish speaking communities.

For additional information or questions, you can contact Lisa Nguyen, Community Relations Specialist at 1-714-246-8809 or via e-mail at lisanguyen@caloptima.org.

Summary of Public Activities

CalOptima participated in 27 community events and coalition and committee meetings:

Date	Events/Meetings	Audience Reached
3/01	Collaborative to Assist Motel Families	Health and Human Service Provider
3/03	Orange County Refugee Forum	Health and Human Service Provider
	Orange County Women's Health Project Advisory Meeting	Health and Human Service Provider
3/04	Covered Orange County General Meeting	Health and Human Service Provider
3/05	Jumpstart Literacy Fair hosted by Jumpstart UC Irvine	Member/Potential Member
3/07	Orange County Health Care Agency Mental Health Services Act Steering Committee	Health and Human Service Provider
3/08	Buena Clinton Coalition Meeting	Health and Human Service Provider
3/10	Orange County Health Improvement Partnership	Health and Human Service Provider
	Orange County Developmental Screening Network	Health and Human Service Provider
3/11	Senior Citizen Advisory Council Meeting	Health and Human Service Provider
3/15	Placentia Community Collaborative	Health and Human Service Provider
3/16	Covered Orange County Steering Committee	Health and Human Service Provider
3/17	Annual Health Fair hosted by the Wellness Center	Member/Potential Member
	Orange County Children's Partnership Committee	Health and Human Service Provider
3/19	Spring Festival 2016 hosted by the City of Westminster (Registration Fee: \$30, includes 10 x 10 booth space, exhibit table, two chairs)	Member/Potential Member
	Intergenerational Health and Resource Fair hosted by KidWorks	Member/Potential Member
3/22	Orange County Senior Round Table	Health and Human Service Provider
3/23	Housing and Community Resource Fair hosted by ResCare Workforce Services	Member/Potential Member
	Senior Mini Resource Fair hosted by the City of Stanton	Member/Potential Member
3/24	South County Mental Health Coalition	Health and Human Service Provider
	Health Funders Partnership of Orange County	Health and Human Service Provider

3/26	Community Health Fair hosted by Orange County Costa Rica Lions Club and Orange Zone B Lions	Member/Potential Member
3/28	Stanton Collaborative	Health and Human Service Provider
3/30	Faith-Based Community Meeting	Member/Potential Member

CalOptima organized/convened 4 community stakeholder events, meetings and presentations:

Date	Event/Meetings	Audience Reached
3/09	Community Alliances Forum	Health and Human Service Provider
3/16	Speakers Bureau Presentation: OneCare Connect Overview presented at the OneCare Connect Forum hosted by Lakeview Senior Center and OMID Multicultural Institute for Development in partnership with CalOptima	Member/Potential Member
3/18	Monthly Health Education Seminar at the Orange County Community Service Center – Consult with Three Cardiologists: Learn About Stroke and Peripheral Arterial Disease	Member/Potential Member
3/22	Speakers Bureau Presentation: OneCare Connect Overview presented at the OneCare Connect Forum hosted Santa Ana Senior Center in partnership with CalOptima	Member/Potential Member

There is one (1) item during this reporting period (letters of support, program/public activity event with support, or use of name/logo).

1. Spring Festival 2016 hosted by the City of Westminster (Listed in Public Activities)

CalOptima Board of Directors Community Activities

For more information on the listed items, contact Claudia Hernandez, Manager of Community Relations, at 714-347-3262 or by email at chernandez@caloptima.org.

Day/Date/Time	Name of Activity/Event	Type of Activity/Event	Location
<h1>April 2016</h1>			
Friday, 4/1 8-11:00am	+2 nd Annual Leadership Forum on Aging	Networking Session and Presentation: Open to the CBO's, Health Advocates and Services Providers <i>Registration recommended</i>	Alzheimer's Orange County 2515 McCabe Way, Irvine
Friday, 4/1 9-10:30am	++Covered OC General Meeting	Steering Committee Meeting: Open to Collaborative Members	The Village at 17 th Street Casa Training Room 1505 E.17 th Street
Saturday-Sunday, 4/2-3, 7am-2pm	+City of Anaheim, Anekant Community Center 10 th Annual Anaheim Free Health Fair	Health/Resource Fair: Open to the Public	Anaheim Convention Center 800 W. Katella Ave., Anaheim
Tuesday, 4/4 10am-1pm	+Spring Health and Safety Fair hosted by Fullerton College	Health/Resource Fair: Open to the Public	Fullerton College 321 E. Chapman Ave. Fullerton
Tuesday, 4/5 10-11:30am	*CalOptima OneCare Connect Community Forum presentation in partnership with Santa Ana Senior Center (<i>Spanish</i>)	Presentation to the seniors in the community and Santa Ana Senior Center participants	Santa Ana Senior Center 424 W. 3 rd St. Santa Ana
Wednesday, 4/6 9-10:30am	++Orange County Aging Services Collaborative	Steering Committee Meeting: Open to Collaborative Members	Alzheimer's Orange County 2515 McCabe Way, Irvine
Wednesday, 4/6 10:30am-12noon	++Orange County Healthy Aging Initiative	Steering Committee Meeting: Open to Collaborative Members	Alzheimer's Orange County 2515 McCabe Way, Irvine

* CalOptima Hosted
+ Exhibitor/Attendee
++ Meeting Attendee

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Day/Date/Time	Name of Activity/Event	Type of Activity/Event	Location
Wednesday, 4/6 10am-12noon	++Anaheim Human Services Meeting	Steering Committee Meeting: Open to Collaborative Members	Downtown Anaheim Community Center 250 E. Center St., Anaheim
Wednesday, 4/6 10-11:30am	++Buena Park Collaborative	Steering Committee Meeting: Open to Collaborative Members	Buena Park Library 7150 La Palma Ave. Buena Park
Friday, 4/8 9-11:30am	++Senior Citizen Advisory Council	Steering Committee Meeting: Open to Collaborative Members	Buena Park Senior Center 8150 Knott St. Buena Park
Saturday, 4/9 10am-3pm	+14 th Annual Faces of Fullerton hosted by Fullerton Collaborative	Health/Resource Fair: Open to the Public	Fullerton Downtown Plaza 301 N Pomona Ave. Fullerton
Saturday, 4/9 10am-12noon	+City of Lake Forest Special Needs Resource Fair	Health/Resource Fair: Open to the Public	Pittsford Park 21701 Pittsford Dr., Lake Forest
Monday, 4/11 11:30-1:30pm	+Community Health Initiatives Healthy Lives Start Here (Tentative)	Networking Session	Anaheim White House 887 S. Anaheim Blvd. Anaheim
Thursday, 4/14, 3-5pm	++Orange County Women's Health Project Advisory Board	Steering Committee Meeting: Open to Collaborative Members	The Village at 17 th Street 1505 E.17 th Street Santa Ana
Thursday, 4/14 4:30-5:30pm	+Share Our Selves 23 rd Annual Wild & Crazy Taco Night (Tentative)	Health/Resource Fair: Open to the Public	SOS Community Health Center 1550 Superior Ave. Costa Mesa
Saturday, 4/16 11am-4pm	+Buena Park School District Spring in to Fitness 2016	Health/Resource Fair: Open to the Public	Buena Park Junior High School 6931 Orangethorpe Ave. Buena Park
Saturday, 4/16 12-4pm	+Orange County Head Start, Inc. 9 th Annual Family Festival	Health/Resource Fair: Open to the Public	McFadden Park 900 S. Melrose Street Placentia
Tuesday, 4/19, 3-4:30pm	*Aging and Disability Resource Connection Snack & Learn: Topic TBD	Networking Session and Presentation: Open to the CBO's, Health Advocates and Services Providers	CalOptima Rooms 107, 108,109-N

* CalOptima Hosted
+ Exhibitor/Attendee
++ Meeting Attendee

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Day/Date/Time	Name of Activity/Event	Type of Activity/Event	Location
		<i>Registration recommended</i>	
Wednesday, 4/20 9-10:30am	++Covered OC Steering Committee	Steering Committee Meeting: Open to Collaborative Members	Orange County United Way 18012 Mitchell S, Irvine
Tuesday, 4/21, 2-4pm	++Continuum of Care Coordinated Entry's Health Care & Housing Integration Workgroup	Steering Committee Meeting: Open to Collaborative Members	The Village at 17 th Street 1505 E.17 th Street Santa Ana, Training Room
Saturday 4/23 11am-2pm	+Anaheim Human Services 2 nd Annual Community and Information Resource Fair	Health/Resource Fair: Open to the Public	Downtown Anaheim Community Center 205 E. Center St. Anaheim
Monday, 4/25 9-11am	++Community Health Research Exchange (formerly OC Health Research Alliance)	Steering Committee Meeting: Open to Collaborative Members	1128 W. Santa Ana Blvd., Santa Ana
Tuesday, 4/26 10-11:30am	*CalOptima OneCare Connect Community Forum presentation in partnership with Santa Ana Senior Center (<i>Mandarin</i>)	Presentation to the seniors in the community and Santa Ana Senior Center participants	Santa Ana Senior Center 424 W. 3 rd St. Santa Ana
Tuesday, 4/26, 2-4pm	++OCTA Special Needs Advisory Committee	Steering Committee Meeting: Open to Collaborative Members	OCTA 600 S. Main St. Orange
Friday, 4/29, 10-11am and 11:30am-12:30pm	*Orange County Community Service Center Education Seminar: Topic TBD	Presentation to senior, caregivers and community members	Orange County Community Service Center 5460 Magnolia Ave., Westminster
Saturday, 4/30 10am-1pm	+8 th Annual Families Forward Community Resource Fair	Health/Resource Fair: Open to the Public	Irvine Valley College 5500 Irvine Center Dr. Irvine
May 2016			
Thursday, 5/12 1-4pm	+Pacific Clinics Recovery 3 rd Annual Cultural Diversity and Resource Fair	Health/Resource Fair: Open to the Public	Pacific Recovery Clinics 401 S. Tustin Ave. Orange

* CalOptima Hosted
+ Exhibitor/Attendee
++ Meeting Attendee

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Day/Date/Time	Name of Activity/Event	Type of Activity/Event	Location
Friday, 5/20 8am-1pm	+2016 South County Senior Summit	Presentation: Open to the CBO's, Health Advocates and Senior Services Providers and Health/Resource Fair: Open to the Public	Laguna Woods Village Club House 3 Laguna Woods
Friday, 5/27, 10-11am and 11:30am-12:30pm	*Orange County Community Service Center Education Seminar: Topic TBD	Presentation to senior, caregivers and community members	Orange County Community Service Center 5460 Magnolia Ave., Westminster
June 2016			
Thursday, 6/2 8:30am-12noon	+Orange County Wraparound Resource Fair	Health/Resource Fair: Open to the Public	Mariners Church Community Center 5001 Newport Center Dr., Irvine
Wednesday, 6/8 9-11am	*CalOptima Community Alliances Forum	Networking Session and Presentation: Open to the CBO's, Health Advocates and Services Providers <i>Registration recommended</i>	Delhi Community Center 505 E. Central Ave. Santa Ana
Friday, 6/10 9am-12noon	+City of Cypress Senior Community Resource Fair	Health/Resource Fair: Open to the Public	Cypress Senior Center 9031 Grindlay St. Cypress
Saturday, 6/18 10am-2pm	+North OC Senior Collaborative and Ageless Alliance 2016 World Elder Abuse Awareness Day	Health/Resource Fair: Open to the Public	Buena Park Senior Center 8150 Knott Ave. Buena Park
Thursday, 6/23 8am-4:30pm	+Mental Health Association of OC Meeting of the Minds Collaboration Forum	Networking Session and Presentation: Open to the CBO's, Health Advocates and Services Providers <i>Registration recommended</i>	Anaheim Marriott 700 W. Convention Way, Anaheim
Friday, 6/24 10-11am and 11:30am-12:30pm	*Orange County Community Service Center Education Seminar: Topic TBD	Presentation to senior, caregivers and community members	Orange County Community Service Center 15460 Magnolia Ave., Westminster

* CalOptima Hosted
+ Exhibitor/Attendee
++ Meeting Attendee

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