NOTICE OF A REGULAR MEETING OF THE CALOPTIMA BOARD OF DIRECTORS

THURSDAY, JUNE 1, 2017
2:00 P.M.

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

BOARD OF DIRECTORS

Paul Yost, M.D., Chair
Lee Penrose, Vice Chair

Supervisor Lisa Bartlett
Supervisor Andrew Do
Ria Berger
Ron DiLuigi
Dr. Nikan Khatibi
Alexander Nguyen, M.D.
Richard Sanchez
J. Scott Schoeffel
Supervisor Michelle Steel, 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 at CalOptima, 505 City Parkway West, Orange, CA 92868, Monday-Friday, 8:00 a.m. – 5:00 p.m. The Board Meeting Agenda and supporting materials are also available online at www.caloptima.org. Board meeting audio is streamed live at https://caloptima.org/en/AboutUs/BoardMeetingsLive.aspx

CALL TO ORDER
Pledge of Allegiance
Establish Quorum

PRESENTATIONS/INTRODUCTIONS

MANAGEMENT REPORTS

1. Chief Executive Officer Report
    a. May Revision Highlights
    b. Department of Health Care Services Medical Loss Ratio Reconciliation
    c. CHRONIC Care Act
    d. Good Health Campaign
    e. Scholarship Winners
    f. Media Coverage

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 May 4, 2017 Regular Meeting of the CalOptima Board of Directors
    b. Receive and File Minutes of the February 15, 2017 Regular Meeting of the CalOptima Board of Directors' Quality Assurance Committee, the February 16, 2017 Regular Meeting of the CalOptima Board of Directors' Finance and Audit Committee, the April 13, 2017 Meeting of the CalOptima Board of Directors' Provider Advisory Committee, and the March 9, 2017 Meeting of the CalOptima Board of Directors' Member Advisory Committee

3. Consider Approval of the CalOptima 2017 Utilization Management Program and 2017 Utilization Management Work Plan

4. Consider Approval of Revised 2017 Delegation Grid, Appendix B to 2017 Quality Improvement Program Description and Work Plan

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

6. Consider Adoption of the Proposed CalOptima Board of Directors Meeting Schedule for Fiscal Year 2017-18

7. Consider Adoption of Resolution Changing the Membership of the CalOptima Board of Directors' Member Advisory Committee

8. Consider Appointments to the Member Advisory Committee (MAC); Consider Appointment of MAC Chair and Vice Chair

9. Consider Appointments to the Provider Advisory Committee (PAC); Consider Appointment of PAC Chair and Vice Chair

10. Consider Appointments to the OCC Member Advisory Committee (OCC MAC); Consider Appointment of OCC MAC Chair and Vice Chair

11. Consider Adopting Resolution Authorizing and Directing the Chairman of the Board of Directors to Execute Contract MS-1718-41 with the California Department of Aging for the Multipurpose Senior Service Program for Fiscal Year 2017-18

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

13. Consider Approval of the Revised Reinsurance Program for Catastrophic Claims and Update CalOptima Policy Accordingly

REPORTS

14. Consider Approval of the CalOptima Fiscal Year 2017-18 Operating Budget

15. Consider Approval of the CalOptima Fiscal Year 2017-18 Capital Budget

16. Consider Authorizing Extensions and Amendments of the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Clinic Contracts, Except Those Associated With the University of California-Irvine and St. Joseph Healthcare and its Affiliates

17. Consider Authorizing Extensions and Amendments of the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Clinic Contracts Associated With the University of California, Irvine

18. Consider Authorizing Extensions and Amendments of the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Clinic Contracts Associated With St. Joseph Healthcare and its Affiliates

19. Consider Authorizing Extensions and Amendments of the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Fee-For-Service (FFS) Primary Care Physician (PCP) Contracts Associated with St. Joseph Healthcare and its Affiliates

20. Consider Authorizing Extensions and Amendments of the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Fee-For-Service (FFS) Primary Care Physician (PCP) Contracts, Except Those Associated with the University of California – Irvine or St. Joseph Healthcare and its Affiliates

21. Consider Authorizing Extensions and Amendments of the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Fee-For-Service (FFS) Primary Care Physician (PCP) Contracts Associated with the University of California – Irvine

22. Consider Authorizing Extensions and Amendments of the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Ancillary Contracts that Expire During Fiscal Year 2017-18

23. Consider Authorizing Extensions and Amendments of the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Fee-For Service (FFS) Hospital Contracts

24. Consider Authorizing Extensions and Amendments of the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Fee-For Service (FFS) Specialist Physician Contracts Except Those Associated with the University of California-Irvine, Children's Hospital of Orange County (CHOC) or St. Joseph Healthcare and its Affiliates

25. Consider Authorizing Extensions and Amendments of the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Fee-For Service (FFS) Specialist Physician Contracts Associated with the University of California-Irvine

26. Consider Authorizing Extensions and Amendments of the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Fee-For Service (FFS) Specialist Physician Contracts Associated with St. Joseph Healthcare and its Affiliates

27. Consider Authorizing Extensions and Amendments of the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Fee-For Service (FFS) Specialist Physician Contracts Associated with Children's Hospital of Orange County (CHOC)

28. Consider Authorizing Extension and Amendment of the CalOptima Medi-Cal Full-Risk Health Network Contract with Kaiser Permanente

29. Consider Authorizing Amendments of the CalOptima Medi-Cal Full-Risk Health Network Contracts with Heritage Provider Network, Inc., Monarch Family Healthcare and Prospect Medical Group

30. Consider Authorizing Amendments to the CalOptima Medi-Cal Shared Risk (SRG) Health Network Physician Contracts for Alta Med Health Services, Arta Western Health Network, Noble Mid-Orange County, Talbert Medical Group, and United Care Medical Network

31. Consider Authorizing Amendment of the CalOptima Medi-Cal Physician Hospital Consortium Health Network Physician Contracts for AMVI Care Health Network, Family Choice Network, Orange County Advantage Medical Group, and Fountain Valley Regional Medical Center

32. Consider Authorizing Amendment of the CalOptima Medi-Cal Physician Hospital Consortium Health Network Physician Contracts for, CHOC Physicians Network and Children's Hospital of Orange County

33. Consider Authorization of Expenditures Related to Board Membership in the National Association of Corporate Directors

34. Consider Authorizing Extension of License Agreement with the County of Orange for Use of Space at the County Community Service Center

35. Consider Adoption of Resolution Approving Updated Human Resources Policy GA. 8058: Salary Schedule and Proposed Market Adjustments

36. Consider Authorizing the Chief Executive Officer to Approve New and Revised Credentialing Policies, and to Retire Those No Longer Needed

37. Consider Adopting a Support Position for the Reauthorization of the Federal Children's Health Insurance Program (CHIP)

38. Consider Authorizing Contracts with the Orange County Health Care Agency and Other Participating Organizations for the Whole Person Care Pilot

39. Consider Chief Executive Officer and Chief Counsel Performance Reviews and Compensation *(to follow Closed Session)*

40. Election of Officers of the Board of Directors for Fiscal Year 2017-18

ADVISORY COMMITTEE UPDATES

41. Provider Advisory Committee Update
    a. FY 2016-17 Accomplishments
    b. FY 2017-18 Goals and Objectives

42. OneCare Connect Cal MediConnect (Medicare-Medicaid Plan) Member Advisory Committee Update
    a. FY 2016-17 Accomplishments
    b. FY 2017-18 Goals and Objectives

43. Member Advisory Committee Update
    a. FY 2016-17 Accomplishments
    b. FY 2017-18 Goals and Objectives

INFORMATION ITEMS

44. April 2017 Financial Summary

45. Compliance Report

46. Federal and State Legislative Advocates Report

47. CalOptima Community Outreach and Program Summary

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

CLOSED SESSION

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

CS 2 Pursuant to Government Code Section 54957.6, CONFERENCE WITH LABOR NEGOTIATORS
Agency Designated Representatives: (Paul Yost, M.D. and Lee Penrose)
Unrepresented Employee: (Chief Executive Officer)

CS 3 Pursuant to Government Code Section 54957, PUBLIC EMPLOYEE PERFORMANCE EVALUATION (Chief Counsel)

CS 4 Pursuant to Government Code Section 54957.6, CONFERENCE WITH LABOR NEGOTIATORS
Agency Designated Representatives: (Paul Yost, M.D. and Lee Penrose)
Unrepresented Employee: (Chief Counsel)

ADJOURNMENT

NEXT REGULAR MEETING: Thursday, August 3, 2017 at 2:00 p.m.

MEMORANDUM

DATE: June 1, 2017

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

May Revision Highlights

In releasing the May Revision of the FY 2017–18 budget, Gov. Brown made clear that California is experiencing worsening financial conditions that require careful attention to ensure the state does not again face large deficits. This environment influenced spending decisions in health care, including for Medi-Cal, which is projected to post a $1.1 billion shortfall for FY 2016–17. Below are four elements in the proposed budget that affect CalOptima. A final budget is expected to be approved in June.

- **Cal MediConnect**: The May Revision reauthorizes through 2019 the duals demonstration pilot we call OneCare Connect in Orange County. The budget forecasts approximately $8 million in General Fund savings based on the proposed continuation of the program. Cal MediConnect was previously included in the January draft budget, and we are optimistic that it will remain in the final budget as well.
- **Tobacco Tax**: Proposition 56 revenue will generate up to $1.2 billion in revenue in FY 2017–18, up $23.3 million compared with the January draft budget. Despite industry urging to use these funds to increase payment rates for Medi-Cal providers, the May Revision does not call for any such increases and instead uses the funding for general obligations.
- **Medicare Part A Recoupment**: The May Revision identifies an issue with beneficiaries who gained Medi-Cal coverage under the Affordable Care Act (ACA) while already being eligible for Medicare Part A. Funding for this group should not have been at the higher ACA rates. Enrollment systems were corrected in August 2016, and the state will now begin recouping $365 million from Medi-Cal managed care plans, including CalOptima. While details about the recoupment methodology are not available from the state at this time, CalOptima will keep your Board informed about the potential financial impact.
- **Children's Health Insurance Program (CHIP)**: CHIP is a federal/state program that California uses to provide Medi-Cal coverage to children in families living at up to 266 percent of the Federal Poverty Level. The ACA increased the federal match to 88 percent, but given the uncertainty with that legislation, the May Revision assumes the federal match will be decreased to the previous 65 percent level. Therefore, after the change to 65/35, the impact to the state budget will be an additional $536 million in CHIP spending. CalOptima has 109,000 members age 0–19 who are eligible because of CHIP.

Department of Health Care Services (DHCS) Medical Loss Ratio (MLR) Reconciliation
DHCS continues to develop a draft methodology for the MLR calculation for Medi-Cal Expansion members. CalOptima expects to learn more at an upcoming All-Plan CFO meeting in mid-June. Still, it is our understanding that the state plans to perform the reconciliation in two phases. Phase 1 includes the first 18 months of Medi-Cal Expansion, from January 2014 to June 2015; Phase 2 is the next 12 months, from July 2015 to June 2016. I will share more information about the reconciliation process once it is available.

CHRONIC Care Act
On May 18, the U.S. Senate Finance Committee unanimously passed the CHRONIC Care Act, which would permanently reauthorize Dual Eligible Special Needs Plans (D-SNPs), including CalOptima OneCare. (CHRONIC stands for Creating High-Quality Results and Outcomes Necessary to Improve Chronic Care.) The bill now awaits further consideration and a vote by the full Senate. D-SNPs are currently set to expire on December 31, 2018, and have historically been reauthorized periodically by Congress. This bill would remove the need to continually reauthorize D-SNPs, providing continuity and assurance for CalOptima's OneCare program and its 1,300 members. CalOptima sent a letter of support to the bill's sponsor, Senate Finance Committee Chairman Sen. Orrin Hatch, to express the need for this important and bipartisan legislation.

Good Health Campaign
CalOptima's Good Health wellness campaign debuted May 13. The campaign was purposely designed with an overarching "Good Health" theme so that it can be used across all CalOptima programs and adjusted to fit a variety of initiatives. The first focus was raising awareness about the importance of cervical cancer screenings, with a goal of boosting our HEDIS scores in this area. Just in time for Mother's Day, CalOptima aired 30-second and 60-second Spanish and Vietnamese radio commercials. These commercials will continue through the remainder of June. We plan to roll out the radio commercials to Korean language stations this summer. English language radio buys are cost prohibitive, but we have recorded English commercials for possible use on our website or "hold" messages. To continue building awareness, "Good Health" print ads, covering both cervical and breast cancer screenings, are also planned to run in English and ethnic media outlets starting mid-June.

Scholarship Winners
For the second year in a row, CalOptima's Employee Activities Committee (EAC) sponsored a scholarship essay contest for members pursuing careers in health care or social services. The first place $1,000 scholarship was awarded to a two-time cancer survivor now attending USC for her master's in social work. Second place ($750) went to a single mom pursuing her bachelor's degree in nursing at Cal State Fullerton. Third place ($500) was for a young woman headed to Cal State Long Beach to study nursing as well. In the same fashion as this past year, our first place winner moves on to the national Association for Community Affiliated Plans contest for a chance at a $5,000 scholarship. EAC scholarship dollars are generated through fundraising events and voluntary donations; no public money was used.

Back to Agenda

Media Coverage

- **Adolescent Depression Screenings Article:** CalOptima was included in a May 17 OC Weekly article about Kaiser's adolescent depression screenings and our new physician incentive program to do the same. The article quoted Donald Sharps, M.D., medical director of Behavioral Health Integration. The online version can be viewed here.
- **Opioid Epidemic Radio Program:** For a program that aired May 28, Tammy Trujillo, host of the Community Cares program on Angels Radio AM 830, interviewed Deputy Chief Medical Officer Richard Bock, M.D., about the opioid epidemic. Dr. Bock provided a history of opioids as well as shared how Orange County is being impacted by the drugs and what CalOptima is doing to prevent overprescribing by physicians and curb abuse by members. Dr. Bock was also invited back this month to discuss another important subject — smoking cessation and the dangers of vaping.
- **New York Times Medicaid Article:** An opinion article in the May 3 edition of the New York Times directly addresses the experience and perspectives of a disabled Medicaid recipient. It provides an insight into the challenges that some of our members may face with Medi-Cal generally and In-Home Supportive Services in particular.

MINUTES

REGULAR MEETING
OF THE
CALOPTIMA BOARD OF DIRECTORS

May 4, 2017

A Regular Meeting of the CalOptima Board of Directors was held on May 4, 2017, at CalOptima, 505 City Parkway West, Orange, California. Chair Paul Yost, M.D., called the meeting to order at 2:00 p.m. Director Khatibi led the Pledge of Allegiance.

ROLL CALL

Members Present: Paul Yost, M.D., Chair; Lee Penrose, Vice Chair; Supervisor Lisa Bartlett (at 2:07 p.m.), Ria Berger, Ron DiLuigi, Supervisor Andrew Do, Dr. Nikan Khatibi, Alexander Nguyen, M.D., Richard Sanchez (non-voting), Scott Schoeffel

Members Absent: All members present

Others Present: Michael Schrader, Chief Executive Officer; Gary Crockett, Chief Counsel; Nancy Huang, Interim Chief Financial Officer; Richard Helmer, M.D., Chief Medical Officer; Ladan Khamseh, Chief Operating Officer; Len Rosignoli, Chief Information Officer; Suzanne Turf, Clerk of the Board

Chair Yost announced the following changes to the agenda: Agenda Items 5 through 11, related to health network contract extensions, are continued to a future Board of Directors meeting; the Board will adjourn to Closed Session after hearing Agenda Item 13, Consider Authorizing and Directing the Chairman of the CalOptima Board of Directors to Execute Amendment A03 to the Agreement with the California Department of Health Care Services for the CalOptima Program of All Inclusive Care for the Elderly (PACE), and will reconvene to consider Agenda Item 14, Consider Authorizing the Chief Executive Officer (CEO) to Submit OneCare Bid for Calendar Year 2018 and Execute Contract with the Centers for Medicare & Medicaid Services; Authorize the CEO to Amend/Execute OneCare Health Network Contracts and Take Other Actions as Necessary to Implement.

PRESENTATIONS/INTRODUCTIONS

On behalf of the Board of Directors, Chair Yost and Vice Chair Penrose presented recognition to former Board Director Mark Refowitz in honor of his service as Chair of the Board of Directors and his commitment to CalOptima and to Orange County's Medi-Cal beneficiaries. Supervisors Bartlett and Do presented a Certificate of Recognition in appreciation of his service on the Board of Directors and to the health and well being of CalOptima's members.

MANAGEMENT REPORTS

1. Chief Executive Officer (CEO) Report
CEO Michael Schrader reported that CalOptima received its rates from the state for Medi-Cal Classic and Expansion members, which includes a $117 million reduction. While staff is seeking clarification from the state, the proposed CalOptima FY 2017-18 Budget is being developed to be in line with the funding level received from the state. It was noted that the proposed FY 2017-18 Operating and Capital Budgets will be presented at the May 18, 2017 Board of Directors' Finance and Audit Committee for review, and to the Board of Directors for consideration at the June 1, 2017 meeting.

PUBLIC COMMENTS
Dr. Marie Torres and Henry Holguin, Alta Med Health Services Corporation; Beverly Dahan and Scott Bough, Innovage – Oral re: PACE Study Session.

CONSENT CALENDAR

2. Minutes
   a. Approve Minutes of the April 6, 2017 Regular Meeting of the CalOptima Board of Directors
   b. Receive and File Minutes of the March 9, 2017 Meeting of the CalOptima Board of Directors' Provider Advisory Committee

3. **Acting as the CalOptima Foundation:** Consider Appointment of CalOptima Foundation Board of Directors' Chairperson

4. Consider Appointment of Director to CalOptima Foundation Board of Directors

Consent Calendar Items 5 through 11 were continued to a future Board of Directors meeting.

Action: ***On motion of Supervisor Do, seconded and carried, the Board of Directors approved the Consent Calendar as presented. (Motion carried 9-0-0)***

REPORTS

12. Consider Adoption of Resolution Approving Updated Human Resources Policies
Ladan Khamseh, Chief Operating Officer, presented the recommended action to adopt Resolution No. 17-0504, Approve Updated Human Resources Policies: GA.8012, Conflicts of Interest; GA.8037, Leave of Absence; and GA.8058, Salary Schedule. Ms. Khamseh noted the following revision to Policy GA.8037, Leave of Absence: on page five, Paragraph III.C., the following language was added to the end of the first sentence: "and the holiday pay will be prorated based on the PTO hours used the day preceding and following the holiday."

Action: ***On motion of Vice Chair Penrose, seconded and carried, the Board of Directors adopted Resolution No. 17-0504, Approve Updated Human Resources Policies with the noted revision to Policy GA.8037, Leave of Absence. (Motion carried 9-0-0)***

Back to Agenda

13. Consider Authorizing and Directing the Chairman of the CalOptima Board of Directors to Execute Amendment A03 to the Agreement with the California Department of Health Care Services (DHCS) for the CalOptima Program of All-Inclusive Care for the Elderly (PACE)

Action: ***On motion of Supervisor Do, seconded and carried, the Board of Directors authorized and directed the Chairman of the Board of Directors to execute Amendment A03 to the PACE Agreement between the DHCS and CalOptima. (Motion carried 9-0-0)***

ADJOURN TO CLOSED SESSION

The Board of Directors adjourned to closed session at 2:26 p.m. pursuant to Government Code Section 54956.87, subdivision (b), Health Plan Trade Secrets – OneCare. It was noted that Supervisors Bartlett and Do, and Director Schoeffel did not participate in closed session due to potential conflicts of interest.

The Board reconvened to open session at 2:41 p.m. with no reportable actions taken.

14. Consider Authorizing the Chief Executive Officer (CEO) to Submit OneCare Bid for Calendar Year 2018 and Execute Contract with the Centers for Medicare & Medicaid Services (CMS); Authorize the CEO to Amend/Execute OneCare Health Network Contracts and Take Other Actions as Necessary to Implement

Supervisors Bartlett and Do did not participate in the discussion and vote on this item based on potential conflicts of interest under the Levine Act. Director Schoeffel did not participate in the discussion and vote on this item due to potential conflicts of interest.

Action: ***On motion of Chair Yost, seconded and carried, the Board of Directors authorized the CEO to submit the Calendar Year 2018 OneCare bid by June 5, 2017, make minor benefit changes to the final bid, as necessary, to address CMS feedback following the release of the National Average Bid, and sign the OneCare contract with CMS; and authorized the CEO to amend OneCare Health Network contracts and take other actions as necessary to implement. (Motion carried 6-0-0; Supervisors Bartlett and Do and Director Schoeffel recused)***

ADVISORY COMMITTEE UPDATES

Member Advisory Committee (MAC) Update

Mallory Vega, MAC Chair, reported that the MAC Goals and Objectives Ad Hoc Subcommittee met to propose goals and objectives for FY 2017-18, which will be considered at the May MAC meeting. The MAC Nominations Ad Hoc Subcommittee convened to select a proposed slate of candidates to fill six MAC seats whose terms expire on June 30, 2017. The proposed slate of candidates will be presented to the Board of Directors for consideration at the June 1, 2017 meeting.

Provider Advisory Committee (PAC) Update

PAC Chair Teri Miranti presented an update of the activities at the April 13, 2017 PAC meeting, including the review and approval of the FY 2016-17 PAC Accomplishment, the FY 2017-18 Goals and Objectives, and the PAC Meeting Schedule for the 2017-18 fiscal year. The Committee

Back to Agenda

received presentations from CalOptima staff, including an update on the opioid epidemic and its effect in Orange County. An ad hoc subcommittee was formed to recommend agenda items for the joint MAC/PAC meeting scheduled in September.

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

Ms. Vega presented the OCC MAC Update on behalf of OCC MAC Chair Patty Mouton. At the March 23, 2017 OCC MAC meeting, the Committee received presentations on the Home and Community-Based Services' Assisted Living Waiver program, and the results of the 2016 Community-Based Adult Services and skilled nursing facilities surveys. The OCC MAC Goals and Objectives Ad Hoc Subcommittee met to propose activities for FY 2017-18, and the OCC MAC Nominations Ad Hoc Subcommittee met to review the proposed slate of candidates for the five OCC MAC seats whose terms expire on June 30, 2017. The proposed recommendations will be presented to the Board for consideration at the June 1, 2017 meeting.

INFORMATION ITEMS

18. Primer to the CalOptima Fiscal Year 2017-18 Budget

Nancy Huang, Interim Chief Financial Officer, presented a brief overview of the proposed Operating Budget assumptions for all lines of business, the proposed Capital Budget assumptions, and the timeline for presentation of the FY 2017-18 budgets to the Board of Directors' Finance and Audit Committee for review, and to the Board of Directors for consideration in June.

The following Information Items were accepted as presented:

19. Update on Intergovernmental Transfer (IGT) 6 and 7
20. March 2017 Financial Summary
21. Compliance Report
22. Federal and State Legislative Advocates Report
23. CalOptima Community Outreach and Program Summary

24. PACE Study Session

Richard Helmer, M.D., Chief Medical Officer, presented an overview of the PACE history, trends, PACE as part of a County Organized Health System (COHS), PACE milestones, and a summary of options to increase access to PACE in Orange County. Joseph Billingsley, Chief, Long-Term Services and Supports, California Department of Health Care Services (DHCS), presented a review of how PACE fits into DHCS' vision of integrated care for seniors, and the regulatory framework for PACE in a COHS. Chris van Reenen, Vice President, Regulatory Affairs, National PACE Association, provided an overview of the national perspective on PACE growth, the evolution of PACE, and the value of alternative care settings (ACS).

After considerable discussion, the Board requested that staff provide the following for Board consideration at a future meeting: additional financial analysis of the viability and cost comparisons of the CBAS and ACS models; legal analysis of the DHCS letter dated April 20, 2017, regarding delegation/subcontracting limitations for PACE organizations in COHS counties; and develop an RFI that addresses expansion of the PACE service area in south Orange County as well as options for future expansion of the program.

Back to Agenda

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

Supervisor Do announced that May is Mental Health Matters Month, and reported that the OC Links Information and Referral Line, 1-855-625-4657, provides telephone and online support for anyone seeking information or linkage to any of the Orange County Health Care Agency's Behavioral Health Services.

Director Khatibi commented on the National Prescription Medication Take Back Day held on April 29, 2017, where unwanted, unused, and expired prescription medications could be dropped off at several locations throughout the county. Supervisor Bartlett commented on the success of last year's event, and reported that the next Prescription Medication Take Back Day will be held in October.

Chair Yost reported that an ad hoc committee composed of the Chair and Vice Chair has met regarding the performance evaluations for the Chief Executive Officer and Chief Counsel. Consistent with the process used in prior years, the ad hoc requested input from the Board in order to prepare the draft reviews, which will be shared with the full Board ahead of the June 1, 2017 meeting, at which time the Board will complete the reviews.

With regard to the progress of Intergovernmental Transfer (IGT) 6 and 7 transactions, Chair Yost announced that he was forming an ad hoc to make recommendations to the full Board on the expenditure of IGT 6 and 7 funds, and recognized the efforts of the previous IGT Ad Hoc Committee comprised of Supervisor Do and Board Directors Nguyen and Schoeffel, for their recommended expenditure plans related to IGT 1 through 5 funds.

Chair Yost reported that the election of the Board Chair and Vice Chair for Fiscal Year 2017-18 will occur at the June 1, 2017 Board meeting. To facilitate the process, a Nominations Ad Hoc Committee was formed to make information available on the duties, responsibilities, and the number of extra hours the Chair and Vice Chair position typically requires above and beyond serving as a member of the Board. Supervisor Bartlett and Director Nguyen will serve on this ad hoc. Board members were asked to contact the ad hoc with interest in being considered or to nominate a fellow Board member for the Chair or Vice Chair position. The Nominations Ad Hoc will present nominations, along with any from the floor, for consideration at the June Board meeting.

ADJOURNMENT

Hearing no further business, Chair Yost adjourned the meeting at 6:29 p.m.

/s/ Suzanne Turf
Suzanne Turf
Clerk of the Board

Approved: June 1, 2017

Back to Agenda

MINUTES

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

CALOPTIMA
505 CITY PARKWAY WEST
ORANGE, CALIFORNIA

February 15, 2017

CALL TO ORDER

Chair Paul Yost called the meeting to order at 3:00 p.m., and led the pledge of Allegiance.

Members Present: Paul Yost, M.D., Chair; Ria Berger; Dr. Nikan Khatibi (at 3:09 p.m.); Alexander Nguyen M.D.

Members Absent: All members present

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

Chair Yost announced the following change to the agenda: Agenda Item 3, Consider Recommending Board of Directors' Approval of the CalOptima 2017 Quality Improvement Program and 2017 Quality Improvement Work Plan to be considered before hearing Agenda Item 2, Consider Opioid Reduction Program and Next Steps.

PUBLIC COMMENTS

Pamela Pimentel, RN, MOMS Orange County – Oral re: Agenda Item 7, Consider Recommending Issuance of Request for Proposal for Medi-Cal Perinatal Support Services.

CONSENT CALENDAR

1. Approve the Minutes of the November 16, 2016 Regular Meeting of the CalOptima Board of Directors Quality Assurance Committee

Action: ***On motion of Director Nguyen, seconded and carried, the Committee approved the Minutes of the November 16, 2016 Regular Meeting of the CalOptima Board of Directors' Quality Assurance Committee as presented. (Motion carried 3-0-0; Director Khatibi absent)***

Back to Agenda

REPORTS

Chair Yost left the proceedings and passed the gavel to Director Khatibi.

3. Consider Recommending Board of Directors' Approval of the CalOptima 2017 Quality Improvement Program and 2017 Quality Improvement Work Plan
Caryn Ireland, Quality Analytics Executive Director, presented the action to recommend Board of Directors' approval of the 2017 Quality Improvement (QI) Program and 2017 QI Work Plan. A review of the proposed revisions to the QI Program for 2017 was presented, which included the following: updates to health network and behavioral health delegate information; adoption of the annual Utilization Management (UM) Program and UM Work Plan; updates to advisory committees, quality committees, and subcommittees that support the QI Program; updates the scope of the Credentialing program; and additional details on the Interdisciplinary Care Teams and risk stratification processes.

Enhancements to the 2017 QI Work Plan include continuous quality improvement projects for the Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS), behavioral health access and coordination of services, long-term support services initiatives, pharmacy and initial health assessments. The Work Plan continues to focus on Member Experience including access and availability, and improvement initiatives related to Healthcare Effectiveness Data and Information Set (HEDIS), CMS star ratings, and Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys. It was noted that the proposed changes are necessary to meet the requirements specified by CMS, DHCS, and NCQA accreditation standards.

Action: ***On motion of Director Nguyen, seconded and carried, the Committee recommended Board of Directors approval of the CalOptima 2017 Quality Improvement Program and 2017 Quality Improvement Work Plan as presented. (Motion carried 3-0-0; Chair Yost absent)***

2. Consider CalOptima Opioid Reduction Program and Next Steps
Richard Bock, M.D., Deputy Chief Medical Officer, presented an overview of the opioid epidemic, the impact on the Medi-Cal program, and opioid use disorder treatment. The Orange County Health Care Agency Behavioral Health Services (HCA BHS) provides mental health and substance use disorder services to eligible youth and adults. It was reported that California received a waiver from the federal government to develop a five-year pilot project to serve people with substance abuse disorder (SUD), and who are eligible for Drug Medi-Cal; HCA BHS provides the majority of the waiver-required services. A Memorandum of Understanding (MOU) between CalOptima and HCA delineates the responsibilities to ensure members receive the appropriate level of care to address mental health issues. An addendum to this MOU is in development to ensure the coordination of SUD screening and the provision of services between CalOptima and HCA.

Dr. Bock reviewed the following CalOptima interventions: formulary restrictions beginning January 1, 2017; member restriction programs including Pharmacy Home Policy, Prescriber Restriction Program Policy, Part D opioid overutilization monitoring and case management, and referring fraud and abuse to Compliance; prescriber outreach programs; quality measures; ongoing continuing medical education (CME) series for physicians; and coalition participation including the Association for Community Health Plans (ACAP), Safe Rx OC, and DHCS Health Homes Program in 2018.

The CalOptima Opioid Reduction Program will be presented to the Board at the March 2, 2017 meeting for additional discussion.

4. Consider Recommending Board of Directors' Approval of the 2017 CalOptima Program of All-Inclusive Care for the Elderly (PACE) Quality Assessment and Performance Improvement (QAPI) Plan
Miles Masatsugu, M.D., Medical Director, presented the action to recommend Board of Directors' approval of the 2017 PACE QAPI Plan. Proposed updates to the 2017 CalOptima PACE QAPI Plan are based on the first three (3) years of data collection, and review and analysis with specific data driven goals and objectives. Revisions to the QAPI Work Plan elements for 2017 include: Physician's Orders for Life-Sustaining Treatment (POLST); 30-day all-cause readmissions; transportation issues regarding one-hour violations, on-time performance and incident resolution; and access and availability to specialty care. Proposed new QAPI Work Plan elements include quality of care for older adults, potentially harmful drug-disease interactions in the elderly, utilization management related to long term placement, and patient satisfaction.

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

Action: ***On motion of Director Berger, seconded and carried, the Committee recommended Board of Directors' approval of the 2017 CalOptima PACE Quality Assessment and Performance Improvement Plan. (Motion carried 3-0-0; Chair Yost absent)***

Chair Yost rejoined the proceedings at 3:50 p.m.

5. Consider Recommending Board of Directors' Approval of the Fiscal Year (FY) 2018 (Measurement Year 2017) Pay for Value Programs for Medi-Cal and OneCare Connect
Dr. Bock presented the action to recommend Board of Directors approval of the FY 2018 (Measurement Year 2017) Pay for Value Programs for Medi-Cal and OneCare Connect. For Measurement Year 2017 programs, it was recommended to maintain elements from the prior year with the following proposed modifications. Medi-Cal modifications include revising the minimum denominator from 100 to 30 eligible members for each specified quality measure to be eligible for incentive payment, and revise CAHPS minimum performance threshold to reflect California benchmarks. In addition to the four clinical incentive measures in the OneCare Connect Pay for Value program, a member experience survey will be added to the program beginning in calendar year 2017. It was noted that clinical measures are weighted at 60 percent; member experience at 40 percent.

Action: ***On motion of Director Berger, seconded and carried, the Committee recommended Board of Directors' approval of the FY 2018 (Measurement Year 2017) Pay for Value Programs for Medi-Cal and OneCare Connect, as described in Attachments 1 and 2, subject to regulatory approval, as applicable. (Motion carried 4-0-0)***

6. Consider Approval of Medi-Cal Quality Improvement and Accreditation Activities During CalOptima Fiscal Year 2016-17 for Member and Provider Incentives
Caryn Ireland, Executive Director, Quality Analytics, presented the action to recommend that the Board of Directors authorize staff to develop and implement Member and Provider incentive programs in the amounts listed on Attachment 1, subject to applicable regulatory approval and guidelines. Proposed member incentives are related to postpartum visits, cervical and breast cancer screenings. Provider

Back to Agenda

incentives include providing office staff incentives related to documentation of postpartum visits, assisting CalOptima members in scheduling pap tests, and extended provider office hours for cervical and breast cancer screenings. It was noted that staff has incorporated DHCS guidance on best practices for member incentives and in accordance with CalOptima policy. Provider offices and clinics identified for the incentive programs will be high volume providers in good standing with CalOptima. Staff will present an analysis of the incentive results to the Committee at a future meeting.

Action: ***On motion of Director Berger, seconded and carried, the Committee recommended that the Board of Directors authorize staff to develop and implement Member and Provider incentive programs in the amounts listed on Attachment 1, subject to applicable regulatory approval and guidelines. (Motion carried 4-0-0)***

7. Consider Recommending Issuance of Request for Proposal for Medi-Cal Perinatal Support Services

Richard Helmer, M.D., Chief Medical Officer, presented the action to recommend the Board of Directors authorize the issuance of a Request for Proposal (RFP) to identify community partner(s) experienced with providing Medi-Cal covered Perinatal Support Services, and authorize the Chief Executive Officer, with the assistance of legal counsel, to contract with qualifying RFP responders and in compliance with Medi-Cal Perinatal Support program requirements established by DHCS.

Pshyra Jones, Health Education and Disease Management Director, presented an overview of the DHCS Perinatal Service requirements, CalOptima's contract for Comprehensive Perinatal Services Program with MOMS Orange County, and CalOptima HEDIS rates for prenatal and postpartum services. The new proposed program is designed to provide a more comprehensive approach, and strategically increase utilization, coordination of services and member engagement. As proposed, staff will conduct an RFP process to identify partner(s) to meet the requirements of the new program design for Perinatal Care for CalOptima members.

Action: ***On motion of Director Khatibi, seconded and carried, the Committee recommended that the Board of Directors authorize the issuance of an RFP to identify community partner(s) experienced with providing Medi-Cal covered Perinatal Support Services, and authorize the Chief Executive Officer, with the assistance of legal counsel, to contract with qualifying RFP responders and in compliance with Medi-Cal Perinatal Support program requirements established by DHCS. (Motion carried 4-0-0)***

INFORMATION ITEMS

8. PACE Member Advisory Committee (PMAC) Update

Mallory Vega, PACE Member Advisory Committee (PMAC) Community Representative, reported on PMAC activities at the December 12, 2016 PMAC meeting, including an update on the Participant Satisfaction Survey indicating an increase in overall satisfaction, new PACE Participant Orientations that began in January, and an update on transportation services. PMAC participants requested additional information prior to attending appointments to specialists, and shared their appreciation for the PACE program.

Back to Agenda

The following Information Items were accepted as presented:

9. Quarterly Reports to the Quality Assurance Committee
    a. Quality Improvement Report
    b. Member Trend Report

COMMITTEE MEMBER COMMENTS

Director Khatibi requested an update on behavioral health integration at a future Committee meeting. Committee members commented on the opioid epidemic, including the importance of an aggressive communication campaign, and the need to address post operative medications.

ADJOURNMENT

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

/s/ Suzanne Turf
Suzanne Turf
Clerk of the Board

Approved: May 22, 2017

Back to Agenda

MINUTES

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

CALOPTIMA
505 CITY PARKWAY WEST
ORANGE, CALIFORNIA

FEBRUARY 16, 2017

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

Members Present: Lee Penrose, Chair; Scott Schoeffel

Members Absent: Ron DiLuigi

Others Present: Michael Schrader, Chief Executive Officer; Gary Crockett, Chief Counsel; Richard Helmer, M.D., Chief Medical Officer; Nancy Huang, Interim Chief Financial Officer; Ladan Khamseh, Chief Operating Officer; Len Rosignoli, Chief Information Officer; Suzanne Turf, Clerk of the Board

MANAGEMENT REPORTS

Chief Financial Officer (CFO) Report
Nancy Huang, Interim Chief Financial Officer, provided an update on the progress of the health network medical loss ratio audit. Audit results will be presented at a future Board of Directors' Finance and Audit Committee meeting.

CalOptima staff is working with the insurance broker regarding the renewal of insurance policies effective April 8, 2017, and an update on insurance coverage will be presented to the Committee at a future meeting.

PUBLIC COMMENT
1. Shirley Dettloff, Maria Zamora, Dr. Marie Torres, AltaMed; and Isabel Becerra, Coalition of Orange County Community Health Centers – Oral re: Agenda Item 3, Receive Program of All-Inclusive Care for the Elderly (PACE) Operational Analysis and Business Plan Follow Up and Consider Recommending Next Steps; and
2. Pamela Pimentel, MOMS Orange County – Oral re: Agenda Item 5, Consider Recommending Issuance of Request for Proposal (RFP) for Medi-Cal Perinatal Support Services.

INVESTMENT ADVISORY COMMITTEE UPDATE

1. Treasurer's Report
Ms. Huang presented an overview of the Treasurer's Report for the period October 1, 2016 through December 31, 2016. Based on a review by the Board of Directors' Investment Advisory Committee, all investments were compliant with Government Code section 53600 *et seq.*, and with CalOptima's Annual Investment Policy.

CONSENT CALENDAR

2. Approve the Minutes of the November 17, 2016 Regular Meeting of the CalOptima Board of Directors' Finance and Audit Committee; Receive and File Minutes of the October 24, 2016 Meeting of the CalOptima Board of Directors' Investment Advisory Committee

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

REPORTS

3. Receive Program of All-Inclusive Care for the Elderly (PACE) Operational Analysis and Business Plan Follow Up and Consider Recommending Next Steps
Richard Helmer, M.D., Chief Medical Officer, reviewed the February 4, 2016 Board action, which authorized staff to submit a PACE Service Area Expansion application to the Department of Health Care Services and the Centers for Medicare & Medicaid Services, initiate a Request for Proposal process for Alternative Care Settings (ACS) model for PACE expansion satellite locations, staff to perform financial analysis of the Community-Based Adult Services (CBAS) business model and present to the Board of Directors' Finance and Audit Committee for review, and when the Garden Grove PACE Center reaches 80% capacity, staff to return to the Board to consider one or more additional PACE Centers.

A follow up presentation on the PACE operational analysis and business plan, as requested by the Board of Directors' Finance and Audit Committee (FAC) at the September 2016 meeting, was provided for discussion, including a review of the following: PACE financial performance; the cost of like populations; the status of interventions in the areas of risk adjustment factor scores, meals, staffing, specialty referrals, inpatient utilization and pharmacy; options to the current PACE model; and the risks of alternative care settings.

After considerable discussion of the matter, Chair Penrose thanked staff for the detailed report in response to the Committee's questions and concerns, and recommended presenting the PACE Operational Analysis and Business Plan Follow Up to the Board of Directors at the March 2, 2017 meeting for further discussion and direction.

Back to Agenda

Action: ***On motion of Chair Penrose, seconded and carried, the Committee received and filed the PACE Operational Analysis and Business Plan Follow Up and recommended presentation of this item to the Board of Directors for further discussion and direction. (Motion carried 2-0-0; Director DiLuigi absent)***

4. Consider Recommending Board of Directors Receive and File Compliance Strategies' Compliance Program Effectiveness Audit Report

Action: ***On motion of Director Schoeffel, seconded and carried, the Committee recommended the Board of Directors receive and file Compliance Strategies' 2016 Compliance Program Effectiveness Audit Report. (Motion carried 2-0-0; Director DiLuigi absent)***

5. Consider Recommending Issuance of Request for Proposal for Medi-Cal Perinatal Support Services

Dr. Helmer presented the actions to recommend Board of Directors authorize the issuance of a Request for Proposal (RFP) to identify community partner(s) experienced with providing Medi-Cal covered Perinatal Support Services, and authorize the Chief Executive Officer, with the assistance of Legal Counsel, to contract with qualifying RFP responders and in compliance with Medi-Cal Perinatal support program requirements established by the California Department of Health Care Services (DHCS). A brief overview of the new proposed program designed to provide a more comprehensive approach to increase utilization, coordination of services and member engagement, was presented for discussion. CalOptima staff proposes to conduct an RFP process to identify partner(s) to meet the requirements of the new program design for Perinatal Care for CalOptima members.

Chief Executive Officer Michael Schrader recommended a modification of the recommended actions to add the following: amend the contract with the current vendor to reflect per member per month and incentive payment based only on the CalOptima Classic Medi-Cal population until the RFP process is completed.

Action: ***On motion of Director Schoeffel, seconded and carried, the Committee recommended the Board of Directors authorize the issuance of a Request for Proposal (RFP) to identify community partner(s) experienced with providing Medi-Cal covered Perinatal Support Services, authorize the Chief Executive Officer, with the assistance of Legal Counsel, to contract with qualifying RFP responders and in compliance with Medi-Cal Perinatal Support program requirements established by the California Department of Health Care Services, and amend the contract with the current vendor to reflect per member per month and incentive payment based only on the CalOptima Classic Medi-Cal population until the RFP process is completed. (Motion carried 2-0-0; Director DiLuigi absent)***

INFORMATION ITEMS

The following Information Items were accepted as presented:

6. December 2016 and November 2016 Financial Summaries
7. CalOptima Computer Systems Security Update
9. Cost Containment Improvements/Initiatives
10. Quarterly Reports to the Finance and Audit Committee
    a. Shared Risk Pool Performance
    b. Reinsurance Report
    c. Health Network Financial Report
    d. Purchasing Report

8. Update on 505 City Parkway West Development Rights

Ms. Huang provided an update on staffing needs for the 505 Building including optimizing telecommuting, recapturing all of the space in the 505 Building, and current space projections, which currently indicates a surplus of 174 spaces.

Glen Allen of Newport Real Estate Services, Inc. presented a review of a preliminary site plan and options for exercising the development rights, including the pros and cons of direct sale, ground lease, direct development, joint venture, or exchange for a nearby property. A conceptual development timeline was also presented. It was noted that the current development agreement expires in October 2020, and an option to extend the current development agreement for additional years beyond 2020 that requires approval by the City of Orange.

After discussion of the matter, Director Schoeffel recommended presentation of this item to the Board of Directors at the March 2, 2017 meeting for further consideration.

ADJOURNMENT

Hearing no further business, Chair Penrose adjourned the meeting at 4:43 p.m.

/s/ Suzanne Turf

Suzanne Turf
Clerk of the Board

Approved: May 18, 2017

MINUTES

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

April 13, 2017

A Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee (PAC) was held on Thursday, April 13, 2017, at the CalOptima offices located at 505 City Parkway West, Orange, California.

CALL TO ORDER
Suzanne Richards, PAC Vice Chair, acting as chair, called the meeting to order at 8:06 a.m. and Steve Flood led the Pledge of Allegiance.

ESTABLISH QUORUM

Members Present: Anjan Batra, M.D.; Donald Bruhns; Theodore Caliendo, M.D.; Steve Flood; Jena Jensen; John Nishimoto, O.D.; Pamela Pimentel, R.N.; Suzanne Richards, RN, MBA, FACHE; Barry Ross, R.N., MPH, MBA; Jacob Sweidan, M.D.

Members Absent: Alan Edwards, M.D.; Pamela Kahn, R.N.; Teri Miranti; George Orras, Ph.D., FAAP; Mary Pham, Pharm.D., CHC

Others Present: Michael Schrader, Chief Executive Officer; Ladan Khamseh, Chief Operating Officer; Richard Bock, M.D., Deputy Chief Medical Officer; Gary Crockett, Chief Counsel; Nancy Huang, Interim Chief Financial Officer; Michelle Laughlin, Executive Director, Network Operations; Phil Tsunoda, Executive Director, Public Policy and Public Affairs; Cheryl Simmons, Staff to the PAC

MINUTES

Approve the Minutes of the March 9, 2017 Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee

Action: ***On motion of Member Ross, seconded and carried, the Committee approved the minutes of the March 9, 2017 meeting. (Motion carried 11-0-0; Chair Miranti and Members Edwards, Kahn, and Pham absent)***

PUBLIC COMMENTS
No requests for public comment were received.

Ladan Khamseh, Chief Operating Officer, introduced Michelle Laughlin, Executive Director, Network Operations.

Back to Agenda

REPORTS

Consider Approval of the FY 2017-2018 PAC Meeting Schedule
PAC members reviewed the proposed FY 2017-18 meeting schedule. As proposed, the PAC will meet on a monthly basis on the second Thursday of the month except during the months of July 2017 and January 2018 when no meetings are scheduled.

Action: ***On motion of Member Jensen seconded and carried, the Committee adopted the FY 2017-18 PAC Meeting Schedule reflecting monthly meetings with the exception of July 2017 and January 2018. (Motion carried 11-0-0; Chair Miranti and Members Edwards, Kahn, and Pham absent)***

Consider Approval of FY 2016-17 PAC Accomplishments
The FY 2016–17 PAC Accomplishments were presented for approval. The accomplishments will be presented as an informational item to the CalOptima Board of Directors at their June 1, 2017 meeting.

Action: ***On motion of Member Pimentel seconded and carried, the Committee approved the FY 2016-17 PAC Accomplishments. (Motion carried 11-0-0; Chair Miranti and Members Edwards, Kahn, and Pham absent)***

Consider Approval of FY 2017-18 PAC Goals and Objectives
The FY 2017–18 PAC Goals and Objectives were presented for approval. The Goals and Objectives will be presented as an informational item to the CalOptima Board of Directors at their June 1, 2017 meeting.

Action: ***On motion of Member Ross seconded and carried, the Committee approved the FY 2017-18 PAC Goals and Objectives. (Motion carried 11-0-0; Chair Miranti and Members Edwards, Kahn, and Pham absent)***

CEO AND MANAGEMENT REPORTS

Chief Executive Officer Update
Michael Schrader, Chief Executive Officer, confirmed that the CalOptima Community Network (CCN) had reached a membership threshold that, according to policy, will prevent any further auto-assignment to CCN. Mr. Schrader noted that each member still has the option of selecting his or her own primary care physician, including those in the CCN. Mr. Schrader also noted that the because of the popularity of the CCN there have been requests that staff consider asking the Board to consider raising the 10% limit. Staff is currently working on a side-by-side comparison of the CCN with the other CalOptima health networks, in categories such as financial performance, cost, quality of care, member satisfaction and audit results. The results of the side-by-side comparison will be vetted before being presented to the Board.

Chief Operating Officer Update
Ladan Khamseh, Chief Operating Officer, provided an update on the Child Health and Disability Prevention (CHDP) program transitioning from the PM 160 form to the CMS 1500 form for claims submission. Ms. Khamseh noted that CalOptima was evaluating the possible impact on business processes should CalOptima migrate to this form.

Chief Medical Officer Update
Richard Bock, M.D., Deputy Chief Medical Officer, provided the PAC with an update on the current opioid epidemic. Dr. Bock noted that Fentanyl-related overdoses have prompted the current Centers for Disease Control and Prevention (CDC) to issue an alert. He noted that the Drug Enforcement Agency (DEA) has issued a nationwide warning on Carfentanil, an animal opioid sedative considered 10,000 times stronger than morphine. Dr. Bock also discussed how overdoses are sometimes caused when Fentanyl and Carfentanil are combined and then mixed into powdered heroin. The use of this combined Benzodiazepine has been associated with 30.1 percent of opioid overdose deaths. Dr. Bock agreed to keep the PAC informed on any changes by the CDC or the DEA as necessary.

Chief Financial Officer Update
Nancy Huang, Interim Chief Financial Officer, presented CalOptima's Financial Summary as of February 2017, including a report of the Health Network Enrollment for the month of February 2017. Ms. Huang summarized CalOptima's financial performance and current reserve levels. At the request of Member Batra, staff will present at a future PAC meeting on CalOptima's investments in the community through Inter-governmental Transfer (IGT) funds. These funds are available to provide enhanced benefits to existing Medi-Cal beneficiaries. All funding categories require state approval.

Michael Schrader reported that staff is working on CalOptima's FY 2017-18 budget, and noted that the State is considering rolling back the Medi-Cal Expansion Rate (MCE) for health plans, which could oblige CalOptima to realign its MCE reimbursement rates with the Medi-Cal classic rates. He noted that CalOptima continues to advocate for higher rates.

INFORMATION ITEMS

Federal and State Budget Update
Phil Tsunoda, Executive Director, Public Policy and Public Affairs, provided a State and Federal legislative update. Mr. Tsunoda also discussed a letter sent to the Congressional Representatives in CalOptima's delegation regarding the proposed American Health Care Act.

PAC Member Updates
Vice Chair Richards reminded the Members that the PAC Nominations Ad Hoc Subcommittee is meeting on April 24, 2017; Members Pham, Bruhns and Batra serve on this ad hoc. As acting chair, Vice Chair Richards also formed an ad hoc consisting of Chair Miranti, Vice Chair Richards and Member Pimentel to meet with the MAC ad hoc to discuss possible agenda items for the joint MAC/PAC meeting scheduled for September 14, 2017.

Back to Agenda

ADJOURNMENT

There being no further business before the Committee, Vice Chair Richards adjourned the meeting at 9:24 a.m.

/s/ Cheryl Simmons_
Cheryl Simmons
Staff to the PAC

Approved: May 11, 2017

Back to Agenda

MINUTES

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

March 9, 2017

A Regular Meeting of the CalOptima Board of Directors' Member Advisory Committee (MAC) was held on March 9, 2017, at CalOptima, 505 City Parkway West, Orange, California.

CALL TO ORDER

Chair Mallory Vega called the meeting to order at 2:33 p.m., and led the Pledge of Allegiance.

ESTABLISH QUORUM

Members Present:	Mallory Vega, Chair; Connie Gonzalez; Patty Mouton; Jaime Muñoz; Carlos Robles; Christina Sepulveda; Velma Shivers; Sr. Mary Therese Sweeney; Christine Tolbert
Members Absent:	Suzanne Butler; Sandy Finestone; Donna Grubaugh; Sally Molnar; Victoria Hersey; Lisa Workman
Others Present:	Michael Schrader, Chief Executive Officer; Candice Gomez, Executive Director, Program Implementation; Donald Sharps, MD, Medical Director; Emily Fonda, MD, Medical Director; Tracy Hitzeman, Executive Director, Clinical Operations; Richard Helmer, MD, Chief Medical Officer; Phil Tsunoda, Executive Director, Public Affairs; Belinda Abeyta, Director, Customer Service; Becki Melli, Customer Service

MINUTES

Approve the Minutes of the January 12, 2017, Regular Meeting of the CalOptima Board of Directors' Member Advisory Committee

Action: ***On motion of Member Christine Tolbert, seconded and carried, the MAC approved the minutes as submitted.***

Chair Mallory Vega welcomed two new MAC members: Carlos Robles representing Recipients of CalWORKs, and Jaime Muñoz representing Foster Children. The members introduced themselves to the committee.

PUBLIC COMMENT

Pamela Pimentel, Co-Chair, Orange County Health Improvement Partnership (OCHIP) – Oral re: OCHIP, a public, private partnership that is dedicated to improving the health of communities in Orange County through community assessments and collaborations with community partners.

Back to Agenda

CHIEF EXECUTIVE OFFICER AND MANAGEMENT TEAM DISCUSSION

Chief Executive Officer Update

Michael Schrader, Chief Executive Officer, reported that CalOptima continues to track potential changes to the Affordable Care Act (ACA) provisions involving Medicaid expansion and to advocate for the best possible outcome for Orange County. Mr. Schrader explained that although the proposed House Republican bill to repeal and replace the ACA has been released, it is too early to know what impact it will have on CalOptima, as many changes will occur as it proceeds through Congress. However, one of the proposed provisions is the transition of federal Medicaid funding to a per-capita cap basis by 2020 from the existing 50/50 split in funding between the federal government and state government. Mr. Schrader noted that CalOptima serves 548,000 members under Medi-Cal classic while Medi-Cal expansion added an additional 234,000 CalOptima members. CalOptima's expansion members are adults between 19-64 years of age.

Chief Medical Officer Update

Dr. Helmer, Chief Medical Officer, announced that several projects are scheduled for the Behavioral Health Integration department, such as integrating behavioral health throughout CalOptima's operations, providing oversight and accountability of behavioral health services and serving as subject matter experts for all lines of business.

CalOptima Pay for Value Update

Abraham Manase, Senior Data Analyst, Quality Analytics, presented the 2016 results from the Pay for Value (P4V) program, noting that the purpose of P4V is to recognize and reward health networks and their providers for demonstrating quality performance and improvement. In addition, P4V provides comparative information to the public on CalOptima's performance and provides industry standard benchmarks and feedback to the health networks on their quality improvement efforts. Mr. Manase also reviewed the proposed 2017 program scoring and payment methodology that rewards providers for performance and improvement, noting that both factors are important when measuring the health network's overall performance. He added that the focus of P4V is to improve members' health, provide better care and lower health care costs.

Mimi Cheung, Supervisor, Quality Analytics, presented the 2017 member and provider incentives designed to improve quality of care. She explained that the member incentives feature women's health screenings and the provider incentives encourage provider offices to improve charting and focus on helping members get their cancer screenings.

Chief Operating Officer Update

Belinda Abeyta, Director, Customer Service, provided the COO report, announcing that the CalOptima Community Network (CCN) will close to new auto assignments as of April 1, 2017. CCN has reached the membership maximum under the auto assignment guidelines. This does not affect members that choose CCN as their network or through family link.

INFORMATION ITEMS

MAC Member Updates

Chair Vega announced that the Provider Advisory Committee (PAC) would like to convene an annual joint MAC/PAC meeting similar to the joint advisory committee meeting last year in which behavioral health issues were addressed. After discussion, MAC members expressed interest in convening a joint meeting to address areas of mutual concern. Members Patty Mouton and Christine Tolbert volunteered to serve on the ad hoc subcommittee to develop the agenda for the combined MAC/PAC meeting.

Chair Vega announced that recruitment has begun for the six MAC seats that will expire on June 30, 2017, including Adult Beneficiaries, Family Support, Medi-Cal Beneficiaries, Persons with Disabilities, Recipients of CalWORKs and Seniors. For those who are reapplying, the application is on the CalOptima website. Chair Vega also noted the appointment of MAC Chair and Vice Chair for FY 2017-18. The deadline to apply for all positions is March 31, 2017.

Boys and Girls Clubs of Garden Grove (BGCGG)

Member Christina Sepulveda, Vice President, Boys and Girls Clubs of Garden Grove (BGCGG) presented an overview of BGCGG, explaining that BGCGG serves over 6,500 youth daily in central Orange County through various youth development programs and family strengthening services. BGCGG serves a culturally diverse community that speaks 70 different languages. Member Sepulveda shared that some of the youth programs include education and career development, character and leadership building, life skills, and sports and recreation. The family strengthening program provides parents the necessary tools, relationships, networks, and supports to raise their children successfully, which includes involving parents as decision makers in how their communities meet family needs. Member Sepulveda added that a key program at BGCGG is ARCHES, which stands for Access to Resources for Children's Health, Education, and Support. ARCHES connects families to resources and services in the community to ensure the needs of the whole child are met.

Managed Behavioral Health Organization (MBHO) Update

Donald Sharps, MD, Medical Director, Behavioral Health Integration, presented an update on the transition of Magellan Health, Inc., as the new MBHO. Dr. Sharps reported that Magellan manages a local call center to serve CalOptima's members. He reported that the call center maintained all its reporting goals during the first couple months of the transition despite an average monthly call volume approximately three times the average. Dr. Sharps also reported that Magellan's providers covered 95 percent of the behavioral health cases for Medi-Cal members and 100 percent for OneCare Connect members. MAC was pleased to learn that members experienced so little disruption during the transition. Dr. Sharps added that a quality improvement initiative for 2017 would assess the behavioral health needs of long-term care members residing in skilled nursing facilities.

Federal and State Legislative Update
Phil Tsunoda, Executive Director, Public Policy and Government Affairs, provided additional information on the process of the proposed House bill to repeal and replace the ACA. He reported that two House Republican committees, the House Ways and Means Committee and the House Energy and Commerce Committee, passed their versions of the proposed bill. The House Budget Committee will take the two versions from the committees and merge them into one bill for the House of Representatives to consider during the week of March 20, 2017.

Chair Vega announced that the next MAC meeting is Thursday, May 11, 2017 at 2:30 p.m.

ADJOURNMENT
Hearing no further business, Chair Vega adjourned the meeting at 4:00 p.m.

/s/ Eva Garcia
Administrative Assistant

Approved: May 11, 2017

Back to Agenda

CalOptima Board Action Agenda Referral

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

Consent Calendar

3. Consider Approval of the 2017 CalOptima Utilization Management (UM) Program and 2017 UM Work Plan

Contact

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

Recommended Action

Consider approval of the recommended revisions to the 2017 Utilization Management (UM) Program and 2017 UM Work Plan.

Background

Utilization Management activities are conducted to ensure that members' 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 consistent delivery of medically necessary, quality health care services. It provides for the delivery of care in a coordinated, comprehensive and 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 processes and metrics for systematically coordinating, managing and monitoring these processes to achieve positive member outcomes.

CalOptima staff has updated the 2017 UM Program Description and related UM Work Plan with revisions to ensure that it is aligned to reflect the health network and strategic organizational changes. This will ensure that all regulatory and NCQA accreditation standards are met in a consistent manner across the Medi-Cal, OneCare and OneCare Connect programs.

Discussion

The 2017 Utilization Management Program is based on the Board-approved 2016 Utilization Management Program and describes: (i) the scope of the program; (ii) the progam structure and services provided; (iii) the populations served; (iv) key business processes; (v) integration across CalOptima; and (vi) 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.

Back to Agenda

The revisions are summarized as follows:

1. Aligned program descriptions and committee references with the Quality Management Program
2. Removed references to the payment arrangements of the delegated Health Networks
3. Updated program to reflect the new Managed Behavioral Health Organization, Magellan
4. Updated Committee Structure Organization Chart, reflecting new structure and operational unit support
5. Assumed responsibility for the Benefit Management Sub-Committee to ensure timely incorporation of regulatory benefit changes
6. Detailed description for measuring UM effectiveness, including fourteen (14) over/under utilization metrics monitored, tracked and evaluated
7. Included Conflict of Interest statement
8. Expanded description of responsibilities for various key positions to align with NCQA elements

The recommended changes are designed to better review, analyze, implement and evaluate the components of the UM Program and Work Plan. 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

1. PowerPoint Presentation – 2017 Utilization Management Program Description
2. 2017 Utilization Management Program – Executive Summary of Revisions
3. Proposed 2017 Utilization Management Program
4. Proposed 2017 Utilization Management Work Plan

/s/ Michael Schrader — *05/25/2017*

Authorized Signature — **Date**

Back to Agenda

2017 Utilization Management
Program Description and Work Plan

Board of Directors Meeting

June 1, 2017

Richard Bock, MD, Deputy Chief Medical Officer

Tracy Hitzeman, RN, Executive Director Clinical Operations

Back to Agenda

2017 UM Program Description Revisions

Summary of Changes

- Aligned with the Quality Management Program
  - Program descriptions
  - Committee references
- Updated Committee Structure Organization Chart
  - Reflects new structure and operational unit support
- Detailed description for measuring UM effectiveness
  - Fourteen (14) over/under utilization metrics monitored, tracked and evaluated
- Included Conflict of Interest statement

Back to Agenda

2017 Utilization Management Workplan
Projects and Initiatives

- Over/Under Utilization tracking, trending and reporting
  - ➢ Enhanced and centralized to highlight over arching trends and facilitate analysis
- Enriched clinical decision making resources
  - ➢ Support appropriate evaluation of complex/highly specialized testing or treatment requests
- Medical management systems enhancements
- Improve coordination of services between CalOptima and County Mental Health Plan

Back to Agenda

2017 Utilization Management Workplan
Projects and Initiatives

- Oversight and internal auditing
  - Consistent with CMS, DHCS and NCQA approach
  - Designation of staff with Medicare expertise for processing of OneCare and OCC authorization referrals
- Improve member notices
  - Task force established to focus on standardization of denial letter - lay language use
- Continued development of Long Term Support Services (LTSS) metrics

Back to Agenda

Utilization Management (UM) Program 2017

Executive Summary of Revisions

1. Aligned program descriptions and committee references with the Quality Management Program
2. Removed references to the payment arrangements of the delegated Health Networks
3. Updated program to reflect the new Managed Behavioral Health Organization, Magellan
4. Updated Committee Structure Organization Chart, reflecting new structure and operational unit support
5. Assumed responsibility for the Benefit Management Sub-Committee to ensure timely incorporation of regulatory benefit changes
6. Detailed description for measuring UM effectiveness, including fourteen (14) over/under utilization metrics monitored, tracked and evaluated
7. Included Conflict of Interest statement
8. Expanded description of responsibilities for various key positions to align with NCQA elements

20~~16~~17 UTILIZATION MANAGEMENT PROGRAM DESCRIPTION

2016~~6~~7
UTILIZATON MANAGEMENT PROGRAM
SIGNATURE PAGE

Utilization Management Committee Chairperson:

______________________ ~~1/~~__________________~~28/2016~~

Francesco Federico, MD __Date
~~**UM Medical Director**~~

Board of Directors' Quality Assurance Committee Chairperson:

______________________ __________________

______________________ ~~1/28/2016~~

~~Viet Van Dang~~Paul Yost, **MD** ___**Date**

Board of Directors Chairperson:

____

~~1/28/2016~~

~~**Mark Refowitz**~~**Paul Yost, MD** ___**Date**

Back to Agenda

TABLE OF CONTENTS

PAGES

1. ABOUT CALOPTIMA, CALOPTIMA PROGRAMS 1
2. UTILIZATION MANAGEMENT PURPOSE, SCOPE 1
3. UTILIZATION MANAGEMENT PROGRAM GOALS 2
4. PROVIDERS 3
5. DELEGATION 3
6. BEHAVIORAL HEALTH SERVICES 5
7. CALOPTIMA DIRECT (COD) 7
8. CALOPTIMA COMMUNITY NETWORK (CCN).. 7
9. DUAL ELIGIBLE PROGRAMS, ONECARE (OC)... 7
10. ONECARE CONNECT CAL MEDICONNECT (OCC)... 8
11. CALOPTIMA BOARD OF DIRECTORS 8
12. CALOPTIMA OFFICERS AND DIRECTORS 9
13. UTILIZATION MANAGEMENT RESOURCES 13
14. PHARMACY DEPARTMENT RESOURCES 15
15. LONG-TERM SERVICES & SUPPORTS RESOURCES 17
16. QUALIFICATIONS AND TRAINING 20
17. COMMITTEE STRUCTURE 21
18. UTILIZATION MANAGEMENT COMMITTEE 21
19. BENEFIT MANAGEMENT SUBCOMMITTEE (BMSC) 22
20. BEHAVIORAL HEALTH QUALITY IMPROVEMENT COMMITTEE (BHQIC).......23
21. LONG-TERM SERVICES & SUPPORTS QUALITY IMPROVEMENT SUBCOMMITTEE (LTSS QISC) 24
22. INTEGRATION WITH THE QUALITY IMPROVEMENT PROGRAM 25
23. CONFLICT OF INTEREST 25

24. CONFIDENTIALITY 26

25. INTEGRATION WITH OTHER PROCESSES 26

26. UTILIZATION MANAGEMENT PROCESS 27

27. BENEFITS 27

28. UTILIZATION MANAGEMENT PROGRAM STRUCTURE 27

29. PRIOR AUTHORIZATION 28

30. CLINICAL INFORMATION 28

31. PHARMACEUTICAL MANAGEMENT 29

32. MEDICAL NECESSITY REVIEW 31

33. BOARD CERTIFIED CLINICAL CONSULTANTS 36

34. INTER-RATER RELIABILITY 37

35. PROVIDER/MEMBER COMMUNICATION 37

36. TIMELINESS OF UTILIZATION MANAGEMENT DECISIONS 39

37. NURSE ADVICE PHONE LINE 45

38. EMERGENCY SERVICES 46

39. ADMISSION/CONCURRENT REVIEW PROCESS 46

40. HOSPITALIST/SNFIST PROGRAM 47

41. DISCHARGE PLANNING REVIEW 48

42. DENIALS 48

43. UTILIZATION MANAGEMENT APPEALS PROCESS 49

44. EXPEDITED APPEALS 50

45. PROVIDER PREVENTABLE CONDITIONS (PPCS) 50

46. LONG-TERM SERVICES & SUPPORTS (LTSS) 50

47. RETROSPECTIVE REVIEW 51

48. Complex Case Management 52

49. Transplant Program 53

50. Disease Management (DM) 54

51. Measuring Effectiveness 55

52. State Fair Hearing (Medi-Cal Line Of Business Only) 55

53. Independent Medical Review 56

54. Program Evaluation 56

55. Satisfaction With The UM Process 56

20167 UTILIZATION MANAGEMENT

PROGRAM DESCRIPTION

PurposeAbout CalOptima

The mission of CalOptima is to provide members with access to quality health care services delivered in a cost effective and compassionate manner.

Caring for the people of Orange County has been CalOptima's privilege since 1995. CalOptima's Medicaid (Medi-Cal) and Medicare members deserve the highest quality care and service throughout the health care continuum.

CalOptima's Programs:

CalOptima has four programs that it administers:

1. CalOptima Medi-Cal — California's Medicaid program is known as Medi-Cal.
2. OneCare (HMO SNP) — A program for persons who qualify for both Medicare and Medi-Cal, but do not qualify for OneCare Connect. — Combined Medicare and Medi-Cal benefits for low-income seniors and people with disabilities.
3. OneCare Connect — OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) a demonstration program for low-income people who qualify for Medicare and Medi-Cal.
4. CalOptima PACE — Program of All-Inclusive Care for the Elderly (PACE) that provides coordinated and integrated health care services to frail elders who live independently.

For more details about CalOptima, as well as the scope of services for the above programs, please see the 2017 Quality Improvement Program pages 1–8.

Utilization Management Purpose

The purpose of the Utilization Management (UM) Program Description is to define the structures and processes within the Utilization ManagementUM Ddepartment, including assignment of responsibility to appropriate individuals, in order to deliver quality, coordinated health care 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.

UM Scope

The scope of the Utilization ManagementUM 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.

UM Program Goals

The goal~~s~~ of the UM Program ~~are~~ is to optimize members' health status.~~,~~ We achieve this by p~~P~~rovid~~e~~ing members with a sense of well-being and ~~,~~ productivity~~,~~ through ~~and~~ access to quality and ~~,~~ cost effective ~~efficient~~ health care.~~,~~ ~~while~~ ~~Occurring c~~Concurrently, there is ~~activeA~~active~~at the same time actively~~ management of ~~ging~~ 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 health care 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 on ~~f~~ medical necessity.
- Establish the process used to review and approve the provision of medical and behavioral health care 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 (LTSS), and/or the ~~Disease Management/~~Health Education & Disease Management 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~~UM process.

Back to Agenda

- 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 ~~D~~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/disease 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 U~~tilization~~ M~~anagement~~ 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 ~~P~~primary ~~C~~care ~~P~~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 (PMO) 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 Pphysician group is capitated, and responsible for all primary and specialty physician services. The Hhospitals 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 (HMO SNP) a (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).~~

Back to Agenda

Delegation
CalOptima ~~P~~physician groups are delegated for the following clinical and administrative functions:

- UM~~tilization~~ and Case Management
- Claims
- 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 P~~p~~lan and policies and procedures. CalOptima conducts ongoing oversight on a regular basis and performs an annual review of each delegate's UM P~~p~~rogram. 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 to 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.)
- Delegates' ~~'s~~ written UM ~~P~~program ~~D~~description/~~P~~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.

Back to Agenda

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 ~~D~~department, UM Committee (UMC) and/or QIC.
- Annual or more frequent evaluation to determine whether the delegated activities are being carried out according to CalOptima ~~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.

Back to Agenda

At the time of pre-delegation, CalOptima evaluates the compatibility of the delegate's UM ~~P~~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 review ~~s~~

Back to Agenda

ongoing accreditation status and compliance. Oversight for all delegated activities is performed by CalOptima's Audit and Oversight ~~D~~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**~~

~~**1.**~~

~~**Medi-Cal Program**~~

~~**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 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.

Nursing Facility:

- Nursing Facility Services for Long--Term Care Services: –CalOptima utilizes the Department of Health Care Services (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:
    - Nursing Facility Level B, (Long--Term Care)
    - Nursing Facility Level A
    - Subacute Adult and Pediatric

Back to Agenda

- Intermediate Care Facility / Developmentally Disabled, (ICF/DD)
- Intermediate Care Facility / Developmentally Disableds Habilitative, (ICF/DD-H)
- Intermediate Care Facility / Developmentally Disabled Nursing, (ICF/DD-N)

Back to Agenda

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~~CBAS 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 ~~S~~site. The CalOptima MSSP ~~S~~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~~IHSS, 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

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 ~~H~~health 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 Magellan Health Inc. ~~College Health Independent Practice Association CHIPA for utilization~~
~~M~~m~~anagement of the Pprovider Nnetwork,~~. ~~CHIPA sub-contracts and delegates to Beacon Health Strategies, LLC (Beacon) other functions that include credentialing the provider network,~~ managing the CalOptima Behavioral Health Phone ~~the Access Line, and several~~ other ~~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, may include ~~including~~ offering ~~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 delegates to Magellan Health Inc. for utilization management of the provider network, credentialing the provider network, managing the CalOptima Behavioral Health Phone Line, and several other 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 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 Phone Line toll-free at~~:~~ ~~1-~~855-877-3885. ~~A CHIPA / Beacon clinician assesses the level of care needed.~~ If office based services are appropriate, the member is registered in the ~~CHIPA / Beacon~~Magellan system and referrals to an appropriate provider are given to the member. If the member meets criteria for Specialty Mental Health Services, ~~more complex needs are identified,~~ the member is referred to the County ~~for Specialty~~ Mental Health Plan. Specialty Mental Health Services are not the responsibility of CalOptima.

Back to Agenda

~~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.~~

~~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. 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 between the medical and behavioral health practitioners involved.

Back to Agenda

Services Not Provided by CalOptima

Under its Medi-Cal ~~P~~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~~ is 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:
    - Prenatal Diagnostic Evaluation
    - Early Intervention Services, (Birth to 36 months)
    - Therapy Services
    - Respite Care Services
    - Child Care Services
    - Adult Day Program Services, (Employment and Community-Based Activities)
    - Transportation Services

Back to Agenda

- Residential Services
- Psychological, Counseling and Behavioral Services
- Medical and Dental Services
- Equipment and Supplies
- 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 ~~S~~state agencies and specialist care when the benefit coverage of the member dictates. The UM ~~D~~department coordinates activities with the Case Management and/or Disease Management ~~D~~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~~ Magellan ~~Behavioral~~ Health Inc. for the behavioral health services portion of ~~care for the~~ OneCare and OneCare Connect ~~line of business~~. Functions delegated to Magellan include ~~CalOptima is responsible for credentialing the provider network and for grievances and appeals. CalOptima delegates~~ u~~U~~tilization m~~M~~anagement, credentialing, and customer service ~~to MagellanWindstone~~. ~~Evidence based MCG guidelines are utilized in the UM decision making process.~~

CalOptima OneCare and OneCare Connect members access Behavioral Health Services by calling Magellan ~~Windstone~~ at ~~1-~~8~~00~~55-~~577~~877-~~4701~~3885. 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.

CalOptima Direct (COD)

~~CalOptima Direct (COD) is comprised of the following component:~~

CalOptima Direct Administrative (COD–A) is a fee-for-service program administered by CalOptima. Some members are enrolled in COD–A on a permanent basis, and may not be eligible

Back to Agenda

to join a health network because they meet certain COD–A eligibility criteria. Permanent members of COD–A include share of cost members, that are not enrolled in either OneCare or OneCare Connect~~dually eligible beneficiaries~~ (members eligible with both Medicare and Medi-Cal), retro-assigned, and out of Orange

Back to Agenda

County residents. COD–-A also provides benefits to new members transitioning to a health network that are enrolled in CalOptima Direct on a temporary basis.

CalOptima Community Network (CCN)
~~CalOptima Community Network (CN) was open to new members beginning in March of 2015.~~ CalOptima Community Network ~~This~~ (CCN) 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. CCN~~This network~~ is open to participation of any willing and qualified provider. CalOptima already contracts with a variety of providers: PHCs, ~~one~~ HMOs, and ~~many~~ SRGs. With ~~the new launch of Community Network~~CCN, individual providers ~~will now~~ have the option of contracting directly with CalOptima.

Dual Eligible Programs
OneCare
For a complete description of the OneCare program and scope of services, please see the 2017 Quality Improvement Program, pages 5–6.

OneCare members qualify for Medicare by age (turning 65) or by disability (24 months of Social Security Disability Insurance [SSDI], End-Stage Renal Disease [ESRD], or Amyotrophic Lateral Sclerosis [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 ~~S~~state Medicaid include a review of income, assets, and in some cases, medical condition.

Back to Agenda

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, African-American~~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.

Back to Agenda

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. This~~,~~ includes~~ing~~, but is not limited to~~,~~ Meals on Wheels, Dayle MacIntosh Developmental Center, Orange County Social Service Agency, and Orange County Goodwill. It also includes ~~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 Sservices~~
- ~~Vision~~
- ~~Non-Mmedical Ttransportation (benefit decreased for 2015)~~

~~Cal MediConnect (~~OneCare Connect~~)~~

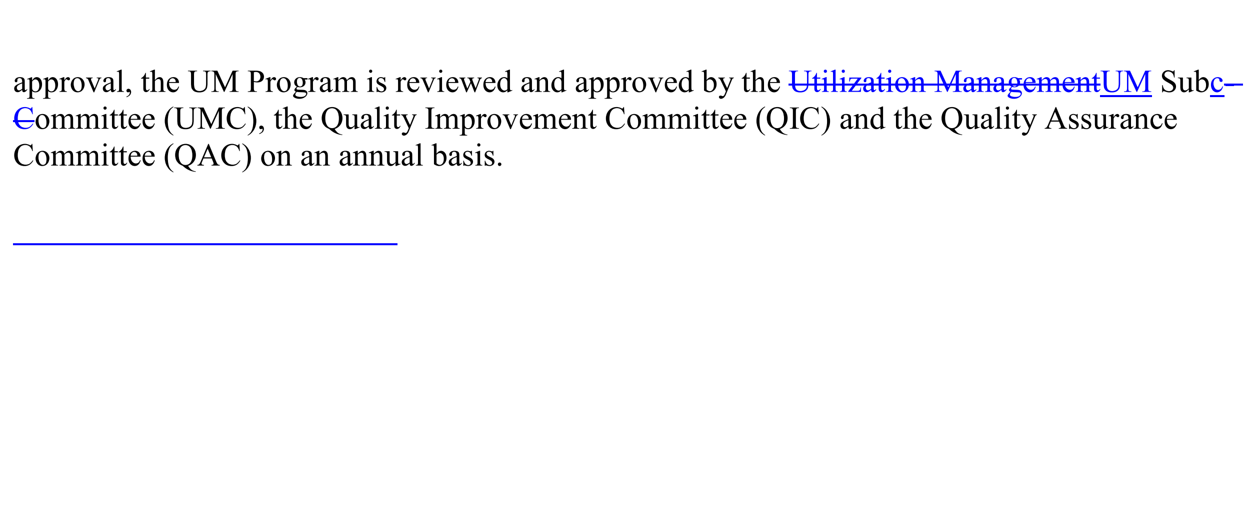
Cal Optima's OneCare Connect (Cal MediConnect) program, is a three ~~(3)~~ year demonstration project ~~in an effort~~ by California and the federal government to begin the process~~,~~ — through a single organized health care delivery system~~,~~ — of integrating the delivery of medical, behavioral health, ~~long term care services and support~~LTSS and ~~community based services~~CBAS 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~~ OneCare Connect is identifying high-risk enrollees who need comprehensive care coordination, and assembling an appropriate care team to develop and track an individualized care plan.

For a complete description of the OneCare Connect program and scope of services, please see the 2017 Quality Improvement Program, pages 6–7.

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~~UM P~~p~~rogram 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~~UM Subc~~-C~~ommittee (UMC), the Quality Improvement Committee (QIC) and the Quality Assurance Committee (QAC) on an annual basis.

Back to Agenda

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 Presiden~~Director~~t~~ of

Back to Agenda

Clinical Operations, and/or any designee as assigned by CalOptima's CEO are the senior executives responsible for implementing the UM P~~p~~rogram 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~~UM 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 health care 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 health care 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 p~~P~~lan members;
- Participates in and provides oversight to the UMC and all other physician committees or s~~S~~ubcommittees;
- 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 ~~P~~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).~~

Back to Agenda

Executive Director of Clinical Operations (ED) is responsible for oversight of all operational aspects of key Medical Affairs functions including: ~~Utilization Management~~UM, 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~~ ED of Clinical Operations 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~~UM 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, as well as monitors documentation for adequacy. In collaboration with the CMO, the Medical Director of ~~Utilization Management~~UM also provides supervisory oversight and administration of the ~~Utilization Management~~UM Program.- ~~, O~~Oversees all clinical decisions rendered for concurrent, prospective and retrospective reviews that support UM medical management decisions, provides clinical education and in-services to staff weekly and on an as needed basis. -Presents key topics on clinical pathways and treatments relating to actual cases being worked in UM, as well as educates on industry trends and community standards in the clinical setting.- ~~, -~~Provides feedback to UM staff on trends identified for over/under utilization, readmissions, one-day stays, and observation initiatives. -Ensures availability to staff either onsite or telephonically during normal business hours and on call after hours. -~~S~~serves on the Utilization and Quality Improvement Committees, serves as the Chair of the ~~Utilization Management Committee~~UMC 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.

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~~UM. In this role, the Medical Director oversees the~~ utilization management~~UM activities of staff that work in concurrent, prospective and retrospective medical management activities, monitors for documentation adequacy, and works with the clinical staff that support~~s~~ the ~~utilization management~~UM process. Ensures availability to staff either onsite or telephonically during normal business hours and on call after hours. -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 health care 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.

Back to Agenda

Medical Director, Senior Programs is a key member of the medical management team and is responsible for the Medi-Medi programs (OneCare and OneCare MediConnect (OneCare)), Managed Long Term Support and ServicesLTSS (MLTSS) programs, and Case Management and Transitions of Care programs. Provides physician leadership

Back to Agenda

~~i~~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~~UM Program, policies, and procedures. Ensures the appropriate use of evidenced-based clinical review criteria/guidelines for medical necessity determinations. The Director of ~~Utilization Management~~UM also provides supervisory oversight and administration of the ~~Utilization Management~~UM 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~~UMC 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 ~~D~~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~~ Services 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~~The Director of Behavioral Health ~~Serivces~~Services is responsible for monitoring, analyzing, and reporting to senior staff on changes in the health care delivery environment and program opportunities affecting or available to assist CalOptima in integrating physical and behavioral health care services. 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, ~~S~~state and ~~F~~federal officials, and representatives of other agencies.

Executive Director of Quality and Analytics 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,

Back to Agenda

~~c~~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~~)~~, Centers for Medicare/Medicaid Services (CMS), and Department of Managed Health Care (DMHC). The Compliance staff works in collaboration with the CalOptima Quality Improvement ~~D~~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~~UM, ~~and~~ Credentialing, and Grievance & Appeals Resolution Services (GARS), 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 ~~S~~state/~~F~~federal requirements, CalOptima policies, and industry best practices. The~~is~~ Director ~~role is to~~ ensures that CalOptima and its subcontracted health networks perform consistently with both CMS and s~~S~~tate requirements for all programs. Specifically, the~~is~~ ~~position~~ Director leads the department in developing audit protocols for all internal and delegated functions to ensure adequate performance relative to both quality and timeliness. Additionally, the Director is ~~R~~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~~ OneCare Connect programs. ~~S/~~The Director 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 & Disease Management is responsible for the development and implementation of ~~Disease Management/~~Health Education and Disease Management programs and determines priorities for health education and member self-care management. The ~~position~~ Director 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~~ Director is also responsible for provider clinical office education for the promotion of quality initiatives.

Back to Agenda

~~Director of Long Term Services and Supports is responsible for LTSS programs which include Community Based Adult Services, (CBAS), In-Home Support 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.~~

Back to Agenda

~~Utilization Management~~UM Resources
The following staff positions provide support for organizational/operational UM ~~D~~department's functions and activities:

Manager, Utilization Manager (Concurrent Review Manager ~~(~~[CCR])~~RN Managers (Referral/Prior Authorization/Retrospective Review and Concurrent Review)~~ manages 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 Manager~~s~~ develops, implements, and maintains processes and strategies to ensure the delivery of quality health care 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 c~~Current and unrestricted Registered Nurse (RN) or Licensed Vocational Nurse (LVN)~~–~~ license in the State of California.
- A Bachelor's degree or relevant experience in a health care field preferred.
- 5 years varied clinical experience required.
- 3~~5-7~~ years managed care experience ~~preferred~~.
- 2-3 years supervisory/management experience in ~~utilization management~~UM activities.

~~Concurrent Review~~ Supervisor, Utilization Management (Concurrent Review)~~RN Supervisor (Concurrent Review)~~ ~~p~~Provides day-to-day supervision of assigned staff, 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~~The Manager is a resource to the CCR ~~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~~.~~ through training and in-servicing activities. Monitor for documentation adequacy including appropriateness of clinical documentation to make a clinical determination, ~~also,~~and audits documentation to assure consistent application of the appropriate clinical guideline to the member's clinical condition. Supervisory staff are available both on-site and telephonically for all UM staff during regular business hours.

Experience & Education

- Current and unrestricted Registered Nurse (RN) or Licensed Vocational Nurse (LVN) license in the State of California.
- A Bachelor's ~~D~~degree or relevant experience in a health care field.
- ~~Current and unrestricted Registered Nurse (RN) or Licensed Vocational Nurse (LVN) license in the State of California.~~
- 3 ~~5 – 7~~ years of managed care experience preferred~~.~~
- Supervisor experience in Managed Care/~~Utilization Management~~UM preferred.

~~Prior Authorization~~ Manager, Utilization Management (Prior Authorization [~~(~~PA]), manages the day-to-day operational activities of the department to ensure staff compliance with company policies

Back to Agenda

and procedures, and regulatory and accreditation agency requirements. The Manager develops, implements and maintains processes and strategies to ensure the delivery of quality health care services to members while establishing and maintaining collaborative working relationships with internal and external resources in order to ensure appropriate support for utilization activities.

Back to Agenda

Back to Agenda

Experience & Education

- Current and unrestricted Registered Nurse (RN) or Licensed Vocational Nurse (LVN) license in the State of California.
- A Bachelor's degree or relevant experience in a health care field preferred.
- 5 years varied clinical experience required.
- 3 years managed care experience.
- 2~~-~~—3 years supervisory/management experience in ~~u~~Utilization ~~m~~Management activities.

~~Prior Authorization~~ Supervisor, Utilization Management ~~RN Supervisor (Referral/Prior/Retrospective Authorization)~~ (PA) ~~P~~provides day-to-day supervision of assigned staff, monitors and oversees ~~the~~assigned daily ~~departmental~~ work activities to ensure that service standards are met.~~,~~ The Supervisor 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 through training and in-servicing activities. ~~-~~Monitors for documentation adequacy including clinical documentation to make a clinical determination also, audits documentation to assure consistent application of the appropriate clinical guideline to the member's clinical condition. -Supervisory staff are available both on-site and telephonically for all UM staff during regular business hours.

Experience & Education

- Current and unrestricted Registered Nurse (RN) license or Licensed Vocational Nurse (LVN) license in the State of California.
- A Bachelor's ~~D~~degree or relevant experience in a health care field preferred.
- ~~Current and unrestricted Registered Nurse (RN) license.~~
- 3 ~~3 – 5~~ years of managed care experience.
- Supervisor and/or Lead experience in Managed Care/~~Utilization Management~~UM preferred.

Notice of Action RN drafts and evaluates denial letters for adequate documentation and utilization of appropriate criteria. -Audits clinical documentation and components of the denial letter to assure denial reasons are free from undefined acronyms, and that all reasons are specific to which particular criteria the member does not meet, assures denial reason is written in plain language that a lay person understands, and is specific to the clinical information presented and criteria referenced.- Works with physician reviewers and nursing staff to clarify criteria and documentation should discrepancies be identified.

Experience & Education

- Current and unrestricted Registered Nurse License (RN) in the State of California
- A Bachelor's d~~D~~egree or relevant experience in a health care field preferred.
- 3 years managed care experience
- Excellent analytical and communication skills required

Back to Agenda

Medical 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 health care services. All potential denial, and/or modifications of p~~P~~rovider 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 Authorization 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 p~~P~~rovider 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 provides high-~~-~~level administrative support to the Director of ~~Utilization Management~~UM, the UM~~RN~~ Managers, Supervisors and the UM Medical Directors.

Experience & Education

- High school diploma or equivalent; a minimum of 2 years of college preferred.
- 2–3 years previous administrative experience 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.~~

Back to Agenda

Pharmacy Department Resources

Director, Clinical 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 ~~S~~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, Clinical Pharmacists 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 health care provided to m~~M~~embers 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~~UM 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

- A current, valid, unrestricted California state Pharmacy License and Pharm.D required.
- 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 Sstate 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 health care provided to m~~M~~embers enrolled in the CalOptima Health Networks and CalOptima Direct. Through various modalities (e.g., provider/plan

profiling, member drug profile reviews, development and updating

Back to Agenda

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~~UM 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, interact ~~s~~ 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

- A current, valid, unrestricted California state Pharmacy License and Pharm.D required.
- ~~Three~~ 3 ~~(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 Sstate 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

- Pharm.D 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~~appropriate regulatory definitions 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~~LTSS Resources

The following staff positions provide support for LTSS operations:

Back to Agenda

~~LTSS Director, (CBAS/IHSS/LTC/MSSP) The~~ Director~~, of~~ Long-~~-~~Term ~~Services and~~ Support sServices (CBAS/IHSS/LTC/MSSP)~~, (LTSS),~~ will develop, manage and implement LTSS,~~the Long Term Care Services and Support~~ including Long-~~-~~Term Care (LTC) facilities, ~~In-Home Supportive Services~~IHSS, ~~Community Based Adult Services~~CBAS and ~~the Multipurpose Senior Services~~MSSP ~~Program~~ and staff associated with those programs. ~~S/~~The Director will be responsible for ensuring high quality and responsive service for CalOptima members residing in ~~Long Term Care~~LTC facilities~~,~~ (all levels of care)~~,~~ and to those members enrolled in other LTSS programs. D~~D~~evelops and~~,~~ evaluates programs and policy initiatives affecting seniors and (SNF/Suba~~A~~cute/ICF/ICF-DD/N/H) and other LTSS services.

Experience & Education

- 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
- 5 – 7 years varied related experience, including five~~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, Long-Term Support Services, RN~~,~~ (CBAS/IHSS/LTC) The Manager is expected to develop and manage the L~~ong Term Services and Supports~~TSS d~~D~~epartment's work activities and personnel. ~~S/~~The Manager 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~~LTSS. The Manager mu~~s~~st~~ch~~ 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. The Manager~~is position~~ will work in conjunction with various department managers and staff to coordinate, develop, and evaluate programs and policy initiatives affecting members receiving LTC~~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 health care 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 health with geriatrics and persons with disabilities.

~~LTSS~~ Supervisor, Long-Term Support Services, 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~~LTSS 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

Back to Agenda

~~i~~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 S~~s~~upervisor will be resolving members and providers issues and barriers ensuring excellent customer service. Additional responsibilities include: m~~M~~anaging 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 B~~b~~achelor's degree or relevant experience in a health care 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~~UM 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~~ Long-Term Support Services ~~LTSS Medical Case Manager,~~ (MCM LTSS) (RN/LVN), ~~is~~ are 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 Bases Adult Services, (~~CBAS~~)~~. They r~~R~~eview~~s~~ and determine~~s~~ medical eligibility based on approved criteria/guidelines, National Committee for Quality Assurance (NCQA) standards, Medicare and Medi-Cal guidelines, and facilitate ~~s~~ communication and coordination amongst all participants of the health care team and the member, to ensure services are provided to promote quality~~,~~ and cost-effective outcomes. The ~~LTSS~~ MCM LTSS provides case management in a collaborative process that includes assessment, planning, implementation, coordination, monitoring and evaluation of the member's needs. The ~~LTSS~~ MCM LTSS is the subject matter expert and acts as a liaison to Orange County base~~d~~s community agencies, CBAS centers, skilled nursing facilities, ~~and to~~ members and providers.

Experience and Education

- A current and unrestricted RN license in the State of California, or a ~~;.~~
- ~~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, CBAS (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 CBAS Program Manager is responsible for the annual CBAS Provider Workshop, CBAS

process

Back to Agenda

improvement, reporting requirements, reviewing~~s~~ monthly files audit, develop~~p~~ing~~s~~ inter-rater reliability questions, performing~~s~~ psychosocial and functional assessments, and serv~~es~~ing as 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~~ responsible for developing strategies and solutions to effectively implement CBAS project deliverables that require collaboration across multiple agencies.

Back to Agenda

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 will involve ~~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
- HIPA~~P~~A 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 are~~is~~ monitored for appropriate application of Review Criteria/Guidelines, processing referrals/service authorizations, and inter-rater reliability. Training -

Back to Agenda

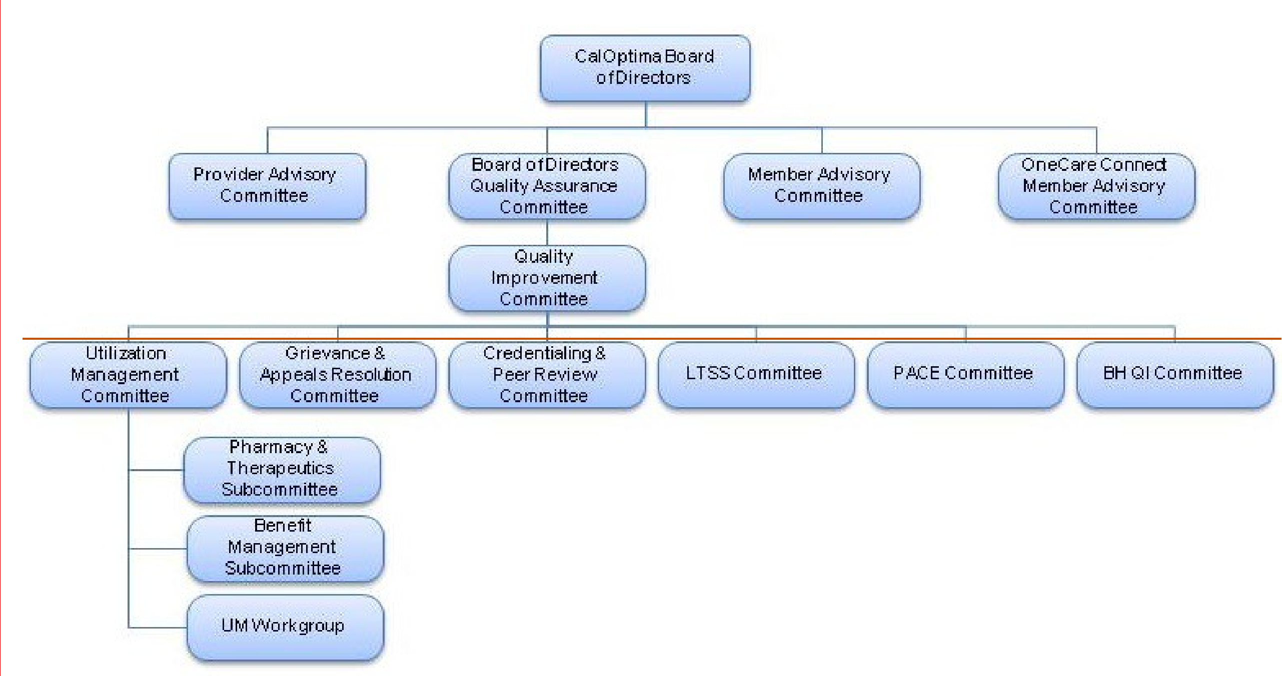
opportunities are addressed immediately as they are identified through regular administration of proficiency evaluations. Any employee who fails the evaluation is provided additional training and provided with a work improvement process. Formal training, including seminars and workshops, are provided to all UM staff on an annual basis.

Appropriately licensed, qualified health professionals supervise the ~~utilization management~~UM 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 health care 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 ~~s~~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.

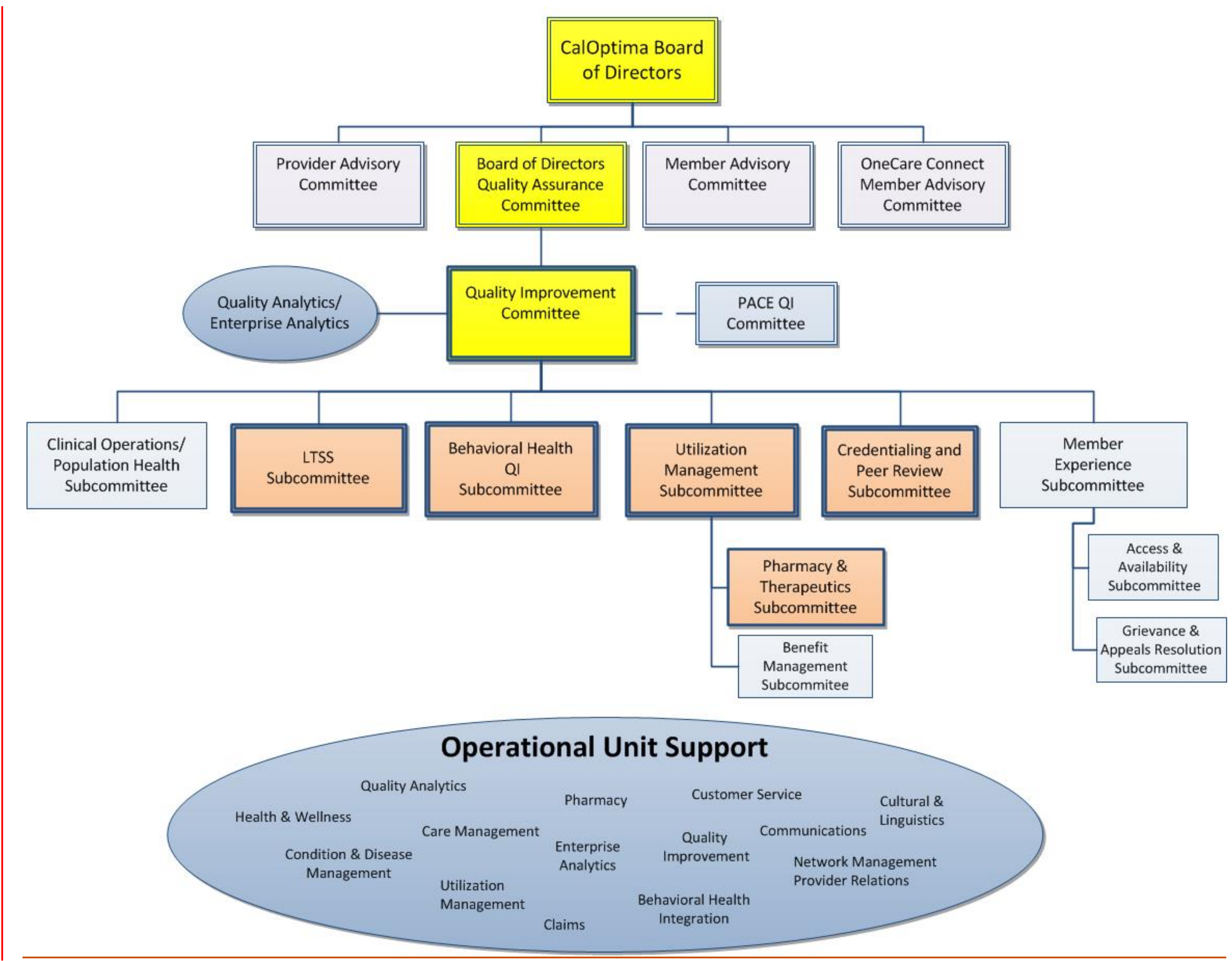
CalOptima and its delegated Utilization Review agents do not permit or provide compensation or anything of value to its employees, agents, or contractors based on:

- 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



Back to Agenda



Back to Agenda

Utilization Management Committee (UMC)

The~~ Utilization Management Committee (~~ UMC~~)~~ is responsible for the review and approval of medical necessity criteria and protocols and ~~utilization management~~UM 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~~UM Program Description, Work Plan and Annual UM Program Evaluation. Before ~~eg~~go~~m~~ing 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 U~~tilization ~~M~~anagement~~ 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 UM~~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~~UMC Scope

- Oversees the UM activities of CalOptima in regard to compliance with contractual requirements, f~~F~~ederal and ~~S~~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 ~~p~~Program, ~~and ~~identify areas for performance improvement, and evaluate performance improvement initiatives;
- 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.

Back to Agenda

~~Utilization Management Committee~~UMC 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 U~~tilization~~ M~~anagement~~ C~~ommittee~~ as appropriate.

Benefit Management Subcommittee (BMSC)

The Benefit Management Subcommittee is a subcommittee of the U~~tilization~~ M~~anagement~~ C~~ommittee~~. The BMSC was chartered by the UMC and~~,~~ 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), Medi-C~~c~~al Managed Care Division (MMCD) All Plan Letters (APLs), and the Medi-Cal Manual.

Back to Agenda

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, Healthy Education & 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.

Back to Agenda

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~~ integration 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 members and providers;~~,~~
- ~~and~~ I~~i~~dentifying 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, and clinical practice guidelines, and complies with regulatory and accrediting agency standards
- Ensure that m~~M~~ember benefits and services are not underutilized and that assessment and appropriate interventions are taken to identify inappropriate over utilization
- Utilize m~~M~~ember 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.

~~Long Term Services and Supports~~LTSS Quality Improvement Subcommittee (LTSS QISC)

In 2014, the ~~Long Term Services and Supports~~LTSS Q~~-~~I~~mprovement~~ SC~~ub~~~~Committee~~ replaced the Long-Term Care ~~Quality Improvement Subcommittee~~QIS. 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.

Back to Agenda

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 ~~M~~members who resides in long--term care facilities and those who receive Home- and Community Based Services (HCBS).

Back to Agenda

The LTSS QISC Responsibilities:

- Identify barriers to keeping m~~M~~embers safe in their own homes or in the community, develop solutions, make appropriate recommendations to improve discharge planning process and prevent ~~ing~~ 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, quali~~t~~fy of services~~,~~ and 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 ~~C~~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~~OC SSA, Deputy Director or Designee
  - ~~Multipurpose Senior Services Program~~MSSP, 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
  - ~~LTSS~~ Director, LTSS
- The LTSS QISC meets quarterly at a minimum or more frequently as needed.
- The LTSS Activity Summary will be reported to QIC and 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;
  - Member~~s~~ 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

Back to Agenda

- 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, and denials rates;
    - ~~Long Term Care (~~LTC~~)~~ ~~S~~statistics include, but is not limited to, bed type, turn-around time, and denials rate;
    - ~~Multipurpose Senior Services Program (~~MSSP~~)~~ statistics such as total number of participants, total number of termination, number of ER visits, average length of stay (ALOS), and skilled nursing facility (SNF) admissions.
    - LTSS Inter-Rater Reliability study result;
    - Rate Adjustments for LTC facilities

Integration with the Quality Improvement Program

The UM Program and Work ~~p~~Plan are evaluated and submitted for review and approval annually by both the CalOptima ~~Utilization Management Committee~~ UMC 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~~UMC 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~~QIC reports to the Board ~~Quality Assurance Committee~~QAC.
- The ~~Utilization Management Committee~~UMC is a sub-committee of the ~~Quality Improvement Committee (~~QI~~C~~) and routinely reports activities to the QIC.

Conflict of Interest

CalOptima maintains a Conflict of Interest policy that addresses the process to identify and evaluate potential social, economic and professional conflicts of interest and take appropriate actions so that they do not compromise or bias professional judgment and objectivity in quality, credentialing and peer review matters. 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 who make or participate in the making of decisions that may foreseeably have a material effect on economic interests, file a Statement of Economic Interests form on an annual basis.

Fiscal and clinical interests are separated. CalOptima and its delegates do not provide any financial rewards or incentives to practitioners or other individuals conducting utilization review for issuing denials of coverage, services or care.

~~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~~

Back to Agenda

~~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 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 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 QI-C~~ommittee~~ 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 ~~is are~~ maintained in confidential files. The HMOs, PHCs, SRGs, Managed Behavioral Health Organizations (MBHOs) and PMGs hold all information in the strictest confidence. Members of the QI-C~~ommittee~~ 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 QI reports required by law or by the State Contract.

Integration with Other Processes

The UM Program, Case Management Program, Behavioral Health Program, Managed ~~Long Term Support and Services~~LTSS 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~~UM, 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 d~~D~~epartment in the format prescribed by CalOptima for review and resolution as needed. The CMO or Medical Director determines if the

Back to Agenda

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 U~~tilization~~ M~~anagement~~ ~~D~~department works closely with the Compliance Officer and the 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~~UM Process

The ~~utilization management~~UM 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 D~~epartment of~~ H~~ealth~~ ~~Care~~ S~~ervices~~ (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 ~~D~~department via its delegation oversight team for compliance.

~~Utilization Management~~UM Program Structure

The UM Program is designed to work collaboratively with delegated entities, including but not limited to, physicians, hospitals, health care delivery organizations, and ancillary service providers in the community in an effort to assure that the member receives appropriate, cost efficient, quality-based health care.

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~~ UM Work Plan is based on the findings of the annual program Work ~~p~~Plan 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.

Back to Agenda

The ~~O~~organization ~~C~~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~~UM 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~~UM Program and W~~w~~ork ~~p~~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 ~~w~~Work ~~p~~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~~non-emergency 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~~ the ~~p~~Prior ~~a~~Authorization ~~l~~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.

CalOptima's ~~A new~~ medical management system, Altruista/GuidingCare is a~~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.

The~~In April 2012,~~ CalOptima Link ~~launched. The~~ system~~s~~ 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 2015.~~ Practitioners also send referrals and requests to the

Back to Agenda

~~Utilization Management~~UM ~~D~~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~~)~~s 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~~non-emergency 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 p~~P~~rovider newsletter and/or CalOptima website.

The CalOptima ~~Pharmacy and Therapeutics~~ P&T 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 ~~D~~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's Pharmacy Management ~~D~~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 pre-service or urgent concurrent denials.

Back to Agenda

- 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/OneCare Connect

CalOptima does not delegate Pharmacy UM responsibilities. Pharmacy coverage determinations follow ~~the appropriate UM~~required CMS timeliness guidelines ~~for~~ and medical necessity review criteria.

~~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 Formularies~~y~~ ~~was~~ were created to offer a core list of preferred medications to all practitioners. ~~Occasionally it is necessary to address requests from local~~Local providers may make requests 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. The CalOptima Formularies~~y~~ are~~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 PBM~~s~~ is monitored according to the Audit and Oversight department's policies and procedures.

~~The following edit checks are completed in the PBM claims system on-line, real-time, as a prescription is being dispensed:~~

Back to Agenda

- 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

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 for Medi-Cal, as well as OneCare and OneCare Connect. Medically necessary means services or supplies that: are appropriate 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 health care 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 ManagementUM 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~~UM ~~D~~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 retrospective 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~~UM Medical Director to determine an appropriate course of action, GG.1508, Authorization and Processing of Referrals;
- Reasons for decisions are clearly documented in the medical management system;
- Notification to ~~M~~members regarding denied, deferred, or modified referrals is made in accordance with mandated regulatory and accreditation agency time frames, 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~~GARS 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 ~~ten (10)~~~~five~~

- ~~(10~~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.

Back to Agenda

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~~UMC 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' 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~~UM 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.

Back to Agenda

Authorization Review Roles				
Authorization Type*	**Criteria Utilized**	**Medical Assistant**	**Nurse**	**Medical Director / Physician Reviewer**
Chemotherapy	MCG / Medi-Cal and Medicare Manuals / CalOptima Pharmacy Authorization Guidelines		X	X
DME (Custom & Standard)	MCG / Medi-Cal and Medicare Manuals		X	X
Diagnostics	MCG / Medi-Cal and Medicare Manuals		X	X
Dialysis	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	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	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	MCG / Medi-Cal and Medicare Manuals	X	X	X
Office Visits (Follow-up)	MCG / Medi-Cal and Medicare Manuals	X	X	X
Orthotics	MCG / Medi-Cal and Medicare Manuals		X	X
Pharmaceuticals	CalOptima Pharmacy Authorization Guidelines	Pharmacy Technician		Pharmacists Physician Reviewer
Procedures	MCG / Medi-Cal and Medicare Manuals		X	X
Prosthetics	MCG / Medi-Cal and Medicare Manuals		X	X
Radiation Oncology	MCG / Medi-Cal and Medicare Manuals		X	X
Therapies (OT/PT/ST)	MCG / Medi-Cal and Medicare Manuals	RCOC Referrals	X	X
Transplants	DHCS Guidelines	Referral	X	X
Administrative Denial	CalOptima Policy	X	X	
Medical Necessity Denial	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

Back to Agenda

Reviewer for review and determination.

Back to Agenda

Long-Term Services and Supports

Authorization Type*	Criteria Utilized	Medical Assistant	Nurse	Medical Director / Physician Reviewer
Community Based Adult Services (CBAS)	DHCS CBAS Eligibility Determination Tool (CEDT)		X	X
Long-Term Care: Nursing Facility B Level	Medi-Cal Criteria Manual Chapter 7: Criteria for Long-Term Care Services / Title 22, CCR, Section 51335		X	X
Long-Term Care: Nursing Facility A Level	Medi-Cal Criteria Manual Chapter 7: Criteria for Long-Term Care Services / Title 22, CCR, Section 51334		X	X
Long-Term Care: Subacute	Medi-Cal Criteria Manual Chapter 7: Criteria for Long-Term Care Services / Title 22, CCR, Sections 51003 and 51303		X	X
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	X DDS or DMH Certified	X	X
Hospice Services	Medi-Cal Criteria Manual Chapter 11: Criteria for Hospice Care / Title 22, California Code of Regulations	X	X	X

*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)~~Magellan~~ Health Inc.~~ ensures there are p~~P~~eer r~~R~~eviewers/c~~C~~linical c~~C~~onsultants. Peer ~~R~~reviewers are behavioral health professionals who are qualified, as determined by Magellan~~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~~P&T 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 ~~M~~members in accordance with policy GG.1534.

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~~P&T 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;
- MCG — Evidence-based nationally recognized criteria;
- National Comprehensive Cancer Network (NCCN) Guidelines;
- Centers of Excellence ~~g~~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 l~~L~~ocal (s~~S~~tate) Determination Guidelines.

Back to Agenda

- National Guideline Clearinghouse
- Medicare Part D: CMS-approved Compendia

Back to Agenda

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~~UM ~~D~~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~~UM ~~D~~department. The manual also outlines CalOptima's ~~Utilization Management~~UM policies and procedures. Similar information is found in the Member Handbook and on the CalOptima website at ~~www.caloptima.org.~~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~~UM leadership takes corrective action. New UM staff is required to successfully complete inter-rater reliability testing prior to being released from training oversight.

Provider/Member 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 toll free at ~~1-~~**800-735-2929**. The phone numbers for these are included in the ~~m~~Member ~~h~~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 ~~D~~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

Back to Agenda

response by CalOptima or notifies CalOptima on-call nurse in cases requiring immediate response. A log is forwarded to the UM ~~D~~department daily identifying those issues that need follow-up by the UM staff the following day.

Back to Agenda

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 ~~P~~provider ~~N~~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~~UM 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~~UM 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 health care 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.

Back to Agenda

Timeliness of UM Decisions

~~Utilization management~~UM 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 Connect~~ ~~OneCare (Medicare)~~

Medi-Cal and OneCare Connect (Medi-Cal)	OneCare (Medicare) and OneCare Connect (Medicare)
Medical ~~and Pharmaceutical -~~-Decision Making	Medical ~~and Pharmaceutical~~ - Decision Making
• Processed by CalOptima ~~Utilization Management~~UM ~~D~~department for members in direct or non-delegated network • Processed by ~~Utilization Management~~UM ~~D~~department at the ~~Physician Medical Groups~~PMGs • Qualified physician review for any modifications or denials • Qualified pharmacist review for any modifications or~~f~~ denials	• Processed by ~~Utilization Management~~UM ~~D~~department at the Physician Medical Groups • Processed by Case Management ~~D~~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

Back to Agenda

<table>
<tr>
<td>Timeframes for Determinations:
• Routine 5 business days
• Urgent 72 hours
• Retrospective 30 days

Timeframes for Notification:
Authorization Request Type:
Routine (Non-Urgent) Pre-
Service: (Oral or Electronic)
Provider: Initial within 24 hours of the decision
Member: None specified
Provider: Within 2 working days of making the decision
Member: Within 2 working days of making the decision not to exceed 14 calendar days from the receipt of the request.

Routine (Non-Urgent): Pre-Service Extension Needed:
Provider: Within 24 hours of making the</td>
<td>Timeframes for Determinations (non-Part B): Routine 14 calendar days
• Urgent 72 hours
• Retrospective 30 days
~~Timeframes for Determinations (Part D):~~
~~• Routine: 72 hours~~
~~• Urgent: 24 hours~~
~~• Retrospective: 14 days~~

Timeframes for Notification (non-Part D)
Authorization Request Type:
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.

For standard determinations the member must be notified of the decision no later than 14 days after receipt of the request.</td>
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Back to Agenda

decision. Member: None specified Written Notification of Denial or Modification: Provider: Within 2 working days of making the decision Member: Within 14 calendar of making the decision, not to exceed 28 calendar days from receipt of the request Expedited Authorization (Pre-Service): (Oral or Electronic) Provider: Within 24 hours of making the decision Member: None specified Written Notification of Denial or Modification: Provider: Within 2 working days of making the decision. Member: Within 2 working days of making the decision. Expedited Authorization (Pre-Service) – Extension Needed: (Oral or Electronic) Provider: Within 24 hours of making the decision Member: None specified Written Notification of Denial or Modification: Provider: Within 2 working days of making the decision Member: Within 2~~w~~ working days of making the decision. Concurrent: (Oral or Electronic) Practitioner: Within 24 hours of making the decision (for approvals and denials). Member: None Specified Written Notification of Denial or Modification: Provider: Within 2 working days of making the decision. Member: Within 2 working days of making the	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.

Back to Agenda

Pharmaceutical - Timeframes for Notification (Part D)
Authorization Request Type:
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.
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.
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.

Back to Agenda

decision. 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. Post Service – Retrospective Review: (Oral or Electronic) Member and Provider: None specified Written Notification of Denial or Modification: Provider and Member: Within 30 calendar days of receipt of request. Post- Service – Extension Needed: (Oral or Electronic) Provider and Member: None specified Written Notification of Denial or Modification: Provider and Member: Within 30 calendar days of receipt of the information necessary to make the determination	
Denial Letter/Member Notification State mandated "Notice of Action"	Denial Letter/Member Notification CMS mandated "Medicare Notice of Non-Coverage" including specific language for expedited appeal for expedited initial organization determination

Back to Agenda

Medi-Cal and OneCare Connect (Medi-Cal)	OneCare (Medicare) and OneCare Connect (Medicare)
Pharmaceutical - Decision Making	Pharmaceutical - Decision Making
• Processed by CalOptima Pharmacy Management ~~D~~department or Pharmacy Benefits Manager • Qualified physician review for any modifications or denials • Qualified pharmacist review for any modifications or denials • Qualified physician review for any appeal denials	• Processed by Pharmacy Management ~~D~~department at CalOptima • Qualified physician review for any appeals
Timeframes for Determinations: • Response (approval, Deferral, Denial) within 24 hours or next business day of receiving the request. • Approvals or Denials • Routine 5 business days • Urgent 72 hours • Retrospective 30 days Timeframes for Notification: Authorization Request Type: Routine (Non-Urgent) Pre-Service: (Oral or Electronic) Provider: Initial within 24 hours of the decision Member: None specified Provider: Within 2 working days of making the decision Member: Within 2 working days of making the decision not to exceed 14 calendar days from the receipt of the request. Routine (Non-Urgent): Pre-Service Extension Needed: Provider: Within 24 hours of making the	Timeframes for Determinations (Part D): • Routine: 72 hours • Urgent: 24 hours • Retrospective: 14 days Pharmaceutical – Timeframes for Notification (Part D) Authorization Request Type: 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. 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. 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

Back to Agenda

decision. Member: None specified Written Notification of Denial or Modification: Provider: Within 2 working days of making the decision Member: Within 14 calendar of making the decision, not to exceed 28 calendar days from receipt of the request Expedited Authorization (Pre-Service): (Oral or Electronic) Provider: Within 24 hours of making the decision Member: None specified Written Notification of Denial or Modification: Provider: Within 2 working days of making the decision. Member: Within 2 working days of making the decision. 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. Post Service – Retrospective Review: (Oral or Electronic) Member and Provider: None specified Written Notification of Denial or Modification: Provider and Member: Within 30 calendar days of receipt of request. Post- Service – Extension Needed: (Oral or Electronic) Provider and Member: None specified Written Notification of Denial or Modification: Provider and Member: Within 30 calendar days of receipt of the information necessary to make the determination	notification must be provided within 3 calendar days of the oral notification.

Back to Agenda

Denial Letter/Member Notification State mandated “Notice of Action”	Denial Letter/Member Notification CMS mandated “Medicare Notice of Non-Coverage” including specific language for expedited appeal for expedited initial organization determination

Back to Agenda

UM 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.

UM Routine/Standard Prior Authorization Services

CalOptima makes determinations for standard, non-urgent, pre-service prior authorization requests within five (5) business 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

~~w~~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 Phone Line

CalOptima has a twenty-four hour, seven days per week NCQA accredited Nurse Advice Phone Line
accessible to all lines of business. 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.

A b~~B~~ilingual staff~~s~~ 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 Nurse Advi~~s~~ce Phone Line also helps support CalOptima member's comprehensive needs by cross referring members to existing programs such as case or disease management, Per~~e~~inatal~~-Natal~~ Support Services, ~~In Home Support Services~~IHSS, ~~Multipurpose Senior Services~~MSSP, Health Education, and local resources available in the community.

Back to Agenda

Emergency Services
Emergency room services are available 24 hours/day, 7 days/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~~ and 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

Back to Agenda

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 time frames, except as related to any claim filing time frames. 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~~UM Medical Director, a Notice of Action (NOA) letter is issued immediately by fax or via overnight ~~C~~certified ~~M~~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~~QI ~~D~~department for investigation and resolution.

Back to Agenda

Hospitalist/SNFist Program

The goal of the Hospitalist/SNFist Program is for early identification and management of members, either in the Emergency Room or ~~I~~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 ~~H~~hospitalists
- Face sheet and/or telephonic notification to CalOptima
- Care Plan development and implementation
- Discharge Planning

Back to Agenda

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;
-

Back to Agenda

- 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 UM~~tilization~~ 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 a 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 time frames 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 time frames 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. A CalOptima Medical Director or appropriate practitioner reviewer (behavioral health practitioner, pharmacist, etc.) serves as the point of contact for 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~~UM Appeals Process
CalOptima has a comprehensive review system to address matters when Medi-Cal, ~~or~~ OneCare or OneCare Connect
members wish to exercise their right to review of a ~~utilization management~~UM 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 ~~A~~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 ~~D~~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:~~-~~

1. ~~h~~Health care acquired conditions (HCAC~~),)1). Those~~ occurring in inpatient acute care hospitals, and~~ 2)~~
2. ~~1.~~Other ~~P~~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~~QI ~~Division~~department 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

Back to Agenda

programs are implemented.

Back to Agenda

~~Community Based Adult Services (~~CBAS~~)~~
An outpatient, facility based program offering day time 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 the center.

~~Multipurpose Senior Services Program (~~MSSP~~)~~
CalOptima has 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~~)~~
CalOptima is responsible for 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 determin~~determines~~ation of~~ eligibility under the program. It ~~as well as~~also determines the number of hours that an individual can ~~will be~~ receiv~~e~~ing services. Under an MOU with the county, CalOptima ~~will be~~ works~~ing~~ 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~~UM~~,~~ 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, UM~~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 ~~D~~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.

Back to Agenda

Back to Agenda

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~~UM activities.

Case Managers are licensed ~~N~~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 ~~D~~department;
- Assessing the outcomes of case management and presenting findings to the Medical Director

Back to Agenda

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 201~~6~~7 Case Management Program document.

Transplant Program

The CalOptima ~~t~~Transplant ~~p~~Program is coordinated by CalOptima's ~~m~~Medical ~~d~~Director and managed
by the Case Management ~~D~~department's collaboration. Transplants are 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 ~~D~~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 ~~t~~Transplant ~~p~~Program benefits the member, the community of transplant staff, and the facilities. CalOptima monitors and maintains oversight of the ~~t~~Transplant ~~p~~Program, and reports to the UM-C~~ommittee~~ to oversee the accessibility, timeliness and quality of the transplant process across networks.

Coordination of Care

Coordination of services and benefits is a key function of C~~c~~ase ~~m~~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 ~~D~~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~~DM is a multidisciplinary, continuum-based approach to health care delivery that proactively identifies populations with, or at risk for, chronic medical conditions. CalOptima's ~~Disease Management~~DM Program is a system of coordinated health care 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 health care professional, and require an extended series of interactions, including a strong educational element. CalOptima's DM~~disease management~~ ~~p~~Programs emphasize prevention and members are expected to play an active role in managing their diseases.

~~Disease Management~~DM Process

CalOptima's DM ~~p~~Programs are disease specific and evaluated for relevance to CalOptima's membership demographics and utilization patterns. DM ~~p~~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 ~~p~~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 ~~c~~Complex ~~c~~Case M~~m~~anagement ~~p~~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 C~~c~~omplex ~~c~~Case ~~m~~Management and ~~disease management~~DM ~~p~~Programs are
measured on, at a minimum, an annual basis. Methods of evaluation include condition specific indicators (e.g. Healthcare Effectiveness Data and Information Set [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 ~~p~~Program evaluation.

Over-/~~U~~under ~~U~~utilization monitoring is tracked by UM and reported to UMC. -Measures are monitored and reviewed for over and under utilization changes in trends. -Actions are determined based on trends identified and evaluated for effectiveness.

The following are measures tracked and monitored for over/under utilization trends:

- ~~Emergency Room~~ER admissions ~~(ER)~~
- Bed Days
- Admits per 1000
- ~~Average Length of Stay (~~ALOS~~)~~
- Readmission Rates
- Used/Unused Authorizations
- Inter-rater Reliability- for all licensed staff utilizing clinical review criteria
- Grievances — - Member per 1000 per Year
- Appeals — - Member per 1000 per Year
- Overturn Rates — - Provider per 1000 per Year
- Satisfaction with Primary Care Access
- Provider Satisfaction
- Member Satisfaction
- HEDIS/Consumer Assessment of Healthcare Providers and Systems (CAHPS)

Back to Agenda

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). T~~he Center for Medicare and Medicaid Services (~~CMS~~)~~ contracts with a Quality Improvement Organizations (QIO) to conduct the reviews. OneCare is notified when a requests 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 ~~p~~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~~GARS 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~~QI ~~D~~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.

2017
UTILIZATION MANAGEMENT WORKPLAN & EVALUATION

Medi-Cal
OneCare
OneCare Connect

Back to Agenda

2017
UTILIZATION MANAGEMENT WORKPLAN & EVALUATION
Medi-Cal, OneCare & OneCare Connect

SIGNATURE PAGE

INITIAL WORKPLAN AND APPROVAL:

Submitted and approved by UMC **Date:** ________________

Submitted and approved by Board of Directors' Quality Assurance Committee (QAC) **Date:** ________________

Submitted and approved by Board of Directors **Date:** ________________

______________________________ ______________

Francesco Federico, MD **Date**
Utilization Management Committee Chairperson

______________________________ ______________

Paul Yost, MD **Date**
Board of Directors' Quality Assurance Committee Chairperson

______________________________ ______________

Paul Yost, MD **Date**
Board of Directors' Chair

2017
UTILIZATION MANAGEMENT
WORKPLAN & EVALUATION
Medi-Cal, OneCare & OneCare Connect

SIGNATURE PAGE

FINAL EVALUATION APPROVAL:

Submitted and approved by UMC **Date:** ________________

Submitted and approved by Board **Date:** ________________

Submitted and approved by Board of Directors **Date:** ________________

Quality Assurance Committee (QAC)

Utilization Management Committee Chairperson:

_____________________________ ________________

Francesco Federico, MD **Date**

Board of Directors' Quality Assurance Committee Chairperson:

_____________________________ ________________

Paul Yost, MD **Date**

Table of Contents

I. Projects and Initiatives

A. Utilization Management (UM) Medical Management — Owner: Debra Armas

1. **Goals**
   a. CalOptima Independence Release (COID) – testing and implementation
   b. Thunderhead letter module – testing and implementation
   c. Align Notice of Action (NOA) team with Audit and Oversight for letter compliancy
   d. UM reports - revaluate

2. **Strategic**
   a. UM
      - Altruista, (Guiding Care) - COID
      - Cerecons – user enhancements
      - Prior Authorization – separate OneCare Connect Team
      - Concurrent Review – separate OneCare Connect Team
      - Notice of Action – compliancy alignment

3. **Metrics Defined**
   a. UM Metrics - demonstrate overall compliancy within regulatory requirements
   b. New GC version and letter module will have a positive effect on productivity
   c. NOA audits with A&O will be aligned with good collaboration

B. Behavioral Health (BH) Integration — Owner: Donald Sharps

1. **Goals**
   a. Appropriate utilization of behavioral health services including psychiatrist office visit, ABA, psychotherapy, and psychological testing for Medi-Cal Program
   b. Appropriate utilization of behavioral health services including psychiatric inpatient hospitalization, partial hospitalization, psychiatrist office visit, psychotherapy, and psychological testing for OneCare and OneCare Connect programs
   c. Improve the coordination of services between CalOptima and County Mental Health Plan

2. **Strategic**
   a. BHI will monitor and analyze prior authorization, encounter, and claim data to identify trends and utilization patterns. Benchmarks will be established to assess the Managed Behavioral Health Organization (MBHO) performance. Any potential under/over utilization will be addressed appropriately
   b. Maintain a close partnership with Orange County Health Care Agency and its affiliated programs to ensure timely and appropriate referrals to specialty mental health services, Drug Medi-Cal, or other County level of care services
   c. BH will utilize 2016 yearly average utilization data as baseline for compare to new capitated services
   d. The utilization of outpatient behavioral health services will be tracked by encounter data (i.e. office visit) PTMPY. Inpatient psychiatric hospitalization will be tracked by admission and bed days PTMPY. Metrics for ABA will include weekly hours per utilizing member by age group, and prior authorization data (approval, denial and modification). MBHO will track the number of members that are referred to county level of care services as part of its monthly call center metrics. All metrics will be reported to UMC on a quarterly basis and summarized in an annual evaluation.

3. **Metrics Defined**
    a. Outpatient behavioral health services encounter data for BH Medi-Cal, Medi-Cal ABA, and OneCare Connect
    b. Inpatient encounter data BH OneCare Connect

C. UM Data Management — Owner: Francesco Federico

1. **Goals**
    a. Medical Management UM Data Management will develop standardized dynamic / static UM reports utilizing Enterprise Analytics resources
    b. UM patterns - understanding patterns / trends using analytics resource tools
    c. Strategies (Strategic) to affect UM outcomes
    d. Monitoring of UM metrics

2. **Strategic**
    a. Continued refinement of analytic tools (Data Mart)
    b. Continued collaboration development of select, standard, periodic reporting
    c. Assistance in development of critical metrics and benchmarks
    d. Maintenance of UM Dashboard

3. **Metrics Defined**
    a. Standard reporting (Quarterly)
    b. Data Mart continued use
    c. Technology Integration (Altruista)

II. Operation Performance

A. Authorization (PA) for Expedited/Urgent/Routine/Retro — Owner: Debra Armas

1. **Goals**
    a. Efficient prior authorization process
    b. Maintain compliance (contractual, regulatory, quality)

2. **Strategic**
    a. Prior authorization oversight
    b. Inter-Rater Reliability

3. **Metrics Defined**
    a. Regulatory requirements
        - Timeliness
        - Classification
        - Member language preference
        - Member notice
        - Provider notice
    b. Clinical decision-making assessments
    c. Medical necessity criteria compliance
    d. Inter-Rater Reliability test scores

B. Denial Letter Process (LTC TAT in development) — Owner: Debra Armas

Back to Agenda

1. **Goals**
    a. Regulatory compliance.

2. **Strategic**
    a. Denial process oversight.

3. **Metrics Defined**
    a. Regulatory compliance

C. Inter-Rater Reliability (IRR), for Physicians, Nurses, Pharmacy Evaluation for Applying MCG Medical Necessity Review Criteria – UM, Pharmacy and LTSS — Owner: Debra Armas

1. **Goals**
    a. Licensed staff who perform medical necessity review utilizing MCG criteria will demonstrate a 90% pass rate for the IRR

2. **Strategic**
    a. MCG case review
    b. Annual internal evaluation

3. **Metrics Defined**
    a. Evaluate and determine an action plan for outliers with LTC turnaround times
    b. Evaluate and determine an action plan for outliers with CBAS turnaround times

III. Utilization Performance - Ambulatory

A. Delegated Provider Group (PMG) Oversight – Over/Under Utilization and Utilization Trends — Owner: Debra Armas

1. **Goals**
    a. Report over/under utilization trends identified through PMG oversight monitoring
    b. Regulatory, PMG and CalOptima compliance

2. **Strategic**
    a. Data collection, monitoring, analysis and reporting of PMGs utilization trends
    b. Data collection, monitoring, analysis and reporting of PMG organizational determinations, (OD)/Denial trends

3. **Metrics Defined**
    a. Plan of action to be taken for outliers identified
    b. Outcomes for action plan placed

B. CCN – Over/Under Utilization and Utilization Trends — Owner: Francesco Federico

1. **Goals**
    a. Report over/under utilization trends identified by the prior authorization process
    b. Report over/under utilization trends identified by the inpatient authorization process
    c. Regulatory and CalOptima compliance

2. **Strategic**
    a. Data collection, monitoring, analysis and reporting of utilization trends identified
    b. Data collection, monitoring, analysis and reporting of OD/Denial trends

3. **Metrics Defined**
    a. Turnaround time tracking and trending

Back to Agenda

- Expedited
- Routine 4-5 days
- Urgent 36 – 48 hrs
- Retro

b. Plan of action to be taken for outliers identified
c. Outcomes for action plan placed

C. Pharmacy Utilization Trends — Owner: Kris Gericke

1. **Goals**
   a. Efficient pharmacy department prior authorization process
   b. Maintain compliance (contractual, regulatory, quality)

2. **Strategic**
   a. Prior authorization process oversight
      - Regulatory compliance
      - PBM delegation
      - Inter-rater reliability

3. **Metrics Defined**
   a. Regulatory requirements
      - Timeliness
      - Classification
      - Member language preference
      - Member notice
      - Provider notice
   b. Clinical decision making assessments
   c. PBM criteria compliance
   d. Inter-rater test scores

D. LTSS (CBAS, LTC) applies to CBAS only (LTC TAT in development) — Owner: Marsha Petersen

1. **Goals**
   a. Regulatory/CalOptima compliance

2. **Strategic**
   a. Data collection, monitoring, analysis and reporting of LTC turnaround time report
   b. Data collection, monitoring, analysis and reporting of Community Based Adult Services (CBAS) turnaround time report

3. **Metrics Defined**
   a. Evaluate and determine an action plan for outliers with LTC turnaround times
   b. Evaluate and determine an action plan for outliers with CBAS turnaround times

IV. Utilization Performance
Facility / Inpatient

A. Facility Utilization — Owner: Francesco Federico

i. Facility (Acute, Post Acute)

1. **Goals**
    a. To improve facility utilization
    b. To promote healthcare value ((Q + S)/C)
    c. To improve quality (provider satisfaction, member experience)

2. **Strategic**
    a. Data Generation (quarterly, yearly) by CalOptima, by Comparative (CA state, CalOptima Networks, CCN)
    b. Utilization of concurrent review process (CCR)
        - Evidence based authorization decision making using MCG guidelines
        - Collaboration with case management at facilities, and with CalOptima for complex care patients
        - Hospitalist program promotion including collaboration with / use of contracted hospitalists,, monitoring the acceptance of hospitalist use in our hospital network
        - Enhance data collection from hospitals by fax, by e-mail, by access to hospital electronic records (select facilities) both onsite by CalOptima nurses (select facilities) and offsite by CalOptima nurses
        - Promotion of appropriate medical director to physician, peer to peer communication
        - Promotion of concurrent review medical management collaboration, communication, education
    c. Utilization of care management (CM) resources
    d. Focused UM attention - 1 day admits, readmissions, etc.

3. **Metrics Defined**
    a. Standard facility UM metrics such as admits/1000, bed days/1000, ALOS, ER visits, re-admissions
    b. DATA by LOB, by Comparative: Health Networks vs CCN
    c. CalOptima contracted hospitalist use by facility providers

ii. LTSS Facility UM — Owner: Marsha Petersen

1. **Goals**
    a. To develop a Long Term Care (LTC) strategy that will:
        - Improve utilization of ER visits, readmissions
        - Increase member satisfaction
        - Increase HEDIS scores

2. **Strategic**
    a. Utilize LTSS department resources

3. **Metrics Defined**
    a. Facility UM metrics (admits/1000, bed days/1000, ALOS, ED visits)
    b. Other metrics (hospitalization, nursing home admissions, hospital re-admissions)

B. Emergency Department (ED) Utilization — Owner: Himmet Dajee

1. **Goals**
    a. To achieve appropriate ER utilization by members by providers

2. **Strategic**
    a. 24 hr on call health line (nurse)
    b. Education of members and providers regarding appropriate ER use
    c. Model of care designed to proactively deal with complex care patients
    d. High utilizer tracking, referral to CM
    e. Provider access assurance by monitoring office times, communication, on call
    f. Urgent care promotion: location, services, differences in wait times, differences in services
    g. UM data tracking by network (delegated vs. CCN), by provider

h. Focus on excess use by providers (corrected for acuity, insurance class, co-morbidities)
i. Education of provider/ members on the CalOptima pharmacy limited emergency prescription (outpatient) 2 days(maximum) by pharmacy
j. Mental health issues identification, coordination, complex care management (ICT)
k. Member communication: newsletter (re screenings, medication management, nurse advice line), wellness events (free flu shots, health screening), new member orientation (re ER/UC, NEMT, Taxi, etc.)
l. Provider communication: hours of operation (UC), access availability standards, screening standards, etc.
m. Follow up care post ER visits
n. Improve HEDIS gaps in diabetic care

3. **Metrics Defined**
   a. ER visits/1000
   b. Urgent care visits/1000

C. Community Network (CN) Development — Owner: Francesco Federico

1. **Goals**
   a. Promote better quality healthcare value through appropriate utilization, improved services
   b. Delineate types of complex care populations served
   c. Promote an effective network comparable to existing CalOptima Network
   d. Promote better patient experience through expanded member and provider choice through the CN network

2. **Strategic**
   a. UM Data Management (generation, analysis, metrics, action)
   b. Multidisciplinary team based management approach
   c. Utilization performance enhancement utilizing comparisons to historical, other network, regional, material trends

3. **Metrics Defined**
   a. Facility utilization metrics
   b. ED utilization metrics
   c. Pharmacy UM performance (TBD)
   d. Outpatient utilization performance (TBD)

I. Projects and Initiatives

A. Utilization Management (UM) Medical Management

Owner: Debra Armas

Monitoring	Narrative	Next Steps
Q1		
Q2		
Q3		
Q4		
Year End		
Outcomes	**Results / Metrics**	**Next Steps**
Q1		
Q2		
Q3		
Q4		
Year End		

Back to Agenda

B. Behavioral Health (BH) Integration

Owner: Edwin Poon

Monitoring	Narrative	Next Steps
Q1		
Q2		
Q3		
Q4		
Year End		
Outcomes	**Results / Metrics**	**Next Steps**
Q1		
Q2		
Q3		
Q4		
Year End		

Back to Agenda

C. UM Data Management

Owner: Francesco Federico

Monitoring	Narrative	Next Steps
Q1		
Q2		
Q3		
Q4		
Year End		

Outcomes	Results / Metrics	Next Steps
Q1		
Q2		
Q3		
Q4		
Year End		

Back to Agenda

II. Operation Performance

A. Authorization (PA) for Expedited/Urgent/Routine/Retro

Owner: Debra Armas

Monitoring	Narrative	Next Steps
Q1		
Q2		
Q3		
Q4		
Year End		
Outcomes	**Results / Metrics**	**Next Steps**
Q1		
Q2		
Q3		
Q4		
Year End		

Back to Agenda

B. Denial Letter Process

Owner: Debra Armas

Monitoring	Narrative	Next Steps
Q1		
Q2		
Q3		
Q4		
Year End		
Outcomes	**Results / Metrics**	**Next Steps**
Q1		
Q2		
Q3		
Q4		
Year End		

Back to Agenda

C. Inter-Rater Reliability (IRR), for Physicians, Nurses, Pharmacy Evaluation for Applying MCG Medical Necessity Review Criteria – UM, Pharmacy and LTSS

Owner: Debra Armas

Monitoring	Narrative	Next Steps
Q1		
Q2		
Q3		
Q4		
Year End		
Outcomes	**Results / Metrics**	**Next Steps**
Q1		
Q2		
Q3		
Q4		
Year End		

	CBAS	MSSP	LTC	IHSS
Q1				
Q2				
Q3				
Q4				

Back to Agenda

III. Utilization Performance - Ambulatory

A. Delegated Provider Group (PMG) Oversight – Over/Under Utilization and Utilization Trends Owner: Debra Armas

Monitoring	Narrative	Next Steps
Q1		
Q2		
Q3		
Q4		
Year End		
Outcomes	**Results / Metrics**	**Next Steps**
Q1		
Q2		
Q3		
Q4		
Year End		

B. CCN – Over/Under Utilization and Utilization Trends

Owner: Francesco Federico

Monitoring	Narrative	Next Steps
Q1		
Q2		
Q3		
Q4		
Year End		
Outcomes	**Results / Metrics**	**Next Steps**
Q1		
Q2		
Q3		
Q4		
Year End		

Back to Agenda

C. Pharmacy Utilization Trends

Owner: Kris Gericke

Monitoring	Narrative	Next Steps

Q1	$PMPM CY17
	• Medi-Cal:
	  • Goal: $49.86
	  • Actual: $49.15
	• OneCare
	  • Goal: $385.00
	  • Actual: $360.05
	• OneCare Connect
	  • Goal: $360.50
	  • Actual: $342.57
	
	The 1Q17 average $PMPM costs are below the goal for all lines of business.
		Next P&T Committee meeting is scheduled for May 18, 2017.

Q2		
Q3		
Q4		
Year End		
Outcomes	**Results / Metrics**	**Next Steps**
Q1		
Q2		
Q3		
Q4		
Year End		

Back to Agenda

D. LTSS (CBAS, LTC) applies to CBAS only (LTC TAT in development)

Owner: Marsha Petersen

Monitoring	Narrative	Next Steps
Q1		
Q2		
Q3		
Q4		
Year End		
Outcomes	**Results / Metrics**	**Next Steps**
Q1		
Q2		
Q3		
Q4		
Year End		

Back to Agenda

IV. Utilization Performance – Facility/Inpatient

A. Facility Utilization

Owner: Francesco Federico

i. Facility (Acute, Post Acute)

Monitoring	Narrative	Next Steps
Q1		
Q2		
Q3		
Q4		
Year End		
Outcomes	**Results / Metrics**	**Next Steps**
Q1		
Q2		
Q3		
Q4		
Year End		

Back to Agenda

A. Facility Utilization **Owner: Marsha Petersen**

ii. LTSS Facility UM

Monitoring	Narrative	Next Steps
Q1		
Q2		
Q3		
Q4		
Year End		
Outcomes	**Results / Metrics**	**Next Steps**
Q1		
Q2		
Q3		
Q4		
Year End		

Back to Agenda

B. Emergency Department (ED) Utilization

Owner: Himmet Dajee

Monitoring	Narrative	Next Steps
Q1		
Q2		
Q3		
Q4		
Year End		
Outcomes	**Results / Metrics**	**Next Steps**
Q1		
Q2		
Q3		
Q4		
Year End		

Back to Agenda

C. Community Network (CN) Development

Owner: Francesco Federico

Monitoring	Narrative	Next Steps
Q1		
Q2		
Q3		
Q4		
Year End		
Outcomes	**Results / Metrics**	**Next Steps**
Q1		
Q2		
Q3		
Q4		
Year End		

Back to Agenda

CalOptima Board Action Agenda Referral

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

Consent Calendar

4. Consider Approval of the 2017 Delegation Grid, Appendix B to 2017 Quality Improvement Program Description and Work Plan

Contact

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

Recommended Action

Consider approval of the 2017 Delegation Grid, Appendix B, to the 2017 Quality Improvement Program Description and Work Plan.

Background

Annually, CalOptima reviews and updates its delegation agreement to meet accreditation and regulatory requirements. For 2017, this also included updating the agreement with elements now delegated to Magellan Healthcare. This document serves as Attachment B to the 2017 Quality Improvement Program Description and Workplan, previously approved by the Board of Directors on March 2, 2017.

Fiscal Impact

There is no fiscal impact for the recommended action to approve the 2017 Delegation Grid, Appendix B, to the 2017 Quality Improvement Program Description and Work Plan.

Concurrence

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

Attachments

1. Proposed 2017 Delegation Grid, Appendix B
2. Board Action dated March 2, 2017, Consider Approval of the 2017 CalOptima Quality Improvement Program and 2017 Quality Improvement Work Plan

/s/ Michael Schrader — *05/25/2017*

Authorized Signature — **Date**

Back to Agenda

2017 Delegation Grid

"Attachment B"

Domain/ Element Name	CalOptima	HN	Kaiser	Magellan	MedImpact	J&J	Comments CO=CalOptima; P&P = Policies & Procedures
QI1A: QI Program Structure	X		X				CO responsibility P&P, even if delegated
QI1B: Annual Evaluation	X		X				CO responsibility P&P, even if delegated
QI2A: QI Committee Responsibilities	X		X				CO responsibility P&P, even if delegated
QI2B: Informing Members and Practitioners	X		X				CO responsibility P&P, even if delegated
QI3A: Practitioner Contracts	X		X				CO responsibility P&P, even if delegated
QI3B: Affirmative Statement- Must pass element	X		X				CO responsibility P&P, even if delegated
QI3C: Provider Contracts	X		X				CO responsibility P&P, even if delegated
QI4A: Member Services Telephone Access	X	X	X				
QI4B: BH Telephone Access Standards	X		X	X			CO responsibility P&P, even if delegated
QI4C: Annual Assessment-Member Experience	X						CO fields CAHPS, Kaiser complaint data included
QI4D: Opportunities for Improvement-Member Experience	X						
QI4E: Annual Assessment of BH and Services-Member Experience	X		X	X			Kaiser:Factor1 & Factor2 ; Magellan Factor2 only
QI4F: BH Opportunities for Improvement-Member Experience	X						

NCQA Standards Abbreviations: QI = Quality Improvement; NET – Network Management; UM – Utilization Management; CR – Credentialing; RR – Member Rights & Responsibilities; MEM – Member Connections; MED – Medicaid Benefits and Services. Standards include multiple "factors" identified by a number & letter. Please contact CalOptima for details on particular standards or elements.

Back to Agenda

2017 Delegation Grid

"Attachment B"

Domain/ Element Name	CalOptima	HN	Kaiser	Magellan	MedImpact	J&J	Comments CO=CalOptima; P&P = Policies & Procedures
QI4G: Assessing Experience With the UM Process	X			X			Magellan: Factor1 & Factor2; Factor3 & Factor4 activities may not be delegated; CO utilizes Kaiser data
QI5A: Population Assessment	X						
QI5B: Program Description-Complex Case Management (CCM)	X	X	X				
QI5C: Identifying Members for CCM	X	X	X				
QI5D: Access to Case Management-CCM	X	X	X				
QI5E: Case Management Systems-CCM	X	X	X				
QI5F: Case Management Process-CCM	X	X	X				CO responsibility P&P, even if delegated
QI5G: Initial Assessment-CCM	X	X	X				
QI5H: Case Management- Ongoing Management-CCM	X	X	X				
QI5I: Experience With Case Management-CCM	X		X				
QI5J: Measuring Effectiveness-CCM	X		X				
QI5K : Action and Re-measurement-CCM	X		X				
QI6A: Program Content-Disease Management (DM)	X		X				

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Back to Agenda

2017 Delegation Grid

"Attachment B"

Domain/ Element Name	CalOptima	HN	Kaiser	Magellan	MedImpact	J&J	Comments CO=CalOptima; P&P = Policies & Procedures
QI6B: Identifying Members for DM Programs	X		X				
QI6C : Frequency of Member Identification-DM	X		X				
QI6D: Providing Members With Information-DM	X		X				
QI6E: Interventions Based on Assessment-DM	X		X				
QI6F: Eligible Member Active Participation-DM	X		X				
QI6G: Informing and Educating Practitioners-DM	X		X				
QI6H: Integrating Member Information-DM	X		X				
QI6I: Experience With DM	X		X				
QI6J: Measuring Effectiveness-DM	X		X				
QI7A: Adoption of Guidelines	X		X				
QI7C: Relation to DM Programs	X		X				
QI8A: Identifying Opportunities-Continuity & Coordination of Care (C&C)	X		X				
QI8B: Acting on Opportunities-C&C	X		X				

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Back to Agenda

2017 Delegation Grid

"Attachment B"

Domain/ Element Name	CalOptima	HN	Kaiser	Magellan	MedImpact	J&J	Comments CO=CalOptima; P&P = Policies & Procedures
QI8C: Measuring Effectiveness-C&C	X		X				
QI8D: Transition to Other Care-C&C	X	X	X	X			
QI9A: Data Collection- C&C Behavioral Health	X						
QI9B: Collaborative Activities- C&C Behavioral Health	X						
QI9C: Measuring Effectiveness- C&C Behavioral Health	X						
QI10A: Delegation Agreement	X						
QI10B: Provision of Member Data to the Delegate	X						
QI10D: Pre-delegation Evaluation-NA	X						
QI10E: Review of QI Program	X						
QI10F: Opportunities for Improvement	X						
NET1A: Cultural Needs and Preferences	X		X				CO responsibility P&P, even if delegated
NET1B: Practitioners Providing Primary Care	X						CO responsibility Factor1-2 P&P, even if delegated
NET1C: Practitioners Providing Specialty Care	X						CO responsibility Factor1-3 P&P, even if delegated

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Back to Agenda

2017 Delegation Grid

"Attachment B"

Domain/ Element Name	CalOptima	HN	Kaiser	Magellan	MedImpact	J&J	Comments CO=CalOptima; P&P = Policies & Procedures
NET1D: Practitioners Providing Behavioral Health (BH)-Auto Credit	X		X	X			CO responsibility Factor1-3 P&P, even if delegated, Magellan/Kaiser Factor4
NET2A: Access to Primary Care	X		X				CO responsibility P&P, even if delegated
NET2B: Access to BH	X		X	X			CO responsibility P&P, even if delegated
NET2C: Access to Specialty Care	X		X				
NET3A: Assessment of Member Experience Accessing the Network	X		X	X			For BH See QI4E: Kaiser Factor 1&2; CO Factor1, Magellan Factor2 only
NET3B: Opportunities to Improve Access to Non-behavioral Healthcare Services	X		X				
NET3C: Opportunities to Improve Access to BH Services	X		X	X			For BH See QI4E: Kaiser Factor1&2; CO Factor1, Magellan Factor2 only
NET5A: Notification of Termination	X	X	X	X			
NET5B: Continued Access to Practitioners	X	X	X	X			
NET6A: Physician Directory Data	X		X				
NET6B: Physician Directory Updates	X		X				

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Back to Agenda

2017 Delegation Grid

"Attachment B"

Domain/ Element Name	CalOptima	HN	Kaiser	Magellan	MedImpact	J&J	Comments CO=CalOptima; P&P = Policies & Procedures
NET6C: Assessment of Physician Directory Accuracy	X		X				
NET6D: Identifying and Acting on Opportunities	X		X				
NET6E: Physician Information Transparency	X		X				
NET6F: Searchable Physician Web-Based Directory	X		X				
NET6G: Hospital Directory Data	X		X				
NET6H: Hospital Directory Updates	X		X				
NET6I: Hospital Information Transparency	X		X				
NET6J: Searchable Hospital Web-Based Directory	X		X				
NET6K: Usability Testing	X		X				
NET6L: Availability of Directories	X		X				
NET7A: Delegation Agreement	X		X				

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Back to Agenda

2017 Delegation Grid

"Attachment B"

Domain/ Element Name	CalOptima	HN	Kaiser	Magellan	MedImpact	J&J	Comments CO=CalOptima; P&P = Policies & Procedures
NET7B: Provisions of Member Data to the Delegate	X		X				
NET7D: Pre-delegation Evaluation	X		X				
NET7E: Review of Delegated Activities	X		X				
NET7F: Opportunities for Improvement	X		X				
UM1A: Written Program Description	X		X				CO responsibility P&P, even if delegated
UM1B: Physician Involvement	X		X				CO responsibility P&P, even if delegated
UM1C: BH Practitioner Involvement	X		X				CO responsibility P&P, even if delegated
UM1D: Annual Evaluation	X		X				CO responsibility P&P, even if delegated
UM2A: UM Criteria	X	X	X	X			CO responsibility P&P, even if delegated
UM2B: Availability of Criteria	X	X	X	X			CO responsibility P&P, even if delegated
UM2C: Consistency in Applying Criteria	X	X	X	X	X		CO responsibility P&P, even if delegated
UM3A: Access to Staff	X	X	X	X			CO responsibility P&P, even if delegated
UM4A: Licensed Health Professionals	X	X	X	X	X		CO responsibility P&P, even if delegated

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Back to Agenda

2017 Delegation Grid

"Attachment B"

Domain/ Element Name	CalOptima	HN	Kaiser	Magellan	MedImpact	J&J	Comments CO=CalOptima; P&P = Policies & Procedures
UM4B: Use of Practitioners for UM Decisions	X	X	X	X	X		CO responsibility P&P, even if delegated
UM4C: Practitioner Review of Non-Behavioral Healthcare Denials	X	X	X				
UM4D: Practitioner Review of BH Denials- Auto Credit	X		X	X			
UM4E: Practitioner Review of Pharmacy Denials	X		X				
UM4F: Use of Board-Certified Consultants	X	X	X	X			
UM4G: Affirmative Statement About Incentives	X	X	X	X			
UM4H: Appropriate Classification of Denials	X	X	X	X			
UM5A: Timeliness of Non-Behavioral UM Decision Making	X	X	X				
UM5B: Notification of Non-Behavioral Decisions	X	X	X				
UM5C: Timeliness of Behavioral Healthcare UM Decision Making- Auto Credit	X		X	X			
UM5D: Notification of Behavioral Healthcare Decisions- Auto Credit	X		X	X			
UM5E: Timeliness of Pharmacy UM Decision Making	X		X		X		
UM5F: Notification of Pharmacy Decisions	X		X		X		

NCQA Standards Abbreviations: QI = Quality Improvement; NET – Network Management; UM – Utilization Management; CR – Credentialing; RR – Member Rights & Responsibilities; MEM – Member Connections; MED – Medicaid Benefits and Services. Standards include multiple "factors" identified by a number & letter. Please contact CalOptima for details on particular standards or elements.

Back to Agenda

2017 Delegation Grid

"Attachment B"

Domain/ Element Name	CalOptima	HN	Kaiser	Magellan	MedImpact	J&J	Comments CO=CalOptima; P&P = Policies & Procedures
UM5G: UM Timeliness Report	X	X	X	X			Magellan delegated for Factor3&4 only; HN Factor1 & Factor2. Factor5; CO Factor6
UM6A: Relevant Information for Non-Behavioral Decisions	X	X	X				
UM6B: Relevant Information for BH Decisions- Auto Credit	X		X	X			
UM6C: Relevant Information for Pharmacy Decisions	X		X				
UM7A: Discussing a Denial With a Reviewer	X	X	X				
UM7B: Written Notification of Non-Behavioral Healthcare Denials	X	X	X				
UM7C: Non-Behavioral Notice of Appeal Rights/Process	X	X	X				
UM7D: Discussing a BH Denial with a Reviewer- Auto Credit	X		X	X			
UM7E: Written Notification of BH Denials-Auto Credit	X		X	X			
UM7F: BH Notice of Appeal Rights/Process- Auto Credit	X		X	X			
UM7G: Discussing a Pharmacy Denial With a Reviewer	X		X				
UM7H: Written Notification of Pharmacy Denials	X		X		X		
UM7I: Pharmacy Notice of Appeal Rights/Process	X		X		X		

NCQA Standards Abbreviations: QI = Quality Improvement; NET – Network Management; UM – Utilization Management; CR – Credentialing; RR – Member Rights & Responsibilities; MEM – Member Connections; MED – Medicaid Benefits and Services. Standards include multiple "factors" identified by a number & letter. Please contact CalOptima for details on particular standards or elements.

Back to Agenda

2017 Delegation Grid

"Attachment B"

Domain/ Element Name	CalOptima	HN	Kaiser	Magellan	MedImpact	J&J	Comments CO=CalOptima; P&P = Policies & Procedures
UM8A: Internal Appeals (Policies and Procedures)	X		X				CO responsibility P&P, even if delegated
UM9A: Pre-service and Post-service Appeals	X		X				CO responsibility P&P, even if delegated
UM9B: Timeliness of the Appeal Process	X		X				
UM9C: Appeal Reviewers	X		X				
UM9D: Notification of Appeal Decision/Rights	X		X				
UM11A: Pharmaceutical Management Procedures(Policies and Procedures)	X		X				
UM11B: Pharmaceutical Restrictions/Preferences	X		X				
UM11C: Pharmaceutical Patient Safety Issues	X		X				
UM11D: Reviewing and Updating Procedures	X		X				
UM11E: Considering Exceptions	X		X				
UM12A: Triage and Referral Protocols-Auto Credit	X		X	X			
UM12B: Supervision and Oversight- Auto Credit	X		X	X			
UM13A: Delegation Agreement	X						

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Back to Agenda

2017 Delegation Grid

"Attachment B"

Domain/ Element Name	CalOptima	HN	Kaiser	Magellan	MedImpact	J&J	Comments CO=CalOptima; P&P = Policies & Procedures
UM13B: Provision of Member Data to the Delegate	X						
UM13D: Pre-delegation Evaluation	X						
UM13E: Review of the UM Program	X						
UM13F: Opportunities for Improvement	X						
CR1A: Practitioner Credentialing Guidelines	X	X	X	X			CO responsibility P&P, even if delegated
CR1B: Practitioner Rights	X	X	X	X			CO responsibility P&P, even if delegated
CR2A: Credentialing Committee	X	X	X	X			
CR3A: Verification of Credentials	X	X	X	X			
CR3B: Sanction Information	X	X	X	X			
CR3C: Credentialing Application	X	X	X	X			
CR4A: Recredentialing Cycle Length	X	X	X	X			
CR5A: Ongoing Monitoring and Interventions	X	X	X	X			
CR6A: Actions Against Practitioners	X	X	X	X			CO responsibility P&P, even if delegated

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Back to Agenda

2017 Delegation Grid

"Attachment B"

Domain/ Element Name	CalOptima	HN	Kaiser	Magellan	MedImpact	J&J	Comments CO=CalOptima; P&P = Policies & Procedures
CR7A: Review and Approval of Provider	X	X	X				
CR7B: Medical Providers	X	X	X				
CR7D: Assessing Medical Providers	X	X	X				
CR8A: Delegation Agreement	X						
CR8C: Pre-delegation Evaluation-NA	X						
CR8D: Review of Delegate's Credentialing Activities	X						
CR8E: Opportunities for Improvement	X						
CR1C: Performance Monitoring for Re-Credentialing (CMS/DHCS)	X	X	X	X			CMS/DHCS Requirement
CR1D: Contracts Opt-Out Provisions (CMS)	X	X	X	X			CMS Requirement
CR1E: Medicare-Exclusions/Sanctions (CMS)	X	X	X	X			CMS Requirement
CR3D: Hospital Admitting Privileges (CMS/DHCS)	X	X	X	X			CMS/DHCS Requirement
CR6B: Monitoring Medicare Opt Out (CMS)	X	X	X	X			CMS Requirement
CR6C: Monitoring Medi-Cal Suspended and Ineligible Provider Reports (DHCS)	X	X	X	X			DHCS Requirement

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Back to Agenda

2017 Delegation Grid

"Attachment B"

Domain/ Element Name	CalOptima	HN	Kaiser	Magellan	MedImpact	J&J	Comments CO=CalOptima; P&P = Policies & Procedures
CR7F: Appeals Process for Termination/Suspension (CMS)	X	X	X	X			CMS Requirement
CR10A: ID of HIV/AIDS Specialists: Written Process	X	X	X				DHCS Requirement
CR10B: ID of HIV/AIDS Specialists: Evidence of Implementation	X	X	X				DHCS Requirement
CR10C: ID of HIV/AIDS Specialists: Distribution of Findings	X	X	X				DHCS Requirement
RR1A: Rights and Responsibility Statement	X						
RR1B: Distribution of Rights Statement	X						
RR2A: Policies and Procedures for Complaints	X		X				CO responsibility P&P, even if delegated
RR2B: Policies and Procedures for Appeals	X		X				CO responsibility P&P, even if delegated
RR3A: Subscriber Information	X						
RR3B: Interpreter Services	X	X	X	X			
MEM1A: Health Appraisal (HA) Components	X		X			X	Auto Credit available with Health Information Products (HIP) Certified
MEM1B: HA Disclosure	X		X			X	Auto Credit available with HIP Certified
MEM1C: HA Scope	X		X			X	Auto Credit available when HIP Certified

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Back to Agenda

2017 Delegation Grid

"Attachment B"

Domain/ Element Name	CalOptima	HN	Kaiser	Magellan	MedImpact	J&J	Comments CO=CalOptima; P&P = Policies & Procedures
MEM1D: HA Results	X		X			X	Auto Credit available when HIP Certified
MEM1E: Formats	X		X			X	Auto Credit available when HIP Certified
MEM1F: Frequency of HA Completion	X		X			X	Auto Credit available when HIP Certified
MEM1G: Review and Update Process	X		X			X	Auto Credit available when HIP Certified
MEM2A: Topics of Tools	X		X			X	Auto Credit available when HIP Certified
MEM2B: Usability Testing	X		X			X	Auto Credit available when HIP Certified
MEM2C: Review and Update Process	X		X			X	Auto Credit available when HIP Certified
MEM2D: Formats	X		X			X	Auto Credit available when HIP Certified
MEM3B: Functionality: Telephone Requests	X	X	X	X			
MEM4A: Pharmacy Benefit Information: Website	X		X		X		PBM delegate possibility for Factors 6-8
MEM4B: Pharmacy Benefit Information: Telephone	X		X				
MEM4C: QI Process on Accuracy of Information	X		X				
MEM4D: Pharmacy Benefit Updates	X		X				

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Back to Agenda

2017 Delegation Grid

"Attachment B"

Domain/ Element Name	CalOptima	HN	Kaiser	Magellan	MedImpact	J&J	Comments CO=CalOptima; P&P = Policies & Procedures
MEM5A: Functionality: Web Site	X		X				CO: Factors 1-3; Kaiser Factors 1,2,3; Factor4 NA
MEM5B: Functionality: Telephone	X	X	X	X			
MEM5C: Quality and Accuracy of Information	X	X	X	X			HN and Magellan For telephone only
MEM5D: E-Mail Response Evaluation	X		X				
MEM6A: Supportive Technology	X		X				
MEM7A: Identifying Members	X		X				
MEM7B: Targeted Follow-Up With Members	X		X				
MEM8A: Delegation Agreement	X						
MEM8B: Provision Of Member Data to the Delegate	X						
MEM8D: Pre-delegation Evaluation	X						
MEM8E: Review of Performance	X						
MEM8F: Opportunities for Improvement	X						
MED1A: Direct Access to Women's Health Services	X						

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Back to Agenda

2017 Delegation Grid

"Attachment B"

Domain/ Element Name	CalOptima	HN	Kaiser	Magellan	MedImpact	J&J	Comments CO=CalOptima; P&P = Policies & Procedures
MED1B: Second Opinion	X	X	X	X			
MED1C: Out-of-Network Services	X	X					
MED1D: Out-of Network Cost to Member	X	X					
MED1E: Hours of Operation Parity	X	X					
MED2A: Distribution of Practice Guidelines	X						
MED3A: Coverage of Emergency Services	X	X					
MED4A: Performance Standards and Thresholds	X						
MED4B: Site Visits and Ongoing Monitoring	X						
MED5A: Privacy and Confidentiality	X						
MED5B: Authorization	X						
MED5C: Communication of PHI	X						

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Back to Agenda

CalOptima Board Action Agenda Referral

Action To Be Taken March 2, 2017
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

3. Consider Approval of the 2017 CalOptima Quality Improvement Program and 2017 Quality Improvement Work Plan

Contact

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

Recommended Action

Approve recommended revisions to the 2017 Quality Improvement Program and 2017 Quality Improvement Work Plan.

Background

As part of existing regulatory and accreditation mandated oversight processes, CalOptima's Quality Improvement Program (" QI Program") and Quality Improvement Work Plan ("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 2017 QI Program Description and related QI Work Plan with revisions to ensure that it is aligned to reflect the changes regarding the health networks and strategic organizational changes. This will ensure that all regulatory requirements and NCQA accreditation standards are met in a consistent manner across the Medi-Cal and OneCare programs.

Discussion

The 2017 Quality Improvement Program is based on the Board-approved 2016 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. Updates the introductory pages to align with CalOptima's Vision, Mission & new Strategic Plan for 2017-19;
2. Updates the plans we offer, scope of services and who we work with – including an updated list of our Health Networks;
3. Updates the Behavioral Health Services delegate to Magellan Health, Inc.for Medi-Cal, OneCare and OneCare Connect ;
4. Updates the list of CalOptima Officers and staff; and included a broader representation of the key areas supporting the QI Program;
5. Incorporates the description of CalOptima's approach to population health management in the design and delivery of care;
6. Reflects the adoption of the annual UM Work Plan which complements the QI Program and Work Plan;
7. Updates the Advisory Committees and Quality Committees/Subcommittees that support the QI Program;
8. Updates the scope of the Credentialing program with the revised list of included practitioners;
9. Updates the Care of Members with Complex Needs to include further details on the Interdisciplinary Care Teams and risk stratification processes
10. Updates the QI Committee structure.

The recommended changes are designed to better review, analyze, implement and evaluate the components of the QI Program and Work Plan. In addition, the 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 action to approve the CalOptima QI Program and Work Plan.

Concurrence

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

Attachments

1. Proposed 2017 Quality Improvement Program – Executive Summary of Revisions
2. Proposed 2017 Quality Improvement Program and 2017 Quality Improvement Work Plan

/s/ Michael Schrader | *2/23/2017*

Authorized Signature | **Date**

CalOptima
A Public Agency
Better. Together.

Quality Improvement (QI) Program 2017

Executive Summary of Revisions

1. Updates the introductory pages to align with CalOptima's Vision, Mission & Strategic Plan for 2017-19;
2. Updates the plans we offer, scope of services and who we work with – including an updated list of our Health Networks;
3. Updates the Behavioral Health Services delegate to Magellan Health, Inc. for Medi-Cal, OneCare and OneCare Connect;
4. Updates the list of CalOptima Officers and staff and included a broader representation of the key areas supporting the QI Program;
5. Incorporates the description of CalOptima's approach to population health management in the design and delivery of care;
6. Reflects the adoption of the annual UM Work Plan which complements the QI Work Plan;
7. Updates the Advisory Committees and Quality Committees/Subcommittees that support the QI Program;
8. Updates the scope of the Credentialing program with the revised list of included practitioners;
9. Updates the Care of Members with Complex Needs to include further details on the Interdisciplinary Care Teams and risk stratification processes;
10. Updates the QI Committee structure
11. Updates the 2017 QI Work Plan;
12. Assures NCQA & DHCS requirements are included in the program description and related work plans.

Back to Agenda

2016~~6~~7

Quality Improvement Program

~~Revised 10/6/2016~~

201~~6~~7 QUALITY IMPROVEMENT PROGRAM SIGNATURE PAGE

Quality Improvement Committee Chair:

______________________________ ______________

Richard ~~Helmer~~Bock, M.D. **_____Date**
Deputy Chief Medical Officer

Board of Directors' Quality Assurance Committee Chair:

______________________________ ______________

Paul Yost, M.D. **Date**

Board of Directors Chair:

______________________________ ______________

Mark Refowitz **Date**

Table of Contents

WE ARE CALOPTIMA pg. 1

~~Our Mission pg. 1~~
~~Our Vision pg. 1~~
~~Our Values pg. 1~~
~~We are "Better.Together." pg. 2~~

WHAT IS CALOPTIMA? pg. 2

~~Our Unique Dual Role pg. 2~~
~~How We Became CalOptima pg. 2~~

WHAT WE OFFER pg. ~~3~~4

Medi-Cal pg. ~~3~~4
OneCare (HMO SNP) pg. ~~3~~5
OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) pg. ~~4~~6
Program of All-Inclusive Care for the Elderly (PACE) pg. ~~4~~7

NEW PROGRAM INITIATIVES ON OUR HORIZON pg. 8

WHOM WE WORK WITH pg. ~~5~~8

Contracted Health Networks/Contracted Network Providers pg. ~~5~~8
CalOptima Community Network ~~(CCN)~~ pg. ~~5~~8
CalOptima Direct ~~(COD)~~ pg. ~~5~~9
Health Networks pg. ~~5~~9

BEHAVIORAL HEALTH SERVICES pg. ~~6~~10

Medi-Cal Ambulatory Behavioral Health Services pg. ~~6~~10
OneCare and OneCare Connect Behavioral Health Services pg. ~~7~~10

~~**OUR LINES OF BUSINESS** pg. 7~~

~~**MEDI-CAL** pg. 7~~

~~Scope of Services pg. 7~~
~~California Children's Services pg. 8~~
~~Members With Special Health Care Needs pg. 8~~
~~Medi-Cal Managed Long-Term Services and Supports pg. 8~~

~~**ONECARE (HMO SNP)** pg. 9~~

~~Scope of Services pg. 9~~

~~ONECARE CONNECT pg. 9~~
~~Scope of Services pg. 9~~

~~PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE) pg. 10~~
~~Scope of Services pg. 10~~

MEMBERSHIP DEMOGRAPHICS **pg. ~~11~~11**

QUALITY IMPROVEMENT PROGRAM **pg. ~~12~~12**

AUTHORITY, ACCOUNTABILITY AND RESPONSIBILITY **pg. ~~12~~12**
Board of Directors **pg. ~~12~~12**
Quality Improvement Program, ~~,~~ Role of CalOptima Officers **pg. ~~12~~13**

QUALITY IMPROVEMENT PROGRAM PURPOSE **pg. ~~14~~14**

QUALITY IMPROVEMENT DEPARTMENT **pg. ~~15~~ 15**

QUALITY ANALYTICS DEPARTMENT **pg. ~~15~~15**

HEALTH EDUCATION & DISEASE MANAGEMENT DEPARTMENT **pg. ~~16~~16**

RESOURCES TO DIRECTLY SUPPORT THE QUALITY IMPROVEMENT PROGRAM AND QUALITY IMPROVEMENT COMMITTEE **pg. ~~17~~17**

QUALITY IMPROVEMENT ~~(QI)~~ STRATEGIC GOALS **pg. ~~18~~ 20**
Quality Improvement Goals and Objectives **pg. ~~19~~ 21**
Quality Improvement Measureable Goals from the Model of Care **pg. ~~20~~22**

QUALITY IMPROVEMENT WORK PLAN **pg. 23**

~~Work Plan pg. 20~~
~~See Attachment A – 2016 QI Work Plan~~

Utilization Management pg. ~~22~~24

Behavioral Health pg. ~~22~~25

Confidentiality pg. 25~~23~~

Conflict of Interest pg. ~~23~~25

Staff Orientation, Training and~~,~~ Education pg. ~~24~~26

Safety Program pg. ~~24~~26

Committees and Key Group Structures pg. ~~26~~28

Board of Directors' Quality Assurance Committee pg. ~~26~~28

Member Advisory Committee (MAC) pg. ~~26~~28

OneCare Connect Member Advisory Committee (OCC MAC) pg. 29

Provider Advisory Committee (PAC) pg. ~~27~~ 30

Quality Improvement Committee (QIC) pg. ~~27~~30

Voting Members pg. ~~29~~ 31

Quorum pg. ~~29~~ 32

Minutes of the Quality Improvement Committee (QIC) pg. ~~29~~32

Quality Improvement Committees and Subcommittees pg. 32

Credentialing and Peer Review Subcommittee (CPRC) pg. ~~30~~ 32

Grievance and Appeals Resolution Services Subcommittee (GARS) pg. ~~32~~ 34

Pharmacy & Therapeutics Subcommittee (P&T) pg. ~~32~~34

Back to Agenda

Utilization Management Subcommittee (UM) pg. 32 34
Benefit Management Subcommittee (BMSC) Long-Term Services and Supports Subcommittee (LTSS) pg. 3335
Benefit Management Subcommittee (BMSC)Long-Term Services and Supports Subcommittee (LTSS) pg. 33 36
Behavioral Health Quality Improvement Committee (BHQIC) pg. 34 36
Clinical Operations/Population Health Subcommittee (COPHS) pg. 37
Member Experience Subcommittee (MES) pg. 37
2017 Committee Organization Structure — Diagram pg. 38

METHODOLOGY pg. 3539
Quality Improvement Project Selections and Focus Areas pg. 3539
Quality Improvement Project Quality Indicators pg. 36 39
Quality Improvement Project Measurement Methodology pg. 36 40

CARE OF MEMBERS WITH COMPLEX NEEDS pg. 3740
Dual Eligible Special Needs Plan (D-SNP)/OC and OCC pg. 3943
OneCare and OneCare Connect pg. 39

DISEASE MANAGEMENT PROGRAM pg. 4043

CLINICAL DATA WAREHOUSEQUALITY ANALYTICS pg. 4044
Identification/Stratification of Members pg. 4144
Identify Over/Under Utilization of Services pg. 4144
Identify Missing Preventive Care Services pg. 4145
Identify Members for Targeted Interventions pg. 4145
Medical Record Review pg. 4245
Interventions pg. 4245
Improvement Standards pg. 4246

Back to Agenda

Documentation of Quality Improvement Projects pg. ~~43~~46

KEY BUSINESS PROCESSES, FUNCTIONS, IMPORTANT ASPECT OF CARE AND SERVICE pg. ~~43~~46

DELEGATED AND NON-DELEGATED ACTIVITIES pg. ~~44~~48

Delegation Oversight pg. ~~45~~48

Non-Delegated Activities pg. ~~45~~48

CULTURAL & LINGUISTIC SERVICES~~PEER REVIEW PROCESS~~ pg. ~~45~~49

PEER REVIEW PROCESS~~CULTURAL & LINGUISTIC SERVICES~~ pg. ~~46~~49

COMPREHENSIVE CREDENTIALING PROGRAM STANDARDS pg. ~~47~~50

Health Care Delivery Organizations pg. ~~47~~50

Use of Quality Improvement Activities in the Recredentialing Process pg. ~~47~~50

Monitoring for Sanctions and Complaints pg. ~~47~~50

FACILITY SITE REVIEW, MEDICAL RECORD AND PHYSICAL ACCESSIBILITY REVIEW SURVEY pg. ~~47~~50

Physical Accessibility Review Survey for Seniors and Persons with Disabilities (SPD) pg. ~~48~~51

Medical Record Documentation Standards pg. ~~48~~51

CORRECTIVE ACTION PLAN(S) TO IMPROVE CARE/SERVICE pg. ~~49~~52

Performance Improvement Evaluation Criteria for Effectiveness pg. ~~49~~52

COMMUNICATION OF QUALITY IMPROVEMENT ACTIVITIES pg. ~~50~~52

Back to Agenda

ANNUAL PROGRAM EVALUATION pg. 5053

IN SUMMARY pg. 5154

QUALITY IMPROVEMENT COMMITTEE STRUCTURE – 2016 pg. 52

APPENDIX A— — 2017 QIUALITY IMPROVEMENT WORK PLAN

APPENDIX B —— 2017 DELEGATION GGRID

WE ARE CALOPTIMA

Caring for the people of Orange County has been CalOptima's privilege since 1995. We believe that our Medicaid (Medi-Cal) and Medicare members deserve the highest 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 vision while upholding our values.

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 every level of the organization. Our mission is focused on our members, and our members are the sole reason why CalOptima exists.

Our Vision

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, OneCare Connect 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.

Back to Agenda

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, State and Federal agencies, and other community stakeholders. Together, we develop innovative solutions and meet our diverse members' health care needs. We are "Better. Together."

Our Strategic Plan
CalOptima's 2017–19 Strategic Plan honors our longstanding mission focused on members while recognizing that the future holds some unknowns given possible changes for Medicaid plans serving low-income people through the Affordable Care Act. Still, any future environment will demand attention to the priorities of more innovation and increased value, as well as enhanced partnerships and engagement. Additionally, CalOptima must focus on workforce performance and financial strength as building blocks so we can achieve our strategic goals. Below are the key elements in our Strategic Plan framework.

Strategic Priorities:

- **Innovation:** Pursue innovative programs and services to optimize member access to care.
- **Value:** Maximize the value of care for members by ensuring quality in a cost-effective way.
- **Partnerships and Engagement:** Engage providers and community partners in improving the health status and experience of members.

Building Blocks:

- **Workforce Performance:** Attract and retain an accountable and high-performing workforce capable of strengthening systems and processes.
- **Financial Strength:** Provide effective financial management and planning to ensure long-term financial strength.

WHAT IS CALOPTIMA?

Our Unique Dual Role
CalOptima is unique in that we must ~~exhibit~~ be~~ing~~ the best of both a public agency upholding public trust, and a health plan seeking quality health care, 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

Back to Agenda

How We 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.

A dedicated coalition of local elected officials, hospitals, physicians and community advocates rallied and created a solution. The answer was to create CalOptima as a county organized health system (COHS) authorized by State and Federal law to administer Medi-Cal benefits in Orange County.

~~**CalOptima was created as a public agency, operates like a private sector health plan and is accountable to stakeholders to build public trust.**~~

CalOptima began serving members in 1995. Today, CalOptima is the largest of six COHS in the United States.

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

- Single-plan ~~responsibil~~responsiblei~~ty~~ for providing ~~services to~~Medi-Cal coverage in the county
- Mandatory enrollment of all full-scope Medi-Cal beneficiaries, including dual eligibles
- ~~Responsibil~~Responsiblei~~ty~~ for almost all medical acute services and Long-Term Services and Supports (LTSS), including custodial long-term care.

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

OneCare (OC) ~~is also a Medicare Advantage Prescription Drug plan. OneCare~~ operates exclusively as a "Zero Cost Share, Medicaid Subset Dual Special Needs Plan." ~~OneCare~~OC only enrolls beneficiaries who qualify as a zero cost sharing Medicaid subset. To identify dual eligible members, ~~OneCare~~OC imports daily member eligibility files from the State and Federal government with Medicaid and Medicare eligibility segments.

In July 2015, CalOptima launched OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan). ~~This~~ OneCare Connect (OCC) is a 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 medical, behavioral health, long-term care services and supports, and community-based services for dual eligible beneficiaries. One of t~~T~~he 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 individual care plan. Members eligible for OCC cannot enroll in OC.

Back to Agenda

~~CalOptima was created as a public agency, operates like a private sector health plan and is accountable to stakeholders to build public trust.~~

What ~~w~~We Offer:

Medi-Cal
In California, Medicaid is known as Medi-Cal. For more than 20 years, CalOptima has been serving Orange County's Medi-Cal population. Due to the implementation of the Affordable Care Act~~,~~ — as more low-income children and adults qualified for Medi-Cal — membership in CalOptima ~~from 2014–16~~ grew by an unprecedented 49 percent between 2014 and 2016~~.~~! ~~More low-income children and adults qualified for Medi-Cal.~~

Medi-Cal covers low-income adults, families with children, seniors, 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 Medi-Cal member must ~~live~~ reside in Orange County ~~and~~ to be enrolled in CalOptima Medi-Cal.

Scope of Services~~:~~
Under our Medi-Cal 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:

Acupuncture	Hospice care	Outpatient mental health services – limited
Adult preventive services	Hospital/inpatient care	Pediatric preventive services
Community-based adult services	Immunizations	Child health and disability prevention (CHDP)
Doctor visits	Laboratory services	Physical therapy
Durable medical equipment	Limited allied health services	Prenatal care
Emergency care	Medical supplies	Specialty care services
Emergency transportation	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 health care	Occupational therapy	

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 Orange County Health Care Agency (OC HCA).
- Substance use disorder services are administered by OC HCA.

- Dental services are provided through California's Denti-Cal program.
- Eligible conditions under California Children's Services (CCS).

Members 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 seniors, people with disabilities and 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 (UM) Program.

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 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 benefit for all Medi-Cal members. CalOptima ensures LTSS services are available to members who have health care needs and meet the program eligibility criteria and guidelines.

LTSS includes four programs:

- Community-Based Adult Services (CBAS)
- Nursing Facility (NF) Services for Long-Term Care (LTC)
- Multipurpose Senior Services Program (MSSP)
- In-Home Supportive Services (IHSS)

~~Prior to July 1, 2015, CalOptima was responsible for all of the LTSS programs with the exception of In-Home Supportive Services (IHSS). In **XXX** 201**X**, IHHS will move back to county responsibility throughout the state.~~

OneCare (HMO SNP)
OneCare (HMO SNP) means total care. 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~~Since 2005, CalOptima has been offering ~~OneCare~~OC to low-income seniors and people with disabilities who quality for both Medicare and Medi-Cal**.** ~~We have~~OC has extensive experience serving the complex needs of the frail, disabled, dual eligible members in Orange County.

To be a member of ~~OneCare~~OC, a 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~~OCC.

Scope of Services~~:~~
OC provides a comprehensive scope of services for the dual eligible members who are not eligible for OCC, and who voluntarily enroll in OC.

These services include but are not limited to the following:

Acupuncture and other alternative therapies	Gym membership	Prescription drugs
Ambulance	Hearing services	Preventative care
Chiropractic care	Home health care	Prosthetic devices
Dental services – limited	Hospice	Renal dialysis
Diabetes supplies and services	Inpatient hospital care	Skilled nursing facility
Diagnostic tests, lab and radiology services, and X-rays	Inpatient mental health care	Taxi rides for medical and pharmacy visits
Doctor visits	Mental health care	Urgently needed services
Durable medical equipment	Outpatient rehabilitation	Vision services
Emergency care	Outpatient substance abuse	
Foot care	Outpatient surgery	

OneCare Connect

~~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. OneCare Connect also integrates the Multipurpose Senior Services Program (MSSP), In-Home Supportive Services (IHSS) and Long-Term Care (LTC).~~

~~At no extra cost, our members also get vision care, 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.~~

OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) launched in 2015 for people who qualify for both Medicare and Medi-Cal. OneCare Connect (OCC) 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 members often have several chronic health conditions and multiple providers, yet their separate insurance plans often create confusion and fragmented care. By combining all benefits into one plan, OCC delivers coordinated care. Care coordination eliminates duplicated services and shifts services from more expensive institutions to home and community-based settings.

At no extra cost, OCC adds supplemental benefits such as vision care, taxi rides to medical appointments, gym benefits and enhanced dental benefits. Additionally, OCC integrates CBAS, MSSP and LTC into the plan benefits. OCC includes personalized support — all to ensure each member receives the services they need, when they need them.

OCC achieves these advancements via CalOptima's innovative Model of Care. Each member has a Personal Care Coordinator (PCC) whose role is to help the member navigate the health care system and receive integrated medical, behavioral and supportive services. Also, the PCCs work with our members and their doctors to create an individualized health care plan that fits each member's needs. Addressing individual needs results is a better, more efficient and higher quality health care experience for the member.

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

Scope of Services:

OCC simplifies and improves health care for low-income seniors and people with disabilities.

These services include but are not limited to the following:

Acupuncture (pregnant women)	Hearing aids – limited	Rehabilitation services
Ambulance services	Hearing screenings	Renal dialysis
Case management	Incontinence supplies – limited	Screening tests
Chiropractic services	Inpatient hospital care	Skilled nursing care
Community-based adult services (CBAS)	Inpatient mental health care	Specialist care
Diabetes supplies and services	Institutional care	Substance abuse services
Disease self-management	Lab tests	Supplemental dental services
Doctor visits	Medical equipment for home care	Taxi rides for medical and pharmacy visits
Durable medical equipment	Mental or behavioral health services	Transgender services
Emergency care	Multipurpose Senior Services Program (MSSP)	Occupational, physical or speech therapy
Eye exams	Over-the-counter drugs – limited Prescription drugs	Urgent care
Foot care	Outpatient care	"Welcome to Medicare" preventive visit
Glasses or contacts – limited	Preventive care	
Gym membership	Prosthetic devices	
Health education	Radiology	

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

In 2013, CalOptima launched the ~~first~~ only 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 acute 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, dieticians, 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 participates.~~

Back to Agenda

To be a PACE participant, members must be eligible for both Medicare Parts A & B, 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.

Scope of Services

PACE provides all the acute 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, dieticians, 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 participates.

Launched 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 ourthe Interdisciplinary Team.

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.

NEW PROGRAM INITIATIVES OON OOUR HHORIZON:

Palliative Care

CalOptima expects to implement palliative care standards for its Medi-Cal members no sooner than April 1, 2017July 1, 20178.

Whole-Person Care

Whole-Person Care is a five-year pilot led by the Orange County Health Care Agency to focus on improving health care outcomes for members who frequently visit the emergency department and are either homeless or have a serious mental illness. Whole-Person Care will be launched in stages, with full implementation by January 1, 2018.

Long-Term Connect

CalOptima plans to realign its internal operations to better support members who reside in a long-term care facility. Referred to as "Long-Term Connect" its focus will be on increasing member/provider visits, preventing avoidable inpatient hospitalizations, and improving health outcomes. Long-Term Connect is expected to launch in July 2017.

WHOM W~~W~~E ~~W~~WORK ~~W~~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 14 health networks (HNs), representing more than 7,500 practitioners.

CalOptima Community Network (CCN)

The CalOptima Community Network provides doctors with an alternate path to contract directly with CalOptima to serve our members. Currently, CalOptima contracts with 13 private ~~health networks~~HNs for Medi-Cal. CCN is administered internally by CalOptima and is the 14th network available for members to select, supplementing the existing health network delivery model and creating additional capacity for growth.

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, and members residing outside of Orange County. ~~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.~~ Members enrolled in CalOptima Direct are not health network eligible.

~~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~~

Health Networks

CalOptima contracts with a variety of health network models to provide care to members. Since 2008, CalOptima's HNs consist of ~~has also included~~ Health Maintenance Organizations (HMOs), Physician/Hospital Consortia (PHCs), Physician Medical Groups (PMGs) and Shared Risk Medical Groups (SRGs). Through these HNs, CalOptima members have access to ~~CalOptima's HMOs, PHCs, PMGs and SRGs include~~ more than ~~3,5~~1,500 Primary Care Providers (PCPs), nearly 6,000 specialists and 30 hospitals and clinics. New networks that demonstrate the ability to comply with CalOptima's delegated requirements are added as needed with CalOptima Board approval.

The following are CalOptima's contracted Health Networks:

Health Network/Delegate ~~No.~~	Medi-Cal	OneCare	OneCare Connect
AltaMed Health Services	SRG	PMG	SRG
AMVI Care Health Network	PHC	PMG	PHC
Arta Western Health Network	SRG	PMG	SRG
CHOC Health Alliance	PHC		
Family Choice Health Network	SRG	PMG	SRG
Heritage	HMO		HMO
Kaiser Permanente	HMO		
Monarch Family HealthCare	~~SRG~~HMO	PMG	~~SRG~~HMO
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 readiness reviews and audits, the ~~health networks~~HNs may be delegated for clinical and administrative functions, which may include:

- Utilization Management (UM)
- Case and Complex Case Management
- Claims (professional and institutional)
- Contracting
- Credentialing of practitioners
- Customer Services activities

Behavioral Health Services

Medi-Cal Ambulatory Behavioral Health Services

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, 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)~~Magellan Health, Inc. [a managed behavioral healthcare organization (MBHO)] for ~~utilization management~~ UM of the provider network,~~.~~ ~~CHIPA subcontracts and delegates to Beacon Health Strategies LLC (Beacon) other functions that include~~ network adequacy and credentialing the provider network, ~~the Access Line~~ customer service/managing the CalOptima Behavioral Health phone 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).

~~B~~Some 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 years of age and older who misuse alcohol. Providers in primary care settings also screen for alcohol misuse and provide people 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 is also contracted with ~~has contracted with Windstone Behavioral Health~~Magellan Health, Inc. for the behavioral health services portion of ~~OneCare~~OC and ~~OneCare Connect~~OCC. ~~CalOptima~~ The ~~F~~delegated functions are identical to those listed above.
~~delegatesd to Magellan include utilization management (UM), credentialing and customer service. to Windstone. Evidence-based MCG guidelines are used in the UM decision-making process.~~

~~OUR LINES OF BUSINESS:~~

~~MEDI-CAL~~

~~**Scope of Services**~~

~~Under our Medi-Cal 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 visits~~	~~Laboratory services~~	~~Physical therapy~~
~~Durable medical equipment~~	~~Limited allied health services~~	~~Prenatal care~~
~~Emergency care~~	~~Medical supplies~~	~~Specialty care services~~
~~Emergency transportation~~	~~Medications~~	~~Speech therapy~~
~~Non-emergency medical~~	~~Newborn care~~	~~Substance use disorder~~

transportation (NEMT)		preventive services – limited
Hearing aid(s)	Nursing facility services	Vision care
Home health care	Occupational therapy	
Hospice care	Outpatient mental health services – limited	

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 Orange County Health Care Agency (OC HCA).
- Substance use disorder services are administered by OC HCA.
- Dental services are provided through California's Denti-Cal program. (CCS).

California Children's Services
Services for children with certain physical limitations, chronic health conditions or diseases are provided through California Children's Services (CCS), which is a statewide program. Currently, CCS authorizes and pays for specific medical services and equipment provided by CCS-approved specialists for CCS-eligible conditions. DHCS manages the CCS program and the Orange County Health Care Agency operates the program. CalOptima is responsible for coordinating care and services for all non-CCS related conditions. There is work underway to integrate CCS services as a benefit of CalOptima. This transition is planned for 2017.

Members 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 seniors, people with disabilities and 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.

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 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 members. CalOptima ensures LTSS services are available to members who have health care needs and meet the program eligibility criteria and guidelines.

LTSS includes four programs:
- Community-Based Adult Services (CBAS)

- Nursing Facility Services for Long-Term Care
- Multipurpose Senior Services Program (MPSS)
- In-Home Supportive Services (IHSS)

OneCare (HMO SNP)

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 services – 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 visits	Mental health care	Transportation – limited
Durable medical equipment	Outpatient rehabilitation	Urgently needed services
Emergency care	Outpatient substance abuse	Vision services

OneCare Connect

Scope of Services

Launched 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 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.

Back to Agenda

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 isn a better, more efficient and higher quality health care experience for the member.

These services include but are not limited to the following:

Acupuncture (pregnant women)	Hearing screenings	Over-the-counter drugs – limited
Ambulance services	Incontinence supplies – limited	Radiology
Case management	In-Home Supportive Services (IHSS)	Rehabilitation services
Chiropractic 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 care	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 care
Hearing aids – limited	Outpatient care	"Welcome to Medicare" preventive visit

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY

Back to Agenda

~~**Scope of Services**~~

~~Launched 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

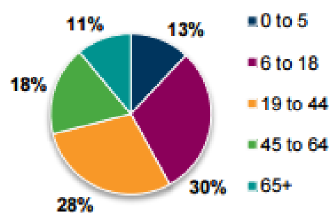
Fast Facts: February 2017

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

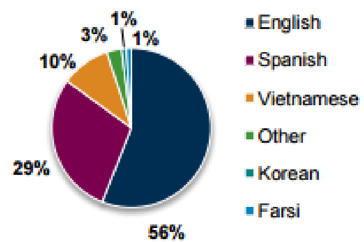
Membership Data as of December 31, 2016

Total CalOptima Membership	Program	Members
800,001	**Medi-Cal**	781,733
	OneCare Connect	16,810
	OneCare (HMO SNP)	1,275
	Program of All-Inclusive Care for the Elderly (PACE)	183

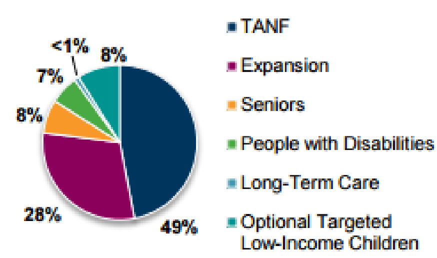
Member Age (All Programs)



Languages Spoken (All Programs)



Medi-Cal Aid Categories



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

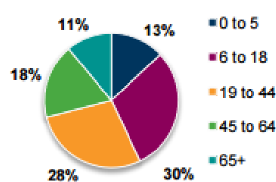
Total CalOptima Membership

779,410

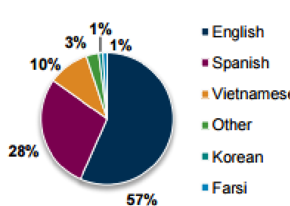
Program	Members
Medi-Cal	779,410
OneCare (HMO SNP)*	11,891
OneCare Connect*	4,437
Multipurpose Senior Services Program*	464
Program of All-Inclusive Care for the Elderly (PACE)*	129

*Membership already accounted for in total Medi-Cal membership

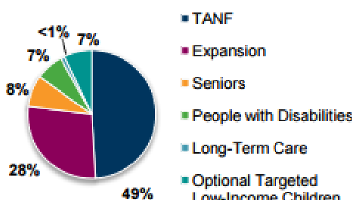
Member Age (All Programs)



Languages Spoken (All Programs)



Medi-Cal Aid Categories



QUALITY IMPROVEMENT PROGRAM

~~CalOptima's~~ CalOptima's ~~Quality~~ 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 incorporate data and best practices tailored to our populations. Our focus extends across the health care continuum, from preventive care, closing gaps in care, care management, disease management and complex care management. Our approach uses support systems for our members with vulnerabilities, disabilities and chronic illnesses.

CalOptima's ~~Quality Improvement~~QI Program includes processes and procedures designed to ensure that all medically necessary covered services are available and accessible to all members including those with limited English proficiency, diverse cultural and ethnic backgrounds, and regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, gender identity, health status, or disability, and that all covered services are provided in a culturally and linguistically appropriate manner.

AUTHORITY, ~~A~~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 oversees the functions of the ~~Quality Improvement~~QI Committee described in CalOptima's State and Federal Contracts — and to CalOptima's Chief Executive Officer (CEO), as discussed below.

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

The QI Program is based on ongoing data analysis to identify the clinical needs, risk levels and appropriate interventions to make certain that the program meets the specific needs of members. The CMO is charged with identifying appropriate interventions and resources necessary to implement the QI Program. Such recommendations shall be aligned with Federal and State regulations, contractual obligations and fiscal parameters.

Quality Improvement Program, Role of CalOptima Officers

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~~QI Committee (QIC) satisfies all remaining requirements of the QI Program, as specified in the State and Federal Contracts.

Chief Medical Officer (CMO) — or physician designee — chairs the QIC, which oversees and provides direction to CalOptima'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,~~CMO oversees strategies, programs, policies and procedures as they relate to CalOptima's medical care delivery system. The DCMO and CMO oversee Quality Analytics, Quality Management, ~~Utilization Management~~UM, Care Coordination, Case Management, H~~ealth~~ E~~ducation~~ &~~-~~D~~isease~~ M~~anagement~~, Pharmacy Management, Behavioral Health Integration and Long-Term Services and Supports.

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

Chief Operating Officer (COO) is responsible for oversight and day-to-day operations of several departments including Operations, Network Management, Information Services, Claims Administration, Customer Service, Grievance and Appeals Resolution Services (GARS), Coding Initiatives, ~~-and~~ Electronic Business and Human Resources.

Executive Director, Quality & Analytics (ED of QA) is responsible for facilitating the company-wide QI Program, driving improvements with Healthcare Effectiveness Data and Information Set (HEDIS), DHCS, CMS S~~s~~tar measures and ratings, and facilitating compliance with National Committee for Quality Assurance (NCQA) standards. The ED of QA serves as a member of the executive team and with the CMO/DCMO 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~~the Director of ~~for~~ Quality Improvement and the Director of Behavioral Health Services.

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

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 Strategic Development and 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 & Oversight department to refer any potential sustained noncompliance issues or trends encountered during audits of ~~health networks~~HNs, ~~provider medical group~~PMGs, and other functional areas. The 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.

Executive Director of Network Operations (ED of NO) ~~is responsible for leading and directing~~leads and directs the integrated operations of the health networks, and must coordinate organizational efforts internally, as well as externally, with members, providers and community stakeholders. The ED of NO is responsible for building an effective and efficient operational unit to serve CalOptima's networks and making sure the delivery of accessible, cost-effective, quality health care services throughout the service delivery network.

Executive Director of Operations (ED of O) is responsible for overseeing and guiding Claims Administration, Customer Service, Grievance & Appeals Resolution Services, Coding Initiatives, and Electronic Business

QUALITY IMPROVEMENT PROGRAM PURPOSE

The purpose of the CalOptima 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, as well as our contracted provider networks. Through the QI Program, and in collaboration with its providers, 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 CalOptima's multiple customers (members, health care providers, community-based organizations and government agencies):

- It is organized to identify and analyze significant opportunities for improvement in care and service.
- It fosters the development of improvement strategies, along with systematic tracking, to determine whether these strategies result in progress toward established benchmarks or goals.
- It is focused on QI activities carried out on an ongoing basis to promote efforts that support the identification and correction of quality of care issues.
- It maintains agencywide practices that support accreditation by the ~~National Commission for Quality Assurance (~~NCQA~~)~~, and meets Department of Health Care Services (DHCS) ~~&~~and Centers for Medicare & Medicaid Services (CMS) quality requirements and measures.

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

QUALITY IMPROVEMENT DEPARTMENT

The ~~Quality Improvement~~QI department is responsible for the execution and coordination of the quality assurance and improvement activities. ~~The QI Department~~It also 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. The QI department fully aligns with the other areas of 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~~QI 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 agencywide
- Evaluate and monitor provider credentials
- Support the maintenance of quality standards across the continuum of care and all lines of business
- Monitor and maintain ~~Maintain~~ agencywide practices that support accreditation and meeting regulatory requirements.~~by the National Commission for Quality Assurance (NCQA)~~

QUALITY ANALYTICS DEPARTMENT

The Quality Analytics (QA) department fully aligns with the QI team to support the organizational mission, strategic goals, required regulatory quality metrics~~ and~~, programs~~,~~ and ~~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~~QA department activities include design, implementation and evaluation of initiatives to:

- Report, m~~M~~onitor and trend outcomes
- Drive solutions and interventions to improve quality of care, access to preventive care, and management of chronic conditions to clinical guidelines
- 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 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 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~~HNs, 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 data
- CMS Stars Ratings (Stars) and Health Outcomes Survey (HOS) scores ~~STARS and HOCC~~ data
- Group Needs Assessments
- Results of Risk Stratification
- HEDIS Performance
- Member and Provider satisfaction surveys
- ~~Quality Improvement~~QI Projects (QIPs, PIPs and CCIPs)
- Health Risk Assessment (HRA) data

HEALTH EDUCATION & DISEASE MANAGEMENT DEPARTMENT

The Health Education & Disease Management (HE & DM) department is the third area in Quality that provides program development and implementation for ~~the~~ agencywide ~~chronic condition~~population health ~~improvement~~ programs. ~~Health Education & Disease Management (~~HE & DM~~)~~ Programs provide for the identification, assessment, stratification and implementation of appropriate interventions for members with certain conditions or chronic diseases. Programs and materials use educational strategies and methods appropriate for members 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, Perinatal Health, ~~Pediatric~~ Shape Your Life/Weight Management and Tobacco Cessation.

Back to Agenda

Primary goals of the department are to achieve member 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.

~~Health Education & Disease Management~~ HE & DM supports CalOptima members with customized 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~~QA and our Health Network Providers.

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

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 CalOptima's QI Program.

The QI 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 Program functions and activities:

Medical Director, Quality
Appointed by the CMO, the Medical Director of Quality 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.

~~Manager~~Director, Quality Improvement
Responsibilities include assigned day-to day operations of the QI department, including Credentialing, Facility Site Reviews, Facility Physical Access Compliance and working with the ED of Quality. -This position is also responsible for implementation of the QI Program and Work Plan implementation.

- The following positions report to the Quality Improvement ~~Manager~~Director:
  - Manager, Quality Improvement
  - Supervisor, Quality Improvement (PQI)
  - Supervisor, Quality Improvement (Credentialing)
  - QI Program Specialists

Back to Agenda

  - QI Nurse Specialists~~,~~
  - Data Analyst
  - Credentialing Coordinators~~,~~
  - Program Specialists
  - ~~Credentialing~~ Program Assistants
  - Facility Site Review Master Trainer
  - Facility Site Review Nurse Reviewers

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

- The following positions report to the Director of Quality Analytics:
  - Quality Analytics HEDIS Manager
  - Quality Analytics ~~Medical Data~~Pay for Value Manager
  - Quality Analytics QI Initiatives Manager
  - Quality Analytics Analysts
  - Quality Analytics Project Managers
  - Quality Analytics Program Coordinators
  - Quality Analytics Program Specialists

Director, Health Education & Disease Management
Provides direction for program development and implementation for the agencywide ~~health education and disease management~~population health initiatives. ~~e~~Ensures linkages supporting a whole-person perspective to health and health care with Case Management, Care Management ~~and~~, ~~Utilization Management~~UM, Pharmacy ~~&~~and Behavioral Health Integration. Also, supports the Model of Care implementation for members. Reports program progress and effectiveness to QIC and other committees to support compliance with regulatory and accreditation ~~agencies~~agency requirements.

- The following positions report to the Director, Health Education & Disease Management:
  - Disease Management Manager (Program Design)
  - Disease Management Manager (Operations)
  - Disease Management Supervisor (Operations)
  - Health Education Manager
  - Health Education Supervisor
  - Disease Management Health Coaches
  - Senior Health Educator
  - Health Educators
  - Registered Dieticians
  - Data Analyst
  - Program Manager
  - Program Specialists
  - Program Assistant

In addition, the following positions and areas support key aspects of the overarching QI Program, and our member-focused approach to improving our member's health status.

~~UM~~

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

Director of Utilization Management assists in the development and implementation of the ~~Utilization Management~~ UM ~~P~~program, policies, and procedures. This ~~D~~director ensures the appropriate use of evidenced-based clinical review criteria/guidelines for medical necessity determinations. -The ~~D~~director of U~~tilization~~ M~~anagement~~ also provides supervisory oversight and administration of the U~~tilization~~ M ~~anagement P~~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~~QI Committees, participates in the ~~Utilization Management~~UM Committee and the Benefit Management Subcommittee.

Director of Clinical Pharmacy Management leads the development and implementation of the Pharmacy Management (PM) ~~P~~program, develops and implements ~~Pharmacy Management~~PM ~~D~~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~~QI Committees. The ~~D~~director of ~~Pharmacy Management~~PM also guides the identification and interventions on key pharmacy quality and utilization measures.

Director of Care Management is responsible for Care Management, Transitions of Care, Complex Case Management and the clinical operations of OCC and OC~~the OneCare and MediConnect programs~~. The~~is~~ ~~D~~director supports improving quality and access through seamless care coordination for targeted member populations. Develops and implements policies, procedures and processes related to program operations and quality measures.

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 "Member-Centric" approach and helps keep~~ing~~ members ~~at~~in the least restrictive living environment, collaborate with stakeholders including community partners, and ensure LTSS services are available to the appropriate population. The ~~D~~director also develops and implements policies, procedures, and processes related to the LTSS program operations and quality measures.

Director of Behavioral Health Services 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. The~~is~~ ~~D~~director leads and assists the organization in developing and successfully implementing short and long~~-~~-term strategic goals and objectives toward integrated care. The ~~D~~director ~~BHI~~ plays a key leadership role in coordinating with all levels of CalOptima staff, is responsible for monitoring, analyzing, and reporting on changes in the health care delivery environment and identifying program opportunities affecting or available to assist CalOptima in integrating physical and behavioral health care services.

Director of Clinical Outcomes supports medical management with program development, data analysis, evaluation, and ~~and~~ specialized education related to the Model of Care and other Medical Affairs initiatives. The ~~D~~director contributes expertise in care management innovation, evaluation methods, data definitions and specifications, and predictive risk models to guide the stratification of members and allocation of appropriate resources. The ~~D~~director assumes leadership role as designated for new program development and/or implementation.

Director of Enterprise Analytics provides leadership across CalOptima in the development and distribution of analytical capabilities. The Director drives the development of the strategy and roadmap for analytical capability and leads a centralized enterprise analytical team that interfaces with all departments and key external constituents to execute the roadmap. Working with departments that supply data, the team will be responsible for developing or extending the data architecture and data definitions. Through work with key users of data, the enterprise analytics department develops platforms and capabilities to meet critical information needs of CalOptima.

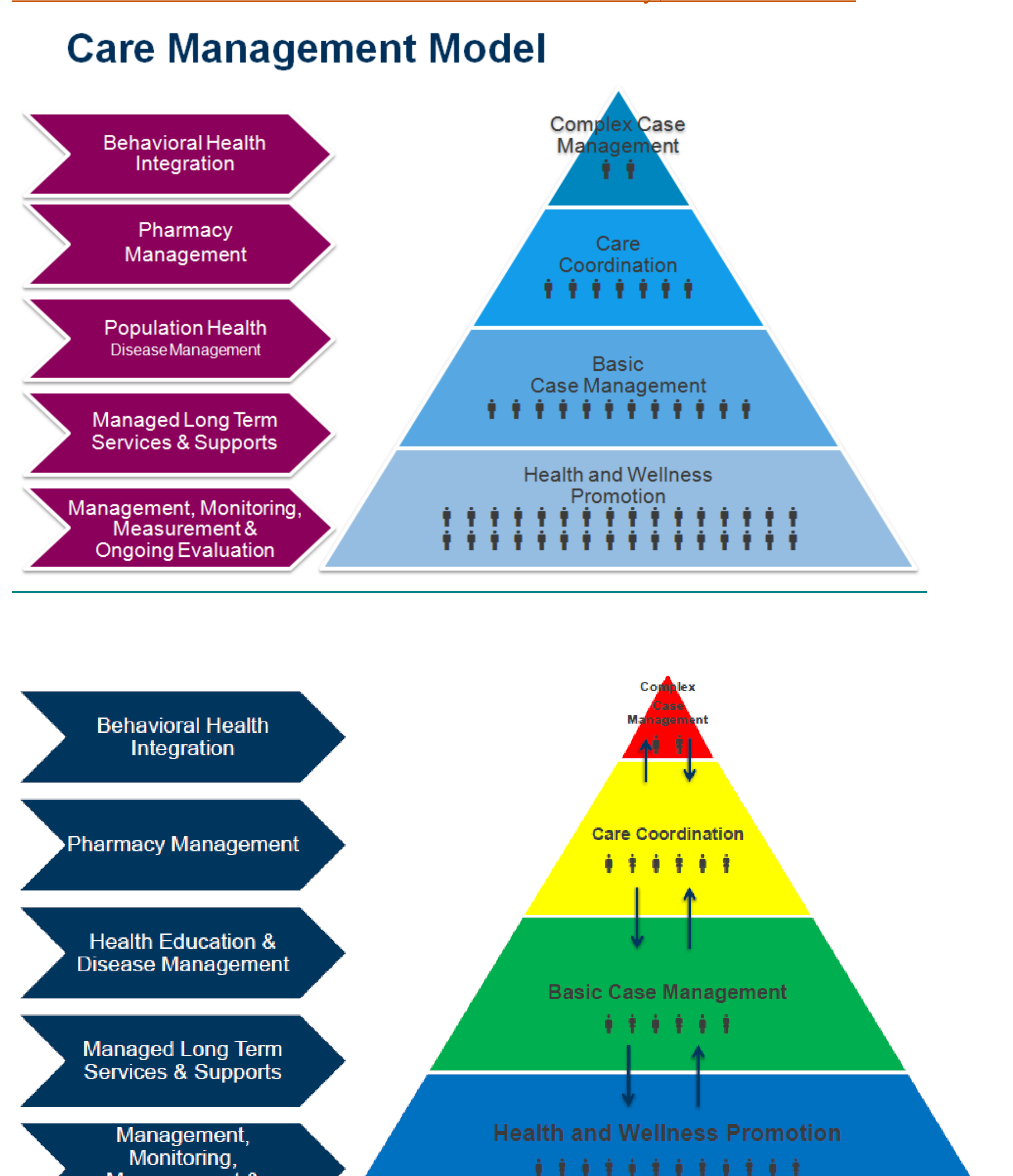
Quality Improvement ~~(QI)~~ Strategic Goals

The purpose of the 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.

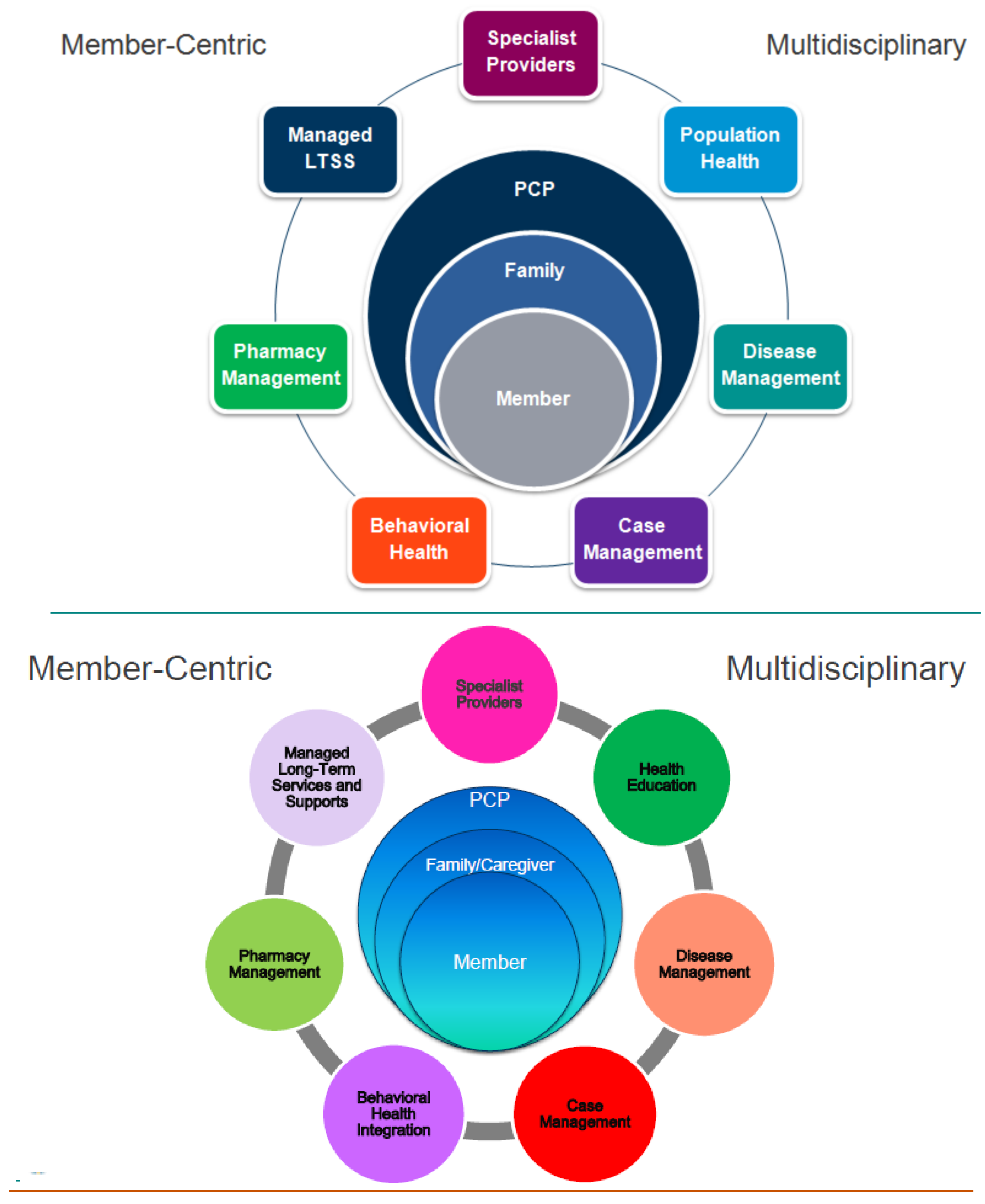
The QI Program incorporates continuous QI methodology that focuses on the specific needs of multiple stakeholders (members, health care providers and community and government agencies):

- It is organized to identify and analyze significant opportunities for improvement in care and service
- It 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

The QI Program supports a population health management approach, stratifying our population based on their health needs, conditions, and issues and aligns the appropriate resources to meet these needs. Our model follows an intervention hierarchy, as shown below:



In addition, our model recognizes the importance of multiple resources to support our members' health needs. The coordination between our various medical and behavioral health providers, pharmacists, care settings — plus our internal experts support a member-centric approach to care/care coordination.



QI Goals and Objectives

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, ~~OneCare~~OC ~~&~~and ~~OneCare Connect~~OCC populations relevant to its demographics, high-risks, 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 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 agency's strategic quality and business goals by utilizing resources appropriately, effectively and efficiently

- In addition, the QI Program:
  - 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
  - Makes certain contracted facilities report outbreaks of conditions and/or diseases to the public health authority — Orange County Health Care Agency — which may include but are not limited to MMethicillin RResistant sS*taphylococcus aureus* (MRSA), staphylococcus aureus infections, scabies, Ttuberculosis, etc., as reported by the health networksHNs.
  - 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 to essential services
- Improving access to affordable care
- Improving coordination of care through an identified point of contact
- Improving seamless transitions of care across health care settings, providers and health services
- Improving access to preventive health services
- Assuring appropriate utilization of services
- Improving integration of medical ~~and~~, behavioral health ~~services~~and pharmacy services
- Improving beneficiary health 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. Please see the Model of Care Quality Matrix in the 2017 QI Work Plan.

Quality Improvement Work Plan

~~(See Attachment A — 2016~~2017 ~~QI Work Plan)~~

The QI Work Plan outlines key activities for the upcoming year. It is reviewed and approved by the QIC and ~~the~~ CalOptima's Board of Directors' Quality Assurance Committee ~~of the Board~~. 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 QI Program and is based on the most recent and trended HEDIS, Consumer Assessment of Healthcare Providers & Systems (CAHPS), Stars and HOS scores, physician quality measures, and other measures identified for attention, including any specific requirements mandated by the State or accreditation standards where these apply. As such, measures targeted for improvement may be adjusted mid-year when new scores are received.

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~~Care Coordination/Complex Case Management
- ~~Client Revisions~~
- LTSS
- ~~Health Education &~~Population Health & Disease Management, Health Assessments and related CCIP, QIP, PIPs

- Access and Availability to Care
- Member Experience and Service (CAHPS)
- Patient Safety and Pharmacy Initiatives
- HEDIS~~/~~, STARS and~~/~~ ~~Health Outcomes Survey (~~HOS~~)~~ Improvement
- Delegation Oversight
- Organizational Quality Projects
- 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.

(SEE ~~ATTACHMENT~~APPENDIX A — 2017 QI WORK PLAN)

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 to ensure that medical decisions are not influenced by fiscal and administrative management considerations. As described in the ~~2016~~2017 ~~Utilization Management (~~UM~~)~~ Program all review staff are trained and audited in these principles. Clinical staff makes all medical necessity decisions and any denial based on medical necessity is made only by a physician reviewer, including those decisions made by delegated ~~health networks~~HNs. Medical 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.

Further details of the UM Program, activities and ~~can~~measurements can be found in the 2017 UM Program Description and related Work Plan.

~~UM WORK PLAN~~

~~(SEE ATTACHMENT B — 2017 UM WORK PLAN)~~

BEHAVIORAL HEALTH

CalOptima focuses on the continuum of care for both medical and behavioral health services. Focusing on continuity and coordination of care, CalOptima monitors and works to improve the quality of behavioral health care and services provided to our members. The QI 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 is involved in the behavioral aspects of the QI Program. The BH Medical Director is available for assistance with member behavioral health complaints, development of behavioral health guidelines, recommendations on service and safety, providinge~~e~~ 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 subcommittee of the CalOptima QI Committee. The BH Medical Director also serves as a voting member of CalOptima'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 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 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 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~~QI reports required by law or by the State Contract.

CONFLICT OF INTEREST

CalOptima maintains a Conflict of Interest policy that addresses the process to identify and evaluate potential social, economic and professional conflicts of interest and take appropriate actions so that they do not compromise or bias professional judgment and objectivity in quality, credentialing and peer review matters. ~~CalOptima maintains a Conflict of Interest policy to make certain potential conflicts area Conflict of Interest policy to make certain potential conflicts is 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 statement~~ who make or participate in the making of decisions that may foreseeably have a material effect on economic interests, file a Statement of Economic Interests form on an annual basis.

Fiscal and clinical interests are separated. CalOptima and its delegates do not provide any financial rewards or incentives to practitioners or other individuals ~~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 A~~A~~ND EDUCATION

CalOptima seeks to recruit highly qualified individuals with extensive experience and expertise in health services 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~~introductory period, with specific training, as applicable to ~~specific~~ individual job descriptions:

- CalOptima New Employee Orientation and B~~b~~oot Camp (CalOptima programs)
- HIPAA and Privacy~~/Corporate Compliance~~
- Fraud, Waste and Abuse, Compliance and Code of Conduct Training
- Workplace Harassment Prevention Training
- Use of technical equipment (phones, computers, printers, facsimile machines, etc.)
- Applicable ~~D~~department ~~P~~program, ~~P~~policies & ~~P~~procedures, etc.
- Appeals ~~P~~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 employee.

MOC-related employees and contracted providers and practitioners networks 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-to-face, interactive and web-based platforms as well as paper format.

SAFETY PROGRAM

Member (~~P~~patient) safety is very important to CalOptima; it aligns with CalOptima's mission statement: *To provide members with access to quality health care services delivered in a 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 and promotion
- Group Needs Assessment
- Over/Under ~~u~~Utilization monitoring
- Medication Management
- Case Management/Disease Management
- Operational Aspects of Care and Service

To ensure m~~M~~ember ~~S~~safety, activities for prevention, monitoring and evaluation include:

- Providing education and communication through the Group Needs Assessment to assess the member's comprehension through their language, cultural and diverse needs
- Distributing member information that improves their knowledge about clinical safety in their own care; (such as member brochures, which outline member concerns or questions that they should address with their practitioners for their care)

Collaborating with ~~Health Networks~~HNs and practitioners in performing the following activities:

- ~~i~~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 & 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 (ADA) and ~~SPD (~~Seniors and Persons with Disabilities (SPD) site review audits into the general facility site review process

Back to Agenda

- 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-Term Care (LTC),~~ CBAS, SNF, ~~and~~ MSSP settings and Long-Term Services and Supports (LTSS) settings
  - Falls and other prevention programs
  - Identification and corrective action implemented to address post-~~-~~operative complications
  - Sentinel events, ~~&~~ critical incident identification ~~and~~, appropriate investigation and remedial action
  - Administration of flu and ~~/~~pneumonia vaccine
- Administrative offices
  - Fire, disaster, and evacuation plan, testing and annual training
  -

COMMITTEES AND KEY GROUP STRUCTURES

~~(SEE PAGE 52 — 2017 QUALITY IMPROVEMENT 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~~ comprised of 15 voting members, each seat represent~~satives of the population~~a constituency served by CalOptima ~~serves~~. The MAC ensures that CalOptima members' values and needs are integrated into the design, implementation, operation, and evaluation of the overall QI program. The 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 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:

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

Two of the 15 positions — held by the Health Care Agency and the Social Services Agency — are permanent. Each of the remaining 13 appointed members serve two-year terms with no term limits.

OneCare Connect Member Advisory Committee

The OCC Member Advisory Committee (OCC MAC) is comprised of 10 voting members, each seat representing a constituency served by OCC and four non-voting liaisons representing county agencies, collaborating on the implementation of the program.

The OCC MAC membership is comprised of representatives from the following constituencies:

- OCC beneficiaries or family members of OCC beneficiaries (three seats)
- CBAS provider representative
- Home- and Community-Based Services (HCBS) representative serving persons with disabilities
- HCBS representative serving seniors
- HCBS representative serving members from an ethnic or cultural community
- IHSS provider or union representative
- LTC facility representative
- Member advocate, such as Health Insurance Counseling and Advocacy Program, Legal Aid Society, or Public Law Center
- Non-voting liaisons include seats representing the following county agencies:
    - Orange County Social Services Agency
    - Orange County Community Resources Agency, Office on Aging

- Orange County Health Care Agency, Behavioral Health
- Orange County IHSS Public Authority

The four non-voting liaison seats held by county agencies are standing seats. The 10 appointed voting members serve two-year terms with no term limits.

Back to Agenda

Provider Advisory Committee

The Provider Advisory Committee (PAC) is comprised of 15 voting members, each seat representing a constituency that works with CalOptima and our members. These include:

- ~~composed of representatives from the following constituencies:~~

~~Health Networks~~

- HNs
- Hospitals
- Physicians
- Nurses
- Allied Health Services
- Community Clinics
- ~~The~~ Orange County Health Care Agency (HCA)
- ~~Long-Term Services and Supports~~LTSS including (LTC ~~F~~facilities and CBAS)
- Mid-~~L~~level ~~P~~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 ~~P~~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 evaluates whether activities are consistent with CalOptima's strategic goals and priorities. It supports efforts to ensure 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~~QI 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 Program through planning, design, implementation and review
- Identifies needed actions and interventions
- Makes certain that there is follow-up as necessary

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 oversees and coordinates 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** ~~—~~ ~~d~~Detailed description and goals
- **Do** ~~—~~ ~~I~~Implementation of the plan
- **Study** ~~—~~Dd~~ata and collection
- **Act** ~~—~~A~~a~~nalyze 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 process to ensure that activities are consistent with CalOptima's strategic goals and priorities. It promotes efforts to ensure 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 Behavioral Health Quality Improvement Committee ~~BH QI Committee~~(BHQIC)
- Executive Director, Clinical Operations
- Director, ~~of~~ Network Management
- Director, Business Integration

The QIC is supported by:

Executive Director, Quality Improvement

~~Manager~~Director, 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. ~~–~~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 phone.

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

QIC and all ~~quality improvement~~QI 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:

- ~~g~~Goals and objectives outlined in the QI Charter ~~and which include but are not limited to:~~
- Active discussion and analysis of quality issues analysis
- 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 are~~ Quality Improvement C~~C~~ommittees A~~A~~nd ~~s~~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~~ ensure 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 at least quarterly.~~, 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 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~~HNs.
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 & Oversight, ~~Quality Improvement~~QI (PQI issues), and GARS (complaints) and take action on credentialing or quality issues, as appropriate.
3. Provide guidance and peer participation in the CalOptima credentialing and re-credentialing 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.
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~~GARS, ~~Utilization Management~~UM, Case Management, ~~and~~ Pharmacy and LTSS) and/or the CMO or his/her physician designee related to CalOptima Direct/CalOptima Care Network or its delegated ~~Health Networks~~HNs.
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, 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 CalOptima'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.

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

Grievance and Appeals Resolution Services Subcommittee (GARS)

The ~~Grievance and Appeals Resolution Services~~GARS 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 for all CalOptima providers. 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 & Therapeutics Subcommittee (P&T)

The ~~Pharmacy & Therapeutics (~~P&T~~)~~ s~~S~~ubcommittee 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 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 includes practicing physicians and the contracted provider networks. A majority of the members of the P&T 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

Back to Agenda

P&T provides written decisions regarding all formulary development and revisions. The P&T meets at least quarterly, and reports to the UM subcommittee.

Utilization Management Subcommittee (UM)

The ~~Utilization Management~~ UM 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~~UM 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 subcommittee monitors the utilization of health care services by CalOptima Direct 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. Additionally, the UMC also includes and is supported by the following staff positions:

~~The UM subcommittee is supported by:~~
CMO/DCMO
Medical Director, Concurrent Review
Director, Utilization Management
Director, Pharmacy
Director, Enterprise Analytics
Manager, Referral/Prior Authorization
Manager, Concurrent Review

Quorum:
A quorum consists of fifty percent (50%) plus one of voting member participation and of the eleven, the minimum quorum must include three 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 practitioner is defined as medical director, clinical director or participating practitioner from the organization.*

Benefit Management Subcommittee (BMSC)
The purpose of the ~~Benefit Management subcommittee~~ BMSC is to oversee, coordinate, and maintain a consistent benefit system as it relates to CalOptima'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 department provides ~~the~~ technical support to the subcommittee, which includes, but is not limited to, analyzing regulations and guidance that impacts the benefit sets and CalOptima's authorization rules.

Long-Term Services and Supports Subcommittee (LTSS)
The LTSS subcommittee is composed of representatives from the ~~Long-Term Care (~~LTC~~)~~, ~~Community-Based Adult Services (~~CBAS~~)~~, IHSS and ~~Multipurpose Senior Services Program (~~MSSP~~)~~ communities, which may include administrators, directors of nursing, facility Medical Directors, and pharmacy consultants, along with appropriate CalOptima staff. ~~Previously, the CBAS Quality Advisory sSubcommittee was integrated into the LTSS Quality Ssubcommittee. 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 and access 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,~~"~~ monitor over and underutilization patterns and partner with facilities to share the information as it is identified. The LTSS subcommittee meets quarterly and reports through Clinical Operations ~~S~~subcommittee to the QIC.

~~**Benefit Management Subcommittee (BMSC)**~~
~~The purpose of the Benefit Management Ssubcommittee is to oversee, coordinate, and maintain a consistent benefit system as it relates to CalOptima'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 department provides the technical support to the subcommittee, which includes, but is not limited to, analyzing regulations and guidance that impacts the benefit sets and CalOptima's authorization rules.~~

Behavioral Health Quality Improvement Committee (BHQIC)
The ~~Behavioral Health Quality Improvement Committee~~BHQIC ~~was established in 2011 to~~ ensures members receive timely and satisfactory behavioral health care services, through enhancing ~~continuity~~ integration 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 ~~M~~member benefits and services are not underutilized and that assessment and appropriate interventions are taken to identify inappropriate over utilization
- Utilize ~~M~~member and ~~N~~network ~~P~~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 ~~N~~network ~~P~~providers

- Document and report all monitoring activities to appropriate committees

The designated ~~C~~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 BHQIC ~~Committee~~ is defined in the BHQIC Charter and includes, but may not be limited to the following:

- Medical Director, Behavioral Health Integration (Chair)
- Chief Medical Officer/Deputy Chief Medical Officer
- Medical Director, Quality and Analytics
- Executive Director, 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 BHQIC shall meet, at a minimum, on a quarterly basis, or more often as needed.

Additionally, CalOptima is formalizing two additional subcommittees to QIC, focusing on Clinical Operations and Member Experience.

Clinical Operations/Population Health -Subcommittee ~~:~~(COPHS)

The purpose of the ~~Clinical Operations Subcommittee~~COPHS is to oversee, guide and ensure the integration and coordination of functions across the continuum of care, including but not limited to population health, disease management, care management, complex case management, ~~utilization management~~UM, LTC~~long term care~~, pharmacy & behavioral health services.- This subcommittee monitors the progress of the established program goals and metrics defined for CalOptima's disease management, complex case management programs and Model of Care. ~~This subcommittee~~COPHS reviews these programs at least quarterly, and includes the following key individuals:

- Chief Medical Officer/Deputy Chief Medical Officer
- Executive Director, Clinical Operations
- Executive Director, Quality & Analytics
- Director, Care Management
- Director, Utilization Management
- Director, Health Education & Disease Management

Back to Agenda

- Director, Enterprises Analytics
- Director, Quality Analytics
- Director, Long--Term Services & Supports
- Director, Quality Improvement
- Director, Clinical Outcomes
- Director, Clinical Pharmacy Management
- Director, Behavioral Health Services.

Member Experience Subcommittee ~~:~~(MES)

The final subcommittee in the quality committees structure is MES and focuses on the issues and factors that influence the member's experience with the health care system for Medi-Cal, ~~OneCare~~OC, O~~ne~~C~~are~~ ~~Connect~~ ~~&~~and LTSS. NCQA Medicaid Plan Ratings measure three dimensions – Prevention, Treatment and Customer Satisfaction.- CalOptima's ~~Quality Improvement~~QI program focuses on the performance in each of these areas. -The ~~Member Experience Subcommittee~~MES is designed to assess the annual results of CalOptima's CAHPS surveys, monitor the provider network including access & availability (CCN & the ~~Health Networks~~HNs), review customer service metrics and evaluate complaints, grievances, appeals, authorizations and referrals for the "pain points" in ~~healthcare~~health care that impact our members.

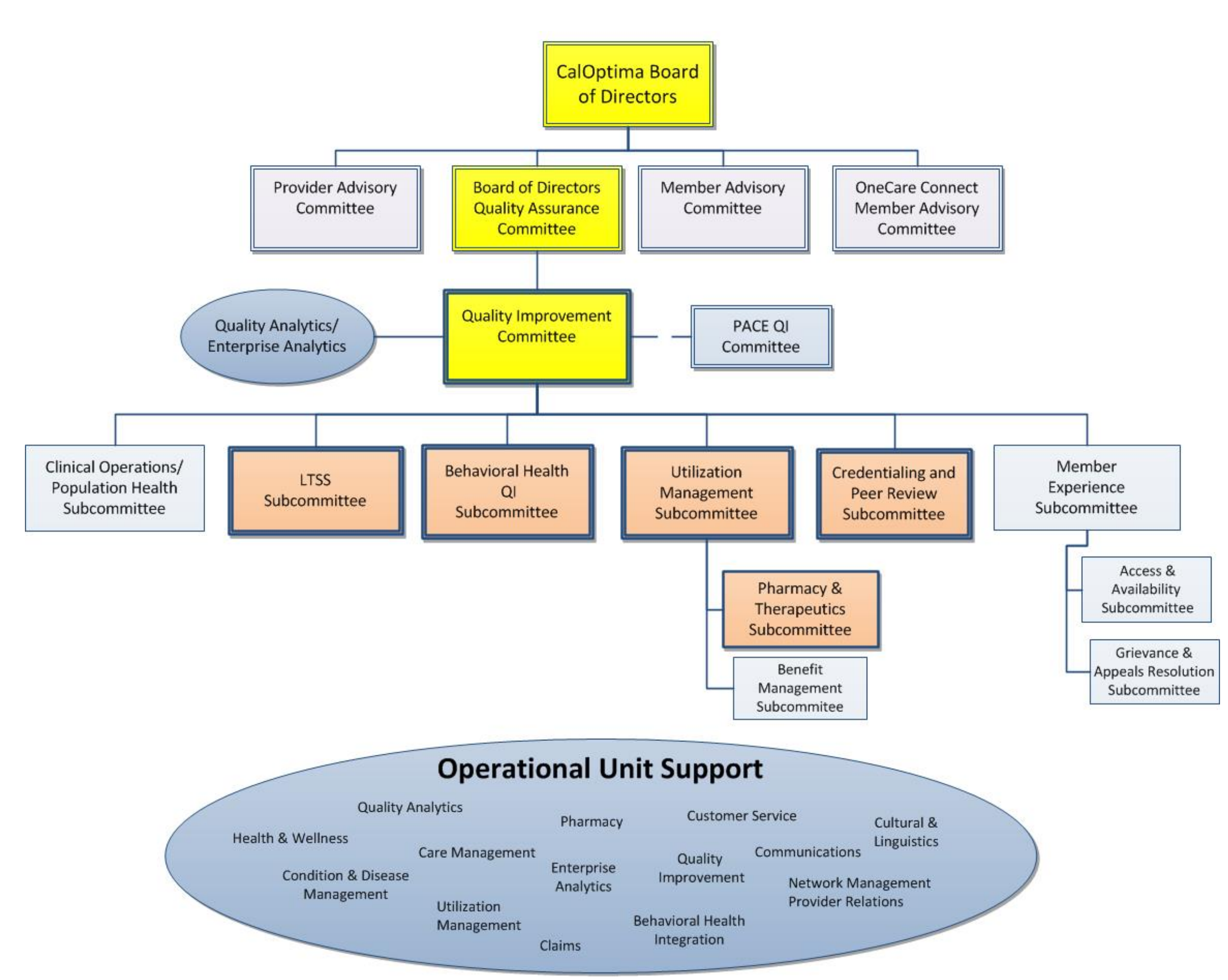
-This subcommittee meets at least bi-monthly and includes the following key individuals:

- Chief Medical Officer/Deputy Chief Medical Officer or designee
- Executive Director, Quality & Analytics
- Director, Customer Service
- Director, Grievances & Appeals
- Director, Network Management
- Director, Provider Services
- Manager, Access & Availability
- Director, Quality Analytics
- Director, Utilization Management~~.~~

The ~~Member Experience Subcommittee~~MES focuses on improving the following key areas of satisfaction:

- Getting needed care & getting care quickly
- How well doctors communicate
- Customer service
- Rating of health care, providers ~~&~~and health plan
- Other areas as defined by specific metrics, focus groups or survey results.

2017 Committee Organization Structure — Diagram



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-term ~~care~~services and supports, and ancillary care services

- Access to and availability of services, including appointment availability, as described in the ~~Utilization Management~~UM Program and in policy and procedure
- Coordination and continuity of care for ~~seniors and persons with disabilities~~SPD
- Provisions of chronic, 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~~or 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~~in order ~~to allow performance of~~ conduct 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 CalOptima'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 or Mmanagement 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-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 care management levels that reflect the health risk status of members. ~~All~~ SPD, OCC and OC 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.~~ This s~~S~~tratification results in the ~~categories~~categorizing members as ~~of~~"high" ~~and~~or "low" ~~risk, for those members who are stratified. The~~risk. The case management levels (CML) of complex, care coordination and basic are specific to SPD, OCC and OC members who have either completed a HRA or have been identified by or referred to case management.

An Interdisciplinary Care Team (ICT) is linked to these members to assist in care coordination and services to achieve the individual's health goals. -The ICT may occur at the PCP (basic), the Health Network/Group ~~&~~and system (primary), or system/transition (complex) level, dependent upon the results of the member's HRA and/or evaluation or changes in the member's health status.

~~The 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 Interdisciplinary Care Team (ICT) for members in basic case management occurs at the primary care provider level. (This is ***not*** the same as saying that low risk members have a ICT at the PCP level. For instance, a member may stratify low risk, have an HRA completed, and as a result of information gathered through the HRA process, be placed in care coordination or complex case management.) Conversely, a member who stratifies as high risk and completes an HRA may ultimately be found to be more appropriate for basic case management.~~

The ~~members of the~~ ICT always includes the member (and caregivers 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, specialist(s), case management team, behavioral health specialist, pharmacist, social worker, dietician, and/or long-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-Risk Members — ~~Basic Team~~occurs at the PCP level
  - Team Composition: member, caregiver or authorized representative, PCP, PCP support staff (nurse, etc.)
    - 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 member's health status
        - Referral to the primary ICT, as needed

- Primary ICT for Moderate to High-Risk Members — ICT occurs at the Physician Medical Group (PMG) level or the Health Plan for Community Network
    - ICT Composition (appropriate to identified needs): member, caregiver, or authorized representative, ~~PMG~~ health network (HN) Medical Director, PCP and/or specialist, ambulatory case manager (CM), hospitalist, hospital CM and/or discharge planners, ~~PMG~~ HN ~~Utilization Management~~UM staff, behavioral health specialist and social worker
        - 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 — ICT at the Physician Medical Group (PMG) level or Health Plan for Community Network
    - Team Composition (a~~A~~s appropriate for identified needs): member, caregiver, or authorized representative, ~~PMG~~ HN Medical Director, CalOptima clinical/~~PMG~~ HN case manager, PCP and/or specialist, social worker, and behavioral health specialist
        - Roles and responsibilities of this team:
            - Consultative for the PCP and ~~PMG~~ HN teams
            - Encourages member engagement and participation in the IC~~D~~T process
            - Coordinating the management of members with complex transition needs and development of ICP
            - Providing support for implementation of the ICP by the ~~PMG~~HN
            - Tracks and trends the activities of the ~~IDTs~~ICTs
            - Analyze data from different data sources in the plan to evaluate the management of transitions and the activities of the ~~IDTs~~ ICTs 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 Eligible Special Needs Plan (SNP)/~~OneCare~~ OC and ~~OneCare Connect~~OCC

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 re~~-~~hospitalization
- 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 management performs these activities and coordinates services for members to optimize their health status and quality of life

CalOptima's goals for ~~2016~~2017 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~~2017 Case Management Program Description for further details and program plans.

DISEASE MANAGEMENT PROGRAM

The Disease Management (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 health care practitioner and CalOptima. The DM program stratifies the population and identifies appropriate interventions based on member needs.

These interventions include coordinat~~es~~ing care for members across ~~time,~~ local~~tes~~ and provid~~es~~ing services, ~~and~~ resources, and support to~~s the~~ members as they learn to care for themselves and their condition. The ~~Disease Management (~~DM~~)~~ ~~P~~program also ~~is a targeted program~~identifies those members in need of closer ~~for the~~ management, coordination~~,~~ and intervention~~. for a highly vulnerable patient population~~. CalOptima assumes responsibility for the ~~Disease Managemen~~DM~~t~~ program for all of its lines of business, therefore the management for ~~Disease Management~~DM is ~~non-~~not delegated to the PHCs, SRGs, HMOs and PMGs. -The contracted PHCs, SRGs, HMOs and PMGs must participate collaboratively with interventions necessary to produce ~~compliant~~ identified quality outcomes. The DM Program is evaluated on an annual basis.

~~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.~~

Further details of the ~~Disease Management~~DM ~~P~~programs, activities and measurements can be found in the 2017 ~~Disease Management~~DM Program Description.

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

~~CLINICAL DATA WAREHOUSE~~~~QUALITY~~QUALITY A~~NALYTICS~~NALYTICS

Core to the QI Program is the statistical analysis of various data sources to support continuous quality improvement of our programs, projects, activities, and initiatives. ~~The~~ CalOptima's Clinical Data Warehouse is a dynamic environment which aggregates data from ~~CalOptima's~~ various core business ~~systems and~~ processes, such as member eligibility, provider, encounters, claims, ~~and~~ pharmacy and care management systems to support the QI program. The clinical data warehouse allows staff to apply logic, population definitions and/or evidence-~~based clinical practice guidelines~~based 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~~ diseases or conditions, 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 or 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 heath education, disease management and HEDIS or Stars 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, STARS~~tars~~ and HOS 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~~ are no other regulatory reporting requirements 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

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

CalOptima provides comprehensive acute and preventive care services, which 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 availability
- Continuity and coordination of care
- Preventive care, including:
  - Initial Health Assessment
  - Initial Health Education
  - Behavioral Assessment
- Patient diagnosis, 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 departments, 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 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 CalOptima's QI standards and to participate in CalOptima'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. 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~~2017 ~~Delegation Grid.)~~

Non-Delegated Activities

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

- ~~Quality Improvement~~QI, as delineated in the Contract for Health Care Services
- QI ~~P~~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~~ DM ~~P~~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 surveys 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~~health care delivery organizations (HDOs)
- Credentialing and re-credentialing of HDOs
- Development of ~~Utilization Management~~UM 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 and Federal agencies, medical boards, insurance companies, and other managed care entities and health care organizations

Further details of the delegated and non-delegated activities can be found in the 2017 Delegation Grid.

See Appendix B~~C~~ — 2017 Delegation Grid

~~Peer Review Process~~

~~Peer Review is coordinated through the QI Ddepartment. Medical staff triage potential quality of care issues and conduct reviews of suspected physician and ancillary quality of care issues. All closed cases are presented to CPRC to assess if documentation is complete, and no further action is required. The QI 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 department are based on referrals to the QI department originated from multiple areas, which include, but are not limited to, the following: prior authorization, concurrent review, case management, legal, compliance, customer service, pharmacy, or grievances and appeals resolution.~~

Cultural & Linguistic Services

CalOptima serves a large and culturally diverse population. The five most common languages spoken for all CalOptima programs are: English at 57 percent, Spanish at 28 percent, Vietnamese at 10 percent, Farsi at one percent, Korean at one percent, Chinese at one percent, Arabic at one percent 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, Farsi, Chinese and Arabic
- ~~OneCare~~ OC member materials are provided in three languages: English, Spanish and Vietnamese
- ~~OneCare Connect~~OCC 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

Back to Agenda

- 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 language or gender specific risks
- Identify and reduce a specific health care disparity affecting a withparticular cultureal, race or, gender group
- Provide information, training and tools to staff and practitioners to support culturally competent communication

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 cases are reviewed by a Medical Director who determines a proposed action, dependent on the severity of the case. The Medical Director presents these cases to CPRC, which provides the final action(s). The QI department tracks, monitors, and trends PQI cases, in order to determine if there is an opportunity to improve care and service. Results of Quality of Care reviews, tracking and trending of service and access issues are reported to the CPRC, and are also reviewed at time of re-credentialing. Potential quality of care case referrals are sent to the QI department from multiple areas at CalOptima, which include, but are not limited to, the following: prior authorization, concurrent review, case management, legal, compliance, customer service, pharmacy, or grievances and appeals resolution.

Comprehensive Credentialing Program Standards

The comprehensive credentialing process is designed to provide ongoing 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, DPMs (doctor of podiatric medicine), DC (doctor of chiropractic medicine), DDS (doctor of dental surgery), allied health and midlevel practitioners, which include, but are not limited to: behavioral health practitioners, certified nurse midwives, certified nurse specialists, nurse practitioners, optometrist, physician assistants, optometrists, registered physician therapists, occupational therapists, speech therapists and audiologists, -etc., both in the delegated and CalOptima direct environments. -Credentialing and recredentialing activities are delegated to the Health NetworksHNs and performed by CalOptima for CCN.

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 or 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~~ 14-004. CalOptima assumes responsibility and conducts and coordinates Facility Site Review (FSR), Medical Record Review (~~/~~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~~14-004 and CalOptima policies. Medical records of new providers shall be reviewed within ninety calendar days of the date on which members are first assigned to the provider. An additional extension of ninety 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 ~~seniors and persons with 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 an 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~~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, continuity of care, and promotes efficiency and effectiveness of treatment. All medical records should, at a minimum, include all information required by State and Federal laws and regulations, and the requirements of CalOptima'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 State law.

CORRECTIVE ACTION PLAN(S) TO IMPROVE CARE, SERVICE

When monitoring by either CalOptima's Q~~uality ~~I~~mprovement D~~department or Audit & Oversight ~~D~~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 QI department or Audit and Oversight ~~D~~department as overseen by the ~~Delegation ~~Audit & Oversight Committee, reporting to the Compliance Committee. –Those activities specific to CalOptima's functional areas will be overseen by the Q~~uality ~~I~~mprovement~~ d~~D~~epartment 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 ~~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: the 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 state 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 Ssubcommittees will report their summarized information to the QIC at least 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 CalOptima'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 synopsized QI report (both web-site and hardcopy availability for both practitioners and members) shall be posted on CalOptima'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
- Member Advisory Committee (MAC), OCC Member Advisory Committee (OCC MAC) and Provider Advisory Committee (PAC).

ANNUAL PROGRAM EVALUATION

The objectives, scope, organization and effectiveness of CalOptima'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 initiatives and incorporated into the QI Work Plan and reported to DHCS & and 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."

APPENDIX A — 2017 QI WORK PLAN

APPENDIX B — 2017 DELEGATION GRID

"Attachment A"

CalOptima
20176 Quality Improvement Work Plan
OneCare Connect/OneCare and Medi-Cal
February, 20167

I. Program Oversight

- **A. Program Sscope- 2017 QI Annual oversight of programs and work plans** 2/9/16
- **B. Program Scope- 20156 QI Program Annual Evaluation**
- **C. Program Scope- 2017 UM Program and UM Work Plan annual oversight**
- **D. Program Scope- 201765 UM Program Annual Evaluation**
- **E. Quality of Care- 2017 Case Management Program annual oversight**
- **F. Quality of Ccare- 20156 Case Management Program Evaluation**
- **G. Quality of Care- 2017 Disease Management Program annual oversight**
- **H. Quality of Care- 20156 Disease Management Program Evaluation**
- **I. Quality of Care- Credentialing Peer Review Committee (CPRC) Oversight**
- **J. NCQA Monitoring & Compliance**

INITIAL WORK PLAN AND APPROVAL:

Submitted and approved by QIC Date:

Submitted and approved by Board Date: 4/1/16

Submitted and approved by Board of Director's Date: 3/23/16

Quality Assurance Committee (QAC)

Quality Improvement Committee Chairperson:

Medical Director Date:

Board of Directors' Quality Assurance Committee Chairperson:

Board of Directors' Quality Assurance Committee Chairperson:

Paul Yost, Viet Van Dang, MD

Date:

II. Case Management

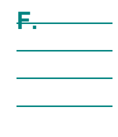
- **A. Quality of Clinical Care- Review of health risk assessments to OCC, OC, SPD members**
- **B. Quality of Clinical Care- Continuity & Coordination of Medicceal/BH**
- **C. Quality of Clinical Care- Review of emergency department communications**
- **B. with PCPs**
- **D.C. Patient Safety, Quality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

III. Behavioral Health

- **A. Quality of Clinical Care: HEDIS Measure for M/C & OCCIntegration of BH services**
- **B. Quality of Clinical Care: Interdisciplinary Care Treatment Team Participationare- Clinical BH Practice Guidelines adoption for Medi-Cal line of business**
- **C. Quality of Clinical Care: Behavioral Health Practice Guidelines**
- **C. Access and Coordination of Care Service and Quality of Clinical Care- Review of behavioral health**
- **D. providers communications with PCPs**

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: Hospital Readmissions**
- **D. Safety of Clinical Care and Quality of Clinical Care-Review and Assess Readmissions for LTSS members participating with each organization/program: Long Term Care Admissions**



~~D.~~ E. **Quality of Clinical Care~~-~~ Review of health risk assessment (HRA) for OneCare Connect (OCC) Long Term Care (LTC) members**

~~E.~~ F. **CBAS Member Satisfaction**

G. **SNF Member Satisfaction**

~~F.~~

“Attachment A”

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 Programs ~~(Asthma)~~
~~C. Quality of Clinical Care, review of Disease Management Program (Diabetes)~~
~~B. Quality of Clinical Care, review of Disease Management Program (CHF)~~
~~E.~~ Quality of Care-Clinical Practice Guidelines adoption for Medi-Cal line of business
~~C. Quality of Clinical Care, review of member satisfaction with DM programs~~
D. 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)~~
E. Implementation of Population Health & Wellness Programs
F. Quality of Clinical Care-Quality and Performance Improvement Projects

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. Pharmacy Benefit Manager (PBM) Oversight Management ~~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 “Measures” worksheet
~~C.~~ Improve CAHPS Measures listed on “Measures” worksheet
C. ~~HEDIS: Launch pediatric wellness clinic~~
D. STARS Medication Related Measures~~improvement- Medication Adherence Measures~~

“Attachment A”

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

X. Delegation Oversight
- **A. Delegation Oversight of CM**
- **B. Quality of Care & S~~s~~ervice of UM through ~~d~~Delegation ~~o~~Oversight ~~r~~Reviews**
- **C. Delegation Oversight of BH Services**

XI. Organizational Projects
- ~~**A. Implementation of the 2016 Value Based P4P program**~~
- **A. Value Based P4P 2017**
- **B. MOC Dashboard 2016-2019**

Previously identified issues to be monitored

"Attachment A"

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: 2/9/16
   Approved by QAC: 3/23/16
   Approved by Board: 4/1/16

2. **Goals**
   - Annual Adoption

B. Program Scope-20166 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: 2/9/16
   Approved by QAC: 3/23/16
   Approved by Board: 4/1/16

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

Owner: Terrie StanleyTracy Hitzeman, Interim 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: 2/9/16
   Approved by QIC: 2/9/16
   Approved by QAC: 3/23/16
   Approved by Board: 4/1/16

2. **Goals**
   - Annual Adoption

D. Program Scope-20166 UM Program Annual Evaluation

Owner: Terrie StanleyTracy Hitzeman, Interimnterim ED Clinical OperationsCO

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

   Approved by QIC: 2/9/16
   Approved by QAC: 3/23/16
   Approved by Board: 4/1/16

2. **Goals**
   - Annual Evaluation

E. Quality of Care-- 201676 Case Management Program Annual Oversight **Owner: Tracy HitzemanSloane Petrillo, Interim Director, Case Management**

1. **Activity**
   - CM Program will be adopted on an annual basis
   - Delegation oversight reported by DOC

Approved by QIC: 2/9/16
Approved by QAC: 3/23/16
Approved by Board: 4/1/16

2. **Goals**
   - Annual Adoption

F. Quality of Care- 20166 Case Management Program Evaluation **Owner: Sloane Tracy HitzemanPetrillo, Interim DirectorDtr, 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:

Approved by QIC: 2/9/16
Approved by QAC: 3/23/16
Approved by Board: 4/1/16

2. **Goals**
   - Annual Evaluation

G. Quality of Care- 201676 Disease Management Program Annual Oversight **Owner: Pshyra Jones, DirDir.ector, of Health Education & Disease Management**

1. **Activity**
   - DM Program will be adopted on an annual basis

Approved by QIC: 2/9/16
Approved by QAC: 3/23/16
Approved by Board: 4/1/16

2. **Goals**
   - Annual Adoption

H. Quality of Care- 20166 Disease Management Program Evaluation **Owner: Pshyra Jones, Ditr. Health EdHE 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:

Approved by QIC: 2/9/16
Approved by QAC: 3/23/16
Approved by Board: 4/1/16

"Attachment A"

2. **<u>Goals</u>**
   - Annual Evaluation

"Attachment A"

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 — Approved by QIC: Q1 Q2 Q3 Q4
   - Delegation oversight reported by DOC — Approved by QIC: QI 4/13/16 Q2 Q3 Q4
2. **Goals**
   - **Quarterly Adoption of Report**

J. NCQA Monitoring & Compliance

Owner: Kelly Rex-KimmetEsther Okajima, Director, Quality ImprovementA

1. **Activity**
   - Evaluate NCQA standards, HEDIS & CAHPS for improvement opportunities to achieve Commendable status — Approved by QIC: Q1 Q2 Q3 Q4

Approved by QIC

2. **Goals** — Q1 Q2 Q3 Q4
   - 2. Annual HIP RankingRating

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"Attachment A"

"Attachment A"

II. Case Management

A. *Quality Of Clinical Care-Review of HHealth rRisk aAssessments to OCC, OC, SPD members

A. Owner: Tracy HitzemanSloane Petrillo, Interim DirectorDtr, -CM

The Approach

1. Objective

- **OCC-** Health Risk Assessment Outreach for members in the OneCare Connect Program monitored for completion and collection
  - Initial HRA
  - Annual HRA
- **OC-** Health Risk Assessment Outreach for members in the OneCare Program monitored for completion
  - Initial HRA
  - Annual HRA
- **SPD-** Health Risk Assessment Outreach for Seniors and Persons with Disabilities monitored for completion
  - Initial HRA
  - Annual HRA

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

- **Completion of Outreach**

  Completion of outreach

  OCC-100% of eligible population
  - **OCCC**- 100% of eligible population
  - **OCSPD**-1- 100% of eligible population
  - **SPD**-100% of eligible population
- **Collection**
  - **OCC**-Collect 56% of high risk OCC HRAs
  - **OCC**-Collect 43% of low risk OCC HRAs
  - **OC**-Collect 78% of initial OC HRAs
  - **OC**-Collect 34% of annual OC HRAs
  - **SPD**-Collect 63% of initial SPD HRAs

Collection

OCC-Collect 56% of high risk OCC HRAs

"Attachment A"

OCC-Collect 43% of low risk OCC HRAs

OC-Collect 78% of initial OC HRAs

OC-Collect 34% of annual OC HRAs

SPD-Collect 63% of initial SPD HRAs

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

"Attachment A"

- **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

220167 Quality Improvement Work Plan--Case Management Owner: Tracy HitzemanSloane Petrillo, Interim DirectorDtr, CM

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			

Q4			
Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1			
Q2			
Q3			
Q4			
Year End			

"Attachment A"

II. Case Management

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

Owners: Tracy Hitzeman Sloane Petrillo, Interim Director Dtr, CM; Edwin Poon, Director, Behavioral Health Services (BHS)

Edwin Poon, Director, Behavioral Health Services (BHS)

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%

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

- 100% participation in ICT for BHI
- 85% participation in ICT for MBHO
- 10% participation in ICT for individual providers
- 20% participation in ICT for county mental health

"Attachment A"

201~~6~~7 Quality Improvement Work Plan~~-~~Case Management **Owner~~s~~: ~~Tracy Hitzeman~~Sloane Petrillo, Interim ~~Director~~Dtr, CM;**

~~,~~ Edwin Poon, D~~irector~~tr, BHS

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

"Attachment A"

"Attachment A"

II. Case Management

C. Patient Safety, Quality of Care Case Management- High ER utilization Owner: Sloane Petrillo, Interim ~~Director~~Dtr, CM;

The Approach

1. Objective
- Evaluation and intervention for ongoing review of high ER utilizers

2. Activity
- Identify top 10 high ER utilizers for CCN per quarter (all lines of business)
- Open to case management with focused group of case managers
- Regular meetings to identify causes of high utilization and effective strategies for reduction in inappropriate ER utilization

3. Goals
- 5% reduction in ER visits among intervention cohort

~~C. *Quality of Clinical Care-Review of emergency department communications with PCPs Owner: Tracy Hitzeman Director, CM~~

~~**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%~~

"Attachment A"

20167 Quality Improvement Work Plan- Case Management Owner: Tracy HitzemanSloane Petrillo, Interim DirectorDtr, CM

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

"Attachment A"

II. Case Management

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

Owner: Sloane Petrillo, Interim ~~Director~~Dtr, CM

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 improve member experience with CM programs
- Revise methodology to increase sample size of responses

3. Goals

- Satisfaction with Case Management - 88%

~~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%~~

“Attachment A”

E. Quality of Clinical Care-Review of member satisfaction with CM programs Owner: Tracy Hitzeman Director, CM

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%

"Attachment A"

201~~6~~7 Quality Improvement Work Plan~~-~~-Case Management Owner: ~~Tracy Hitzeman, Director, CM; Novella Quesada, Manger QI~~Sloane Petrillo, Interim ~~Director~~Dtr, CM

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

“Attachment A”

~~2016 Quality Improvement Work Plan- Case Management: Review of member satisfaction with CM programs~~
~~Owner: Tracy Hitzeman, Director, CM~~

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

"Attachment A"

E. Quality of Ad~~e~~herence to Complex Case Management NCQA Standards — Owner: Sloane Petrillo, Interim ~~Director~~Dtr, CM

The Approach

1. Objective

- Improve adherence to NCQA standards for all Health Networks

2. Activity

- Monthly review of complex case files (5 or 5%)
- Monthly feedback provided to health networks

3. Goals

- All Health Networks will achieve an average score of 85% or greater on their monthly file reviews

~~F. Quality of Identification Of Complex Case Management — Owner: Tracy Hitzeman, Director, CM~~

~~The Approach~~

~~1. Objective~~

- ~~Identify all members eligible for Complex Case Management~~

~~2. Activity~~

- ~~Health Networks are required to report members identified for Complex Case Management~~

~~3. Goals~~

- ~~Health Networks are identifying members eligible for Complex Case Management~~

20167 Quality Improvement Work Plan- Case ~~Management~~ _ Management Owner: ~~Tracy Hitzemen~~Sloane Petrillo, Interim ~~Director~~Dtr, CM

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			

Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
Q1			
Q2			
Q3			
Q4			
Year End			

"Attachment A"

III. Behavioral Health

~~A. *Quality of Clinical Care: Integration of BH Services~~ ~~Owner: Dr. Donald Sharps, Medical Director, BHI~~

~~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 2015~~

A. *Quality of Clinical Care: HEDIS Measures for M/C & OCC Owner: Dr. Donald Sharps, Medical Director, BHI

The Approach

1. Objective
- Behavioral Health HEDIS measures will be monitored and measured

2. Activity
- Design and implement activities to improve HEDIS measures relating to Behavioral Health

3. Goals
- At or above the 50th Percentile

"Attachment A"

"Attachment A"

20172[01]67 Quality Improvement Work Plan--Behavioral Health_ Owner: Terrie Stanley, ED Clinical OperationsDr. Donald Sharps, Medical DirectorDtr, BHI

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

“Attachment A”

III. Behavioral Health

B. *Quality of Clinical Care: Interdisciplinary Care Treatment Team Participation

Owner: Dr. Donald Sharps, Medical ~~Director~~Dtr, BHI

~~Medical Director, BH~~

~~T~~The Approach

1. Objective

- BH Services, integration & coordination of care will be monitored and measured

2. Activity

- Monitor and ~~i~~Identify opportunities to improve integration and coordination of care across settings and~~-~~/or transitions of care through ICT/ICP

3. Goals

- 10% Improvement over 2016

~~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%~~

"Attachment A"

“Attachment A”

“Attachment A”

20167 Quality Improvement Work Plan- Behavioral Health Owner: DRr. Donald Sharps, Medical DirectorDtr, BHI

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

“Attachment A”

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%~~

C. *Quality of Care- Clinical Behavioral Health Practice Guidelines Owner: Dr. Donald Sharps, Medical D~~irector~~, BHI

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 guidelines will be reviewed and adopted

3. Goals
- 100%

"Attachment A"

“Attachment A”

20167 Quality Improvement Work Plan- Behavioral Health Owner: Dr. Donald Sharps, Medical Director, BHI

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

“Attachment A”

Q4			
Year End			

"Attachment A"

III. Behavioral Health

D. *Access and Coordination of Care (NEW) Owner: Dr. Donald Sharps, Medical Director, BHI

The Approach

1. Objective

- Appropriate, timely, and effective access for Behavioral Health services in LTC/SNF facilities
- Explore opportunities for coordination of care with PCPs

2. Activity

- Identify and survey existing LTC/SNF facilities,
- conduct analysis; and
- Propose interventions to address barriers to access Behavioral Health services

3. Goals

- Maintain amount of encounters from previous MBHO
- Establish gap analysis and needs for Behavioral Health support to PCPs
- Establish gap analysis and needs for Behavioral Health in LTC
- Develop uniform process for accessing Behavioral Health in LTC

“Attachment A”

"Attachment A"

2017 Quality Improvement Work Plan-Behavioral Health Owner: Dr. Donald Sharps, Medical Director, BHI

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

“Attachment A”

Q4			
Year End			

“Attachment A”

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 HarveyMarie EarvolinoTracy Hitzeman, Interim Director, LTSSED, Clinical COOperations Clinical Operations

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

"Attachment A"

"Attachment A"

20167 Quality Improvement Work Plan- LTSS ______Owner: Suzanne HarveyMarie EarvolineTracy Hitzeman, Interim Director, LTSSED, Clinical Operations

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

"Attachment A"

IV. LTSS

B. *Safety of Clinical Care and Quality of Clinical Care-Review and assess emergency department visits for LTSS members participating with each oorganization/program

Owner: Suzanne HarveyMarie EarvolinoTracy Hitzeman, Interim Director, LTSSED, ClinicalO Operations Operations

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;
   - REstablishing goals inReview 2016 data to establish goals for IHSS, LTC, MSSP
   - Monitor progress towards goals quarterly

"Attachment A"

"Attachment A"

"Attachment A"

20167 Quality Improvement Work Plan- LTSS Owner: Suzanne HarveyMarie EarvolinoTracy Hitzeman, Interim Director, LTSSED, Clinical Operations

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

"Attachment A"

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 HarveyMarie EarvolinoTracy Hitzeman, Interim Director, LTSSED, CO Clinical Operations Operations

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;
   - Review 2016 data to establish goals for IHSS, LTC, MSSP
   - Establishing goals in 2016 for IHSS, LTC, MSSP

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20167 Quality Improvement Work Plan- LTSS Owner: Suzanne HarveyMarie EarvolinoTracy Hitzeman, Interim Director, LTSSED, Clinical Operations

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

"Attachment A"

IV. LTSS

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

Owner: ~~Marie Earvolino~~Tracy Hitzeman, Interim ~~Director, LTSS~~ED, CO~~Clinical Operations~~ ~~Clinical Operations~~

The Approach

1. Objective

- Members reviewed for Long Term Care Admissions (LTC) (for each organization/program)

2. Activity

- Measure and assess admissions to LTC ~~ong Term Care~~ for members in each program to drive interventions to minimize hospital readmissions~~:~~
  1. CBAS
  2. IHSS
  3. MSSP

3. Goals

- 2% CBAS
- ~~; Establishing goals in~~Review data from 2016 and establish goals for ~~for~~ IHSS, LTC, MSSP

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“Attachment A”

2017 Quality Improvement Work Plan- LTSS Owner: ~~Marie Earvolino~~Tracy Hitzeman, Interim ~~Director, LTSS~~ED, Clinical Operations

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

“Attachment A”

IV. LTSS

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

Owner: Suzanne HarveyMarie Earvolino, Interim 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%

“Attachment A”

"Attachment A"

20167 Quality Improvement Work Plan- LTSS Owner: Suzanne HarveyMarie Earvolino, Interim Director, LTSS

	Assessments, Findings, Monitoring of Previous Issues	Next Steps	
	Results / Metrics	Next Steps	

"Attachment A"

IV. LTSS

E. CBAS Member Satisfaction

Owner: Novella QuesadaEsther Okajima, ManagerDirector, QII

E.

The Approach

1. **Objective**
   - **Monitor and/or improve member satisfaction in CBAS/LTSS**

2. **Activity**
   - **Measur**e, assess and identify areas for improvement and implement
   - interventions

   to assure high member satisfaction

3. **Goals**
   - -5% Improvement over previous year

"Attachment A"

20167 Quality Improvement Work Plan-LTSS Owner: Novella QuesadaEsther Okajima, ManagerDirectoror, QI

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

"Attachment A"

IV. LTSS

A. SNF Member Satisfaction

Owner: Novella QuesadaEsther Okajima, ManagerDirector, 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**
   - 5% Improvement over previous year

"Attachment A"

“Attachment A”

20167 Quality Improvement Work Plan- LTS S Owner: Novella QuesadaEsther Okajima, ManagerDirector, QI

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

"Attachment A"

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%~~

A. *Quality of Care-All new members will complete the Initial Health Assessment and related IHEBA/SHAs — Owner: Pshyra Jones, Director, Health E~~D~~ducation & ~~and~~ Disease Management

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

“Attachment A”

- within 120 days of enrollment
- Reports will be available for Health Networks on IHA/SHA completion

Facility Site Reviews will review a 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 2016 by 10%

20167 Quality Improvement Work Plan- Health Education & Disease ManagementHE & DM _Owner: Pshyra Jones, Director, Health EdD & DM

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

"Attachment A"

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

B. Quality of Clinical Care, Rreview of Disease Management Programs Owner: Pshyra, Jones, Director, Health Ed & and DMDtr, HE & DM

The Approach

1. Objective

Disease Management activity reviewed to assess clinical care delivered to
- members with Asthma,
Diabetes,Diabetes and Heart Failure

2. Activity
- Incorporate HEDIS improvement into DM program interventions
- Assure DM programs are implemented across all populations

"Attachment A"

- Conduct annual member satisfaction of DM programs
- Evaluate the overall effectiveness of the Program-Participation Member Rates, ED, IP and RX related utilization

3. Goals

Medi-Cal

- Increase to 75th percentile for Asthma Medication Ratio (AMR) Ages 5-11
- Increase to 75th percentile for Medication Management for People with Asthma (MMA), ages 5-85
- Increase to 50th percentile for HbA1c Testing
- Increase to 90th percentile for HbA1c Poor Control
- Increase to 75th percentile for Eye Exams
- Increase to 50th percentile for Annual Monitoring for Patients on Persistent Medications -(MPM) Ace Inhibitors or ARB~~S~~s - Increase to 50th percentile for HbA1c Testing - Medicare
- Increase to 50th percentile for Controlling High Blood Pressure (CBP~~C~~)~~ - Medicare~~
- 85% satisfaction with DM Programs

"Attachment A"

20167 Quality Improvement Work Plan- Health Education & Disease ManagementHE & DM ________ -Owner: Pshyra Jones, DirDtr.ector Health Ed & DM

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
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~~

C. *Quality of Care-Clinical Practice Guidelines adoption for Medi-Cal line of business Owner: Pshyra Jones, D~~irector~~tr, HE & DM

~~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%

"Attachment A"

2016~~6~~7 Quality Improvement Work Plan- ~~Health Education & Disease Management~~ HE & DM Owner: Pshyra Jones, D~~irec~~t~~o~~r H~~ealth~~ E~~d~~ & DM

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

"Attachment A"

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%~~

D. Quality of Clinical Care-Review of Cardiovascular Disease **Owner: Pshyra Jones, D~~irecto~~r, H~~ealth~~ E~~d~~ &~~and~~ DM**

The Approach

1. Objective
- CCIP Chronic Care Improvement Projects

2. Activity
- CCIP-CMS m~~M~~andatory topic New Goal
  Achieve high BP control or improvement among 50% of the members

actively opting 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 date and receiving health coaching interventions through 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

"Attachment A"

20167 Quality Improvement Work Plan- Health Education & Disease Management ManagementHE & DM
Owner: Pshyra Jones, Directoor Health Edd & DM

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

"Attachment A"

Q4			
Year End			

"Attachment A"

V. Health Education & Disease Management

E. Implementation of Population Health & Wellness Programs

Owner: Pshyra Jones, Director, Health Ed & DM

The Approach

1. Objective

- Expand child and adolescent components for the Shape Your Life/Weight Management Program
- Implement Weight Watchers benefit for Shape Your Life CalOptima Medi-Cal members age 15 years or greater
- Design and implement a comprehensive Perinatal Health Program

2. Activity

- Establish program goals, objectives and interventions
- Develop clinical and operational components to expand the reach and capability
- Identify program resources and vendor support (Provider, Health Ed/RD linkages, Community Based Organizations)
- Implementation of revised program design

3. Goals

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

~~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)~~

"Attachment A"

~~**3. Goals**~~

- ~~100%~~

"Attachment A"

"Attachment A"

20167 Quality Improvement Work Plan- HE & DMHealth Education & Disease Management _____Owner: Pshyra Jones, Director Health Ed & DM

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

"Attachment A"

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

- 90% satisfaction with the DM program

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

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

"Attachment A"

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 opting 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 date 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

"Attachment A"

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

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

"Attachment A"

“Attachment A”

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~~

H. Quality of Clinical Care – Quality and Performance Improvement Projects **Owner: Kelly Rex-Kimmet, Director, Quality Analytics, ~~PIPS~~Pshyra Jones, Dtr, HE & DM**

The Approach

1. Objective
- Implement DHCS and CMS Quality and Performance Improvement Projects (QIPs and PIPs)

2. Activity
- QIPs
  - OneCare Diabetes QIP to Improve HbA1c Testing
  - OneCare Connect QIP to Improve 30-day Readmission Rate
- PIPs
  - Medi-Cal Diabetes PIP to Improve HbA1c Testing
  - Medi-Cal PIP to Improve Initial Health Assessments
  - OneCare Connect LTSS PIP to Improve In-Home Support Services Care Coordination

“Attachment A”

3. Goals

- HbA1c Testing rate at the 50th percentile based on the 2016~~5~~ NCQA Quality Compass
- 16.8% readmissions rate
- 80% HbA1c Testing
- 25% IHA rate
- 35% IHSS Participation rate

"Attachment A"

201~~6~~7 Quality Improvement Work Plan- ~~Health Education & Disease Management~~HE & DM Owners: Kelly Rex-Kimmet, D~~irec~~t~~o~~r, QA;

Pshyra Jones, Dtr, HE & DM ~~PIPS~~

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

“Attachment A”

“Attachment A”

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

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

“Attachment A”

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

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

“Attachment A”

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

"Attachment A"

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

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

"Attachment A"

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)
- 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 Work Plan- Health Education & Disease Management Owner: Pshyra Jones, Director Health Ed & DM

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			
Year End			

Outcomes	Results / Metrics	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			
Year End			

“Attachment A”

"Attachment A"

VI. Access & Availability

A. *Quality of Service and Quality of Clinical Care-Review of Notification to Members

Owners: Laura Grigoruk, Director Provider Relations; Belinda Abeyta Director, Customer Service

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%

“Attachment A”

"Attachment A"

"Attachment A"

20167 Quality Improvement Work Plan- Access & Availability
Owners: Laura Grigoruk, Director, Provider Relations; & Belinda Abeyta, Director, Customer Service

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

“Attachment A”

VI. Access & Availability

B. *Access to Care: Credentialing of P~~p~~rovider ~~n~~Network is ~~m~~Monitored — Owner: Esther Okajima, Di~~rec~~t~~o~~r, QI

The Approach

1. **Objective**
   - Credentialing program activities monitored for volume and timeliness

2. **Activity**
   - New applicants processed within 180 calendar days of receipt of application
   - Report of initial credentialing file activity to CPRC

3. **Goals**
   - 90~~% of~~% of initial credentialing applications are processed within 120 days of receipt of application~~.~~

~~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 P~~p~~rovider N~~n~~etwork is M~~m~~onitored — Owner: Esther Okajima, Di~~rec~~t~~o~~r, QI

The Approach

"Attachment A"

1. Objective
    - Recredentialing of practitioners is completed timely

2. Activity
    - Recredentialing is processed every~~with~~ 36 months
    - Report of Admin term due to missed recredentialing cycle
    -
    - Report of re-credentialing activity to CPRC

3. Goals
    - 100% of all recredentialing files are processed within 36 months of last credentialing date.

~~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%~~

“Attachment A”

20167 Quality Improvement Work Plan- Access & Availability y Owner: Novella QuesadaEsther Okajima, ManagerDirector, QI

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

“Attachment A”

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%~~

D. *Accessibility: Review of access to care **Owner: Marsha Choo, Manager, QA**

The Approach

“Attachment A”

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. Urgent care appointments without prior authorization within 48 hours of request
  2. Urgent appointments with prior authorization with 96 hours of request
  3. Non-urgent primary care appointments within 10 business days of request
  4. Appointment with specialist within 15 business days of request
  5. Non-urgent mental health appointment within 10 business days of request
  6. Non-urgent appointment for ancillary services within 15 business days of request
  7. First pre-natal visit within 10 business days
  8. Member services, by telephone ASA 30 seconds with abandonment rate <5%

- Health Networks will be issued Corrective Action Plans in accordance with CalOptima’s Access and Availability Policies: GG.1600 and MA.7007

3. Goals

- Appointment:~~t.:~~ 90% minimum performance level
- Phone: ASA 30 seconds; Abandonment rate <5%

"Attachment A"

20167 Quality Improvement Work Plan- Access & Availability ______Owner: Esther OkajimaMarsha Choo, Manager, QA

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

“Attachment A”

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) in 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 he 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 forty0five (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)~~

"Attachment A"

~~3. Goals~~

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

E. *Availability: Review of Availability of Practitioners

Owners: Marsha Choo, Manager, QA; Dr. Donald Sharps, Medical Director, BHI

The Approach

1. Objective

- Practitioner availability (practitioner to member ratio) 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
- Practitioner availability (geographic distribution) is measured, assessed and adjusted to meet 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

2. Activity

- Data against goals will be measured and analyzed for the following through the implementation of our provider data pull from FACETS and GeoAccess Software
  1. Practitioner network by practitioner type (i.e., PCP, high volume specialists, high impact specialists, ancillary providers, health delivery organizations, etc.) will be measured for minimum number of providers against goals, assessed and adjusted as necessary
  2. Practitioner network on the cultural, ethnic, racial and linguistic needs of membership minimum number of providers will be measured against goals, assessed and adjusted as necessary
  3. Practitioner network by practitioner type (i.e., PCP, high volume specialists, high impact specialists, ancillary providers, health delivery organizations, etc.) will be measured for geographic distribution performance against set standards

4. Practitioner network by BH practitioner type (i.e., psychiatrist, psychologist, marriage and family therapist and licensed clinical social worker, etc.) will be measured for minimum number of providers against goals, assessed and adjusted as necessary
5. Practitioner network by BH practitioner type (i.e., psychiatrist, psychologist, marriage and family therapist and licensed clinical social worker, etc.) will be measured for geographic distribution performance against set standards

3. Activity (cont.)

- Health Networks will be issued Corrective Action Plans in accordance with CalOptima's Access and Availability Policies: GG.1600 and MA.7007

4. Goals

- Minimum performance levels in CalOptima's Access and Availability Policies: GG.1600 and MA.7007

"Attachment A"

201~~6~~7 Quality Improvement Work Plan~~-~~ Access & Availability Owners: ~~Esther Okajima~~Marsha Choo, Manager, QA;

Donald Sharps, MD, Medical D~~irec~~t~~o~~r, BHI

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
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: Esther Okajima, D~~irect~~o~~r~~, QI

The Approach

1. Objective

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

2. Activity

- Facility Site Reviews (FSR), Medical Record R~~r~~eviews (MRR) and Physical Accessibility Review Surveys (PARS) are completed as part of initial and ~~&~~ re-credentialing cycles
- Report of FSR/MRR/PARS activity to CPRC

3. Goals

- 100% of FSR/MRR/PARS Initial or Full Scope S~~s~~urveys are completed ~~timely as part of~~ within initial and re-credentialing ~~cycles~~ timeframes~~.~~

~~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%~~

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201~~6~~7 Quality Improvement Work Plan- Patient Safety ______ Owner: ~~Novella Quesada~~Esther Okajima, ~~Manager~~Director, QI

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

"Attachment A"

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%~~

B. Timeliness of Clinical Care R~~care-r~~eview and F~~f~~ollow-up on Potential Quality of Care Issues Owner: Esther Okajima, Di~~rec~~tor, QI

The Approach

1. Objective

To assure patient safety and enhance patient experience by timeliness of clinical care reviews.

2. Activity

- QI Nurse Specialists and Medical Directors review cases and provide determination.
- Report all case results to CPRC for discussion.
- ~~any~~Present cases that have a severity rating of 1 ~~exceed the threshold level of 1~~ (one) or higher will be presented to CPRC for action.

Follow through on Medical Director determination, when applicable, to ensure

- closure and compliance
  of all cases
- Conduct a PQI trend analysis at least two times a year
  of all cases.

Conduct a PQI trend analysis at least two times/year

3. Goals

- To achieveAchieve a turnaround time of 90 days on 90% of cases received
- Review data for trends and& patterns for potential further actions.

"Attachment A"

20167 Quality Improvement Work Plan- Patient Safety Owner: Novella QuesadaEsther Okajima, ManagerDirector, QI

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

"Attachment A"

VII. Patient Safety

~~C. *Safety of Clinical Care and Quality of Clinical Care reviewed through Pharmacy Management~~ ~~Owner: Kris Gericke,PharmD, Director, Pharmacy Management~~

~~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 opiod overuse to include Pharmacy home, Monthly RX limit, Opiod overutilization (MED over 120mg.)~~

~~3. Goals~~
- ~~100%~~

C. *Safety of Clinical Care and Quality of Clinical Care reviewed through Pharmacy Management Owner: Kris Gericke, Pharm.D., Director, Pharmacy Management

The Approach

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

2. Activity

- Monitor for underutilization of pharmaceuticals and provide education to providers
  - Underutilization of long-term controllers for members diagnosed with asthma
  - Underutilization of osteoporosis therapies for members receiving corticosteroids
  - Underutilization of calcium for members with a diagnosis of osteoporosis
  - Underutilization of statins for members with diabetes
- Programs to prevent overutilization include:
  - Monthly prescription limit
  - Pharmacy Home Program
  - Prescriber Restriction Program
  - Opioid overutilization monitoring

3. Goals

- Reductions in underutilization and overutilization measures

“Attachment A”

20167 Quality Improvement Work Plan- Patient Safety Owner: Kris Gericke, Pharm.D., Director, Pharmacy Management

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

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"Attachment A"

VII. Patient Safety

D. *Safety of Clinical Care and Quality of Clinical Care- Review of Specialty Drug Utilization **Owner: Kris Gericke,PharmD, Director, Pharmacy Services**

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

"Attachment A"

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

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

"Attachment A"

VII. Patient Safety

D. *Patient Safety-Review and assessment of CBAS Quality Monitoring   Owner: Esther Okajima, Director, 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 QI Subcommittee
- Report Member Satisfaction Survey Results
- Report CDA audit results in comparison to past results

3. Goals

- 100% CDA Audit Results

E. Patient Safety-Review and Assessment of SNF Quality Monitoring   Owner: Esther Okajima, Director, QI

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

“Attachment A”

3. Goals

- 100% DHCS Audit results

“Attachment A”

~~**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-sire visits and CAPs issued~~
- ~~Report on Member Satisfaction Survey Results~~

~~**3. Goals**~~
- ~~100% DHCS Audit results~~

"Attachment A"

20167 Quality Improvement Work Plan- Patient Safety Owner: Novella QuesadaEsther Okajima, ManagerDirector, QI

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

“Attachment A”

VII. Patient Safety

~~G.~~F. *Safety of Clinical Care-Review of antibiotic usage Owner: Kelly Rex-Kimmet ~~Dir~~Dir~~.~~tr, ~~of Quality Analytics~~QA

The Approach

1. **Objective**
   - Increase the appropriate testing for children with Pharyngitis rate (CWP)
   - Appropriate treatment for children with upper respiratory infection (URI) to meet goals
   - Improve appropriate use of antibiotics in Adults with Acute Bronchitis (AAB)

2. **Goals**
   - Appropriate Testing for Children with Pharyngitis~~-~~: 63.24% (25th percentile)~~68.53%~~
   - Appropriate treatment for Children with URI:~~L~~ 93.~~2~~38% (75th percentile)
   - Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB) 22.25% (25th percentile)~~91.21%~~

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201~~6~~7 Quality Improvement Work Plan- Patient Safety Owner: Kelly Rex-Kimmet, D~~irec~~t~~o~~r, QA

Monitoring	Assessments, Findings, Monitoring of Previously Identified Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			
Year End			
Outcomes	**Results / Metrics**	**Next Steps**	**Target Completion**
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~~

G. Pharmacy Benefit Manager (PBM) Oversight Management **Owner: Kris Gericke, Pharm.D., Director, Pharmacy Management**

The Approach

1. Objective

- Provide ongoing monitoring of the PBM: quality of care, service, timeliness

2. Activity

- Review and report on clinical and service metrics for MedImpact, as it relates to performance guarantees

3. Goals

- Meet performance guarantees per the contract

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20167 Quality Improvement Work Plan- Patient Safety ______Owner: Kris Gericke, Director, Pharmacy

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

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

"Attachment A"

"Attachment A"

20167 Quality Improvement Work Plan-Member Experience ______Owner: Kelly Rex-Kimmet, Director, QA

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

“Attachment A”

"Attachment A"

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**
   - 85% of calls resolved at first call

“Attachment A”

20167 Quality Improvement Work Plan- Member Experience ____Owner: Belinda Abeyta, Director, Customer Service

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

“Attachment A”

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%

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20167 Quality Improvement Work Plan- Member Experience Owner: Belinda Abeyta, Director, Customer Service

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

"Attachment A"

VIII. Member Experience

D. Quality of Care and ~~&~~ Service Reviewed through GARS & PQI (MOC)

Owners: Janine Kodama, Director, ~~GARS~~Grievance ~~D.~~ & Appeals; ~~;~~ ~~Novella Quesada, Manager~~Laura Guest, Supervisor, 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 o~~of grievance and PQI ~~and steps taken to address with HN~~
   - Conduct a GARS trend analysis at least two times per y~~/y~~ear

3. **Goals**
   - Improve over 2015 performance

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20167 Quality Improvement Work Plan- Member Experience Owners: Janine Kodama, Director, GARS; Novella Quesada, ManagerLaura Guest, Supervisorisor, QI

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

"Attachment A"

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~~

"Attachment A"

~~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~~

"Attachment A"

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%

"Attachment A"

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	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. Also explore the use of member engagement technologies to improve rates. These measures are also incentivized through our P4V program. (interventions based on unique member characteristics)	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)	Readmission Rate will be minimized through member education and Quality Incentive Program. A reporting mechanism will be established followed by analysis of data.	Medi-Cal <15% Readmission rate Medicare <14% Readmission rate	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 to meet goal	Compliance with flu and pneumococcal immunizations will increase through flu reminders and education.	90%	2016 April, July, October - - -

“Attachment A”

Scope	Objective	Activity	Goals or Baseline	Target Completion
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

"Attachment A"

~~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 2nd birthday will increase through member reminders and education (Combo 10)~~ ~~This measure is also incentivized in our P4V program.~~	~~MC: Combo 10: 49.63% (90th 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

A. Improve identified HEDIS HEDIS Measures listed on “Measures” worksheet Owners: Kelly Rex-Kimmet Director, Quality Analytics

The Approach

1. Objective

- Maintain “Commendable” NCQA accreditation rating

“Attachment A”

- Maintain or exceed NCQA 4.0 health plan rating
- Earn Quality Withhold Dollars back for OneCare Connect for all HEDIS measures in OCC QW programMaintain “Commendable” NCQA accreditation rating
- Maintain or exceed NCQA 4.0 health plan rating

2. Activity

- See Mmeasures worksheet for specific activities

3. Goals

- See Mmeasures worksheet

"Attachment A"

HEDIS Measures Worksheet

Scope	Objective	Activity	Goals or Baseline	Target Completion (Proposed reporting months to QIC)
****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	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. Also explore the use of member engagement technologies to improve rates. These measures are also incentivized through our P4V program. (interventions based on unique member characteristics)	Medicaid: • A1C Screening: ~~86.0%~~85.95% (50th percentile) • A1C Control <8.0%: ~~55.47%~~52.55% (~~Between~~ 75th ~~and 90th~~ percentile) • A1C Control >9.0%: ~~33.05%~~36.87% (lower score is better) ~~Between~~ (75th ~~and 90th~~ percentile) • Eye Exams: ~~65.1%~~61.5 (75th percentile) • Nephropathy Screening: 90.51% (50th percentile) • BP Control: ~~72.17%~~68.61% (~~between~~ 75th ~~and 90th~~ percentile) Medicare: • A1C Screening: 91.4% • A1C Control <8.0%: 72.8% • A1C Control >9.0 18.8% (lower score is better) • Eye Exams: 82% Nephropathy Screening: 95.8% • BP Control: 79.3%	2017 April, July, October
****HEDIS/STARS** Improvement: Review all-cause hospital readmissions with Medi-Cal & OneCare Connect	Reduce 30 day All Cause Readmissions (PCR)	Readmission Rate will be minimized through member education and Quality Incentive Program.	Medi-Cal <14~~5~~% Readmission rate Medicare <14% Readmission rate OCC <11% readmission Rate (Quality Withhold goal)	2017 April, July, October - -

Scope	Objective	Activity	Goals or Baseline	Target Completion (Proposed reporting months to QIC)
members (PCR)		A reporting mechanism will be established followed by analysis of data.		- -
****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 to meet goal	Compliance with flu and pneumococcal immunizations will increase through flu reminders and education.	90%	2017 April, July, October
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: 82.25% (50th percentile) MC Postpartum: ~~65.96~~67.53% (~~66th~~75th -percentile)	2017 April, July, October

“Attachment A”

Scope	Objective	Activity	Goals or Baseline	Target Completion (Proposed reporting months to QIC)
~~Cervical Cancer Screening~~**Lead Screening (Monitoring Measure)**	Increase lead screening rate~~Increase the cervical cancer screening rate for Medi-Cal to meet DHCS MPL of 25th percentile~~	~~Cervical cancer screening rate will increase through office staff, provider and member incentives as well as planned campaigns for women’s health preventive screenings.~~Analyze data to determine low performing HN. Implement initiatives to address identified barriers to better performance (data strategy as well as provider outreach)	MC: 75.7% (66th percentile)~~MC:~~	
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: 42.19% (50th percentile) Maintenance Phase: ~~40.91~~52.47% (~~25~~50th percentile)	2017 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.	MC: Acute Phase Treatment: ~~56.65%~~59.52 (~~66~~75th percentile) MC: Continuation Phase Treatment: 41.46% (66th percentile) OC: Effective Phase Treatment 68.66% (50th percentile) OC: Continuation Phase Treatment 54.76% (50th percentile)	2017 Mar Jun Sep Dec
****HEDIS/STARS**: Review and assessment of	Increase the osteoporosis management in women	Osteoporosis management in women who had a	OC: 47.6% (66th percentile)	2017 April, July, October

Scope	Objective	Activity	Goals or Baseline	Target Completion (Proposed reporting months to QIC)
osteoporosis management (OMW)	who had a fracture rate in OC women who suffered a fracture to meet goal	fracture will increase through improved member identification using claims and pharmacy data and provider education.		- -
~~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: 22.25% (25th percentile)~~	~~2017 April, July, October~~
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 2nd birthday will increase through member reminders and education (Combo 10) This measure is also incentivized in our P4V program.	MC: Combo 10: 40.9% (75th percentile)	2017 April, July, October
-	-			-
HEDIS: Review and assessment of use of imaging studies for low back pain ~~**HEDIS:** Review and assessment of adult's access to preventive/ambulatory health (AAP)~~	Increase the use of appropriate treatment for low back pain (decrease the use of imaging studies for persons with low back pain) ~~Increase MC and OC adult's access to preventive/ambulatory health to meet goal~~	Imaging studies will decrease for persons diagnosed with low back pain through provider outreach and education ~~Comprehensive member and provider outreach with reminders to increase access for adults~~	MC: ~~77.09~~73.71% (~~75~~50th percentile) ~~MC: 83.84% (50th percentile)~~ ~~OC: 95.56% (50th percentile)~~	2017 April, July, October ~~2017 April, July, October~~
HEDIS: Review and	Increase MC and OC	Comprehensive member	MC: 82.15% (50th percentile)	2017 April,

Scope	Objective	Activity	Goals or Baseline	Target Completion (Proposed reporting months to QIC)
assessment of adult's access to preventive/ambulatory health (AAP)	adult's access to preventive/ambulatory health to meet goal	and provider outreach with reminders to increase access for adults	OC: 95.56% (50th percentile)	July, October
HEDIS: Review and assessment of children's access to primary care practitioners (CAP)	Increase children's access to primary care practitioners to meet goal	Comprehensive member and provider outreach with reminders to increase access for children	MC: 1) 12-24 months ~~96.28%~~95.74% (50th percentile) 2) 25 months -6 years ~~91.22%~~90.98% (75th percentile) 3) 7-11 years 93.~~90~~25% (75th percentile) 4) 12-19 years ~~90.06%~~89.37% (50th percentile)	2017 April, July, October
HEDIS: Review and assessment of cervical cancer screening (CCS)	Increase the cervical cancer screening in our MC female members 21-64 to meet goal	Increase cervical cancer screening through member and provider outreach and education with reminders.	MC: ~~67.88~~55.94% (~~75~~50th percentile)	2017 April, July, October
HEDIS: Review and assessment of well child visits in the first 15 months of life (W15)	Increase the well care visits for MC children in their first 15 months of life to meet goal	Increase of well care visit for children in their first 15 months of life through member and provider outreach and education with reminders	MC: 59.~~76~~57% (6 or more visits) (50th percentile)	2017 April, July, October
HEDIS: Review and assessment of breast cancer screening (BCS)	Increase the breast cancer screening for MC and OC female members to meet goal	Increase the breast cancer screening through member and provider education and outreach with reminders as ways to decrease barriers to screening	MC: 71.~~41~~52% (90th percentile) OC: 71.36% (50th percentile)	2017 April, July, October
HEDIS/STARS: Review and assessment of colorectal cancer screening (COL)	Increase the colorectal cancer screening for OC members to meet goal	Increase colorectal cancer screening through member and provider outreach as well as ways to decrease barriers to screening	OC: 67.27% (50th percentile) Monitor for Medicaid population. Develop internal benchmark as National Medicaid Benchmark does not exist.	2017 April, July, October
HOS/STARS: 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		2017 Mar Jun Sep Dec

"Attachment A"

Scope	Objective	Activity	Goals or Baseline	Target Completion (Proposed reporting months to QIC)

Scope	Objective	Activity	Goals or Baseline	Target Completion (Proposed reporting months to QIC)
**HEDIS/STARS: Review and assessment Comprehensive Diabetes	Increase the comprehensive diabetes care measures MC and OC	Comprehensive diabetes care will increase through member education to	Medicaid: A1C Screening: 86.0% (50th percentile) A1C Control <8.0%: 55.47% (Between 75th and 90th percentile)	20167 April, July, October

"Attachment A"

Scope	Objective	Activity	Goals or Baseline	Target Completion (Proposed reporting months to QIC)
Care (CDC)	members – in conjunction with Diabetes Disease Management Program	identified members with diabetes and collaboration with targeted providers to better outreach to their patients for comprehensive screening and care. Also explore the use of member engagement technologies to improve rates. These measures are also incentivized through our P4V program. (interventions based on unique member characteristics)	A1C Control >9.0%: 33.05% (lower score is better) Between 75th and 90th percentile Eye Exams: 65.1% (75th percentile) Nephropathy Screening: 90.51% (50th percentile) BP Control: 72.17% (between 75th and 90th) Medicare: A1C Screening: 91.4% A1C Control <8.0%: 72.8% A1C Control >9.0 18.8% (lower score is better) Eye Exams: 82% Nephropathy Screening: 95.8% BP Control: 79.3%	
**HEDIS/STARS Improvement: Review all-cause hospital readmissions with Medi-Cal & OneCare Connect members (PCR)	Reduce 30 day All Cause Readmissions (PCR)	Readmission Rate will be minimized through member education and Quality Incentive Program. A reporting mechanism will be established followed by analysis of data.	Medi-Cal <15% Readmission rate Medicare <14% Readmission rate OCC <11% readmission Rate (Quality Withhold goal)	20167 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	Compliance with flu and pneumococcal immunizations will increase through flu reminders and education.	90%	20167 April, July, October

Scope	Objective	Activity	Goals or Baseline	Target Completion (Proposed reporting months to QIC)
	2. OC members 65 years old and older 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: 82.25% (50th percentile) MC Postpartum: 65.96% (66th percentile)	20167 April, July, October
Cervical Cancer Screening	Increase the cervical cancer screening rate for Medi-Cal to meet DHCS MPL of 25th percentile	Cervical cancer screening rate will increase through office staff, provider and member incentives as well as planned campaigns for women's health preventive screenings.	MC:	
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: 42.19% (50th percentile) Maintenance Phase: 40.91% (25th percentile)	20167 April, July, October
HEDIS: Review and assessment of antidepressant	Increase the antidepressant medication management rate in MC	Antidepressant medication management rates will increase with the	MC: Acute Phase Treatment: 56.65% (66th percentile) MC: Continuation Phase Treatment: 41.46% (66th percentile) OC: Effective Phase Treatment 68.66% (50th percentile)	20167 Mar Jun Sep Dec

Scope	Objective	Activity	Goals or Baseline	Target Completion (Proposed reporting months to QIC)
medication management (AMM)	and OC members with a diagnosis of major depression to meet goal	distribution of member health education material.	OC: Continuation Phase Treatment 54.76% (50th percentile)	
**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: 47.6% (66th percentile)	20167 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: 22.25% (25th percentile)	20167 April, July, October
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 2nd birthday will increase through member reminders and education (Combo 10) This measure is also incentivized in our P4V program.	MC: Combo 10: 40.9% (75th percentile)	20167 April, July, October

Scope	Objective	Activity	Goals or Baseline	Target Completion (Proposed reporting months to QIC)
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: 63.24% (25th percentile)	20167 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: 77.09% (75th percentile)	20167 April, July, October
HEDIS: Review and assessment of adult's access to preventive/ambulatory health (AAP)	Increase MC and OC adult's access to preventive/ambulatory health to meet goal	Comprehensive member and provider outreach with reminders to increase access for adults	MC: 83.84% (50th percentile) OC: 95.56% (50th percentile)	20167 April, July, October
HEDIS: Review and assessment of children's access to primary care practitioners (CAP)	Increase children's access to primary care practitioners to meet goal	Comprehensive member and provider outreach with reminders to increase access for children	MC: 1) 12-24 months 96.28% (50th percentile) 2) 25 months -6 years 91.22% (75th percentile) 3) 7-11 years 93.90% (75th percentile) 4) 12-19 years 90.06% (50th percentile)	20167 April, July, October
HEDIS: Review and assessment of cervical cancer screening (CCS)	Increase the cervical cancer screening in our MC female members 21-64 to meet goal	Increase cervical cancer screening through member and provider outreach and education with reminders.	MC: 67.88% (75th percentile)	20167 April, July, October
HEDIS: Review and assessment of well child visits in the first 15 months of life (W15)	Increase the well care visits for MC children in their first 15 months of life to meet goal	Increase of well care visit for children in their first 15 months of life through member and provider outreach and education with reminders	MC: 59.76% (50th percentile)	20167 April, July, October
HEDIS: Review and assessment of breast	Increase the breast cancer screening for MC and OC	Increase the breast cancer screening through member	MC: 71.41% (90th percentile) OC: 71.36% (50th percentile)	20167 April, July, October

Scope	Objective	Activity	Goals or Baseline	Target Completion (Proposed reporting months to QIC)
cancer screening (BCS)	female members to meet goal	and provider education and outreach with reminders as ways to decrease barriers to screening		
HEDIS/STARS: Review and assessment of colorectal cancer screening (COL)	Increase the colorectal cancer screening for OC members to meet goal	Increase colorectal cancer screening through member and provider outreach as well as ways to decrease barriers to screening	OC: 67.27% (50th percentile)	20167 April, July, October
HOS/STARS: 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		20167 Mar Jun Sep Dec

“Attachment A”

IX. HEDIS/STARS Improvement

B. Improve identified STARS midentified STARS measures listed on “Measures” worksheet

Owners: Kelly Rex-Kimmet Director, Quality Analytics;
Kris Gericke, Pharm.D., Director, Pharmacy
Management; Tracy Hitzeman, Interim Executive Director,
Clinical Operations ; Kris Gericke, Pharm.D., Director, Pharmacy
Management, Tracy Hitzemen, Executive Director, Clinical Operations

The Approach

1. Objective

- Attain 4.0 CMS STAR ratingttain 4.0 CMS STAR rating

2. Activity

- See Mmeasures worksheet for specific activities

3. Goals

- See Mmeasures worksheet

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“Attachment A”

STARSHEDIS 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	Comprehensive diabetes care will increase through member education to identified members with diabetes and collaboration with targeted providers to	90th percentile for all subsmeasures	20167 April, July, October

“Attachment A”

Scope	Objective	Activity	Goals or Baseline	Target Completion
	Diabetes Disease Management Program	better outreach to their patients for comprehensive screening and care. Also explore the use of member engagement technologies to improve rates. These measures are also incentivized through our P4V program. (interventions based on unique member characteristics)		
**HEDIS/STARS Improvement: Review all-cause hospital readmissions with Medi-Cal & OneCare Connect members (PCR)	Reduce 30 day All Cause Readmissions (PCR)	Readmission Rate will be minimized through member education and Quality Incentive Program. A reporting mechanism will be established followed by analysis of data.	Medicare <14% Readmission rate	20167 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 to meet goal	Compliance with flu and pneumococcal immunizations will increase through flu reminders and education.	90%	20167 April, July, October
**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)	20176 April, July, October
HEDIS/STARS: Review and assessment of colorectal cancer screening (COL)	Increase the colorectal cancer screening for OC members to meet goal	Increase colorectal cancer screening through member and provider outreach as well as ways to decrease barriers to screening	OC: 67.27% (50th percentile)	20167 April, July, October
HOS/STARS: 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		20167 Mar Jun Sep Dec

“Attachment A”

Scope	Objective	Activity	Goals or Baseline	Target Completion
****HEDIS/STARS**: Review and assessment Comprehensive Diabetes Care (CDC)	Increase the comprehensive diabetes care measures OC and OCC members - in conjunction with	Comprehensive diabetes care will increase through member education to identified members with diabetes and collaboration with	Medicare: 1) A1C Control >9:.0 16% (lower score is better;	2017 April, July, October

"Attachment A"

Scope	Objective	Activity	Goals or Baseline	Target Completion
	Diabetes Disease Management Program	targeted providers to better outreach to their patients for comprehensive screening and care. Also explore the use of member engagement technologies to improve rates. These measures are also incentivized through our P4V program. (interventions based on unique member characteristics)	CMS 5 star goal) 2) Eye Exams: 82% (maintain 2016 above CMS 5-star goal) 3) Nephropathy Screening: 96% (CMS 4 star goal)	-
****HEDIS/STARS** Review Adult BMI Assessment	Increase the BMI assessment in adults	Assessment of BMI will increase through provider education and dissemination of BMI assessment tools.	Medicare: 96% (CMS 5 star goal)	2017 April, July, October
****HEDIS/STARS** Improvement: Review Care of Older Adult	Increase the Care of Older Adult Rate in: 1) Medication Review 2) Pain Screening 3) Functional Status Assessment	Care of Older Adult measures to increase through provider education and dissemination of provider tools.	OneCare Only: 1) Medication Review: 87% (CMS 5 star goal) 2) Pain Screening: 88% (CMS 5 star goal) 3) Functional Status Assessment: 74% (CMS 4 star goal)	2017 April, July, October
****HEDIS/STARS** Improvement: Review all-cause hospital readmissions with OneCare & OneCare Connect members (PCR)	Reduce 30 day All Cause Readmissions (PCR)	Readmission Rate will be minimized through member education and Quality Incentive Program. A reporting mechanism will be established followed by analysis of data.	Medicare: <10% Readmission rate (CMS 4 star goal)	2017 April, July, October -
****HEDIS/STARS** Improvement: Review of flu and pneumococcal immunization rates*	Increase the flu and pneumococcal screening rate in OC and OCC members 65 years old and older to meet goal	Compliance with flu and pneumococcal immunizations will increase through flu reminders and education.	Medicare: 74% (CMS 4 star goal)	2017 April, July, October

Scope	Objective	Activity	Goals or Baseline	Target Completion
**HEDIS/STARS: Review and assessment of osteoporosis management (OMW)	Increase the osteoporosis management in women who had a fracture rate in OC and OCC 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.	Medicare: 51% (CMS 4 start goal)	2017 April, July, October
**HEDIS/STARS: Review and assessment of colorectal cancer screening (COL)	Increase the colorectal cancer screening for OC and OCC members to meet goal	Increase colorectal cancer screening through member and provider outreach as well as ways to decrease barriers to screening	Medicare: 71% (CMS 4 star goal)	2017 April, July, October
**HEDIS/STARS: Review and assessment of breast cancer screening (BCS)	Increase the breast cancer screening for OC and OCC members to meet goal	Increase breast cancer screening through member and provider outreach as well as ways to decrease barriers to screening	Medicare: 76% (CMS 5 star goal)	2017 April, July, October
**HEDIS/STARS: Review and assessment of monitoring physical activity	Increase the monitoring of physical activity for OC and OCC members to meet goal	Increase of monitoring of physical activity through provider outreach and education and dissemination of provider tools	Medicare: 57% (CMS 5 star goal)	2017 April, July, October
**HEDIS/STARS: Review and assessment of controlling blood pressure (CBP)	Increase of controlling blood pressure rate	Increase of controlling blood pressure rate through provider and member outreach and education	Medicare: 75% (CMS 5 star goal)	2017 April, July, October
**HEDIS/STARS: Improvement: Rheumatoid Arthritis Management	Increase of rheumatoid arthritis management rate	Increase of rheumatoid arthritis management through provider education	Medicare: 72% (CMS 3 star goal)	2017 April, July, October
**HEDIS: Follow-up after Hospitalization for Mental Illness (7 days / 30 days)	Increase follow-up after hospitalization for mental illness	Increase follow-up after hospitalization through collaboration with our behavioral health partner to conduct provider education and member outreach through reminders.	Medicare: 56% (Quality Withhold Goal)	2017 April, July, October
**HOS/STARS: 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	Medicare: 1) Reducing Risk of Falls: 73% (CMS 5 star goal) 2) Improving Physical Health Status: 72% (CMS 4 star goa 3) Improving Mental Health Status: 87% (CMS 5 star goa	2017 Mar Jun Sep Dec

IX. HEDIS/STARS Improvement

C. Improve CAHPS measures listed on "Measures" worksheet

Owner: Kelly Rex-Kimmet Director, Quality Analytics

The Approach

1. Objective

- Achieve 3.0 CAHPS score
- Attain 4.0 CMS STAR rating
- Meet CMS STAR Goals

2. Activity

- See Measures worksheet for specific activities

3. Goals

- See Measures worksheet

"Attachment A"

CAHPS MHEDIS Measures Worksheet

Scope	Objective	Activity	Goals or Baseline	Target Completion
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	20167 Mar Jun Sep Dec
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	50th Percentile or higher (2.52)	20167 Mar Jun Sep Dec

~~Scope~~	~~Objective~~	~~Activity~~	~~Goals or Baseline~~	~~Target Completion~~
		~~of Getting Needed Care.~~		
~~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~~	~~20167 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~~	~~20167 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~~	~~20167 Mar Jun Sep Dec~~

Scope	Objective	Activity	Goals or Baseline	Target Completion
STARS: 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.	Medicaid: 50th Percentile or higher Medicare: 82% (CMS 3 star goal)	2017 Mar Jun Sep Dec
STARS: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.	Medicaid: 50th Percentile or higher (2.52) Medicare: 79% (CMS 2 star goal)	2017 Mar Jun Sep Dec
STARS: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	Medicaid: 50th Percentile or higher	2017 Mar Jun Sep Dec

Scope	Objective	Activity	Goals or Baseline	Target Completion
		capacity and geoaccess standards will improve rating of Getting Care Quickly.	Medicare: 72% (CMS 2 star goal)	
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.	Medicaid: 50th percentile or higher	2017 Mar Jun Sep Dec
STARS: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.	Medicaid: 50th percentile or higher Medicare: 86% (CMS 3 star goal)	2017 Mar Jun Sep Dec
STARS:CAHPS: Getting Needed Prescription Drugs	Increase CAHPS score on Getting Needed Prescription Drugs		Medicare: 89% (CMS 3 star goal)	2017 Mar Jun Sep Dec
STARS:CAHPS: Care Coordination	Increase CAHPS score on Care Coordination	Provider and office staff in-service on best practices to better coordinate care for members will improve rating on Care Coordination.	Medicare: 82% (CMS 2 star goal)	2017 Mar Jun Sep Dec
STARS: CAHPS: Overall Rating of Health Care Quality	Increase CAHPS score on Overall Rating of Health Care Quality	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.	Medicare: 82% (CMS 2 star goal)	2017 Mar Jun Sep Dec

“Attachment A”

IX. HEDIS/STARS Improvement

D. STARS-Medication Related Measures

Owner: Kris Gericke, Pharm.D., Director, Pharmacy Management

The Approach

1. Objective

- Optimal Performance in the CMS Pharmacy Star and Display Measures.

2. Activity

- Decrease utilization of high-risk medications
  - Formulary controls
  - Prior authorization criteria
  - Prescriber education
- Antipsychotic use in members with dementia in nursing homes

- Prescriber education
- LTC quality incentive program

- Appropriate dosing of oral diabetes medications
  - Formulary controls
  - Prior authorization criteria
  - Prescriber education
- Medication Adherence
  - Comprehensive member and provider outreach to identified members who appear non-adherent with medication management (interventions based on unique member characteristics)
  - Interventions include
    - Outreach
    - Pre-Assessment: Modified Morisky Scale (MMS) for knowledge, motivation and confidence
    - Mailings - letter with member's action plan, Healthy You, medication log;
    - follow up calls as needed
  - Outcomes include
    - Pre and Post PDC rates to measure program success
    - Evaluate member's improvement in knowledge, motivation (MMS) and confidence
    - Evaluate member survey results

3. Goals

- Scores above the national MA-PD average as reported by CMS

“Attachment A”

HEDIS Measures Worksheet

Scope	Objective	Activity	Goals or Baseline	Target Completion
***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	20167 Mar Jun Sep Dec

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IX. HEDIS/STARS Improvement

E. 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%

"Attachment A"

"Attachment A"

HEDIS Measures Owner: Marsha Choo,~~,~~ M~~ana~~ag~~e~~er, QA

	Results / Metric	Next Steps	Target Completion
Diabetes C~~c~~are			
Controlling Blood Pressure			
30-~~-~~Day ~~Readmmsions~~Readmissions			
Flu & ~~Pheumoccal~~Pneumococcal Rates			
Prenatal Care			
~~Post Partum~~Post-Partum			
AD~~M~~HD			
Antidepressant Medication ~~Mgmt~~Management			
Osteoporosis ~~Mgmt~~Management			

Antibiotics Use/ Bronchitis			
Childhood Immunizations. Combo 10			
Adolescent Immunizations	Not on HEDIS Measures worksheet		
Low Back Pain			
Adult Access to Preventive Care (AAP)			

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CAHPS Measures **Owner: Member Experience Team**

	Results / Metric	Next Steps	Target Completion
Rating of Health			
Getting Needed Care			
Getting Care Quickly			
How Wwell Doctors Communicate			
Customer Service			

“Attachment A”

"Attachment A"

STARS **Owner: Kris Gericke, PharmDPharm.D, Director, Pharmacy**

	Results / Metric	Next Steps	Target Completion
Cholesterol			
Hypertension			
Diabetes			

Health Outcomes Survey **Owner: Marsha Choo, Manager, QA**

	Results / Metric	Next Steps	Target Completion
Reducing Risk of Falls			
Improving Physical Health Status			
Improving Mental Health Status			

“Attachment A”

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%~~

A. Delegation Oversight of CM

Owner: Sloane Petrillo, Interim D~~irecto~~r, CM

The Approach

1. Objective
- Regular review of the Health Network’s performance of CM functions

2. Activity
- Review of 100% of MOC files with monthly feedback provided to Health Networks
- Assure compliance to all regulatory and accreditation delegation oversight requirements
- **Report from DOC

3. Goals
- 90%

"Attachment A"

"Attachment A"

“Attachment A”

20167 Quality Improvement Work Plan-Delegation Oversight Owner: Tracy HitzemanSloane Petrillo, Interim Director, CM

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

“Attachment A”

X. Delegation Oversight

B. Quality of Care and ~~&~~ Service of UM through D~~d~~elegation ~~o~~Oversight ~~r~~Reviews Owner: Solange Marvin D~~irec~~t~~o~~r, 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 ~~D~~AOC
3. **Goals**
   - 98%

"Attachment A"

20167 Quality Improvement Work Plan-Delegation Oversight Owner: Solange Marvin, Director, Audit & Oversight

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

"Attachment A"

X. Delegation Oversight

C. Delegation oversight of BH Services

Owner: Solange MarvinDr. Edwin Poon, Director, Audit & OversightBHISI

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 DAOC

3. **Goals**
   - 98%

“Attachment A”

20167 Quality Improvement Work Plan-Delegation Oversight Owner: Solange MarvinDr. Edwin Poon, Directeor, Audit & OversightBHISI

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

“Attachment A”

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

~~20167 Quality Improvement Work Plan- Organizational Projects~~ ~~Owner: Medical Director, QA~~

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

"Attachment A"

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~~

A. Value Based P4P 2017- **Owner: Sandeep Mital, Manager, Quality P4V**

The Approach

1. Objective
- Present MY~~MY~~2017 P4V program to QAC and Board of Directors by 3/1/17
- Re-Evaluate Auto Assignment Quality Measures and Recommend Changes to measures and algorithm
- Design 2018 P4Value program based on interim measures

2. Activity

Design new program in conjunction with provider/~~-~~Health Network s~~S~~takeholders,
- PAC & MAC input
- ~~;~~ D~~d~~evelop COBAR for presentation to board
- Define analytics and matching resources to ~~support~~define ~~new~~2018 P4Value Program

“Attachment A”

3. Goals

- Implement 2017 prospective rates by 3/1/17
- Design 2018 P4V by 4th Quarter, 2017

“Attachment A”

20167 Quality Improvement Work Plan- Organizational Projects Owner: Kelly Rex-KimmetSandeep Mital, DirectorManager, Quality QAP4V

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

“Attachment A”

XII. Organizational Projects

B. MOC Dashboard

Owner: Esther. Okajima, Director, Quality Improvement

The Approach

~~Objective~~
~~Activity~~

1. ~~Goal~~Objective
   - Present OC/OCC & SPD MOC Quality Matrix to QAC and Board of Directors by 2nd Quarter, 2017
   - Re-~~e~~Evaluate measurements through data analysis

2. Activity
   - Define analytics and resources to support the Model of Care for OC/OCC & SPD members
   - Implement activities to meet or exceed measures

3. Goals
   - Meet or exceed defined MOC metrics

G:\Model of Care\CalOptima Model of Care\MOC Dashboard\Latest version\MOC Dashboard_12.12.16.xlsx
(right click and select “open hyperlink)

	A	B	C	D	E	F	G	H	I	J
1	**OneCare Connect**	Goals	Data Source & Owner	Frequency	7/1/2015 - 12/31/2015 Results	Met Not Met	CY 2016 Results	Met Not Met	CY 2017 Results	Met Not Met
2	**Program Structure:**									
3	QI Program Description (submission date)	Date	Esther	Annual	Apr-15	Met	Apr-16	Met		
4	QI Work Plan (submission date)	Date	Esther	Annual	Apr-15	Met	Apr-16	Met		
5	QI Evaluation (submission date)	Date	Esther	Annual	Apr-16	Met				
6										
7	**Network Management**									
8	Strong Network (Access)-Survey	See report	Marsha C.	Annual	See access report	N/A				
9	Strong Network (Availability)-Quarterly Report	See report	Marsha C.	Quarterly	See availability report	N/A				
10	Behavioral Health Access (BH Access & Availability)	See report	Dr. Poon	Quarterly	See Member Satisfaction Survey Report	N/A				
11	LTSS Access & Availability	TBD	Marie E.	Quarterly						
12	Complaints associated with Network Access	%/1000	Janine	Quarterly	0%	Y				
13	Use of Dental Benefit	41.50%	Lizeth	Monthly						
14	Complaints associated with use of Dental Benefit	1.80%	Janine	Quarterly	15%	N				
15	Utilization of Taxi Benefit (Transportation Services)	29.80%	Belinda	Annual	19.43%	Y				
16	Complaints associated with Taxi Benefit (Transportation Services)	2.70%	Janine	Quarterly	8%	N				
17										

	A	B	C	D	E	F	G	H	I	J
1	**OneCare Connect**	Goals	Data Source & Owner	Frequency	7/1/2015 - 12/31/2015 Results	Met Not Met	CY 2016 Results	Met Not Met	CY 2017 Results	Met Not Met
18				**Coordination of Care**						
19	% of calls resolved at first call	85%	Belinda	Quarterly	NA					
20	Member voluntary disenrollment rate	3.00%	Belinda	Quarterly	14.25%	N				
21	Transitions of Care									
22	Sending Member's Care Plan to Next Care Setting	% sent	Denise	Quarterly						
23	Notification to PCP of Transition	% notified	Denise	Quarterly						
24	HRA Outreach Completion Rate	90%	Cecelia	Quarterly	99%	Met				
25	HRA completion rate	TBD	Cecelia	Quarterly	22.90%					
26	ICP/ICT									
27	ICP (% of members with ICP)	90%	Denise	Quarterly						
28	ICT (% of members with ICT)	TBD	Denise	Quarterly						
29	DM inclusion in ICP (CCN)	30%	Pshyra	Quarterly						
30	Over/Under-Utilization of Services (Unused Auths?)			Quarterly	See HN rpt tab					
31	In-Patient Admits/1000	Admits/1000	Debra/Solange	Semi-Annual	See HN rpt tab					
32	Readmission Rate	<9.9%	Debra/Solange	Semi-Annual	See HN rpt tab					
33	Reduction in ER Visits (visit/1000 members)	585/1000	Debra/Solange	Quarterly	See HN rpt tab					
34	ALOS	4	Debra/Solange	Monthly	See HN rpt tab					
35	Response to Key Events (Need definition)	TBD	Denise	Quarterly						
36	F/Up after MH hospitalization (7 & 30 day)	50th %tile	Paul J	Annual	7 day = 81.35% 30 day = 85.49% (One Care)					
37	LTSS:									
38	Access to LTSS (utilization of LTSS services)	TBD	Marie E.	Quarterly						
39	Inpatient Days/1000 LTSS	Days/1000	Marie E.	Quarterly	Process not finalized in 2015					

	A	B	C	D	E	F	G	H	I	J
1	**OneCare Connect**	Goals	Data Source & Owner	Frequency	7/1/2015 - 12/31/2015 Results	Met Not Met	CY 2016 Results	Met Not Met	CY 2017 Results	Met Not Met
40	ER Visits (visits/1000)	Visits/1000	Marie E.	Quarterly	Process not finalized in 2015					
41	Annual Analysis of Risk Level Classification (% Low/% High)	TBD	Cecelia	Quarterly	74%/26%					
42	Disease Mgmt penetration for Basic CM members	30%	Pshyra	Quarterly						
43	Other									
44										
45	**QIP/CCIP**									
46	Topic : Improving In-Home Supportive Services Care Coordination	% improvement	Marie E./Marsha C	Quarterly	PIP not in place for 2015; 2016 only					
47	Topic: Readmission within 30 days	baseline year	Tracy/ Marsha C	Quarterly	QIP not in place for 2015; 2016 only					
48										

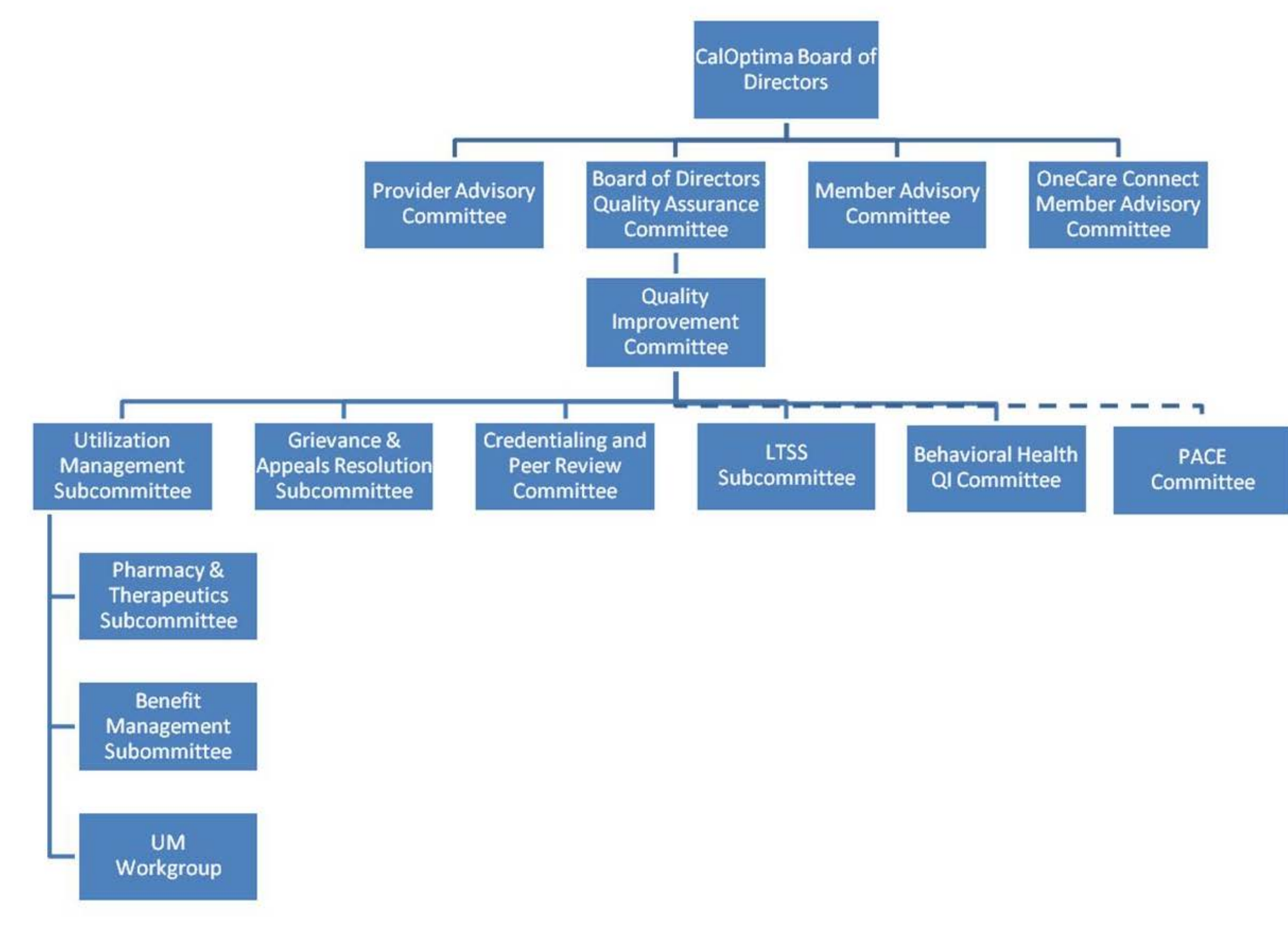
	A	B	C	D	E	F	G	H	I	J
1	**OneCare Connect**	Goals	Data Source & Owner	Frequency	7/1/2015 - 12/31/2015 Results	Met Not Met	CY 2016 Results	Met Not Met	CY 2017 Results	Met Not Met
49	**Health Outcomes**									
50	HEDIS performance (Stars Measure)				One Care Results for 2015					
51	Improvement in Adult Preventive Service	94.8% (50th %tile)	Paul J	Annual	93.61%	N				
52	Measure 1 (Controlling Blood Pressure)	4 Star Goal	Paul J	Annual	69.68%					
53	Measure 2 (Diabetes Care - A1C Control)	4 Star Goal	Paul J	Annual	72.51%					
54	Measure 3 (Diabetes Care - Nephropathy Monitoring)	4 Star Goal	Paul J	Annual	95.15%					
55	Measure 4 (Breast Cancer Screening)	69.80%	Paul J	Annual	68.69%	N				
56	Measure 5 (Colorectal Cancer Screening)	54.70%	Paul J	Annual	64.36%	Y				
57	Measure 6 (Acute Phase Depression Tx)	63.40%	Paul J	Annual	55.25%	N				
58	Measure 7 (Rheumatoid Arthritis)	4 Star Goal	Paul J	Annual	66.00%					
59	Measure 8 (Osteoporosis)	4 Star Goal	Paul J	Annual	44.87%					
60	Pharmacy Measures									
61	Medication Adherence - Hypertension	4 Star Goal	Nicki	Annual	5 stars (86%)	Y				
62	Medication Adherence - Diabetes	4 Star Goal	Nicki	Annual	4 stars (82%)	Y				
63	Medication Adherence - Cholesterol	4 Star Goal	Nicki	Annual	5 stars (82%)	Y				
64	HOS performance									

	A	B	C	D	E	F	G	H	I	J
1	**OneCare Connect**	Goals	Data Source & Owner	Frequency	7/1/2015 - 12/31/2015 Results	Met Not Met	CY 2016 Results	Met Not Met	CY 2017 Results	Met Not Met
65	Maintaining or improving physical health status	4 Star Goal	Marsha C	Annual	HOS not conducted in 2016					
66	Maintaining or improving mental health status	4 Star Goal	Marsha C	Annual	HOS not conducted in 2016					
67	Reducing the risk of falling	4 Star Goal	Marsha C	Annual	HOS not conducted in 2016					
68										
69	**Member Experience**									
70	CAHPS Performance (Stars Measures)				One Care Results for 2015					
71	Getting Needed Care	4 Star Goal	Marsha C	Annual	77%	Not Met				
72	Rating of Drug Plan	4 Star Goal	Marsha C	Annual	82%	Not Met				
73	Customer Service	4 Star Goal	Marsha C	Annual	85%	Not Met				
74	Getting Appointments & Care Quickly	4 Star Goal	Marsha C	Annual	70%	Not Met				
75	Getting Needed Prescription Drugs	4 Star Goal	Marsha C	Annual	88%	Not Met				
76	Care Coordination	4 Star Goal	Marsha C	Annual	80%	Not Met				
77	Overall Rating of Plan	4 Star Goal	Marsha C	Annual	82%	Not Met				
78	Overall Rating of Health Care Quality	4 Star Goal	Marsha C	Annual	81%	Not Met				

	A	B	C	D	E	F	G	H	I	J
1	**OneCare Connect**	Goals	Data Source & Owner	Frequency	7/1/2015 - 12/31/2015 Results	Met Not Met	CY 2016 Results	Met Not Met	CY 2017 Results	Met Not Met
79	**Medical Record Review (HN compliance to policies)**									
80	MRR results - CalOptima	Clinical Ops	Esther	Annual						
81										
82	**IRR for UM activities**									
83	Annual IRR for Staff	90%	Debra	Annual	96-100%	Y				
84	Annual IRR for RX	TBD	Solange	Annual	Completed?					
85	**Delegated functions oversight**									
86	Health Network performance	A/O Report	Solange	Quarterly						
87	MRR results - HN	A/O Report	Esther	Quarterly						
88	IRR for Delegates	A/O Report	Solange	Annual	Completed?					
89	**Clinical Practice Guidelines**									
90	Reviewed annually (linked with DM)	QIC minutes	Pshyra	Annual						

"Attachment A"

~~QUALITY IMPROVEMENT COMMITTEE STRUCTURE –~~ 2016



Back to Agenda

CalOptima Board Action Agenda Referral

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

Consent Calendar
5. Consider Appointment to the CalOptima Board of Directors' Investment Advisory Committee

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

Recommended Action
Consider reappointment of Rodney Johnson to the CalOptima Board of Directors' Investment Advisory Committee for a two-year term beginning June 7, 2017.

Background
At a Special Meeting of the CalOptima Board of Directors held on September 10, 1996, the Board authorized the creation of the CalOptima Investment Advisory Committee (IAC), established qualifications for committee members, and directed staff to proceed with the recruitment of the volunteer members of the Committee.

When creating the IAC, the Board specified that the Committee would consist of five (5) members; one (1) member would automatically serve by virtue of his or her position as CalOptima's Chief Financial Officer. The remaining four (4) members would be Orange County residents who possess experience in one (1) or more of the following areas: investment banking, investment brokerage and sales, investment management, financial management and planning, commercial banking, or financial accounting.

At the September 5, 2000, meeting, the Board approved expanding the composition of the IAC from five (5) members to seven (7) members in order to have more diverse opinions and backgrounds to advise CalOptima on its investment activities.

Discussion
The candidate recommended for reappointment, Rodney Johnson, has consistently provided leadership and service to CalOptima's investment strategies through his participation as an IAC member.

Mr. Johnson has served as a member of the IAC since June 6, 2013. Mr. Johnson has extensive experience working with public agencies. He is currently Deputy Treasurer of the Orange County Transportation Authority (OCTA), where he has worked for over 19 years. He is responsible for daily analysis of short-term and long-term cash flow needs, executing investments, overseeing five (5) different investment management firms, and ensuring compliance with the OCTA investment policy. Prior to that, Mr. Johnson held positions at BNY Western Trust Company, Fund Services Associates, Inc., and Muni Financial Services, Inc. Mr. Johnson has a M.P.A. from California State

University Long Beach, and a B.A. from California State University Fullerton. In addition, he was part of CalOptima's investment manager request for proposal (RFP) evaluation team. His current term expires on June 6, 2017.

Fiscal Impact
There is no fiscal impact. Individuals appointed to the IAC are responsible for assisting CalOptima in meeting the objectives of CalOptima's annual investment policy, including preservation of capital, meeting the agency's liquidity needs, and obtaining an acceptable return on investment of available funds.

Rationale for Recommendation
The individual recommended for CalOptima's IAC has extensive experience that meets or exceeds the specified qualifications for membership on the IAC. In addition, the candidate has already provided outstanding service as a member of the IAC.

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

Attachment
None

/s/ Michael Schrader *5/25/2017*
Authorized Signature **Date**

Back to Agenda

CalOptima Board Action Agenda Referral

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

Consent Calendar
6. Consider Adoption of the Proposed CalOptima Board of Directors Meeting Schedule for Fiscal Year (FY) 2017-18

Contact
Michael Schrader, Chief Executive Officer, (714) 246-8400

Recommended Action
Adopt the proposed meeting schedule of the CalOptima Board of Directors, the Finance and Audit Committee, and the Quality Assurance Committee for the period July 1, 2017 through June 30, 2018.

Background
Section 5.2.(b) (1) of the CalOptima Bylaws specifies that the Board shall conduct an annual organizational meeting at a regular meeting to be designated in advance by the Board. The annual organizational meeting is scheduled for the June Board meeting each year. At the annual organizational meeting, the Board shall adopt a schedule stating the dates, times, and places of the Board's regular meetings for the following year.

Discussion
The proposed schedule of meetings for the period July 1, 2017 through June 30, 2018 is as follows:

1. The Board of Directors will meet at 2 p.m. on the first Thursday of each month, with the following exceptions:
    - Due to the Independence Day holiday, staff recommends that the Board consider not meeting in July. Should unanticipated items arise during July 2017 that requires Board review/approval, the Chief Executive Officer (CEO) will confer with the Board Chair or Vice Chair, and items will be presented for ratification at the following regularly scheduled Board meeting
    - Due to the New Year's holiday, staff recommends that the Board consider not meeting in January 2018. Should unanticipated items arise during January requiring Board review/approval, the CEO will confer with the Board Chair or Vice Chair, and items will be presented for ratification at the following regularly scheduled Board meeting.

2. The Finance and Audit Committee will meet quarterly at 2:00 p.m. on the third Thursday in the months of September, November, February and May.

3. The Quality Assurance Committee will meet quarterly at 3:00 p.m. on the third Wednesday in the months of September, November, February and May.

The meetings of the Board of Directors, the Finance and Audit Committee, and the Quality Assurance Committee are held at the CalOptima offices located at 505 City Parkway West, 1st Floor, Orange, California, unless notice of an alternate location is provided. The proposed FY 2017-18 Board of Directors Meeting Schedule is attached.

Back to Agenda

Fiscal Impact
The fiscal impact for FY 2017-18 Board of Directors Meetings is up to $27,000 in per diem costs, and up to $9,000 in mileage reimbursement for certain Board members. Funding is included as part of the CalOptima FY 2017-18 Operating Budget pending Board approval.

Rationale for Recommendation
The recommended action will confirm the Board's meeting schedule for the next fiscal year as required in Section 5.2 of the Bylaws.

Concurrence
Gary Crockett, Chief Counsel

Attachment
Proposed Schedule of Meetings of the CalOptima Board of Directors, the Finance and Audit Committee, and the Quality Assurance Committee – July 1, 2017 through June 30, 2018

/s/ Michael Schrader *05/25/2017*
Authorized Signature **Date**

Back to Agenda

Proposed

Board of Directors Meeting Schedule
July 1, 2017 – June 30, 2018

All meetings are held at the following location, unless notice of an alternate location is provided:

505 City Parkway West
Orange, California 92868

Board of Directors **Monthly – First Thursday** **Meeting Time: 2:00 p.m.**	**Finance and Audit Committee** **Quarterly – Third Thursday** **Meeting Time: 2:00 p.m.**	**Quality Assurance Committee** **Quarterly – Third Wednesday** **Meeting Time: 3:00 p.m.**
July 2017^		
August 3, 2017		
September 7, 2017	September 21, 2017	September 20, 2017
October 5, 2017		
November 2, 2017	November 16, 2017	November 15, 2017
December 7, 2017		
January 2018^		
February 1, 2018	February 15, 2018	February 14, 2018
March 1, 2018		
April 5, 2018		
May 3, 2018	May 17, 2018	May 16, 2018
June 7, 2018[1]		

^No Regular meeting scheduled
[1] Organizational Meeting

Back to Agenda

CalOptima Board Action Agenda Referral

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

Consent Calendar

7. Consider Adoption of Resolution Changing the Membership of the CalOptima Board of Directors' Member Advisory Committee

Contact

Ladan Khamseh, Chief Operating Officer, (714) 246-8400

Recommended Action

Adopt Resolution No. 17-0601-01 to reclassify a seat on the Member Advisory Committee (MAC) from the Long-Term Care (LTC) representative to the Long-Term Supports and Services (LTSS) representative, effective upon Board approval.

Background

Since CalOptima's inception, the CalOptima Board of Directors has benefited from stakeholder involvement in the form of advisory committees. The Board of Directors established the Member Advisory Committee (MAC) and the Provider Advisory Committee (PAC) pursuant to Resolution No. 95-0214 to represent CalOptima constituencies and to advise the Board of Directors concerning the CalOptima program.

The MAC is comprised of fifteen voting members, each seat representing a constituency or population that CalOptima serves. The Board of Directors is responsible for the approval of MAC and PAC members. One of the original seats on the MAC includes an individual representing, or represents the interests of members in long-term care.

California is working towards redirecting service delivery from institutional care towards home and community-based care and optimizing the use of Medi-Cal resources. The Department of Health Care Services (DHCS) is enacting regulations to further integrate LTSS services into Medi-Cal managed care plans' (MCPs) Member Advisory Committees, effective July 1, 2017. LTSS services include a variety of services and supports that help members meet their daily needs for assistance and improve the quality of their lives. LTSS services are provided over an extended period, predominantly in homes and communities, but also in facility-based settings such as nursing facilities.

Discussion

Medi-Cal managed care plans have an expanded role to provide care coordination for members receiving LTSS. Consistent with Resolution No. 95-0214 and CalOptima policy, the advisory committees were developed to include maximum member and provider involvement in the CalOptima program, as well as provide dedicated representation for each population served. In order to better represent LTC members, the MAC recommends reclassifying the Long-Term Care representative to a Long-Term Supports and Services representative.

If the proposed change is approved by the Board, CalOptima policy AA.1219a: Member Advisory Committee would be updated accordingly.

Fiscal Impact
There is no fiscal impact.

Rationale for Recommendation
The MAC proposes reclassifying the Long-Term Care representative to a Long-Term Supports and Services representative to better reflect the constituency it serves.

Concurrence
Member Advisory Committee
Gary Crockett, Chief Counsel

Attachment
Resolution No. 17-0601-01, Approve Change in Membership of the Member Advisory Committee

/s/ Michael Schrader *05/25/2017*
Authorized Signature **Date**

Back to Agenda

RESOLUTION NUMBER 17-0601-01

RESOLUTION OF THE BOARD OF DIRECTORS
ORANGE COUNTY HEALTH AUTHORITY
Orange Prevention and Treatment Integrated Medical Assistance
d.b.a. CalOptima

APPROVE CHANGE IN MEMBERSHIP OF THE
MEMBER ADVISORY COMMITTEE

WHEREAS, the CalOptima Board of Directors established the Member Advisory Committee (MAC) pursuant to Resolution No. 95-0214 to represent the constituencies served by CalOptima and to advise the Board of Directors; and

WHEREAS, the Resolution was amended to add a Consumer representative to MAC pursuant to Resolution No. 11-1103 to provide direct representation of a recipient of CalOptima's services; and later amended to modify a seat to a Family Support representative pursuant to Resolution No. 13-0307 to provide representation of families and the interests of children; and again amended to add a Vice Chair pursuant to Resolution No. 16-0804-01 to assist the Board-appointed chair with committee administration; and

WHEREAS, the MAC recommends the reclassification of the Long-Term Care representative to a representative for Long-Term Supports and Services to better reflect the constituency it serves.

NOW, THEREFORE, BE IT RESOLVED:
That the Board of Directors hereby approves and adopts the reclassification of the Long-Term Care (LTC) services seat to the Long-Term Supports and Services (LTSS) seat, effective June 1, 2017.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a. CalOptima, this 1st day of June 2017.

AYES:

NOES:

ABSENT:

ABSTAIN:

/s/____________________________________
Title: Paul Yost, M.D., Chair, Board of Directors
Printed Name and Title:

Attest:
/s/_______________________________________
Suzanne Turf, Clerk of the Board

Back to Agenda

CalOptima Board Action Agenda Referral

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

Consent Calendar

8. Consider Recommended Appointments to the CalOptima Board of Directors' Member Advisory Committee (MAC); Consider Appointments of MAC Chair and Vice Chair

Contact

Ladan Khamseh, Chief Operating Officer, (714) 246-8400

Recommended Actions

The MAC recommends:

1. Reappointment of the following individuals to serve two-year terms on the Member Advisory Committee, effective July 1, 2017 to June 30, 2019:
    a. Sandy Finestone as the Adult Beneficiaries Representative;
    b. Patty Mouton as the Medi-Cal Beneficiaries Representative;
    c. Suzanne Butler as the Persons with Disabilities Representative;
    d. Carlos Robles as the Recipients of CalWORKs Representative; and
    e. Mallory Vega as the Seniors Representative.

2. Appointment of Ilia Rolon as the Family Support Representative for a term ending June 30, 2019.

3. Appointment of Sally Molnar as Chair and appointment of Patty Mouton as Vice Chair for a one-year term ending June 30, 2018.

Background

The CalOptima Board of Directors established the Member Advisory Committee (MAC) by resolution on February 14, 1995 to provide input to the Board. The MAC is comprised of fifteen voting members. Pursuant to the resolution, MAC members serve two-year terms with the exception of the two standing seats, which are representatives from the Social Services Agency (SSA) and the Health Care Agency (HCA). The CalOptima Board is responsible for the appointment of all MAC members. With the fiscal year ending on June 30, 2017, six MAC seats will expire: Adult Beneficiaries, Family Support, Medi-Cal Beneficiaries, Persons with Disabilities, Recipients of CalWORKs, and Seniors.

Discussion

CalOptima conducted recruitment to ensure that there would be a diverse applicant pool from which to choose candidates. The recruitment included several notification methods, including placing articles in newsletters, sending outreach flyers to community-based organizations (CBOs) and targeting community outreach to agencies and CBOs serving the various open positions. CalOptima staff received the applications from interested candidates and submitted them to the Nominations Ad Hoc Subcommittee for review.

Prior to the Nominations Ad Hoc Subcommittee meeting on April 19, 2017, subcommittee members evaluated each of the applications. Subcommittee Members Sally Molnar, Velma Shivers and Connie Gonzalez selected a candidate for each of the open seats as well as the Chair and Vice Chair and forwarded the proposed slate of candidates to the MAC for consideration.

At the May 11, 2017 meeting, the MAC considered and approved the recommended slate of candidates, Chair and Vice Chair, as proposed by the Nominations Ad Hoc.

Candidates for open positions are as follows:

Adult Beneficiaries Representative Candidates
Sandy Finestone*
Georgina Maldonado

Sandy Finestone is the Executive Director of the Association of Cancer Patient Educators and works with many CalOptima members. She has been involved with the delivery of health care in the community for over thirty years, both as an advocate and as a health care provider. As an ardent breast cancer advocate, she understands what the financial impact can be on someone with a cancer diagnosis.

Georgina Maldonado is the Executive Director of the Community Health Initiative of Orange County, which serves a population that includes 82 percent Medi-Cal eligible beneficiaries. Ms. Maldonado has worked with uninsured individuals on enrollment issues for over ten years. In addition, she has provided education to newly insured families on how to navigate the health care system.

Medi-Cal Beneficiaries Representative Candidates
Patty Mouton*
Georgina Maldonado

Patty Mouton is the Vice President of Outreach and Advocacy at Alzheimer's Orange County, and has worked in the area of health care for older adults for fifteen years. She oversees professional and clinical activities and events, provides community education programs, and coordinates the legislative advocacy and public policy forming activities. In addition, she speaks to community groups about issues of medical coverage and defining the continuum of care.

Georgina Maldonado is the Executive Director of the Community Health Initiative of Orange County, which serves a population that includes 82 percent Medi-Cal eligible beneficiaries. Ms. Maldonado has worked with uninsured individuals on enrollment issues for over ten years. In addition, she has provided education to newly insured families on how to navigate the health care system.

*Indicates MAC recommendation

Persons with Disabilities Representative Candidates
Suzanne Butler*
Sandy Finestone

Suzanne Butler has worked with individuals with developmental disabilities for over twenty-five years. In her current position with the Regional Center of Orange County (RCOC), she assists RCOC staff, individuals with disabilities and their families understand Social Security, Medi-Cal, and Medicare benefits and how to access the appropriate services and supports through those agencies.

Sandy Finestone is the Executive Director of the Association of Cancer Patient Educators and works with many CalOptima members. She has been involved with the delivery of health care in the community for over thirty years, both as an advocate and as a health care provider. As an ardent breast cancer advocate, she understands what the financial impact can be on someone with a cancer diagnosis.

Recipients of CalWORKs Persons Representative Candidates
Carlos Robles*

Carlos Robles is a Program Supervisor for ResCare Workforce Services. ResCare, a subcontractor for the Social Services Administration (SSA), implements Orange County's Welfare to Work program, which is CalWORKs. Mr. Robles helps link CalWORKs' recipients with the appropriate services and resources to assist them in achieving self-sufficiency. In addition, he started an outreach organization that assists low-income families by providing resources and necessities to families in need.

Seniors Representative Candidates
Mallory Vega*
Patty Mouton
Vivien Tran

Mallory Vega has been the Executive Director of Acacia Adult Day Services for over thirty years, providing adult day care, adult day health care, dementia care, and now Community Based Adult Services to seniors. In addition, she serves on numerous community agency boards that serve this population, including CalOptima's PACE Development Advisory Committee (PDAC).

Patty Mouton is the Vice President of Outreach and Advocacy at Alzheimer's Orange County, and has worked in the area of health care for older adults for fifteen years. She oversees professional and clinical activities and events, provides community education programs, and coordinates the legislative advocacy and public policy forming activities. In addition, she speaks to community groups about issues of medical coverage and defining the continuum of care.

Vivien Tran is a consultant in health care administration. She has over twelve years of experience working with managed care systems and developing strategies to improve member engagement and

*Indicates MAC recommendation

Back to Agenda

satisfaction. Ms. Tran has worked with an organization that provides supportive resources to Vietnamese seniors that have a life limiting illness.

Family Support Representative Candidates
Ilia Rolon*
Rhys Burchill

Ilia Rolon is the Director for the Children and Families Commission of Orange County. Ms. Rolon has managed and coordinated health promotions programs for families and clients from low-income communities for twenty-five years. In her current role, she oversees the development, implementation and management of the Healthy Children funding portfolio.

Rhys Burchill has advocated for improved quality of life for individuals with developmental disabilities for several decades. As the parent of an adult daughter with a developmental disability, Ms. Burchill has worked with several agencies that serve individuals with developmental disabilities, including Team of Advocates for Special Kids and Area Board XI for Developmental Disabilities.

MAC Chair Candidate
Sally Molnar*

Sally Molnar advocates for breast health screenings and treatment programs that provide a safety net for under-insured and uninsured women in Orange County. She currently serves as the Public Policy Chair and advocates for breast cancer services at the state and federal level. She has volunteered with Susan G. Komen in Orange County for twenty-five years in various capacities.

MAC Vice Chair Candidate
Patty Mouton*

Patty Mouton is the Vice President of Outreach and Advocacy at Alzheimer's Orange County, and has worked in the area of health care for older adults for fifteen years. She oversees professional and clinical activities and events, provides community education programs, and coordinates the legislative advocacy and public policy forming activities. In addition, she speaks to community groups about issues of medical coverage and defining the continuum of care.

Fiscal Impact
There is no fiscal impact.

Rationale for Recommendation
As stated in policy, the MAC established a Nominations Ad Hoc to review potential candidates for vacancies on the Committee. The MAC met to discuss the recommended slate of candidates, Chair and Vice Chair and concurred with the Subcommittee's recommendations. The MAC forwards the recommended slate of candidates, Chair and Vice Chair to the Board of Directors for consideration.

*Indicates MAC recommendation

Back to Agenda

Concurrence
Member Advisory Committee Nominations Ad Hoc
Member Advisory Committee
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader *05/25/2017*
Authorized Signature **Date**

*Indicates MAC recommendation

Back to Agenda

CalOptima Board Action Agenda Referral

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

Consent Calendar

9. Consider Appointments to the CalOptima Board of Directors' Provider Advisory Committee (PAC); Consider Appointment of PAC Chair and Vice Chair

Contact

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

Recommended Actions

The PAC recommends:

1. Reappointment of the following individuals to serve an additional three-year term on the Provider Advisory Committee (PAC), effective July 1, 2017:
    a. Suzanne Richards, Hospital Representative for term ending June 30, 2020;
    b. Jacob Sweidan, M.D., as the Physician Representative for a term ending June 30, 2020;
    c. Jena Jensen as the Traditional/Safety Net Representative for a term ending June 30, 2020;

2. Appointment of Craig Myers as the Community Health Clinics Representative for a three-year term ending June 30, 2020;

3. Reappointment of Teri Miranti, PAC Chairperson effective July 1, 2017; and

4. Reappointment of Suzanne Richards, PAC Vice-Chairperson effective July 1, 2017

Background

The CalOptima Board of Directors established the Provider Advisory Committee (PAC) by resolution on February 14, 1995 to provide input to the Board. The PAC is comprised of fifteen voting members. Pursuant to Resolution No. 15-0806-03, PAC members serve three-year terms with the exception of the one standing seat, which is a representative from Health Care Agency (HCA). The CalOptima Board is responsible for the appointment of all PAC members. With the fiscal year ending on June 30, 2017, four (4) PAC seats will expire: one (1) Community Health Clinics seat, one (1) Hospital seat, one (1) Physician seat, and one (1) Traditional/Safety Net seat. There was one applicant each for the Chairperson and Vice Chairperson.

Discussion

CalOptima conducted recruitment to ensure that there would be a diverse applicant pool from which to choose candidates. The recruitment included notification methods, such as: sending outreach flyers to community-based organizations (CBOs) and targeting community outreach to agencies and CBOs serving the various open positions. CalOptima staff received the applications from interested candidates and submitted them to the Nominations Ad Hoc Subcommittee for review.

Prior to the Nominations Ad Hoc Subcommittee meeting on April 24, 2017, subcommittee members evaluated each of the applications. The subcommittee, including Members Drs. Bata, Pham and Bruhns,

selected a candidate for each of the open seats as well as the Chairperson and Vice-Chairperson and forwarded the proposed slate of candidates to the PAC for consideration.

At the May 11, 2017 meeting, the PAC voted to accept the recommended slate of candidates and Chairperson as proposed by the Nominations Ad Hoc.

The slate of candidates is as follows:

Community Health Centers Representative
Craig G. Myers*
Jeremy Elkins
Jorge Mario Galdamez, M.D., M.P.H.
Patty Mouton

Mr. Myers currently works as a health care consultant and is on the board of the Coalition for Community Health Centers, serving as the Coalition's Interim President of the Board. Mr. Myers has previously served as the PAC Hospital Representative.

Mr. Elkins currently serves as Executive Director, Government Programs for St. Joseph Heritage Healthcare. He was formerly with Share Our Selves as Chief Operating Officer. He holds a master's degree in business administration and is a Certified Physician Assistant for the State of California.

Dr. Galdamez is a physician practicing in Orange County who has served as the Medical Director with AltaMed for the past three years. Dr. Galdamez is board certified in family medicine by the American Academy of Family Physicians through 2024 and holds a valid California physician and surgeon license through September 2018.

Ms. Mouton is currently Vice President, Outreach and Advocacy for Alzheimer's Association Orange County where she is responsible for planning and management of community and clinical outreach in Orange County. She is an active member of CalOptima's Member Advisory Committee (MAC) and serves as the Chair for the OneCare Connect Member Advisory Committee (OCC MAC).

Hospital Representative
Suzanne Richards, M.B.A., FACHE*

Ms. Suzanne Richards has served on the PAC since October 2014 and is the CEO of Health Operations, KPC Healthcare and CEO of Orange County Global Medical Center. In addition to her duties as a corporate and hospital CEO, Ms. Richards is an active surveyor for The Joint Commission and has conducted accreditation surveys of health care entities throughout the United States since 2005. The Hospital Association of Southern California (HASC) supports Ms. Richards' candidacy for reappointment as the Hospital Representative on the CalOptima PAC.

*Indicates PAC recommendation

Physician Representative
Jacob Sweidan, M.D.*

Dr. Jacob Sweidan has served on the PAC since 2009. He is the President at Noble Mid-Orange County. He is a practicing pediatrician with four offices in Anaheim, Garden Grove and Santa Ana serving CalOptima patients since the agency's inception.

Traditional/Safety Net Representative
Jena Jensen*
Jeremy Elkins, M.B.A.

Ms. Jena Jensen has served on the PAC since 2013. She is the Chief Government Relations Officer at CHOC Children's Hospital of Orange California. CHOC Children's has been a participant in CalOptima since the agency's inception in 1993. Ms. Jensen's 20-plus year tenure with CHOC Children's dates back to 1992, when she joined the hospital as director of marketing and public relations. She currently serves as CHOC Children's central resource for legislative advocacy as well as development and maintenance of relationships with federal, state and local elected officials, government, and community and opinion leaders. Ms. Jensen served as PAC Chair from 2014–2016.

Mr. Elkins is currently the Executive Director of Government Programs for St. Joseph Heritage Healthcare. He was formerly with Share Our Selves as their Chief Operating Officer. He holds a master's degree in business administration and is a Certified Physician Assistant for the State of California.

Chairperson
Teri Miranti*

The Nominations Subcommittee recommends Teri Miranti, Health Network Representative, serve as Chairperson for FY 2017-2018. Ms. Miranti has been a PAC member since 2015 and has served as PAC Chair for FY 2016-2017.

Vice Chairperson
Suzanne Richards*

The Nominations Subcommittee recommends Suzanne Richards, Hospital Representative, serve as the Vice Chairperson for FY 2017-2018. Ms. Richards has been a PAC member since 2013 and has served as Vice Chair for FY 2016-17.

Fiscal Impact
There is no fiscal impact.

Rationale for Recommendation
As stated in policy, the PAC established a Nominations Ad Hoc to review potential candidates for vacancies on the Committee. The PAC met to discuss the recommended slate of candidates and

*Indicates PAC recommendation

Chairperson and concurred with the Subcommittee's recommendations. The PAC forwards the recommended slate of candidates and Chairperson to the Board of Directors for consideration.

Concurrence
PAC Advisory Committee Nominations Ad Hoc
PAC Advisory Committee
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader | *05/25/2017*
Authorized Signature | **Date**

*Indicates PAC recommendation

Back to Agenda

CalOptima Board Action Agenda Referral

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

Consent Calendar

10. Consider Recommended Appointments to the CalOptima Board of Directors' OneCare Connect Member Advisory Committee (OCC MAC); Consider Appointment of OCC MAC Chair and Vice Chair

Contact

Ladan Khamseh, Chief Operating Officer, (714) 246-8400

Recommended Actions

The OCC MAC recommends:

1. Reappointment of the following individuals to serve two-year terms on the OneCare Connect Member Advisory Committee, effective July 1, 2017:
   a. Josefina Diaz as the OneCare Connect Member/Family Member Representative for a term ending June 30, 2019;
   b. Sandy Finestone as the Representative Serving Persons with Disabilities for a term ending June 30, 2019; and
   c. Sara Lee as the Representative Serving Persons from an Ethnic or Cultural Community for a term ending June 30, 2019.
2. Appointment of the following individual to serve a two-year term on the OneCare Connect Member Advisory Committee, effective July 1, 2017:
   a. Richard Santana as the In-Home Supportive Services (IHSS)/Union Provider Representative for a term ending June 30, 2019.
3. Appointment of Gio Corzo as Chair, and appointment of Patty Mouton as Vice Chair for a one-year term ending June 30, 2018.

Background

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

The OCC MAC is comprised of ten voting members, seven of whom represent community seats and three of whom are OneCare Connect members or family of members. There are also four non-voting members representing Orange County agencies. OCC MAC voting members serve two-year terms, with no limit on the number of terms a representative may serve. The five seats due to expire on June 30, 2017 include the representative serving persons with disabilities, the representative serving persons from an ethnic or cultural community, the IHSS/union provider representative and two OCC member/family member seats.

Back to Agenda

Discussion
CalOptima conducted recruitment to identify candidates for the impending vacancies. Recruitment activities included sending an announcement to over 950 community partners, such as non-profit, social services, adult day services, senior centers, health care partners, and advocates, as well as placing articles in newsletters, posting on CalOptima's website and conducting targeted community outreach to agencies and CBOs serving the various open positions. Upon receipt of the applications from interested candidates, CalOptima staff submitted them to the Nominations Ad Hoc Subcommittee for review.

The OCC MAC Nominations Ad Hoc Subcommittee, composed of OCC MAC committee members Lena Berlove, Ted Chigaros and Patty Mouton, evaluated each of the applications for the impending openings and forwarded the proposed slate of candidates to the OCC MAC for consideration. The proposed slate of candidates included four candidates for the five vacancies. One of the OCC MAC member/family member seats will remain vacant until an eligible candidate is identified. OCC MAC is reopening the recruitment for this seat.

At the May 25, 2017 meeting, OCC MAC accepted the recommended slate of candidates, Chair and Vice Chair, as proposed by the Nominations Ad Hoc and forwarded the proposed slate of candidates to the CalOptima Board for consideration.

The candidates for the open positions are as follows:
Persons with Disabilities Representative Candidate
Sandy Finestone*

Sandy Finestone is the Executive Director of the Association of Cancer Patient Educators. Ms. Finestone works daily with individuals who have become disabled due to stage IV cancer. She facilitates support groups, meets individually with patients and their families and has created a peer support system. Ms. Finestone has been involved with the delivery of health care in the community for over thirty years, both as an advocate and as a health care provider.

Persons from an Ethnic or Cultural Community Representative Candidate
Sara Lee*

Sara Lee is an attorney for the Health Consumer Action Center (HCAC) for Legal Aid of Orange County. Ms. Lee assists dual eligible members that encounter barriers to accessing health care. She provides outreach and education to Korean speaking dual eligibles. Ms. Lee supervises the HCAC to provide culturally and linguistically competent services to members of all ethnicities and abilities.

IHSS/Union Provider Representative Candidate
Richard Santana*

Richard Santana is a Field Organizer with the United Domestic Workers of America. In that capacity, Mr. Santana works with the IHSS service providers that provide custodial care to CalOptima's dual eligible members. By working closely with the caregivers, he has gained an understanding of the needs of seniors and persons with disabilities.

*Indicates OCC MAC recommendation

OneCare Connect Member/Family Member Representative Candidate (Two open seats; one candidate)
Josefina Diaz*

Josefina Diaz has a parent who is an OneCare Connect member. Ms. Diaz has many years of experience working in the Orange County community. She currently works as a paralegal with the Legal Aid Society of Orange County (LASOC). Ms. Diaz's work at LASOC has provided her with knowledge and experience working with a diverse community.

OCC MAC Chair
Gio Corzo*

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

OCC MAC Vice Chair
Patty Mouton*

Patty Mouton is the Vice President of Outreach and Advocacy at Alzheimer's Orange County, and has worked in the area of health care for older adults for fifteen years. She oversees professional and clinical activities and events, provides community education programs, and coordinates the legislative advocacy and public policy forming activities.

Fiscal Impact
There is no fiscal impact.

Rationale for Recommendation
As stated in policy, the OCC MAC established a Nominations Ad Hoc to review potential candidates for the OneCare Connect MAC. The OCC MAC met to discuss the Ad Hoc's recommended slate of candidates, Chair and Vice Chair and concurred with the Subcommittee's recommendations. The OCC MAC forwards the recommended slate of candidates and Chairperson to the Board of Directors for consideration.

Concurrence
OneCare Connect Member Advisory Committee Nominations Ad Hoc
OneCare Connect Member Advisory Committee
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader   *5/25/2017*
Authorized Signature   **Date**

*Indicates OCC MAC recommendation

Back to Agenda

CalOptima Board Action Agenda Referral

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

Consent Calendar

11. Consider Adopting Resolution Authorizing and Directing the Chairman of the Board of Directors to Execute Contract MS-17-18-41 with the California Department of Aging for the Multipurpose Senior Services Program (MSSP) for Fiscal Year 2017-18

Contact

Richard Helmer, M.D., Chief Medical Officer, (714) 246-8400
Nancy Huang, Interim Chief Financial Officer, (714) 246-8400

Recommended Action

Adopt Board Resolution No. 17-0601-02, authorizing and directing the Chairman of the Board to execute Contract MS-17-18-41 with the California Department of Aging for the Multipurpose Senior Services Program.

Background

The Multipurpose Senior Services Program (MSSP) is a home and community-based services program, operated pursuant to a waiver in the State's Medi-Cal program. MSSP provides case management of social and health care services as a cost-effective alternative to institutionalization of the frail elderly.

The California Department of Health Care Services (DHCS), through an Interagency Agreement, delegates the administration of the MSSP to the California Department of Aging (CDA). The CDA contracts with local government entities and private non-profit organizations for local administration of MSSP in various areas of the State.

As the operator of the MSSP site for Orange County, CalOptima improves the quality of care for our aging population by linking frail, elderly members to home and community-based services as an alternative to institutionalization, and helps to contain long-term care costs by reducing unnecessary or inappropriate nursing facility placements. CalOptima has successfully implemented the MSSP program over the past sixteen (16) years for up to a maximum of 568 members at any given point in time. Currently, CalOptima serves between 475 to 490 clients.

Discussion

CalOptima has received CDA Contract MS-17-18-41 for execution by the Chairman of the CalOptima Board, which, upon the adoption of a Board resolution and execution of the contract will extend the MSSP program through June 30, 2018, with the maximum amount of the contract set at $1,949,675. The scope of work and other obligations are consistent with existing contract obligations. There are a number of proposed changes to the contract language, including the following:

- Service data will now be required to be submitted by the 5th day of the calendar month following the 95th day from the month of services, rather than the 15th day of calendar month following the 105th day from the month of services (i.e., 10 days earlier). However, this requirement does not affect CalOptima because MSSP is within

Back to Agenda

CalOptima, rather being operated by a separate entity as it is in other Medi-Cal Managed Care programs, and MSSP shares service data with CalOptima on a weekly basis to capture all currently enrolled MSSP CalOptima members.

- A new California Civil Rights Law certification requirement has been added. Staff is currently unaware of any issues with filing this certification.
- The record retention period has been increased from six years after case closure to seven years after. While this is a change in the contract, the record retention period for all MSSP records has been standard at seven years under the CDA's MSSP Site Manual (2015 version), and so this requirement is already being met.
- The information privacy and security requirements now explicitly apply to subcontractors and vendors, instead of just to CalOptima (Exhibit D., Article XVIII.), and the full DHCS Business Associate Agreement is now part of the contract, rather than being only partially integrated into it. (Exhibit F.). All Information privacy and security requirements are were already stipulated in CalOptima's contracts with all MSSP assigned vendors, and there are no subcontractors, so those changes will have no effect. In addition, MSSP has been operating in full compliance with HIPAA, so the inclusion of the full BAA is also not an issue.
- Additional minor changes include:
    - A change regarding notice of change in representatives, which just aligns the contract with the MSSP Site Manual.
    - A change with the reference to the budget, which was changed from a reference to the filed budget to actually listing the required budget elements for that filed budget. The budget elements are binding, however, in either case.
    - Minor changes to definitions.
    - Compliance with the Unruh Civil Rights Act was added as a requirement (compliance is legally required even without the contract provision).
    - A redundant sub-contractor identification provision was deleted.
    - The information assets section was made more specific.
    - A new subsection was added to the copyrights provision.

Staff does not anticipate any of these changes will have a significant operational or financial impact as they are largely already in operation.

With the advent of the Coordinated Care Initiative (CCI) on July 1, 2015, the MSSP program now falls within CalOptima's Long Term Services and Supports (LTSS) Department. While CDA programmatic requirements remain the same, CalOptima is required to pay MSSP per enrolled member per month based upon a monthly reconciliation. CalOptima is required to continue funding MSSP at the same rate as would have applied had CalOptima not participated in CCI. DHCS provides CalOptima with Medi-Cal revenue for the MSSP program through the established capitation rate setting process.

Fiscal Impact
MSSP revenues and expenses are budgeted items and are included in the proposed CalOptima FY 2017-18 Operating Budget pending Board approval.

Rationale for Recommendation

Adoption of Board Resolution No. 17-0601-02, authorizing and directing the Chairman of the Board of Directors to execute the FY 2017-18 contract with the CDA for the MSSP program will allow CalOptima to continue to address the long-term community care needs of some of the frailest older adult CalOptima members by helping them to remain in their homes.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Board Resolution No. 17-0601-02, Execute Contract No. MS-17-18-41 with the State Of California Department of Aging for the Multipurpose Senior Services Program (MSSP)

/s/ Michael Schrader *5/31/2017*

Authorized Signature **Date**

Back to Agenda

RESOLUTION NO. 17-0601-02

RESOLUTION OF THE BOARD OF DIRECTORS
ORANGE COUNTY HEALTH AUTHORITY
Orange Prevention and Treatment Integrated Medical Assistance
d.b.a. CalOptima

EXECUTE CONTRACT NO. MS-17-18-41
WITH THE STATE OF CALIFORNIA
DEPARTMENT OF AGING FOR THE
MULTIPURPOSE SENIOR SERVICES PROGRAM (MSSP)

WHEREAS, The Orange County Health Authority, d.b.a. CalOptima ("CalOptima") continues to provide services as a Multipurpose Senior Service Program Site under contract with the California Department of Aging; and,

WHEREAS, the California Department of Aging notified CalOptima of its intent to contract for the assignment of up to 568 MSSP participant slots to CalOptima; and,

WHEREAS, the California Department of Aging has requested the execution of Contract MS-17-18-41; and,

WHEREAS, the Board of Directors has determined that it is in the best interest of the ongoing development of CalOptima home and community based services to the Medi-Cal beneficiaries residing in Orange County to approve CalOptima executing the Contract.

NOW, THEREFORE, BE IT RESOLVED:

I. That CalOptima is hereby authorized to enter into contract MS-17-18-41with the State of California Department of Aging on the terms and conditions set forth in the form provided to this Board of Directors; and,

II. That the Chair of this Board of Directors is hereby authorized and directed to execute and deliver the Contract by and on behalf of CalOptima on the terms and conditions set forth in the form provided to this Board of Directors.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a. CalOptima, this 1st day of June, 2017.

AYES:

NOES:

ABSENT:

ABSTAIN:

/s/____________________________________
Title: Chair, Board of Directors
Printed Name and Title: Paul Yost, M.D., Chair, Board of Directors

Attest:
/s/_______________________________________
Suzanne Turf, Clerk of the Board

Back to Agenda

CalOptima Board Action Agenda Referral

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

Report Item

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

Contact

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

Recommended Actions

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

Background

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

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

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

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

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

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

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

Amendment for Rate Changes

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

Discussion

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

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

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

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

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

Back to Agenda

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

Back to Agenda

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

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

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

Back to Agenda

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

Fiscal Impact

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

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

Rationale for Recommendation

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

Concurrence

Gary Crockett, Chief Counsel

Attachment

Appendix summary of amendments to Primary Agreements with DHCS

/s/ Michael Schrader *5/25/2017*
Authorized Signature **Date**

Back to Agenda

APPENDIX TO AGENDA ITEM 12

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

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

Back to Agenda

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

A-25 extends the contract term to December 31, 2016. DHCS is obtaining a continuation of the services identified in the original agreement.	May 7, 2015
A-26 . adjusts the 2013-2014 Intergovernmental Transfer (IGT) rates.	May 7, 2015
A-27 Adjusts the 2013-2014 capitation rates for the Optional Expansion and Senate Bill (SB) 239.	May 7, 2015
A-28 incorporates language requirements and supplemental payments for BHT into the primary agreement	October 2, 2014
A-29 added optional expansion rates for January- June 2015; also added updates to MLR language	April 2, 2015
A-30 incorporates language regarding Provider Preventable Conditions (PPC), determination of rates, and adjustments to 2014-2015 capitation rates with respect to Intergovernmental Transfer (IGT) Rate Range and Hospital Quality Assurance Fee (QAF).	December 1, 2016
A-31 extends the Primary Agreement with DHCS to December 31, 2020.	December 1, 2016

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

Amendments to Secondary Agreement	Board Approval
A-01 implemented rate amendments to conform to rate amendments contained in the Primary Agreement with DHCS (08-85214).	July 8, 2010
A-02 implemented rate adjustments to reflect a decrease in the statewide average cost for Sensitive Services for rate period of July 1, 2010 through June 30, 2011.	August 4, 2011
A-03 extended the term of the Secondary Agreement to December 31, 2014	June 6, 2013
A-04 incorporates rates for the periods July 1, 2011 through June 30, 2012, and July 1, 2012 through June 30, 2013 as well as extends the current term of the Secondary Agreement to December 31, 2015.	January 5, 2012 (FY 11-12 and FY 12-13 rates) May 1, 2014 (term extension)
A-05 incorporates rates for the periods July 1, 2013 through June 30, 2014, and July 1, 2014 through June 30, 2015. For the period July 1, 2014 through June 30, 2015, Amendment A-05 also adds funding for the Medi-Cal expansion population for services provided to the Secondary Agreement.	December 4, 2014

Back to Agenda

A-06 incorporates rates for the period July 1, 2015 onward. A-06 also extends the term of the Secondary Agreement to December 31, 2016.	May 7, 2015 (term extension) Ratification of rates requested April 7, 2016
A-07 extends the Secondary Agreement with the DHCS to December 31, 2020.	December 1, 2016

Back to Agenda

CalOptima Board Action Agenda Referral

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

Consent Calendar

13. Consider Approval of the Revised Reinsurance Program for Catastrophic Claims and Update CalOptima Policy Accordingly

Contact

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

Recommended Actions

1. Approve proposed revision of the CalOptima reinsurance program for capitated health networks, excluding health maintenance organizations (HMO) that are at-risk for catastrophic claims, to include reinsurance attachment points of $17,000 for physician groups and $150,000 for hospitals and a coinsurance level of 20% effective July 1, 2017; and
2. Direct staff to update CalOptima Policy No. FF.1007: Health Network Reinsurance Coverage, consistent with the proposed changes for Policy Year 2017-2018.

Background

CalOptima has provided a reinsurance program for eligible Medi-Cal health networks in order to relieve the financial stress on health networks caused by catastrophic claims. Under the program, capitated HMOs, physician groups and hospitals are reimbursed for submitted claims exceeding the thresholds, and shared risk pools are adjusted for claims exceeding the thresholds. Over the past few years, CalOptima has increased the reimbursement rates to our providers. The changes are including Medi-Cal Expansion enhanced payment, shift to APR-DRG hospital reimbursement and other rate increases. As a result of these increases, more claims now qualify for reinsurance reimbursement, including a larger share of regular, non-catastrophic claims that are outside the original intent of the reinsurance policy.

At its October 1, 2009, meeting, the CalOptima Board of Directors approved the 2009 reinsurance program for capitated HMOs, physician groups and hospitals. Specifically, the board action updated the reinsurance attachment points and changed the reinsurance program year from a calendar year basis to a fiscal year basis. The purpose of the reinsurance program is to mitigate costs incurred by capitated health networks for member care costs that exceed a designated threshold.

Pursuant to CalOptima Policy FF.1007, 2016-2017: Health Network Reinsurance Coverage, CalOptima shall provide reinsurance coverage to its eligible health networks, excluding any HMOs that are at-risk for catastrophic claims. Effective July 1, 2016, through June 30, 2017, the reinsurance attachments points are as follows:

- $100,000 of covered hospital expenses per member during the coverage period; and
- $13,000 of covered physician expenses per member during the coverage period.

Discussion
Staff estimated Fiscal Year (FY) 2017-18 reinsurance expense for capitated and shared risk entities using the same experience as FY 2016-17 and applying the proposed higher deductibles. CalOptima Policy FF.1007, 2016-17 states that CalOptima will indemnify 90% of covered expenses for losses in excess of the annual deductible. For Policy Year 2017-18, Staff recommends an increase to the coinsurance level from 10% to 20%. In addition, Staff recommends revising the attachment points to $17,000 for physician groups and $150,000 for hospitals. The intent of these changes is to restore the original intent of the policy, which was to provide reinsurance for truly catastrophic claims.

The following table provides a comparison of projected reinsurance costs between FY 2016-17 and FY 2017-18.

Summary of Limits for the FY 2017-18 CalOptima Reinsurance Policies

	Physician Group		Hospital		Total	
	FY 2016-17	FY 2017-18	FY 2016-17	FY 2017-18	FY 2016-17	FY 2017-18
Annual Budget	$5.6M	$3.6M	$10.0M	$6.2M	$15.6M	$9.8M
Deductible	$13,000	$17,000	$100,000	$150,000	--	--

By adopting the updated attachment points and coinsurance level, Staff anticipates that the FY 2017-18 reinsurance program will save $5.8 million as compared to FY 2016-17.

Fiscal Impact
The fiscal impact of the revised reinsurance program for FY 2017-18 is estimated to be $9.8 million. This total cost includes direct payment to eligible health networks and the impact to the shared risk pool payouts. Funding will be budgeted under the proposed CalOptima FY 2017-18 Operating Budget pending Board approval.

Rationale for Recommendation
The proposed action updates the current reinsurance program for capitated health networks, excluding HMOs that are at-risk for catastrophic claims.

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

Attachments
PowerPoint Presentation: Reinsurance Coverage

/s/ Michael Schrader *5/25/2017*
Authorized Signature **Date**

Back to Agenda

Reinsurance Coverage

Board of Directors Meeting
June 1, 2017

Nancy Huang
Interim Chief Financial Officer

Back to Agenda

Overview

- Background
    - Reimbursement Process
    - Attachment Point Changes
    - Rate Increases and Effects
- Reinsurance Expense Trend
- Recommended Actions

Back to Agenda

Background

- Purpose
  - Relieve the financial stress on health networks caused by catastrophic claims
  - Capitated networks and hospitals are reimbursed for submitted claims exceeding thresholds
  - Shared Risk Pools are adjusted for claims exceeding thresholds

- Most recent update to the policy
  - 11/1/12: Internal CalOptima policy for Fiscal Year (FY) 2012-13 updated with revised attachment points

Back to Agenda

Reimbursement Process

- Eligible Medi-Cal networks and hospitals may submit reinsurance claims for the coverage period
  - ➢ Eligible networks and hospitals submit claims quarterly
  - ➢ Required to submit all claims within 6 months after the end of the coverage period
- Shared risk pools are credited for claims exceeding reinsurance attachment points

Model	Covered Physician Expenses	Covered Hospital Expenses
HMO*	Yes	Yes
PHC	Yes	Yes
SRG	Yes	No**

* Excludes Kaiser
** Covered hospital expenses for SRGs complies with FF.1010: Shared Risk Pool

Back to Agenda

Attachment Point Changes

- Attachment points have not been updated since 11/1/12
- CalOptima indemnifies 90% of covered expenses for losses in excess of the annual deductible

Annual Deductibles (in 1,000s)

$120
$100
$80
$60
$40
$20
$0

$75
$81
$100
$15
$11
$13

2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016 2017

Professional Hospital

Back to Agenda

Reinsurance Expense Trend

- 550% increase in professional reinsurance claims from 2012 to 2016.
- 400% increase in hospital reinsurance claims and risk pool adjustments from 2012 to 2016.

	Professional	Hospital
FY 2012	$0.9M	$2.0M
FY 2013	$1.0M	$2.1M
FY 2014	$1.5M	$2.5M
FY 2015	$4.5M	$7.7M
FY 2016	$5.6M	$10.0M

Y-axis: $0, $2,000,000, $4,000,000, $6,000,000, $8,000,000, $10,000,000, $12,000,000

Back to Agenda

Updating the Reinsurance Program

- Reinsurance program was designed to assist eligible networks and hospitals cover catastrophic cases
  - CalOptima has provided this enhanced supplemental benefit since 1996
  - Not provided by the majority of other public plans in the State

- Reset the program to the appropriate level of protection
  - Program has not been updated since 2012

Proposed Annual Deductible (per member)

Date	Covered Physician Expenses	Covered Hospital Expenses	Coinsurance Level
11/1/12	$13,000	$100,000	10%
Proposed	***$17,000***	***$150,000***	***20%***

Back to Agenda

Recommended Actions

- Consider approval of the following actions:
  - Increase the attachment point for covered physician expenses from $13,000 to $17,000
  - Increase the attachment point for covered hospital expenses from $100,000 to $150,000
  - Increase the coinsurance level to 20%

- Fiscal Impact
  - Staff estimates that the FY 2017-18 reinsurance program will save $5.8 million as compared to FY 2016-17

Back to Agenda

CalOptima Board Action Agenda Referral

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

Report Item

14. Consider Approval of the CalOptima Fiscal Year 2017-18 Operating Budget and Ratify Renewal of Insurance Policies.

Contact

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

Recommended Actions

1. Approve the CalOptima Fiscal Year (FY) 2017-18 Operating Budget;
2. Authorize the expenditure and appropriate the funds for items listed in Attachment B: Administrative Budget Details, which shall be procured in accordance with CalOptima Policy GA.5002: Purchasing Policy;
3. Approve continued Medi-Cal medical expenditures at payment rates in effect on June 30, 2017, except for provider capitation payments for Hospital services for Medi-Cal Expansion (MCE) members, which are being reduced by 29%, until the Board approves a final FY 2017-18 Medi-Cal medical budget. In authorizing continued Medi-Cal medical expenditures, the Board expressly reserves the right to consider retroactive adjustments based on Board approved rate amendments from the State; and
4. Ratify renewal of insurance policies in an amount not to exceed $2.1 million. for net annual premiums.

Background

The CalOptima FY 2017-18 Operating Budget provides revenues and appropriations for the period of July 1, 2017, through June 30, 2018, and includes the following budget categories:

- Medi-Cal;
- OneCare Connect;
- OneCare;
- Program for All-Inclusive Care for the Elderly (PACE);
- Facilities; and
- Investment income.

Staff is submitting the complete budget for all lines of business for approval with assumptions based on available information to date. Pursuant to CalOptima Policies GA. 3202: CalOptima Signature Authority, GA. 5002: Purchasing Policy, and GA.5003: Budget and Operations Forecasting, the Board's approval of the budget appropriates the funds requested and authorizes the expenditure of the item without further Board action.

The primary revenue source is the State of California. As of this writing, the Legislature continues to meet in hearings to discuss the Governor's budget proposal released in January. The January Budget included funding for mandatory and optional Medi-Cal expansion, continued implementation of the Cal MediConnect program, removal of financing for In-Home Supportive Services (IHSS) in managed care, delayed implementation of certain initiatives, including palliative care, Whole-Child

Back to Agenda

Model, Health Homes Program, and Whole Person Care Pilots, FQHC Alternative Payment Methodology, and implementation of federal Medicaid managed care regulations.

On May 11, 2017, the Governor revised the proposed state budget with updated revenue projections and additional budget proposals, including revising the implementation date for the palliative care benefit in managed care to January 1, 2018. The Legislature will consider the additional proposals, take final actions on pending items, and pass a final budget by June 15, 2017.

Until the final budget is enacted, CalOptima's budget will have a level of uncertainty.

- FY 2017-18 rates for Medi-Cal, including rates for both the Classic and Expansion populations, were made available in draft form on April 28, 2017. However, draft rates are subject to change, and are not finalized until the California Department of Health Care Services (DHCS) receives federal approval and CalOptima executes a signed contract amendment with DHCS; and

- FY 2017-18 rates for Medi-Cal supplemental benefits, such as Behavioral Health Treatment (BHT), and Managed Long Term Services and Supports (MLTSS) have not yet been released.

CalOptima Budget Overview

I. Consolidated Operating Budget

The FY 2017-18 consolidated operating budget is a combined income and spending plan for all CalOptima programs and activities.

	FY 2017-18 Budget
Average Monthly Enrollment	803,499
Revenue	$3,186,646,826
Medical Costs	$3,047,173,526
Administrative Costs	$143,667,453
Operating Income/Loss	**($4,194,154)**
Investments, Net	$3,000,000
Change in Net Assets	**($1,194,154)**
Medical Loss Ratio (MLR)	95.62%
Administrative Loss Ratio (ALR)	4.51%

Budget Assumptions

Medical Cost: Several methods were utilized in the development of the medical expense forecasts. Predominantly, projections were based on trends calculated from historical experience. In addition, adjustments were applied to account for any known changes to operations, program structure, benefits, and regulatory policies. For new programs, Staff used proxy data and industry benchmarks, and source data, assumptions, and results were checked for reasonability and credibility.

Administrative Cost: To take into consideration seasonal and cyclical spending patterns, FY 2017-18 was forecasted on a 12 month rolling actual. To ensure inclusion in the budget, Staff reviewed all contract encumbrances. Lastly, internal departments identified resource requirements based on changes to enrollment, regulatory and organizational needs. Staff considered:

- Salaries, Wages & Benefits for current staff, unfilled budgeted positions and new budgeted

positions;
- Professional Fees, Purchased Services, Printing & Postage and Other Operating Costs based on the needs and priorities of providing care to members;
- Depreciation & Amortization on current assets and projected assets according to Generally Accepted Accounting Principles (GAAP); and
- Indirect Cost Allocation based on revenue and refined, where appropriate.

Of note, CalOptima has several contracts for claims administration, credit balance recovery, and Social Security Income conversion that are paid on a contingency basis. The following table provides a comparison of consolidated general and administrative expenses from the previous fiscal year.

	FY 2016-17 Budget	FY 2016-17 Annualized*	FY 2017-18 Budget	FY 2018 Budget vs. FY 2017 Annualized
Revenues	$3,385,703,076	$3,370,164,864	$3,186,646,826	($183,518,038)
Salaries & Wages	$93,158,686	$74,192,570	$82,916,883	$8,724,313
Non-Salaries & Wages	$47,140,105	$36,607,675	$60,750,570	$24,142,895
Total G&A	**$140,298,791**	**$110,800,245**	**$143,667,453**	**$32,867,208**
ALR	**4.14%**	**3.29%**	**4.51%**	**1.22%**
ALR Breakdown:				
Salaries & Wages	2.75%	2.20%	2.60%	**0.40%**
Non-Salaries & Wages	1.39%	1.09%	1.91%	**0.82%**

* Annualized as of March 2017

The FY 2017-18 Operating Budget ALR is 4.51%. The increase in general and administrative expenses is due to FY 2017-18 expenses that were not included in the previous year, including:
- Salaries & Wages:
  - $5.8 million in open positions;
  - $136,000 increase in new positions;
  - $2.8 million increase to Salaries & Related;
- Non-Salaries & Wages:
  - $9.6 million in behavioral health contractual administrative fees;
  - $1.6 million in depreciation expense due to new capital; and
  - $13.3 million for contractual obligations and increases to member communications.

Attachment B: Administrative Budget Details provide additional information regarding all general and administrative expenses included in the FY 2017-18 Operating Budget.

II. Enrollment by Line of Business

The following table provides a comparison of total average enrollment for the past two (2) fiscal years.

Total Average Enrollment by Program

Program	FY 2015-16 Actual*	FY 2016-17 Forecast*	FY 2017-18 Budget*	% Change 17 v. 18
Medi-Cal	777,033	784,400	787,881	0.4%
OneCare Connect	18,384	15,670	15,698	0.2%
OneCare	1,174	1,306	1,420	8.7%
PACE	167	212	271	27.8%
Total	**796,758**	**801,587**	**805,269**	**0.5%**

*Enrollment as of June of every fiscal year when available, otherwise most current month

III. Operating Budget by Line of Business

A. Medi-Cal Program

Through a contract with DHCS, CalOptima has administered the Medi-Cal program for Orange County since October 1995. CalOptima's current contract expires on December 31, 2020. The table below illustrates the Consolidated Medi-Cal Operating Budget.

FY 2017-18 Medi-Cal Consolidated Operating Budget – Includes MSSP

	FY 2016-17 Annualized*	FY 2016-17 Budget	FY 2017-18 Budget
Average Monthly Enrollment	778,289	781,461	786,312
Revenue	$2,987,292,092	$2,821,016,503	$2,835,653,991
Medical Costs	$2,891,328,771	$2,706,100,756	$2,716,207,230
Administrative Costs	$87,106,234	$108,495,427	$117,471,799
Operating Income/Loss	$8,857,088	$6,420,321	$1,974,961
MLR	96.79%	95.93%	95.79%
ALR	2.92%	3.85%	4.14%

* Annualized as of March 2017

The Medi-Cal membership is defined into two primary categories: Medi-Cal Classic and Medi-Cal Expansion. The following table illustrates the Medi-Cal Operating Budget by each of these categories.

FY 2017-18 Medi-Cal Operating Budget by Group

	Medi-Cal Classic	Medi-Cal Expansion	Total
Average Monthly Enrollment	549,643	236,669	786,312
Revenue	$1,563,400,467	$1,272,253,524	$2,835,653,991
Medical Costs	$1,552,993,143	$1,163,214,087	$2,716,207,230
Administrative Costs			$117,471,799
Operating Income/Loss			$1,974,961
MLR	99.33%	91.43%	95.79%
ALR			4.14%

DHCS uses Category of Aid (COA) to classify Medi-Cal enrollment into cohorts of similar acuity. DHCS develops CalOptima's capitation rates based on these cohorts. The following table shows the projected enrollment distribution by COA.

FY 2017-18 Medi-Cal Enrollment Projection

	FY 2016-17 Annualized*	FY 2017-18 Budget*	Variance	
			Diff	%
BCCTP	617	617	-	0.0%
Disabled	48,733	48,837	104	0.2%
Long Term Care	3,268	3,268	-	0.0%
Aged	61,466	66,134	4,668	7.6%
TANF <= 18	330,215	328,572	(1,643)	-0.5%
TANF > 18	104,202	103,289	(913)	-0.9%
Subtotal - Medi-Cal Classic	548,501	550,718	2,217	0.4%
Medi-Cal Expansion	235,899	237,163	1,264	0.5%
Total	**784,400**	**787,881**	**3,481**	**0.4%**

*Enrollment as of June of every fiscal year when available, otherwise most current month

General Budget Assumptions – Medi-Cal

Consolidated Enrollment: Enrollment projections are based on actual data through March 2017 and trended through June 2018. The budget assumes a maturation of Medi-Cal Expansion enrollment, and slight growth in the Aged aid category offset by small decreases in the Adult and Child aid categories.

Classic Revenue: The FY 2017-18 Operating Budget applies draft FY 2017-18 capitation rates released by DHCS on April 28, 2017. Rates reflect a reduction of 4.6% from the prior fiscal year rates. In addition, the following program changes have been incorporated into the revenue assumptions:

- Coordinated Care Initiative rates are based on Calendar Year (CY) 2015 draft rates for the Duals population; and
- Capitation rates for BHT for autism services are based on FY 2016-17 rates.

Classic Medical Cost: Provider capitation payments were based on capitation rates and enrollment distribution as of February 2017. Fee-for-service (FFS) costs were based on historical claims trended to June 2018, and were developed by network type, aid code, and category of service. Provider reimbursement rates for Classic members were kept at FY 2016-17 levels. Attachment points for the reinsurance program were increased to $17,000 for Professional and $150,000 for Hospital and coinsurance was increased to 20%. Mental health expenses were converted from FFS reimbursement to a capitation expense. The budget also incorporated Monarch and Prospect transitioning from a Shared Risk Group (SRG) to a Health Maintenance Organization (HMO) network type. The budget reflects the removal of IHSS as a managed care benefit effective January 2018, and projected expenses for quality improvement programs.

Expansion Revenue: The FY 2017-18 Operating Budget applies draft FY 2017-18 capitation rates released by DHCS on April 28, 2017. Rates reflect a reduction of 4.8% from prior fiscal year. [j1]

Back to Agenda

Expansion Medical Cost: Provider capitation payments for Professional Services were kept at FY 2016-17 levels. Provider capitation payments for Hospital services were reduced by 29% to account for the revenue reductions by the State. Analysis shows that the current reimbursement level for this population is significantly higher than membership acuity and experience suggests. FFS costs trends were developed by network type, COA, and category of service. Staff maintained current FFS reimbursement levels (including hospital inpatient/outpatient and specialist/Primary Care Provider contract rates). Attachment points for the reinsurance program were increased to $17,000 for Professional and $150,000 for Hospital and coinsurance was increased to 20%. The budget includes projected expenses for quality improvement programs.

Medi-Cal Consolidated Administrative Budget Assumptions

Medi-Cal administrative costs reflect both Medi-Cal Classic and Medi-Cal Expansion. The following table illustrates changes from FY 2016-17 to FY 2017-18 by major administrative expense categories.

Medi-Cal Administrative Cost by Category

Medi-Cal (000's)	FY 2016-17 Annualized*	FY 2016-17 Budget	FY 2017-18 Budget	% Change 17 v. 18
Administrative Expenses				
Salaries, Wages & Benefits	$63,285	$80,380	$70,738	11.78%
Professional Fees	$1,594	$3,817	$3,832	140.45%
Purchased services	$8,339	$9,336	$18,690	124.14%
Printing & Postage	$2,381	$3,747	$4,807	101.90%
Depreciation & Amortization	$3,945	$4,597	$5,535	40.31%
Other Operating Expenses	$11,934	$13,103	$17,215	44.25%
Indirect Cost Allocation, Occupancy Expense	($4,371)	($6,484)	($3,345)	-23.46%
Total	$87,106	$108,495	$117,472	34.86%
ALR	2.92%	3.85%	4.14%	42.07%

* Annualized as of March 2017

Primary variances between the FY 2016-17 Annualized and FY 2017-18 Budget include:

- Salaries, Wages & Benefits: Increase due to program changes, unfilled positions, annual merit, and increase in benefit costs;
- Professional Fees: Increase related to anticipated Mock Audit, legal and other professional fees;
- Purchased Services: Increase due to behavioral health contractual administrative fee and increase to contingency fee contracts;
- Printing & Postage: Increase due to regulatory requirements for member communications;
- Depreciation & Amortization: Reflects new capital; and
- Other Operating Expense: Includes claims editing tool and hardware/software maintenance expense.

B. OneCare Connect

Through a three-way contract with the Center for Medicare & Medicaid Services (CMS), DHCS, and CalOptima, CalOptima began the OneCare Connect Program in July 2015. The Cal MediConnect (CMC) program is a three-year Medicare and Medicaid demonstration program that promotes coordinated health care delivery to seniors and persons with disabilities who are dually eligible for Medicare and Medi-Cal services. The initial demonstration period began October 2013, and ends on December 31, 2019. The table below illustrates the OneCare Connect Operating Budget.

FY 2017-18 OneCare Connect Operating Budget

	FY 2016-17 Annualized*	FY 2016-17 Budget	FY 2017-18 Budget
Average Monthly Enrollment	17,195	21,828	15,576
Revenue	$350,284,781	$533,118,659	$314,293,716
Medical Costs	$342,682,725	$504,173,683	$296,135,555
Administrative Costs	$20,963,313	$28,007,571	$22,966,711
Operating Income/Loss	($13,361,257)	$937,405	($4,808,549)
MLR	97.83%	94.57%	94.22%
ALR	5.98%	5.25%	7.31%

* Annualized as of March 2017

General Budget Assumptions – OneCare Connect

Enrollment: OneCare Connect membership has begun to stabilize in recent months and is projected to begin a steady growth of approximately 15 to 20 members per month at the start of the fiscal year due to improved sales growth and a declining disenrollment rate.

Revenue: The FY 2017-18 Operating Budget applies rates from CY 2017 actuals for Medicare Parts C and D, and projects a 3% increase to Part C base rates effective January 2018 (per the CMS 2018 rate book). Forecasted Risk Adjustment Factors (RAF) of are based on actual prior experience. Staff applied Medi-Cal Calendar Year 2015 rates and adjusted for actual enrollment in the specified population cohorts. The final Medi-Cal revenue will be adjusted to reflect the actual population mix. The budget does not include projections for sweep risk adjustment. In addition, the budget assumes a Year 3 savings target of 5.5% and a quality withhold of 3%.

Medical Cost: Provider capitation payments were based on Percent of Premium (POP) rates for the Medicare component and fixed per member per month (PMPM) rates for the Medi-Cal component. FFS expenses were projected based on actual OneCare Connect experience, trended through June 2018. Staff applied the projected enrollment mix for Physician Hospital Consortia, SRGs, HMOs, and the CalOptima Community Network taking into account recent health network risk changes. In addition, the budget includes expenses for approved supplemental benefits.

MLTSS costs were based on data provided by DHCS. The budget reflects the removal of IHSS as a managed care benefit effective January 2018, and projected expenses for quality improvement programs.

Administrative Cost:

OneCare Connect Administrative Cost by Category

OneCare Connect (000's)	FY 2016-17 Annualized*	FY 2016-17 Budget	FY 2017-18 Budget	% Change 17 v. 18
Administrative Expenses				
Salaries, Wages & Benefits	$9,539	$11,405	$10,766	12.86%
Professional Fees	$424	$959	$460	8.45%
Purchased services	$1,603	$2,160	$2,879	79.60%
Printing & Postage	$681	$1,699	$1,246	82.94%
Depreciation & Amortization	$0	$0	$0	0.00%
Other Operating Expenses	$453	$535	$604	33.45%
Indirect Cost Allocation, Occupancy Expense	$8,264	$11,250	$7,013	-15.13%
Total	$20,963	$28,008	$22,967	9.56%
ALR	5.98%	5.25%	7.31%	22.10%

* Annualized as of March 2017

Primary variances between the FY 2016-17 Annualized and FY 2017-18 Budget include:

- Salaries, Wages & Benefits: Increase due to program changes, open positions, annual merit, and increase in benefit costs;
- Purchased Services: Increase reflects change in behavioral health contractual administrative fee;
- Printing & Postage: Increase due to regulatory requirements for member communication; and
- Other Operating Expenses: Increase reflects hardware/software maintenance expense.

C. OneCare

Through a contract with the CMS and the Department of Managed Health Care (DMHC), CalOptima has administered a Medicare Advantage Dual Eligible Special Needs Plan (D-SNP) since October 2005. OneCare will continue to provide services for beneficiaries not eligible for the OneCare Connect program.

The table below illustrates the OneCare Operating Budget.

FY 2017-18 OneCare Operating Budget

	FY 2016-17 Annualized*	FY 2016-17 Budget	FY 2017-18 Budget
Average Monthly Enrollment	1,235	1,186	1,367
Revenue	$17,176,889	$16,771,979	$17,160,358
Medical Costs	$15,502,191	$15,191,738	$17,373,904
Administrative Costs	$1,103,692	$1,253,728	$1,175,027
Operating Income/Loss	$571,005	$326,512	($1,388,573)
MLR	90.25%	90.58%	101.24%
ALR	6.43%	7.48%	6.85%

* Annualized as of March 2017

The Operating Income/Loss variance between the FY 2016-17 Annualized and FY 2017-18 Budget is primarily due to decreasing revenue rates.

General Budget Assumptions – OneCare
Enrollment: The FY 2017-18 Operating Budget assumes OneCare enrollment will increase slightly at 0.7% per month (10 members per month) due to increased sales growth.

Revenue: Staff based Medicare Parts C and D rates on CY 2017 Monthly Membership Report (MMR) actuals, and projected a 3% increase to Part C base rates effective January 2018. Forecasted Risk Adjustment Factors (RAF) of are based on actual prior experience. The budget does not include projections for sweep risk adjustment.

Medical Cost: Provider capitation payments were based on 38.6 POP (inclusive of quality incentive payments). FFS medical expenses were based on historical claims incurred through January 2017. In addition, the budget includes expenses for approved supplemental benefits, and a change to the Part D member cost sharing amounts.

Administrative Cost:

OneCare Administrative Cost by Category

OneCare (000's)	FY 2016-17 Annualized*	FY 2016-17 Budget	FY 2017-18 Budget	% Change 17 v. 18
Administrative Expenses				
Salaries, Wages & Benefits	$239	$258	$247	3.24%
Professional Fees	$193	$190	$160	-17.02%
Purchased services	$286	$293	$144	-49.60%
Printing & Postage	$95	$158	$239	152.36%
Depreciation & Amortization	$0	$0	$0	0.00%
Other Operating Expenses	$3	$1	$2	-23.94%
Indirect Cost Allocation, Occupancy Expense	$288	$354	$383	32.73%
Total	$1,104	$1,254	1,175	6.46%
ALR	6.43%	7.48%	6.85%	6.57%

* Annualized as of March 2017

Primary variances between the FY 2016-17 Annualized and FY 2017-18 Budget include:
- Salaries, Wages & Benefits: Annual merit adjustments and increase in benefit costs; and
- Printing & Postage: Increase due to regulatory requirements for member communication.

D. PACE
Through a contract with CMS, CalOptima began Orange County's first PACE program on October 1, 2013. The PACE program provides coordinated care for persons age 55 and older who need a higher level of care to remain in their homes.

The table below illustrates the PACE Operating Budget.

FY 2017-18 PACE Operating Budget

	FY 2016-17 Annualized*	FY 2016-17 Budget	FY 2017-18 Budget
Average Monthly Enrollment	184	193	244
Revenue	$15,121,226	$14,540,515	$19,495,986
Medical Costs	$13,216,169	$15,567,776	$17,456,837
Administrative Costs	$1,399,891	$1,450,395	$1,827,801
Operating Income/Loss	$505,166	($2,477,656)	$211,348
MLR	87.40%	107.06%	89.54%
ALR	9.26%	9.97%	9.38%

* Annualized as of March 2017

Although PACE has reached the operational breakeven point during FY 2016-17, Management will continue to focus on several areas of opportunities to improve the PACE program, including:

- Migration to a Rate Development Template (RDT) process (effective CY 2018 per state guidance) to better reflect actual experience and costs;
- More acute management of medical utilization, mix, and expense; and
- Implementation of initiatives to gain greater administrative efficiencies and operational economies of scale.

General Budget Assumptions – PACE

Enrollment: The FY 2017-18 Operating Budget assumes PACE enrollment will increase net 5 members per month (ending at 271 members by June 2018) which is consistent with the prior year's growth. Population is projected to consist of 52% Dual members and 48% Medi-Cal only members.

Revenue: The FY 2017-18 Operating Budget applies rates from CY 2017 actuals for Medicare Parts C and D, and projects a 2.2% increase to Part C base rates effective January 2018 (per the CMS 2018 rate book).. Medi-Cal PMPM rates are based on CY 2016 AWOP (Amount That Would Have Otherwise Been Paid) rates provided by DHCS on January 27, 2016. Staff applied a projected RAF score of 2.25 to Part C revenue. No additional trend assumptions were applied.

Medical Cost: Medical expenses were projected using a combination of actual experience and industry benchmarks. The budget includes material depreciation costs associated with start-up capital expenses. Staff reclassified some administrative expenses to medical expenses at 96%. The projected aggregate MLR is 89.6%, and will decrease to 84.6% by June 30, 2018.

Administrative Cost:

PACE Administrative Cost by Category

PACE (000's)	FY 2016-17 Annualized*	FY 2016-17 Budget	FY 2017-18 Budget	% Change 17 v. 18
Administrative Expenses				
Salaries, Wages & Benefits	$1,129	$1,115	$1,167	3.32%
Professional Fees	$59	$115	$60	2.43%

Back to Agenda

Purchased services	$51	$12	$254	401.36%
Printing & Postage	$3	$21	$67	1807.66%
Depreciation & Amortization	$25	$25	$25	0.02%
Other Operating Expenses	$105	$151	$222	110.60%
Indirect Cost Allocation, Occupancy Expense	$28	$12	$34	22.15%
Total	$1,400	$1,450	$1,828	30.57%
ALR	9.26%	9.97%	9.38%	1.27%

* Annualized as of March 2017

Primary variances between the FY 2016-17 Annualized and FY 2017-18 Budget include:

- Purchased Services: Increase reflects the transfer of marketing expenses from Medi-Cal to PACE;
- Printing & Postage: Increase due to regulatory requirements for member communication; and
- Other Operating Expenses: Reflects building security services.

E. Facilities

CalOptima purchased the 505 City Parkway West Building in 2011 as the headquarters for all operations. Currently, CalOptima leases one-half (1/2) of a floor to a tenant, with the remainder of the building housing CalOptima operations.

The table below illustrates the Facilities Operating Budget.

	FY 2016-17 Annualized*	FY 2016-17 Budget	FY 2017-18 Budget
Rental Income	$289,875	$225,419	$42,774
Operating Costs	$227,115	$1,091,669	$226,115
Operating Income/Loss	$62,760	($836,250)	($183,341)

* Annualized as of March 2017

Budget Assumptions – Facilities

Revenue: Revenues of $42,774 is in accordance with the tenant lease.

Operating Cost: Building costs include common area maintenance, building and tenant improvement depreciation, repair and maintenance, as well as building management fees.

F. Investment Income

The table below illustrates projected net investment income.

	FY 2016-17 YTD March 2016	FY 2016-17 Budget	FY 2017-18 Budget
Investment Income	$11,814,575	$2,500,000	$3,000,000

Budget Assumptions – Investment Income

The projected $3,000,000 net investment income for the FY 2017-18 Budget is lower than FY 2016-17 Annualized due to forecasted cash outflows from CalOptima's portfolio in FY 2017-18. This

includes the Medi-Cal Expansion rate adjustment from DHCS' recoupment of overpayment, a contingency payable to DHCS due to the 85% MLR reconciliation, and the FY 2016-17 and FY 2017-18 shared risk pool payout.

G. Insurance Policies

On February 16, 2017, and again on May 18, 2017, CalOptima staff updated the Board of Directors' Finance and Audit Committee regarding the current year liability insurance renewal process. CalOptima purchases insurance through an insurance broker, AON Risk Solutions. All of CalOptima's insurance expires in April, and there is a short time period between receiving insurance coverage quotations and the prior insurance coverage expiration dates. Accordingly, staff proceeded with renewing and/or procuring new insurance policies and is requesting that the Board ratify the purchase of the insurance policies in an amount not to exceed $2.1 million for net annual premiums.

Fiscal Impact

As outlined above and more detailed information contained in Attachment A: FY 2017-18 Budget for all Lines of Business, the FY 2017-18 Operating Income totals a loss of $4.2 million. In addition, the budget includes investment income of $3 million, resulting in a total loss of $1.2 million in changes to net assets. The proposed reduction in MCE hospital capitation rates is expected to total $115 million, including shared risk pool funding adjustments. Anticipated insurance policy costs of $2,028,593 are included in the proposed FY2017-18 Operating Budget.

Rationale for Recommendation

Management submits the FY 2017-18 Operating Budget for all program areas using the best available assumptions in order to provide health care services to CalOptima's forecasted enrollment. Staff recommends the renewal of insurance policies as specified in Attachment C.

Concurrence

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

Attachments

Attachment A: FY 2017-18 Budget for all Lines of Business
Attachment B: Administrative Budget Details
Attachment C: Business Insurance Policy Year (PY) 17 v P18 Comparison

/s/ Michael Schrader *05/25/2017*
Authorized Signature **Date**

Attachment A

CalOptima Fiscal Year 2017-18 Budget
By Line of Business

	Medi-Cal (Classic)	Medical (Expansion)	Total	OCC	OneCare	PACE	Facilities	Other	Consolidated
Member Months	6,595,717	2,840,025	9,435,742	186,915	16,407	2,922	-		**9,641,986**
Avg Members	549,643	236,669	786,312	15,576	1,367	244	-		**803,499**
Revenues									
Capitation revenue	$ 1,563,400,467	$ 1,272,253,524	$ 2,835,653,991	$ 314,293,716	$ 17,160,358	$ 19,495,986	$ 42,774		**$ 3,186,646,826**
Total	$ 1,563,400,467	$ 1,272,253,524	$ 2,835,653,991	$ 314,293,716	$ 17,160,358	$ 19,495,986	$ 42,774		**$ 3,186,646,826**
Medical Costs									
1 Provider capitation	$ 420,934,241	$ 578,439,821	$ 999,374,062	$ 104,734,909	$ 4,754,013	$ -	$ -		**$ 1,108,862,984**
2 Claims Payments	$ 401,698,105	$ 336,466,814	$ 738,164,919	$ 68,695,980	$ 6,435,469	$ -	$ -		**$ 813,296,369**
3 LTC/Skilled Nursing Facilities	$ 471,975,488	$ 21,332,539	$ 493,308,027	$ 39,704,782	$ -	$ -	$ -		**$ 533,012,809**
4 Prescription Drugs	$ 220,988,042	$ 218,409,977	$ 439,398,019	$ 66,532,953	$ 5,825,416	$ -	$ -		**$ 511,756,388**
5 Case Mgmt & Oth Medical	$ 36,173,005	$ 8,564,936	$ 45,962,203	$ 16,466,930	$ 359,006	$ 17,456,837	$ -		**$ 80,244,977**
Total	$ 1,551,768,881	$ 1,163,214,087	$ 2,716,207,230	$ 296,135,555	$ 17,373,904	$ 17,456,837	$ -		**$ 3,047,173,526**
MLR	***99.26%***	***91.43%***	***95.79%***	***94.22%***	***101.24%***	***89.54%***	***0.00%***	*	*95.62%*
Gross Margin	$ 11,631,586	$ 109,039,437	$ 119,446,761	$ 18,158,161	$ (213,546)	$ 2,039,149	$ 42,774		**$ 139,473,299**
Administrative Expenses									
Salaries, Wages, & Employee Benefits			$ 70,737,591	$ 10,765,591	$ 247,130	$ 1,166,570	$ -		**$ 82,916,883**
Professional Fees			$ 3,832,257	$ 460,000	$ 160,000	$ 60,000	$ 0		**$ 4,512,257**
Purchased services			$ 18,690,418	$ 2,878,516	$ 143,930	$ 253,632	$ 278,231		**$ 22,244,727**
Printing & Postage			$ 4,806,825	$ 1,245,605	$ 238,952	$ 66,566	$ 0		**$ 6,357,948**
Depreciation & Amortization			$ 5,534,951	$ 0	$ -	$ 24,624	$ 1,937,684		**$ 7,497,259**
Other Operating Expenses			$ 17,215,174	$ 603,864	$ 2,100	$ 222,041	$ 2,006,859		**$ 20,050,038**
Indirect Cost Allocation, Occupancy Expense			$ (3,345,417)	$ 7,013,134	$ 382,915	$ 34,368	$ (3,996,659)		**$ 88,341**
Total			$ 117,471,799	$ 22,966,711	$ 1,175,027	$ 1,827,801	$ 226,115		**$ 143,667,453**
ALR			***4.14%***	***7.31%***	***6.85%***	***9.38%***		*	*4.51%*
Operating Income/(Loss)			$ 1,974,961	$ (4,808,549)	$ (1,388,573)	$ 211,348	$ (183,341)	$ -	**$ (4,194,154)**
Investment Income								$ 3,000,000	$ 3,000,000
MCO Tax Revenue			$ 131,028,771						$ 131,028,771
MCO Tax Expense			$ (131,028,771)						$ (131,028,771)
CHANGE IN NET ASSETS			**$ 1,974,961**	**$ (4,808,549)**	**$ (1,388,573)**	**$ 211,348**	**$ (183,341)**	**$ 3,000,000**	**$ (1,194,154)**

Back to Agenda

Attachment B

Specific Type	Objective of the Item Proposed	Budget FY2018 Input	Authorization	Appropriation
	Medi-Cal: Professional Fees			
Legal	General and Adversarial Legal Fees	1,200,000	X	X
Consulting	Consulting Services Related to Information System and Support for Maintenance of Business	326,274	X	X
Consulting	Executive Office Consulting Services	265,100	X	X
Consulting	Government Affairs Contract and Management of State and Federal Lobbyists	236,000	X	X
Consulting	Consulting Fees To Support Program Outreach, Website Redesign Efforts, Acquisition Of Data For Strategic Direction, And Digital Initiatives	213,200	X	X
Audit Fees	Health Network Medical Loss Ratio Audit	200,000	X	X
Audit Fees	Financial Audit Annual Contract	175,000	X	X
Consulting	Rebasing, Network Support and Other Related Actuarial Consulting Services	150,000	X	X
Consulting	Health Insurance Portability and Accountability Act (HIPAA) Security	135,000	X	X
Consulting	Consultant for Medi-Cal Mock Audit	100,000	X	X
Consulting	Consulting Support for Palliative Care, Homeless, Members with Behavioral Health Conditions, and Other Related Services	80,000	X	X
Consulting	Investment Advisory Annual Contract	77,500	X	X
Professional Fees	Core System (Facets) Upgrade Consultation Support	76,000	X	X
Professional Fees	Professional Fees for Various Accounting Projects	75,700	X	X
Professional Fees	Consulting Service for Claims System Enhancements and Additional Module Functionality	60,000	X	X
Consulting	Virtualization Architecture Assessment	60,000	X	X
Consulting	Core Application Support	56,000	X	X
Professional Fees	Consulting Services to Provide Outreach to the Vietnamese and Latino Community	54,850	X	X
Consulting	Consulting Support for California Technical Assistance Program (CTAP)	54,800	X	X
Consulting	Semi-Annual Chronic Illness and Disability Payment System (CDPS) Risk Adjustment	40,000	X	X
Consulting	Real Estate Consultant	37,000	X	X
Consulting	Space Planning Services	29,000	X	X
Professional Fees	Professional Services Required for Corporate Applications and Systems	28,200	X	X
Professional Fees	Professional Services to Support the Accounting Application and Finance Systems	25,000	X	X
Consulting	General Consulting Services for Budgeting and Vendor Management, Audit and Oversight and Behavioral Health Integration	20,300	X	X
Professional Fees	Miscellaneous Consulting/Professional Services at the CalOptima Data Center	15,000	X	X
Consulting	Annual IBNR Certification Review	15,000	X	X
Professional Fees	Professional Fees to Enhance the Use of the HR Application Virtualization Architecture Assessment	12,333	X	X
Consulting	Required Annual A-133 Audit	10,000	X	X
Professional Fees	Professional Services for Ad-Hoc Updates Request by Customer Service for Phone Surveys	5,000	X	X
	Total Professional Fees	**3,832,257**		

Back to Agenda

Attachment B

Specific Type	Objective of the Item Proposed	Budget FY2018 Input	Authorization	Appropriation
	Medi-Cal: Purchased Services			
Purchased Services	Behavioral Health Contractual Administrative Fees	8,200,000	X	X
Purchased Services	Pharmacy Benefits Management Fees (70% Administrative)	2,875,000	X	X
Claims Review	Coordination Of Benefits (COB) Project	1,500,000	X	X
Claims Review	Forensic Validation Review Services	1,000,000	X	X
Purchased Services	Additional Expenses Related to Claims Recovery Fees and Other Services for Maintenance of Business	695,691	X	X
Claims Review	Claims Web Based Fraud, Waste, and Abuse Services	600,000	X	X
Imaging Services	Claims Imaging and Indexing Services	450,000	X	X
EDI Claims Clearinghouse	Electronic Data Interchange Institutional Claims	425,000	X	X
Purchased Services	Conversion Of Temporary Assistance To Needy Families (TANF) to Supplemental Security Income (SSI)	330,000	X	X
Purchased Services	Disaster Recovery Technology Services	269,200	X	X
Interpretive Services	Language Interpreter Services	253,483	X	X
Bank Fees	Business Bank Fees	252,000	X	X
Claims Review	Long-Term Care Rate Adjustments	250,000	X	X
Purchased Services	Third Party Check Printing and Mailing Fees	180,000	X	X
Advertising	Radio, Television, Print, Outdoor and Digital Advertising to Promote and Support Enrollment and Participation	177,000	X	X
Advertising	Online Career Site for Recruitment Advertisement and Sourcing	170,000	X	X
Purchased Services	Application Security Testing to Reduce Chance of Loss of Restricted Data	120,000	X	X
Purchased Services	Benefit Broker Services	100,000	X	X
Purchased Services	Temporary Outsource Service	99,000	X	X
Broker Services	Insurance Broker Services	79,008	X	X
Purchased Services	Tax Form Processing Fees and Other General Purchased Services	69,900	X	X
Purchased Services	Claims Pricing Automation Enhancements	63,000	X	X
Bank Fees	Custodial Bank Fees	60,000	X	X
Translation Services	Language Translation Services of Written Materials	53,352	X	X
Purchased Services	Healthcare Productivity Automation Services	50,000	X	X
Purchased Services	Offsite Backup Tape Storage and Services	48,850	X	X
Purchased Services	Regulatory 508 Compliance Remediation Services for PDF Files to Make Them Accessible to People with Disabilities on the Website as Required by the Centers for Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS) and Section 508 Regulations	47,570	X	X
Purchased Services	OCSD (Orange County Sheriff Department) Armed Security Services for Board and Other Meetings, Restacking Services, Flu Shots and Tuberculosis (TB) Tests	42,396	X	X
Purchased Services	Retirement Funds Advisory	41,500	X	X
Employee Benefits	Flexible Spending Accounts (FSA)/ Consolidated Omnibus Budget Reconciliation Act (COBRA)	31,500	X	X

Back to Agenda

Attachment B

Specific Type	Objective of the Item Proposed	Budget FY2018 Input	Authorization	Appropriation
	Medi-Cal: Purchased Services			
Purchased Services	Photography Services and Stock Photograph Purchases for Use in Member, Provider, Marketing, Outreach and Other Community Oriented Materials	25,000	X	X
Purchased Services	Application Security Measures to Prevent Gaps in the Security Policy of an Application or the Underlying System (Vulnerabilities) through Flaws in the Design, Development, Deployment, Upgrade, or Maintenance of the Application	20,000	X	X
Purchased Services	General Services for Customer Services, Member Liaison, Provider Data Management Services, Provider Relations, and Other Various Departments	19,135	X	X
License fees	Compensation System Subscription Fee	15,000	X	X
Wellness Program	Background Screening	15,000	X	X
Purchased Services	Imaging Services and Member Experience Satisfaction Survey	14,400	X	X
EDI Claims Clearinghouse	Electronic Data Interchange Translator for Testing and Validating Files	13,468	X	X
Purchased Services	Destruction of Electronic Media	10,000	X	X
Purchased Services	Online Phishing Testing Service and Security Newsletter Subscription	9,200	X	X
Interpretive Services	Video Interpretative Services and Design Software for Regulatory Mandated Annual Member Materials	7,215	X	X
Purchased Services	Drug Screenings	3,500	X	X
Imaging Services	Imaging Services	3,050	X	X
Purchased Services	Language Interpreter Services	2,000	X	X
	Total Purchased Services	**18,690,418**		

Back to Agenda

Attachment B

Specific Type	Objective of the Item Proposed	Budget FY2018 Input	Authorization	Appropriation
	Medi-Cal: Printing & Postage			
Printing	Print, Fulfillment and Postage for all Regular Monthly Mailings	2,716,194	X	X
Postage	General Postage for Outgoing Mail	529,992	X	X
Printing	Print Fulfillment and Postage for Quarterly Newsletters	466,766	X	X
Printing	Print Fulfillment and Postage for New Member/Enrollment Packages	450,441	X	X
Printing	Additional Printing and Postage Expenses Related To Regulatory Requirements and Anticipated Increase To Postage	368,357	X	X
Printing	Programming Changes for New And Existing Packets	69,000	X	X
Printing	Printing of the Annual Report to the Community, Holiday Cards, CalOptima Brochures, Marketing Materials, Ad Hoc Materials, Provider Press Mailings, Stock Photo License and Community Events Materials	62,900	X	X
Courier	Mail Services Charges, Courier/Delivery of Materials	44,640	X	X
Printing	Printing Services for Facilities Projects/Events (Business Continuity Plan (BCP), Safety and Security, Other CalOptima Departments Printing Needs)	39,000	X	X
Printing	Miscellaneous Member Materials, Printing Expenses and Supplies For Various Departments	32,535	X	X
Printing	Printing of Member Needs Assessment Report, Posters, Fliers, and Brochures	27,000	X	X
	Total Printing & Postage	**4,806,825**		

Back to Agenda

Attachment B

Specific Type	Objective of the Item Proposed	Budget FY2018 Input	Appropriation	Authorization
	Medi-Cal: Other Operating Expenses			
Maintenance	Network Connectivity Maintenance And Support For CalOptima Sites (Network Monitoring Tools, Web Filters, All Main Distribution Frame and Intermediate Distribution Frame Batteries, Internet Optimizers, Routers, Wireless Application Protocol Devices, Other Tools)	1,617,677	X	X
Maintenance	CalOptima Link Software Licenses, an Online System for Provider Networks to Submit and View Authorizations, Check Claim Status and Remittance Payment Advice, and to Verify Member Eligibility for Point of Service and Care	1,576,856	X	X
Equipment	Telecommunications and Network Connectivity Expenses	1,482,382	X	X
Maintenance	Facets Core System (Enrollment, Claims, Authorizations, and Other Modules) License Renewal and Maintenance	1,462,600	X	X
Maintenance	Clinical Editing Tool and Maintenance	1,232,000	X	X
Maintenance	Corporate Software Maintenance (Provider Sanctioning and Analytics, Data Warehouse Cleansing, Analytics, Business Application Workflow, Website Content Management, Compliance Applications)	785,420	X	X
Maintenance	Server Connectivity Maintenance and Support for Server Equipment (Servers, Storage, Virtual Machine Licenses, Backup Software)	619,892	X	X
Other Expenses	Hardware and Software Expenses Related to New Capital Acquisitions And Other Expenses for Maintenance of Business Including Security, Network, Analytics Software, Fraud, Waste and Abuse, Infrastructure and Software to Support New Regulatory Requirements	591,018	X	X
Maintenance	Maintenance and Support Annual Renewal for the Telecommunications Network Systems	547,493	X	X
Professional Dues	Association Membership Dues (Provide Advocacy, Program Support, Technical Support Regarding State and Federal Regulatory Issues)	508,500	X	X
Equipment	Replacement Hardware for Operating System Upgrade	500,000	X	X
Maintenance	Operating Systems and Office Software Suite License Costs to Support Entire Organization	447,664	X	X
Maintenance	Additional Software License and Upgrade Costs for Operating Systems and Office Software Suite	447,050	X	X
Office Supplies	Office Supplies (Paper, Toner, Batteries, Mouse Pads, Keyboards, Environmental Health And Safety, Disaster Recovery, Other Miscellaneous Items) for Company-Wide Usage	352,700	X	X
Maintenance	Human Resources Corporate Application Software Maintenance (Training, Recruitment, Performance Evaluation, HR Benefits, Employee Time and Attendance and Payroll)	344,200	X	X
Subscriptions	Healthcare Information Research and Analysis and Information Systems Audit and Control Association Subscription Renewal	281,962	X	X
Maintenance	Contract Management System	272,364	X	X
Repair & Maintenance	Maintenance for Windows and Carpet Cleaning, Furniture Repair, Refreshment, Doors, Audio Visual Equipment, Plumbing and Other General Maintenance Needs	259,800	X	X
Maintenance	Facets Software True-Up Maintenance	258,880	X	X
Equipment	Purchases and Installation of Office Furniture for Adds, Moves, Furniture, Fixture And Equipment, and Various Other Articles of Minor Equipment	246,300	X	X
Maintenance	Information Security Data Loss Prevention Solution Annual Maintenance	189,720	X	X
Maintenance	24/7 Support to Assist CalOptima's Operating Systems and Office Software Suite Related Questions and Issues	179,065	X	X
Equipment	Business Telephones and Accessories (Desk Phones, Headsets, Tablets Accessories)	167,700	X	X
Maintenance	Maintenance and Support for the Production/Development Citrix Operating System/Software Environments	161,159	X	X

Back to Agenda

Attachment B

Specific Type	Medi-Cal: Other Operating Expenses Objective of the Item Proposed	Budget FY2018 Input	Appropriation	Authorization
Maintenance	Software to Generate and Interface with Facets Letters	151,852	X	X
Maintenance	Finance Corporate Applications Software Maintenance (Accounting and Finance, Procurement, Bids, Accounting, Administrative Contract Management, Budget Systems)	139,586	X	X
Maintenance	User Licenses for Claims Medicare Pricing Software	137,577	X	X
Maintenance	Application Software Maintenance - IT Development Tools (Data Modeling, Architecture, Technical Libraries, Documentation, Technical Frameworks, Electronic Data Interchange, Software Development Testing)	130,852	X	X
Maintenance	Office Suite Software Upgrade License	125,346	X	X
Software	Desktop Software License Audit	100,000	X	X
Office Supplies	Office Supplies for Various Departments' Needs for Everyday Operations	91,098	X	X
Maintenance	Database Administrator License Renewals, Maintenance, and Support	87,742	X	X
Public Activities*	Sponsorship, Registration Fees and Other Related Costs for New and Anticipated Community Events and Health Fairs	84,500	X	X
Maintenance	Provider and Physician Credentialing System Maintenance and License Renewal	78,280	X	X
Training	System and Software Update Training	74,400	X	X
Training & Seminar	Training and Seminars for Professional Development and Education to Provide Additional Support	70,000	X	X
Maintenance	Subscription Renewal for Standard Medical Coding Schedules and Multiple User Licenses	67,600	X	X
Education	Tuition Reimbursement for Staff Development	66,000	X	X
Training & Seminar	Human Resources Conferences and Training Supplies for Staff	61,400	X	X
Maintenance	Accounting Software Annual Maintenance	53,400	X	X
Maintenance	Information Services Corporate Software Maintenance - Enterprise Help Desk Management Application	52,500	X	X
Travel	Travel Expenses for Various Conferences and State Health Organization Meetings	50,000	X	X
Travel	Travel Expenses for Conferences/Seminars and Meetings	43,465	X	X
Equipment	Laptops, Desktops, Flat Panel Monitors, Printers for New Employees and Other Minor Equipment	41,925	X	X
Allowances	Board Stipends	36,000	X	X
Training & Seminar	Training and Seminars for Professional Development and Education	35,178	X	X
Maintenance	Annual Maintenance for MSSP Software License	35,000	X	X
Travel	Travel Expenses for Conferences/Seminars and Meetings	33,750	X	X
Public Activities	Employee Engagement Events	30,200	X	X
Maintenance	Maintenance and Support for Printers	30,000	X	X
Training	Board Member Conferences and Training	30,000	X	X
Travel	Travel Expenses for Annual Audits, Training, Conferences/Seminars and Meetings	28,000	X	X
Maintenance	Maintenance and Renewal for Procurement Software	27,000	X	X
Travel	Mileage Reimbursement for Duties Required by Job Function and Travel to Community Presentations, Provider Offices, and Member Enrollment	25,230	X	X
Food Services	Employee Appreciation Events	25,200	X	X
Public Activities	Supplies and Costs Associated with Various Outreach, Community Events, Sponsorships and Health Fairs	24,748	X	X
Telephone	Field Staff Phone Service and Other Telephone Expenses	24,300	X	X

Back to Agenda

Attachment B

Specific Type	Objective of the Item Proposed	Budget FY2018 Input	Appropriation	Authorization
	Medi-Cal: Other Operating Expenses			
Education	Organizational Development Programs (CalOptima Special Speakers, Trainers, Computer Classes, Other Training Events)	24,000	X	X
Training & Seminar	Training, Seminars and Conferences for Staff Development	23,300	X	X
Subscriptions	Subscription Fees for Various Licenses, Literature and Organizations	22,810	X	X
Food Services	Food Services Allowances as Needed for Sponsoring Member and Provider Meetings, Conferences and Other Events	22,369	X	X
Professional Dues	Professional Dues and Member Fees for Various Professional Associations	22,176	X	X
Training & Seminar	Accounting and Reporting Software Upgrade and Other Training	21,500	X	X
Public Activities	Orange County Community Indicators Report	20,610	X	X
Software	Computer Software for Medical Coding and Design of Print Materials	20,591	X	X
Maintenance	Maintenance and Renewal for Budgeting Software	20,000	X	X
Training & Seminar	Professional Development and Education related to Department Functions (Staff Training, Seminars/Conferences, Professional Certifications, Additional Development Opportunities)	19,600	X	X
Food Services	General Supplies for CalOptima Staff	19,596	X	X
Travel	Travel Expenses for State Meetings, Regulatory and Legislative Issues, Strategic Development, Conferences/Seminars, and Association Meetings	19,595	X	X
Training & Seminar	Training and Seminars for Certifications, Continuing Legal Education and Staff Development	17,635	X	X
Food Services	Food Services for Provider Advisory Committee and CalOptima Community Network Lunch and Learn Events and CCN Anniversary Event	17,000	X	X
Training & Seminar	Training and Seminars for Professional Development and Education	17,000	X	X
Training & Seminar	Training for Facilities Staff in International Facilities Management Association (IFMA) Classes, Environmental Health & Safety (EH&S) Classes, OSHA Classes, Floor Warden Training and Other Training Courses	16,800	X	X
Food Services	Food Services for CalOptima Informational Series, Legislative Luncheon Events, Member And Provider Meetings/Conferences, Board Meetings and Other Events	16,750	X	X
Professional Dues	Medical Licenses and Required Certifications	16,000	X	X
Subscriptions	Subscription Fees for Both Clinical and Programmatic Support, as well as Normal Maintenance of Certification Licensure	16,000	X	X
Maintenance	Maintenance of Computer Software and Hardware	15,575	X	X
Maintenance	Facets Network Connection License	15,000	X	X
Training & Seminar	Training and Seminars for Professional Development and Education	15,000	X	X
Travel	Staff Mileage and Travel Expenses (Airfare, Hotel, Food) for Sacramento Meetings Three Times per Year	15,000	X	X
Subscriptions	Subscription Fees for Various Professional Organizations, Institutes and Associations	14,450	X	X
Education	Continuing Education for Actuarial Certification	14,000	X	X
Maintenance	Encryption Key Replacement	13,430	X	X
Training	Process Improvement Training and Personnel Development	13,300	X	X
Training & Seminar	Training and Seminars for Professional Development And Education	13,200	X	X
Public Activities	Promotional/Marketing and Outreach Activities to Help Elevate the CalOptima Brand in the Community to Support Enrollment	13,000	X	X
Maintenance	Maintenance and Support for Batch Scheduler System	12,580	X	X

Back to Agenda

Attachment B

Specific Type	Objective of the Item Proposed	Budget FY2018 Input	Appropriation	Authorization
	Medi-Cal: Other Operating Expenses			
Food Services	Food Services for Community Events and Department Training	11,300	X	X
Public Activities	Physician Forums for California Children's Services (CCS) Transition	11,000	X	X
Equipment	Laptops, Desktops, Flat Panel Monitors, Printers for New Employees	10,400	X	X
Public Activities	Orange County Strategic Plan for Aging	10,000	X	X
Subscriptions	Subscriptions for Existing Software and Databases	9,576	X	X
Incentives	Incentive Items for Provider Outreach and Employee Engagement Events	8,000	X	X
Other Expenses	State Non-Reimbursable Funds for Services and Items for MSSP Clients	2,500	X	X
	Total Other Operating Expenses	**17,215,174**		

* All Community Events And Activities Involving Financial Support From Caloptima Of Over $1,000 Require Prior Explicit Board Approval

Back to Agenda

Attachment B

	OneCare Connect: Professional Fees			
Specific Type	**Objective of the Item Proposed**	**Budget FY2018 Input**	**Appropriation**	**Authorization**
Consulting	Annual Mock Audit using Centers for Medicare & Medicaid Services (CMS) Audit Protocols	325,000	X	X
Consulting	Annual Compliance Program Effectiveness (CPE) Audit	85,000	X	X
Actuary	Provider Capitation Development, Revenue Cap Review and Other Related Actuarial Consulting Services	50,000	X	X
	Total Professional Fees	**460,000**		

	OneCare Connect: Purchased Services			
Specific Type	**Objective of the Item Proposed**	**Budget FY2018 Input**	**Appropriation**	**Authorization**
Purchased Services	Behavioral Health Contractual Administrative Fees	1,400,000	X	X
Purchased Services	Pharmacy Benefits Management	940,000	X	X
Advertising	Advertising and Media Buys (Newspapers, Magazines, Radio, Bus Shelter, Other Media)	268,700	X	X
Interpreter Services	Telephonic Language Interpretation and Translation of Member Materials	129,099	X	X
Data Transmission	Claims Processing through Automation Data Flow	109,200	X	X
Data Transmission	Data Submission To and From Centers For Medicare & Medicaid Services (CMS) for Enrollment and Regulatory Reporting and Hierarchical Condition Category (HCC) Scores Analytics	24,000	X	X
Purchased Services	Service to Review Member Phone Number Data Accuracy, Materials for Customer Service Week and Compliance Week and Compliance Badge Attachments	7,517	X	X
	Total Purchased Services	**2,878,516**		

Back to Agenda

Attachment B

Specific Type	Objective of the Item Proposed	Budget FY2018 Input	Appropriation	Authorization
	OneCare Connect: Printing & Postage			
Member Communications	Maintenance of Enrolled Members (Printing, Fulfillment, Postage)	417,579	X	X
Member Communications	Member Routine Annual and Quarterly Mailings	301,467	X	X
Printing & Postage	Marketing Materials Including Sales Brochures, Posters, Handouts and Other Member and Provider Oriented Materials and Postage	235,500	X	X
Member Communications	Health Risk Assessment Mailings	106,581	X	X
Member Communications	New Member Enrollment Packets	71,151	X	X
Member Communications	Printing Programming Service	55,200	X	X
Imaging	Imaging for Record Keeping	29,397	X	X
Printing & Postage	Printing of Enrollment Materials and Other Related Printing Expenses	23,400	X	X
Member Communications	Member and Provider Materials and Other Printing Fees for Various Departments	5,330	X	X
	Total Printing & Postage	**1,245,605**		

Specific Type	Objective of the Item Proposed	Budget FY2018 Input	Appropriation	Authorization
	OneCare Connect: Other Operating Expenses			
Maintenance	User Licenses for Claims Medicare Pricing Automation	431,340	X	X
Public Activities	Marketing and Outreach Activities and Promotional Items for Various Events	43,832	X	X
Public Activities	Fees for Registration, Sponsorships, Promotional Items for Community Events, Resource Fairs, Health Fairs and Other Events; Costs Tied to Supplies to Prepare And Participate	31,368	X	X
Training & Seminars	Training and Seminars for Professional Development and Education	18,900	X	X
Travel	Travel Allowance for Staff as Required by their Job Functions	18,210	X	X
Travel	Travel Expenses for Visits to Provider Offices, Presentations, Health Fairs, Community Events, Annual Audits and Conferences	18,925	X	X
Food Services	Food Services Allowances as Needed for Sponsoring Member and Provider Meetings, Conferences and Other Events	14,860	X	X
Subscriptions	Subscriptions and Professional Dues	11,329	X	X
Office Supplies	Office Supplies Needed for Everyday Department Operations	9,100	X	X
Equipment	Printers, Monitors, Desktops, Laptops and Other Minor Equipment	6,000	X	X
	Total Other Operating Expenses	**603,864**		

Back to Agenda

Attachment B

	OneCare: Professional Fees			
Specific Type	Objective of the Item Proposed	Budget FY2018 Input	Appropriation	Authorization
Consulting	Annual Contract Bid for Calendar Year 2018	160,000	X	X
	Total Professional Fees	**160,000**		

	OneCare: Purchased Services			
Specific Type	Objective of the Item Proposed	Budget FY2018 Input	Appropriation	Authorization
Purchased Services	Pharmacy Benefits Management	120,000	X	X
Interpreter Services	Telephonic Language Interpretation and Translation of Member Materials	23,600	X	X
Purchased Services	Service to Improve Member Phone Number Data Accuracy	330	X	X
	Total Purchased Services	**143,930**		

	OneCare: Printing & Postage			
Specific Type	Objective of the Item Proposed	Budget FY2018 Input	Appropriation	Authorization
Member Communications	Maintenance of Enrolled Members (Printing, Fulfillment, Postage)	128,349	X	X
Member Communications	Member Routine Annual and Quarterly Mailings	78,148	X	X
Member Communications	Health Risk Assessment Mailings	18,088	X	X
Member Communications	Printing of OneCare Brochures	7,500	X	X
Member Communications	Member Marketing Materials	2,700	X	X
Imaging	Imaging of Records Fees	2,388	X	X
Member Communications	New Member Enrollment Packets	1,779	X	X
	Total Printing & Postage	**238,952**		

Back to Agenda

OneCare: Other Operating Expenses

Specific Type	Objective of the Item Proposed	Budget FY2018 Input	Appropriation	Authorization
Travel	Travel Allowance for Various Departments as Required by their Job Functions	800	X	X
Office Supplies	Office Supplies for Various Departments Needed for Everyday Operations	600	X	X
Public Activities	Public Activities for Various Outreach, Community Events, Sponsorships and Health Fairs	300	X	X
Training & Seminars	Training, Conferences and Professional Certifications for Professional Development and Education	250	X	X
Food Services	Food Services Allowances as Needed for Sponsoring Member and Provider Meetings and Conferences	150	X	X
	Total Other Operating Expenses	**2,100**		

Back to Agenda

Attachment B

Specific Type	PACE: Professional Fees Objective of the Item Proposed	Budget FY2018 Input	Appropriation	Authorization
Professional Fees	Part D Actuarial Services and Other Consulting Fees	60,000	X	X
	Total Professional Fees	**60,000**		

Specific Type	PACE: Purchased Services Objective of the Item Proposed	Budget FY2018 Input	Appropriation	Authorization
Purchased Services	Advertising (Radio, Television, Print, Outdoor, Digital) to Promote and Support Enrollment and Participation	193,000	X	X
Purchased Services	Encounter Reporting Services, and Translation Services	60,632	X	X
	Total Purchased Services	**253,632**		

Specific Type	PACE: Printing & Postage Objective of the Item Proposed	Budget FY2018 Input	Appropriation	Authorization
Printing	Communication (Mass Mailers, Fliers, Letterheads, Envelopes, Brochures In Multiple Languages)	66,566	X	X
	Total Printing & Postage	**66,566**		

Back to Agenda

	PACE: Other Operating Expenses			
Specific Type	**Objective of the Item Proposed**	**Budget FY2018 Input**	**Appropriation**	**Authorization**
Repairs & Maintenance	Repairs and Maintenance of Minor Equipment, Building and Unforeseen Incidentals and Building Security Services	101,306	X	X
Public Activities	Outreach Events and Promotional Marketing Items to Help Elevate PACE Center and Support Program Enrollment	34,623	X	X
Insurance	Professional and General Liability and Property Tax Assessment	31,835	X	X
Training	Staff Development Training (Registration Fees, Travel, Accommodations, Incidentals)	15,000	X	X
Minor Equipment & Supplies	Minor Equipment and Supplies (Kitchen, Rehab, Social Day, Staff Break Room, Clinic Small Equipment)	11,254	X	X
Supplies	Office Supplies for Staff	10,000	X	X
Food Services	Food Services Allowances, as Needed, for Sponsoring Member and Provider Meetings and Conferences	7,429	X	X
Travel	Staff Travel and Mileage For Home Visits, Marketing and Enrollment	7,000	X	X
Subscriptions	Subscriptions, Membership, Registration for Dietetic and Other Discipline Specific Memberships	1,816	X	X
Telephone	Business Telephone Accessories	1,778	X	X
	Total Other Operating Expenses	**222,041**		

Back to Agenda

Attachment B

	Facilities: Purchased Services			
Specific Type	Objective of the Item Proposed	Budget FY2018 Input	Appropriation	Authorization
Building Administration	Property Management Company Fee	190,358	X	X
Building Administration	Management Fee	72,000	X	X
Building Administration	Various Administration Expenses (Telephone, Office Supplies, Permits, Licenses, Fees, Furniture, Equipment Lease, Postage, Courier)	15,873	X	X
	Total Purchased Services	**278,231**		

	Facilities: Other Operating Expenses			
Specific Type	Objective of the Item Proposed	Budget FY2018 Input	Appropriation	Authorization
Utilities	Electricity	481,000	X	X
Janitorial	Janitorial Night Contract	289,416	X	X
Fire/Life Safety Security	Security Contract	144,374	X	X
Janitorial	Janitorial Day Contract	119,996	X	X
Insurance	Property, Liability, and Earthquake Insurance	109,400	X	X
Janitorial	Janitorial Supplies	67,200	X	X
Landscape	Exterior Landscape Contract	33,000	X	X
Fire/Life Safety Security	Other Fire/Life Safety Expenses (Phone, Emergency Generator, Other Expenses)	27,215	X	X
Utilities	Water-Building	22,700	X	X
Landscape	Landscape Extras	21,500	X	X
Property Tax	Property Tax Assessments	19,254	X	X
Fire/Life Safety Security	Security Equipment and Maintenance	17,424	X	X
Building Expenses	Various Building Expenses (Trash, Water For Irrigation, Interior Plants)	12,300	X	X
Utilities	Gas	11,970	X	X
	Total Other Operating Expenses	**1,376,749**		

Back to Agenda

	Facilities: Repairs & Maintenance			
Specific Type	**Objective of the Item Proposed**	**Budget FY2018 Input**	**Appropriation**	**Authorization**
Other Repairs & Maintenance	Engineering Contract	260,000	X	X
Other Repairs & Maintenance	Plumbing	49,990	X	X
Repairs & Maintenance	HVAC Miscellaneous	41,400	X	X
Other Repairs & Maintenance	Electrical Repairs and Supplies	36,750	X	X
Other Repairs & Maintenance	Other Repair and Maintenance (Signage, Steam Cleaning, Roof, Locksmith, Pest Control Contract, Other Maintenance)	35,830	X	X
Other Repairs & Maintenance	Painting	31,200	X	X
Other Repairs & Maintenance	Windows	26,400	X	X
Parking Lot Maintenance	Parking Lot Maintenance	25,420	X	X
Other Repairs & Maintenance	Common Area and Lobby Maintenance Miscellaneous	24,800	X	X
Repairs & Maintenance	Elevator Maintenance Contract	23,280	X	X
Other Repairs & Maintenance	Walls/Ceilings/Floors/Sidewalks/Railings	17,500	X	X
Other Repairs & Maintenance	Common Area Maintenance and Repairs	16,400	X	X
Other Repairs & Maintenance	Door Maintenance and Repair	16,100	X	X
Repairs & Maintenance	HVAC Maintenance Contract	15,040	X	X
Repairs & Maintenance	Water Treatment	10,000	X	X
	Total Repairs & Maintenance	**630,110**		

Back to Agenda

Attachment C

Comparison PY17 v PY18

CalOptima Insurance Coverage Summary by Type
For 2017-18
Includes 505 City Parkway West, Data Center, and PACE center
Includes Taxes/Fees and Discounts/Credits

	PY2017				PY2018				Net	
Coverage	**Limits**	**Deductible**	**Company**	**Net Annual Premium**	**Limits**	**Deductible**	**Company**	**Net Annual Premium**	**Premium (Inc)/Dec**	
Managed Care E&O	$10M	$150k	Homeland Ins of NY (One Beacon)	$ 253,457	$10M	$150k	Homeland Ins of NY (One Beacon)	$ 253,457		
Excess E&O	$10M	-	Ironshore Specialty Ins. Co	$ 144,366	$10M	-	Ironshore Specialty Ins. Co	$ 144,366		
Subtotal				$ 397,823				$ 397,823	$ -	0.0%
D&O/Empl Practices	$5M	$100k	AIG	$ 103,140	$5M	$125K	Atlantic Specialty (One Beacon)	$ 136,054		
Commercial Crime	$5M	$25k	AIG	$ 18,187	$5M	$25k	Atlantic Specialty (One Beacon)	$ 14,290		
Excess D&O	$15M	-	Multiple	$ 94,812	$15M	-	Multiple	$ 99,813		
Subtotal				$ 216,139				$ 250,157	$ (34,018)	-15.7%
Umbrella Liability	$10M	-	Am. Guarantee & Liability (Zurich)	$ 10,638	$10M	-	Am. Guarantee & Liability (Zurich)	$ 10,630		
Excess Liability	$25M	-	Great American	$ 38,530	$25M	-	Firemans' Fund	$ 35,030		
Subtotal				$ 49,168				$ 45,660	$ 3,508	7.1%
Network & Privacy	$10M	$250k	Lloyd's of London/Ascent	$ 119,180	$10M	$250k	Ace America (Chubb)	$ 111,709	$ 7,471	6.3%
Pollution (3 years)	$1M/$2M	$25k	Steadfast Ins. Co	$ 7,081	$2M/4M	$25k	Ironshore Specialty	$ 5,273		
Earthquake	$50M	$50k min.	Multiple	$ 163,056	$50M	$50k min.	Multiple	$ 153,149		
Commercial Package*	$120	$5k	Zurich American Ins. Co	$ 67,948	$119M	$5k	Zurich American Ins. Co	$ 65,151		
Subtotal				$ 238,085				$ 223,573	$ 14,512	6.1%
Workers Comp	Stat $1M/1M/1M	-	Zurich American Ins. Co	$ 1,198,523	Stat $1M/1M/1M	-	Am Guarantee & Liability (Zurich)	$ 972,100	$ 226,423	18.9%
Med Malpractice - PACE	$1M/3M	$5k	Illinois Union (ACE)	$ 17,544	$1M/3M	$5k	Illinois Union (ACE)	$ 27,571	$ (10,027)	-57.2%
TOTAL COVERAGE				**$ 2,236,462**				**$ 2,028,593**	**$ 207,869**	**9.3%**
									Savings	

*Includes General Liability, Property, and Auto

Back to Agenda

Fiscal Year 2017-18
Proposed Operating and Capital Budget

Board of Directors Meeting
June 1, 2017

Nancy Huang, Interim Chief Financial Officer

Back to Agenda

Background

- Budget Period: July 1 – June 30 (Fiscal Year)
- General Assumptions
  - ➢ Enrollment drives the budget
  - ➢ Budget is based on a per capita methodology
    - ▪ Revenues
    - ▪ Medical expenses
  - ➢ General and administrative expenses
    - ▪ Based on current run rate and business requirements
    - ▪ Direct & indirect allocation to LOBs
      - Labor
      - Non-Labor
  - ➢ Capital Budget
    - ▪ Information systems
    - ▪ 505 Building Improvements
    - ▪ PACE

Back to Agenda

Overview

- Consolidated Operating Budget
- Operating Budgets by Line of Business
  - Medi-Cal
  - OneCare Connect
  - OneCare
  - PACE
  - Facilities (505 Building)
- Capital Budget

Back to Agenda

Lines of Business

	Start Date	Program Type	Contractor/ Regulator
Medi-Cal CalOptima A Public Agency Better. Together.	October 1995	California's Medicaid program	California Department of Health Care Services (DHCS)
OneCare (HMO SNP) CalOptima A Public Agency Better. Together.	October 2005	Medicare Advantage Special Needs Plan (SNP)	Centers for Medicare & Medicaid Services (CMS)
PACE CalOptima A Public Agency Better. Together.	October 2013	Medicare and Medicaid Program	Three-way contract: CMS, DHCS and CalOptima
OneCare Connect CalOptima A Public Agency Better. Together.	July 2015	Medicare and Medicaid Duals Demonstration	Three-way contract: CMS, DHCS and CalOptima

- Medi-Cal program includes: (1) Classic and (2) Medi-Cal Expansion

Back to Agenda

FY 2017-18 Program Changes/Delays

- Coordinated Care Initiative
  - Cal MediConnect will continue through 12/31/19
  - Jan 2018: Removes IHSS financing from managed care

- Program Delays

Program	Implementation Date
Palliative Care	• No sooner than 1/1/18
Whole-Child Model (CCS Redesign)	• Phase 1: No sooner than 7/1/18 • Phase 2 (includes Orange County): No sooner than 1/1/19
Health Homes Program	• Phase 1: No sooner than 7/1/18 • Phase 2 (includes Orange County): No sooner than 1/1/19
Whole Person Care Pilots	• Begins 7/1/17 in Orange County
FQHC Alternate Payment Methodology	• No sooner than 1/1/18

- Budget uncertainty
  - State payment reconciliation for Medi-Cal Expansion and IHSS

Back to Agenda

CalOptima
A Public Agency
Better. Together.

Comparative Budget - Consolidated

	FY 2016-17 Annualized*	FY 2016-17 Budget	FY 2017-18 Budget
Average Monthly Enrollment	796,903	804,667	803,499
Revenue	$3,370,164,864	$3,385,703,076	$3,186,646,826
Medical Costs	$3,262,729,856	$3,241,033,953	$3,047,173,526
Administrative Costs	$110,800,245	$140,298,791	$143,667,453
Operating Income/Loss	**($3,365,238)**	**$4,370,332**	**($4,194,154)**
Investments, Net	$11,814,575	$2,500,000	$3,000,000
Change in Net Assets	**$8,449,337**	**$6,870,332**	**($1,194,154)**
Medical Loss Ratio	96.81%	95.73%	95.62%
Administrative Loss Ratio	3.29%	4.14%	4.51 %

* Annualized as of March 2017

Back to Agenda

Major Changes in the FY 2017-18 Budget

- Decreased Revenue
  - $117 million decrease in Medi-Cal capitation rates
  - Discontinuation of IHSS as a managed care benefit
  - Deterioration of RAF scores for OneCare Connect and OneCare
- Increased Administrative Cost
  - Inclusion of behavioral health contractual administrative fees
  - Budget includes unfilled FTEs
  - Contractual obligations
  - Increases in member communication expenses
- Investment Income Variance
  - Reduction of total portfolio balance after DHCS reconciliation

Back to Agenda

FY 2017-18 Consolidated Enrollment

Program	FY 2015-16 Actual*	FY 2016-17 Forecast*	FY 2017-18 Budget*	% Change 17 v. 18
Medi-Cal	777,033	784,400	787,881	0.4%
OneCare Connect	18,384	15,670	15,698	0.2%
OneCare	1,174	1,306	1,420	8.7%
PACE	167	212	271	27.8%
Total	**796,758**	**801,587**	**805,269**	**0.5%**

* Annualized as of March 2017

** Enrollment as of June of every fiscal year when available, otherwise most current month

Enrollment Assumptions

- Medi-Cal: Maturation of Medi-Cal Expansion enrollment; Slight growth in Aged offset by small decreases in Adult and Child enrollment
- OneCare Connect: Increased sales efforts, combined with an improving disenrollment rate, are projected to reverse declining enrollment starting in August 2017
- OneCare: Projected net new enrollment of 0.7% per month
- PACE: Population currently consists of approximately 52% duals and 48% Medi-Cal only; Net monthly enrollment is projected to increase by 5 members

Back to Agenda

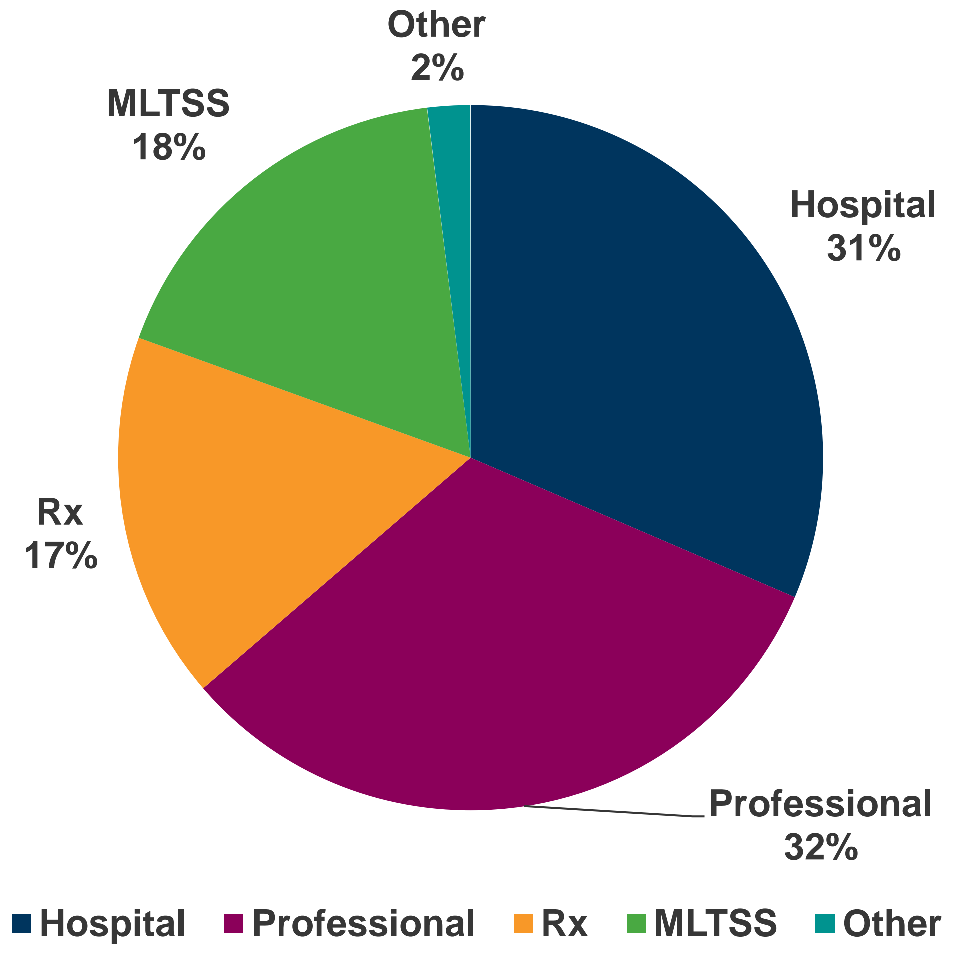
FY 2017-18 Consolidated Revenues

Medi-Cal Classic 49.06%
Medi-Cal Expansion 39.93%
OneCare 0.54%
OCC 9.86%
PACE 0.61%

■ Medi-Cal Classic ■ Medi-Cal Expansion ■ OneCare ■ OCC ■ PACE

Back to Agenda

FY 2017-18 Medical Expenses by Type



Back to Agenda

Consolidated General and Administrative Expenses

	FY 2016-17 Budget	FY 2016-17 Annualized*	FY 2017-18 Budget	FY 2018 Budget vs. FY 2017 Annualized
Revenues	$3,385,703,076	$3,370,164,864	$3,186,646,826	($183,518,038)
Salaries & Wages	$93,158,686	$74,192,570	$82,916,883	$8,724,313
Non-Salaries & Wages	$47,140,105	$36,607,675	$60,750,570	$24,142,895
Total G&A	**$140,298,791**	**$110,800,245**	**$143,667,453**	**$32,867,208**
Admin Loss Ratio (ALR)	**4.14%**	**3.29%**	**4.51%**	**1.22%**
ALR Breakdown:				
Salaries & Wages	2.75%	2.20%	2.60%	**0.40%**
Non-Salaries & Wages	1.39%	1.09%	1.91%	**0.82%**

* Annualized as of March 2017
Note: FY 2016-17 annualized figures do not include unfilled open positions

Back to Agenda

Consolidated General and Administrative Expenses

- Total ALR increase from FY 2017 Annualized to FY 2018 Budget = 1.22%

Breakdown of ALR Increase	Major Changes
0.4% from Salaries & Wages	• Comprises one-third of increase • Unfilled positions in FY 2017 due to: ➢ Delay hires ➢ Difficult to fill positions • $10 million less than FY 2017 Budget
0.82% from Non-Salaries & Wages	• Comprises two-thirds of increase ➢ Behavioral health contractual administrative fee ➢ Depreciation of new capital ➢ Contractual obligations ➢ Increase to member mailings

Back to Agenda

Consolidated General and Administrative Expenses (cont.)

- Justification for increase in FY 2017-18 G&A

Salaries & Wages	• Unfilled FTEs: 46 = $5.8 million • New FTEs: 3 = $136,000 • Merit Increases : $2.8 million
Non-Salaries & Wages	• Behavioral health: $9.6 million • Depreciation and Amortization – New capital: $1.6 million • Contractual obligations and increases to member communications: $13.3 million

- Attachment B to the COBAR provides a detailed listing of all G&A expenses

Back to Agenda

CalOptima Consolidated Income Statement: Attachment A

Attachment A

CalOptima Fiscal Year 2017-18 Budget

By Line of Business

	Medi-Cal (Classic)	Medical (Expansion)	Total	OCC	OneCare	PACE	Facilities	Other	Consolidated
Member Months	6,595,717	2,840,025	9,435,742	186,915	16,407	2,922	-		**9,641,986**
Avg Members	549,643	236,669	786,312	15,576	1,367	244	-		**803,499**
Revenues									
Capitation revenue	$ 1,563,400,467	$ 1,272,253,524	$ 2,835,653,991	$ 314,293,716	$ 17,160,358	$ 19,495,986	$ 42,774		**$ 3,186,646,826**
Total	$ 1,563,400,467	$ 1,272,253,524	$ 2,835,653,991	$ 314,293,716	$ 17,160,358	$ 19,495,986	$ 42,774		**$ 3,186,646,826**
Medical Costs									
1 Provider capitation	$ 420,934,241	$ 578,439,821	$ 999,374,062	$ 104,734,909	$ 4,754,013	$ -	$ -		**$ 1,108,862,984**
2 Claims Payments	$ 401,698,105	$ 336,466,814	$ 738,164,919	$ 68,695,980	$ 6,435,469	$ -	$ -		**$ 813,296,369**
3 LTC/Skilled Nursing Facilities	$ 471,975,488	$ 21,332,539	$ 493,308,027	$ 39,704,782	$ -	$ -	$ -		**$ 533,012,809**
4 Prescription Drugs	$ 220,988,042	$ 218,409,977	$ 439,398,019	$ 66,532,953	$ 5,825,416	$ -	$ -		**$ 511,756,388**
5 Case Mgmt & Oth Medical	$ 36,173,005	$ 8,564,936	$ 45,962,203	$ 16,466,930	$ 359,006	$ 17,456,837	$ -		**$ 80,244,977**
Total	$ 1,551,768,881	$ 1,163,214,087	$ 2,716,207,230	$ 296,135,555	$ 17,373,904	$ 17,456,837	$ -		**$ 3,047,173,526**
MLR	***99.26%***	***91.43%***	***95.79%***	***94.22%***	***101.24%***	***89.54%***	***0.00%***	*	***95.62%***
Gross Margin	$ 11,631,586	$ 109,039,437	$ 119,446,761	$ 18,158,161	$ (213,546)	$ 2,039,149	$ 42,774		**$ 139,473,299**
Administrative Expenses									
Salaries, Wages, & Employee Benefits			$ 70,737,591	$ 10,765,591	$ 247,130	$ 1,166,570	$ -		**$ 82,916,883**
Professional Fees			$ 3,832,257	$ 460,000	$ 160,000	$ 60,000	$ 0		**$ 4,512,257**
Purchased services			$ 18,690,418	$ 2,878,516	$ 143,930	$ 253,632	$ 278,231		**$ 22,244,727**
Printing & Postage			$ 4,806,825	$ 1,245,605	$ 238,952	$ 66,566	$ 0		**$ 6,357,948**
Depreciation & Amortization			$ 5,534,951	$ 0	$ -	$ 24,624	$ 1,937,684		**$ 7,497,259**
Other Operating Expenses			$ 17,215,174	$ 603,864	$ 2,100	$ 222,041	$ 2,006,859		**$ 20,050,038**
Indirect Cost Allocation, Occupancy Expense			$ (3,345,417)	$ 7,013,134	$ 382,915	$ 34,368	$ (3,996,659)		**$ 88,341**
Total			$ 117,471,799	$ 22,966,711	$ 1,175,027	$ 1,827,801	$ 226,115		**$ 143,667,453**
ALR			***4.14%***	***7.31%***	***6.85%***	***9.38%***		*	***4.51%***
Operating Income/(Loss)			$ 1,974,961	$ (4,808,549)	$ (1,388,573)	$ 211,348	$ (183,341)	$ -	**$ (4,194,154)**
Investment Income								$ 3,000,000	$ 3,000,000
MCO Tax Revenue			$ 131,028,771						$ 131,028,771
MCO Tax Expense			$ (131,028,771)						$ (131,028,771)
CHANGE IN NET ASSETS			**$ 1,974,961**	**$ (4,808,549)**	**$ (1,388,573)**	**$ 211,348**	**$ (183,341)**	**$ 3,000,000**	**$ (1,194,154)**

Back to Agenda

FY 2017-18 Operating Budget

Budgets by Line of Business

Back to Agenda

Medi-Cal Program

Start Date	October 1995
Program Type	California's Medicaid Program
Contractor/ Regulator	California Department of Health Care Services (DHCS)
Eligibility	• Child and family • Senior • Persons with disabilities • Low-income (includes Medi-Cal Expansion)
Services	• Comprehensive health • Prescriptions • Vision • Mental Health • MLTSS • (Dental provided by DHCS)

Back to Agenda

Medi-Cal Budget

	FY 2016-17 Annualized*	FY 2016-17 Budget	FY 2017-18 Budget
Average Monthly Enrollment	778,289	781,461	786,312
Revenue	$2,987,292,092	$2,821,016,503	$2,835,653,991
Medical Costs	$2,891,328,771	$2,706,100,756	$2,716,207,230
Administrative Costs	$87,106,234	$108,495,427	$117,471,799
Operating Income/Loss	**$8,857,088**	**$6,420,321**	**$1,974,961**
Medical Loss Ratio	96.79%	95.93%	95.79%
Administrative Loss Ratio	2.92%	3.85%	4.14%

* Annualized as of March 2017

Back to Agenda

Enrollment: Medi-Cal Classic & Expansion

Members

900,000
800,000
700,000
600,000
500,000
400,000
300,000
200,000
100,000
0

← Actual | Forecast →

July 2015: 742,645

July 2016: 778,192

July 2017: 784,698

June 2018: 787,881

Jul-15 Oct-15 Jan-16 Apr-16 Jul-16 Oct-16 Jan-17 Apr-17 Jul-17 Oct-17 Jan-18 Apr-18

■ Medi-Cal Classic ■ Expansion

Back to Agenda

Medi-Cal Assumptions: Classic

- Revenue
  - Based on draft FY 2017-18 capitation rates released on April 28, 2017; Medi-Cal Classic rates decreased by 4.6%
  - CCI rates are based on CY15 draft rates for the Duals population; Removal of IHSS as a managed care benefit effective January 2018
  - Behavioral Health Treatment rates based on FY 2016-17 rates
- Medical Costs
  - FFS costs trends developed by network type, aid code, and service type
  - Current provider reimbursement rates are kept at FY 2016-17 levels
  - Reinsurance attachment points increased to $17K (Professional) and $150K (Hospital); Coinsurance increased to 20%
  - Mental health expense converted from FFS reimbursement to capitation
  - Monarch and Prospect converted from SRG to HMO network types
  - Removal of IHSS as a managed care benefit effective January 2018
  - Includes projected expenses for Quality Improvement programs

Back to Agenda

Medi-Cal Assumptions: Expansion

- Revenue
  - Based on draft FY 2017-18 rates released on April 28, 2017; Medi-Cal Expansion rates decreased by 4.8%
- Medical Costs
  - FFS costs trends developed by network type, aid code, and service type
  - Assumes a 29% decrease to Medi-Cal Expansion hospital capitation rates
  - All other provider reimbursement rates are kept at FY 2016-17 levels
  - Reinsurance attachment points increased to $17K (Professional) and $150K (Hospital); Coinsurance increased to 20%
  - Includes projected expenses for Quality Improvement programs

Back to Agenda

Medi-Cal Revenue Impact

- Classic rate setting methodology matches actual risk
  - ➢ Based on Managed Care Plan's actual costs (RDT filing)
    - FY 2017-18 Rates are based on CY 2015 data and trended forward
  - ➢ Rates are submitted and certified by CMS
- MCE rates uses a blend of RDT and initial base data
  - ➢ Cost and utilization similar to Adult TANF
  - ➢ DHCS will likely move to 100% of actual experience
- FY 2017-18 Medi-Cal Revenue Change:

Revenue Type	% Change vs FY 16/17 Rate	$ Change vs FY 16/17 Rate
Classic	-4.6%	-$55M
Expansion	-4.8%	-$62M
Total	-4.7%	-$117M

Back to Agenda

Medi-Cal Expansion Capitation History

- MCE health network capitation rates
  - Professional rates derived from a 50/50 blend of Adult TANF and Disabled populations
  - Hospital rates based on 100% of the Disabled population
  - Expectation of high risk for MCE population at program start
  - Incentive to develop sufficient provider networks

- MCE Capitation Rate History:

Service Type	Adult Classic	Jan 2014	Sep 2014	Sep 2015	Jul 2016
Prof Cap	$88.68	$147.97	$199.91	$170.17	$144.64
Hospital Cap	$58.56	$267.66	$361.61	$307.81	$261.64
Total Cap	$147.24	$415.63	$561.52	$477.98	$406.28
% Change		+20%	+35.1%	-15.0%	-15.0%

Back to Agenda

Proposed MCE Capitation Change

- Proposed MCE rate change

Service Type	Jul 2016 – Current	Proposed	PMPM Change	% Change
Prof Cap	$144.64	$144.64	$0.00	0%
Hospital Cap	$261.64	$185.76	-$75.88	-29.0%
Total Cap	$406.28	$330.41	-$75.88	-18.7%

- Fiscal impact of rate reduction

Cost Type	$ Change
Professional Cap	$0
Hospital Cap	-$83M
Shared Risk Pool	-$32M
Total	-$115M

Back to Agenda

Medi-Cal Assumptions: Administrative Cost

- FY 2016-17 ALR is low due to:
  - ➢ Higher aggregate revenue due to higher rates and IHSS benefit
  - ➢ Lag time in filling open positions
  - ➢ Some projects remain in implementation stage

- FY 2017-18 includes the following items:
  - ➢ Behavioral health contractual administrative fee
  - ➢ Increase in regulatory requirements for member communication
  - ➢ Increasing CalOptima Community Network (CCN) population

Back to Agenda

OneCare Connect Program

Start Date	July 2015
Program Type	Medicare and Medicaid Duals Demonstration
Contractor/ Regulator	CMS and DHCS
Eligibility	Medi-Cal member who also has Medicare (i.e., dual eligible)
Services	• Comprehensive health • Prescriptions • Vision • MLTSS • Assessment • Care planning • Care coordination • Supplemental benefits

Back to Agenda

Enrollment: OneCare & OneCare Connect

Members

20,000
18,000
16,000
14,000
12,000
10,000
8,000
6,000
4,000
2,000
-

← Actual | Forecast →

July 2015: 12,992

July 2016: 18,917

July 2017: 15,488

June 2018: 15,698

July 2016: 1,173

July 2017: 1,315

June 2018: 1,420

Jul-15 Sep-15 Nov-15 Jan-16 Mar-16 May-16 Jul-16 Sep-16 Nov-16 Jan-17 Mar-17 May-17 Jul-17 Sep-17 Nov-17 Jan-18 Mar-18 May-18

OneCare — OneCare Connect

OneCare Connect
- July 2015: Voluntary enrollment began
- Jan 2016: Passive enrollment began

Back to Agenda

OneCare Connect Budget

	FY 2016-17 Annualized*	FY 2016-17 Budget	FY 2017-18 Budget
Average Monthly Enrollment	17,195	21,828	15,576
Revenue	$350,284,781	$533,118,659	$314,293,716
Medical Costs	$342,682,725	$504,173,683	$296,135,555
Administrative Costs	$20,963,313	$28,007,571	$22,966,711
Operating Income/Loss	($13,361,257)	$937,405	($4,808,549)
Medical Loss Ratio	97.83%	94.57%	94.22%
Administrative Loss Ratio	5.98%	5.25%	7.31%

* Annualized as of March 2017

Back to Agenda

OneCare Connect Assumptions

- Revenue
  - Medicare rates are based on CY 2017 rate report from CMS
  - Part C base rate applies a 3% increase effective January 2018
  - Assumes improved Aged/Disabled Part C RAF score to 1.11
  - Medi-Cal rates are based on CY 2015 draft rates from DHCS
  - Applies Year 3 savings targets of 5.5% and quality withhold of 3%
  - Projected population mix by cohort based on actual enrollment
- Medical cost
  - Applied projected enrollment mix for PHC, SRG, HMO, and CCN networks
  - Capitation rates were based on POP rates for the Medicare component and fixed PMPM rates for the Medi-Cal component
  - FFS expenses are based on actual OneCare Connect experience trended through June 2018

Back to Agenda

OneCare Connect Assumptions (cont.)

- Medical cost
  - ➢ Includes expenses for approved supplemental benefits
  - ➢ MLTSS costs are based on utilization data provided by DHCS
  - ➢ Removal of IHSS as a managed care benefit effective January 2018
  - ➢ Includes projected expenses for Quality Improvement programs
- Administrative cost
  - ➢ Behavioral health contractual administrative fee
  - ➢ Increase in regulatory requirements for member communication

Back to Agenda

OneCare Program

Start Date	October 2005
Program Type	Medicare Advantage Special Needs Plan (SNP)
Contractor/ Regulator	Centers for Medicare & Medicaid Services (CMS)
Eligibility	Medi-Cal member who also has Medicare (i.e., dual eligible)
Services	• Comprehensive health • Prescriptions • Vision • Mental Health • Supplemental Benefits

Back to Agenda

OneCare Budget

	FY 2016-17 Annualized*	FY 2016-17 Budget	FY 2017-18 Budget
Average Monthly Enrollment	1,235	1,186	1,367
Revenue	$17,176,889	$16,771,979	$17,160,358
Medical Costs	$15,502,191	$15,191,738	$17,373,904
Administrative Costs	$1,103,692	$1,253,728	$1,175,027
Operating Income/Loss	**$571,005**	**$326,512**	**($1,388,573)**
Medical Loss Ratio	90.25%	90.58%	101.24%
Administrative Loss Ratio	6.43%	7.48%	6.85%

* Annualized as of March 2017

Back to Agenda

OneCare Assumptions

- Revenue
  - Medicare Part C and Part D rates based on CY 2017 Monthly Membership Report (MMR) actuals
  - Part C base rate applies a 3% increase effective January 2018
  - Assumes improved Aged/Disabled Part C RAF score of 1.01
- Medical cost
  - Provider capitation payments based on 38.6 percent of premium (POP)
  - FFS medical costs based on historical claims through January 2017
  - Change to Part D member cost sharing amounts
  - Includes expenses for approved supplemental benefits
- Administrative cost
  - Contains both direct and indirect costs. Indirect costs are allocated based on percentage of revenue

Back to Agenda

PACE Program

Start Date	October 2013
Program Type	Medicare and Medicaid Program
Contractor/ Regulator	CMS and DHCS
Eligibility	Member who is: • ≥ 55; • Meet nursing facility level of care; and • Live in a PACE service area
Services	• All Medicare and Medicaid services • 16 additional services, such as social services, nursing facility care, personal care, nutritional counseling and recreational therapy

PACE Budget

Program	FY 2016-17 Annualized*	FY 2016-17 Budget	FY 2017-18 Budget
Average Monthly Enrollment	184	193	244
Revenue	$15,121,226	$14,540,515	$19,495,986
Medical Costs	$13,216,169	$15,567,776	$17,456,837
Administrative Costs	$1,399,891	$1,450,395	$1,827,801
Operating Income/Loss	**$505,166**	**($2,477,656)**	**$211,348**
Medical Loss Ratio	87.40%	107.06%	89.54%
Administrative Loss Ratio	9.26%	9.97%	9.38%

* Annualized as of March 2017

Back to Agenda

Enrollment: PACE

Members

300
250
200
150
100
50
-

← Actual | Forecast →

July 2015: 99

July 2016: 175

July 2017: 216

June 2018: 271

Jul-15 Aug-15 Sep-15 Oct-15 Nov-15 Dec-15 Jan-16 Feb-16 Mar-16 Apr-16 May-16 Jun-16 Jul-16 Aug-16 Sep-16 Oct-16 Nov-16 Dec-16 Jan-17 Feb-17 Mar-17 Apr-17 May-17 Jun-17 Jul-17 Aug-17 Sep-17 Oct-17 Nov-17 Dec-17 Jan-18 Feb-18 Mar-18 Apr-18 May-18 Jun-18

PACE

Back to Agenda

PACE Assumptions

- Revenue
  - Based on current Medicare Parts C and D and Medi-Cal PMPM rates
    - Medi-Cal rates based on CY 2016 AWOP rates
    - Assumes 2.2% increase to Medicare Part C base rate effective January 2018
    - Medicare Part D rates and subsidies are based on CY 2017 payments
  - Applies projected Part C Aged & Disabled RAF score of 2.25
    - CMS updated RAF methodology for the duals population
    - Assumes improved coding and submission of diagnostic data
- Medical cost
  - Based on mix of trended historic experience and industry benchmarks
  - Includes material depreciation costs associated with start-up capital expenses
  - Some administrative expenses are reclassified at 96% to medical

Back to Agenda

Facilities (505 Building) Budget

Program	FY 2016-17 Annualized*	FY 2016-17 Budget	FY 2017-18 Budget
Rental Income	$289,875	$255,419	$42,774
Operating Costs	$227,115	$1,091,669	$226,115
Operating Income/Loss	**$62,760**	**($836,250)**	**($183,341)**

* Annualized as of March 2017

Key points

- Lower rental income due to tenant's exit
- Operating costs include:
  - ➢ Common area maintenance;
  - ➢ Building and tenant improvement depreciation;
  - ➢ Repair and maintenance;
  - ➢ Building management fees

Back to Agenda

FY 2017-18 Capital Budget

Capital Budget by Category

Capital Budget

Category	FY 2017-18 Budget
Information Systems	
Hardware	$2,214,667
Software	$2,566,000
Professional fees related to implementation	$2,141,500
Subtotal	**$6,922,167**
505 Building Improvements	$1,395,356
PACE	$52,000
Total	**$8,369,523**

Back to Agenda

Information Systems Budget

Project Type	FY 2017-18 Budget
Infrastructure	$2,758,167
Applications Management	$1,341,000
Applications Development	$2,323,000
Electronic Health Data Integration	$500,000
Total	**$6,922,167**

- Represents nearly 82.7% of total Capital Budget
- Addresses information technology infrastructure needs
- Supports internal operations
- Ensures compliance with state and federal statutory, regulatory and contractual requirements

Back to Agenda

505 Building Improvements

Project Type	FY 2017-18 Budget
10th Floor Building Improvement	$400,000
8th Floor Remodel	$215,000
Upgrade HVAC Automation	$133,000
Xerox Capital Lease	$125,156
Video Streaming for 1st Floor Assembly Rooms	$110,000
Upgrade Card Access System	$105,000
Asphalt Repairs, Slurry Seal and Re-Stripe	$65,000
HVAC Condenser Pump	$45,000
Replace Lights in Passenger Elevators	$40,000
Convert Pneumatic Controls	$38,000
Retrofit Lobby Doors	$32,000
Fire Proofing	$30,000
505 Tower Light Sensors	$25,000
Retro Commissioning	$15,000
Central Plant Controller	$9,000
Automate Chilled Water Pump	$8,200
Total	**$1,395,356**

Back to Agenda

PACE Budget

Project Type	FY 2017-18 Budget
Furniture, Fixtures & Equipment	$25,000
Cold Laser Therapy	$10,000
Dishwasher	$10,000
Sun Protection - Patio	$4,000
Freezer	$3,000
Total	**$52,000**

Back to Agenda

CalOptima Board Action Agenda Referral

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

Report Item
15. Consider Approval of the CalOptima Fiscal Year 2017-18 Capital Budget

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

Recommended Actions
1. Approve the CalOptima Fiscal Year (FY) 2017-18 Capital Budget; and
2. Authorize the expenditure and appropriate the funds for the items listed in Attachment A: Fiscal Year 2017-18 Capital Budget by Project, which shall be procured in accordance with CalOptima policy.

Background
As of March 31, 2017, CalOptima has recorded gross capital assets of $90.2 million in the 505 building, building improvements, furniture, equipment, and information systems. To account for these fixed assets wearing out over time, staff has charged against the cost of these assets an accumulated depreciation totaling $37.2 million. Staff will record capital assets acquired in FY 2017-18 at acquisition cost and will depreciate the value on a straight-line basis over their estimated useful lives as follows:

- 5 years for office furniture and fixtures;
- 3 years for computer equipment and software;
- The lesser of 15 years or remaining term of lease for leasehold improvements; and
- 10 to 20 years based on components for building improvements.

The resulting net book value of these fixed assets was $53.0 million as of March 31, 2017. Prior board-approved capital budgets were $10.1 million in FY 2016-17, and $7.8 million in FY 2015-16 respectively.

Pursuant to CalOptima Policies GA. 3202: CalOptima Signature Authority, GA. 5002: Purchasing Policy, and GA. 5003: Budget and Operations Forecasting, the Board's approval of the budget appropriates the funds requested and authorizes the expenditure of the item without further Board action.

Discussion
Management proposes a Capital Budget of $8,369,523 for FY 2017-18 for the following asset types within three (3) asset categories:

Category	Amount	% of Total
Information Systems		
Hardware	$2,214,667	

Back to Agenda

Category	Amount	% of Total
Software	$2,566,000	
Professional fees related to implementation	$2,141,500	
Subtotal	$6,922,167	82.7%
505 Building Improvements	$1,395,356	16.7%
PACE	$52,000	0.6%
Total	**$8,369,523**	**100%**

1. Information Systems
Information Systems represent the largest portion of the Capital Budget (82.7%). This asset category primarily addresses CalOptima's information technology infrastructure needs.

Project Type	Amount	% of Total
Infrastructure	$2,758,167	39.8%
Applications Management	$1,341,000	19.4%
Applications Development	$2,323,000	33.6%
Electronic Health Data Integration	$500,000	7.2%
Total	**$6,922,167**	**100%**

The Capital Budget includes hardware, software, and professional fees related to implementation to fund multiple systems upgrades. More detailed information is provided in Attachment A: Fiscal Year 2017-18 Capital Budget by Project. These upgrades are necessary to support internal operations, and to continue to comply with state and federal contractual, regulatory and statutory requirements.

2. 505 Building Improvements
505 Building Improvements represents (16.7%) of the Capital Budget. The largest item (28.7%) within the 505 Building capital expenditures is for improvements to the 10th floor of the building.

Project Type	Amount	% of Total
10th Floor Building Improvement	$400,000	28.7%
8th Floor Remodel	$215,000	15.4%
Upgrade HVAC Automation	$133,000	9.5%
Xerox Capital Lease	$125,156	9.0%
Video Streaming for 1st Floor Assembly Rooms	$110,000	7.9%
Upgrade Card Access System	$105,000	7.5%
Asphalt Repairs, Slurry Seal & Re-Stripe	$65,000	4.7%
HVAC Condenser Pump	$45,000	3.2%
Replace Lights in Passenger Elevators	$40,000	2.9%
Convert Pneumatic Controls	$38,000	2.7%
Retrofit Lobby Doors	$32,000	2.3%
Fire Proofing	$30,000	2.1%
505 Tower Light Sensors	$25,000	1.8%
Retro Commissioning	$15,000	1.1%
Central Plant Controller	$9,000	0.6%
Automate Chilled Water Pump	$8,200	0.6%
Total	**$1,395,356**	**100%**

Back to Agenda

3. Program for All-Inclusive Care for the Elderly (PACE)
The remaining portion of the Capital Budget (0.6%) is for capital expenditures at the PACE center.

Project Type	Amount	% of Total
Furniture, Fixtures & Equipment	$25,000	48.1%
Cold Laser Therapy	$10,000	19.2%
Dishwasher	$10,000	19.2%
Sun Protection - Patio	$4,000	7.7%
Freezer	$3,000	5.8%
Total	**$52,000**	**100%**

Fiscal Impact
Investment in the Capital Budget will reduce CalOptima's investment principal by $8,369,523. At a 1% return rate, this would reduce annual interest income by approximately $83,695. Depreciation expense for Current Program Infrastructure and 505 Building Improvements is reflected in CalOptima's operating budget.

Rationale for Recommendation
The FY 2017-18 Capital Budget will enable necessary system upgrades, enhance operational efficiencies, support strategic initiatives, comply with federal and state requirements, and provide expansion of building capacity to accommodate CalOptima's growth.

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

Attachments
Attachment A: Fiscal Year 2017-18 Capital Budget by Project

/s/ Michael Schrader — *05/25/2017*
Authorized Signature — **Date**

Attachment A

Fiscal Year 2017-18 Capital Budget by Project

INFRASTRUCTURE		HARDWARE		SOFTWARE		PROFESSIONAL FEES RELATED TO IMPLEMENTATION		TOTAL CAPITAL
Disaster Recovery		750,000		-		200,000		950,000
Security		144,000		650,000		76,000		870,000
Upgrades/Replacements		216,167		30,000		269,000		515,167
Network		274,500		-		13,500		288,000
Storage		70,000		65,000		-		135,000
TOTAL INFRASTRUCTURE	**$**	**1,454,667**	**$**	**745,000**	**$**	**558,500**	**$**	**2,758,167**

APPLICATIONS MANAGEMENT		HARDWARE		SOFTWARE		PROFESSIONAL FEES RELATED TO IMPLEMENTATION		TOTAL CAPITAL
SSNRI Medicare HICN to MBI		100,000		-		250,000		350,000
Altruista Community Portal		50,000		300,000		-		350,000
Altruista Guiding Care Enhancement		-		-		250,000		250,000
ACE Implementation; CES Phase 2		-		-		175,000		175,000
Legal File Tracking Software System		-		100,000		10,000		110,000
TriZetto Workflow Customer Service Implementation		-		-		100,000		100,000
Member Safety First Quality Management		-		6,000		-		6,000
TOTAL APPLICATIONS MANAGEMENT	**$**	**150,000**	**$**	**406,000**	**$**	**785,000**	**$**	**1,341,000**

APPLICATIONS DEVELOPMENT		HARDWARE		SOFTWARE		PROFESSIONAL FEES RELATED TO IMPLEMENTATION		TOTAL CAPITAL
Analytics Software		150,000		500,000		100,000		750,000
Modernize the HIPAA X12 Standard Gateway Product		220,000		100,000		312,000		632,000
Fuel Data Warehouse Expansion		240,000				286,000		526,000
Fraud Waste and Abuse		-		400,000				400,000
911 Emergency Notification System				15,000				15,000
TOTAL APPLICATIONS DEVELOPMENT	**$**	**610,000**	**$**	**1,015,000**	**$**	**698,000**	**$**	**2,323,000**

ELECTRONIC HEALTH DATA INTEGRATION		HARDWARE		SOFTWARE		PROFESSIONAL FEES RELATED TO IMPLEMENTATION		TOTAL CAPITAL
EHR / HIE Data Integration		-		400,000		100,000		500,000
TOTAL ELECTRONIC HEALTH DATA INTEGRATION	**$**	**-**	**$**	**400,000**	**$**	**100,000**	**$**	**500,000**

505 BUILDING IMPROVEMENTS		BUILDING						TOTAL CAPITAL
10th Floor Building Improvement		400,000		-		-		400,000
8th Floor Remodel		215,000		-		-		215,000
Upgrade HVAC Automation		133,000		-		-		133,000
Xerox Capital Lease		125,156		-		-		125,156
Video Streaming for 1st Floor Assembly Rooms		110,000		-		-		110,000
Upgrade Card Access System		105,000		-		-		105,000
Asphalt Repairs, Slurry Seal & Re-Stripe		65,000		-		-		65,000
HVAC Condenser Pump		45,000		-		-		45,000
Replace Lights in Passenger Elevators		40,000		-		-		40,000
Convert Pneumatic Controls		38,000		-		-		38,000
Retrofit Lobby Doors		32,000		-		-		32,000
Fire Proofing		30,000		-		-		30,000
505 Tower Light Sensors		25,000		-		-		25,000
Retro Commissioning		15,000		-		-		15,000
Central Plant Controller		9,000		-		-		9,000
Automate Chilled Water Pump		8,200		-		-		8,200
TOTAL 505 BUILDING IMPROVEMENTS	**$**	**1,395,356**	**$**	**-**	**$**	**-**	**$**	**1,395,356**

PACE		EQUIPMENT						
Furniture, Fixtures & Equipment		25,000		-		-		25,000
Cold Laser Therapy		10,000		-		-		10,000
Dishwasher		10,000		-		-		10,000
Sun Protection - Patio		4,000		-		-		4,000
Freezer		3,000		-		-		3,000
TOTAL PACE	**$**	**52,000**	**$**	**-**	**$**	**-**	**$**	**52,000**

TOTAL FY18 NEW CAPITAL BUDGET	**$**	**3,662,023**	**$**	**2,566,000**	**$**	**2,141,500**	**$**	**8,369,523**

Back to Agenda

CalOptima Board Action Agenda Referral

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

Report Item

16. Consider Authorizing Extensions and Amendments of the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Clinic Contracts, Except Those Associated With the University of California-Irvine and St. Joseph Healthcare and its Affiliates

Contact

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

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to:

1. Extend the Medi-Cal, OneCare, OneCare Connect and PACE fee-for-service (FFS) clinic contracts through June 30, 2018, except those associated with the University of California-Irvine or St. Joseph Healthcare and its affiliates, and to:
2. Amend these contracts and revise member rates to the extent authorized by the Board of Directors in a separate Board action; and
3. Amend these contracts' terms to reflect applicable regulatory requirements

Background/Discussion

CalOptima currently contracts with several clinics to provide Primary Care services on a fee-for-service (FFS) basis to Medi-Cal, OneCare, OneCare Connect and PACE members. A contract is offered to any willing provider, as long as they meet credentialing and participation requirements. These provider contracts extend on an annual basis contingent upon approval from the CalOptima Board of Directors.

Extending contracts per Board approval was first approved in 2010. Prior to this all contracts included firm termination dates. In 2012, CalOptima added contract language indicating that contracts will be renewed under the same terms and conditions for an additional one-year term, upon approval by the Board.

The continued renewal of the contracts will support the stability of CalOptima's contracted provider network and allow the Board to preside over contracting directives. Contract language allows for CalOptima and the providers to terminate individual contracts with or without cause.

This staff recommendation impacts all CalOptima FFS Clinic contracts except those associated with UC-Irvine and St. Joseph Healthcare and its affiliates

Fiscal Impact

Management has included expenses associated with the extended contracts in the proposed CalOptima FY 2017-18 Operating Budget. Assuming continuance of the contracts under the same terms and conditions, the recommended action to extend clinic contracts, except for those associated with UC Irvine or St. Joseph Healthcare and its affiliates, for one year is a budgeted item with no additional fiscal impact.

Back to Agenda

Rationale for Recommendation

CalOptima staff recommends this action to maintain and continue the contractual relationship with the provider network and to fulfill regulatory and CalOptima policy requirements.

Concurrence

Gary Crockett, Chief Counsel

Attachments

None

/s/ Michael Schrader *05/25/2017*

Authorized Signature **Date**

Back to Agenda

CalOptima Board Action Agenda Referral

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

Report Item

17. Consider Authorizing Extensions and Amendments of the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Clinic Contracts Associated With the University of California, Irvine

Contact

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

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to:

1. Extend the Medi-Cal, OneCare, OneCare Connect and PACE fee-for-service (FFS) clinic contracts through June 30, 2018, associated with the University of California, Irvine, and to:
2. Amend these contracts and revise member rates to the extent authorized by the Board of Directors in a separate Board action; and
3. Amend these contracts' terms to reflect applicable regulatory requirements

Background/Discussion

CalOptima currently contracts with several clinics to provide Primary Care services on a fee-for-service (FFS) basis to Medi-Cal, OneCare, OneCare Connect and PACE members. A contract is offered to any willing provider, as long as they meet credentialing and participation requirements. These provider contracts extend on an annual basis contingent upon approval from the CalOptima Board of Directors.

Extending contracts per Board approval was first approved in 2010. Prior to this all contracts included firm termination dates. In 2012, CalOptima added contract language indicating that contracts will be renewed under the same terms and conditions for an additional one-year term, upon approval by the Board.

The continued renewal of the contracts will support the stability of CalOptima's contracted provider network and allow the Board to preside over contracting directives. Contract language allows for CalOptima and the providers to terminate individual contracts with or without cause.

This staff recommendation impacts all CalOptima FFS Clinic contracts associated with the University of California, Irvine.

Fiscal Impact

Management has included expenses associated with the extended contracts in the proposed CalOptima FY 2017-18 Operating Budget. Assuming continuance of the contracts under the same terms and conditions, the recommended action to extend clinic contracts associated with the University of California, Irvine, for one year is a budgeted item with no additional fiscal impact.

Back to Agenda

Rationale for Recommendation
CalOptima staff recommends this action to maintain and continue the contractual relationship with the provider network and to fulfill regulatory and CalOptima policy requirements.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader *05/25/2017*
Authorized Signature **Date**

Back to Agenda

CalOptima Board Action Agenda Referral

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

Report Item

18. Consider Authorizing Extensions and Amendments of the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Clinic Contracts Associated With St. Joseph Healthcare and its Affiliates

Contact

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

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel to:

1. Extend the Medi-Cal, OneCare, OneCare Connect and PACE fee-for-service (FFS) clinic contracts through June 30, 2018, associated with St. Joseph Healthcare and its affiliates, and to:
2. Amend these contracts and revise member rates to the extent authorized by the Board of Directors in a separate Board action; and
3. Amend these contracts' terms to reflect applicable regulatory requirements

Background/Discussion

CalOptima currently contracts with several clinics to provide Primary Care services on a fee-for-service (FFS) basis to Medi-Cal, OneCare, OneCare Connect and PACE members. A contract is offered to any willing provider, as long as they meet credentialing and participation requirements. These provider contracts extend on an annual basis contingent upon approval from the CalOptima Board of Directors.

Extending contracts per Board approval was first approved in 2010. Prior to this all contracts included firm termination dates. In 2012, CalOptima added contract language indicating that contracts will be renewed under the same terms and conditions for an additional one-year term, upon approval by the Board.

The continued renewal of the contracts will support the stability of CalOptima's contracted provider network and allow the Board to preside over contracting directives. Contract language allows for CalOptima and the providers to terminate individual contracts with or without cause.

This staff recommendation impacts all CalOptima FFS Clinic contracts associated with St. Joseph Healthcare and its affiliates

Fiscal Impact

Management has included expenses associated with the extended contracts in the proposed CalOptima FY 2017-18 Operating Budget. Assuming continuance of the contracts under the same terms and conditions, the recommended action to extend clinic contracts associated with St. Joseph Healthcare and its affiliates, for one year, is a budgeted item with no additional fiscal impact.

Back to Agenda

Rationale for Recommendation
CalOptima staff recommends this action to maintain and continue the contractual relationship with the provider network and to fulfill regulatory and CalOptima policy requirements.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader *05/25/2017*
Authorized Signature **Date**

CalOptima Board Action Agenda Referral

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

Report Item

19. Consider Authorizing Extensions and Amendments of the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Fee-For-Service (FFS) Primary Care Physician (PCP) Contracts Associated with St. Joseph Healthcare and its Affiliates

Contact

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

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to:

1. Extend the Medi-Cal, OneCare, OneCare Connect and PACE fee-for-service (FFS) Primary Care (PCP) contracts through June 30, 2018 associated with St. Joseph Healthcare and its Affiliates, and to:
2. Amend these contracts and revise member rates to the extent authorized by the Board of Directors in a separate Board action; and
3. Amend these contracts' terms to reflect applicable regulatory requirements

Background/Discussion

CalOptima currently contracts with many individual physicians and physicians groups to provide Primary Care services on a fee-for-service (FFS) basis to Medi-Cal, OneCare, OneCare Connect and PACE members. A contract is offered to any willing provider meeting credentialing and participation requirements. These provider contracts extend on an annual basis contingent upon approval from the CalOptima Board of Directors.

Extending contracts per Board approval was first approved in 2010. Prior to this all contracts included firm termination dates. In 2012, CalOptima added contract language indicating that contracts will be renewed under the same terms and conditions for an additional one-year term, upon approval by the Board.

The continued renewal of the contracts will support the stability of CalOptima's contracted provider network and allow the Board to preside over contracting directives. Contract language allows for CalOptima and the providers to terminate individual contracts with or without cause.

This staff recommendation impacts all CalOptima FFS PCP contracts associated with St. Joseph Healthcare and its Affiliates.

Fiscal Impact

Management has included expenses associated with the extended contracts in the proposed CalOptima FY 2017-18 Operating Budget. Assuming extension of the contracts under the same terms and conditions, the recommended action to extend CalOptima FFS PCP contracts associated with St. Joseph Healthcare and its Affiliates, for one year is a budgeted item with no additional fiscal impact.

Back to Agenda

Rationale for Recommendation
CalOptima staff recommends this action to maintain and continue the contractual relationship with the provider network and to fulfill regulatory and CalOptima policy requirements.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader *05/25/2017*
Authorized Signature **Date**

Back to Agenda

CalOptima Board Action Agenda Referral

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

Report Item

20. Consider Authorizing Extensions and Amendments of the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Fee-For-Service (FFS) Primary Care Physician (PCP) Contracts, Except Those Associated with the University of California – Irvine or St. Joseph Healthcare and its Affiliates

Contact

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

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to:

1. Extend the Medi-Cal, OneCare, OneCare Connect and PACE fee-for-service (FFS) Primary Care (PCP) contracts through June 30, 2018, except those associated with the University of California-Irvine or St. Joseph Healthcare and its Affiliates, and to:
2. Amend these contracts and revise member rates to the extent authorized by the Board of Directors in a separate Board action; and
3. Amend these contracts' terms to reflect applicable regulatory requirements

Background/Discussion

CalOptima currently contracts with many individual physicians and physicians groups to provide Primary Care services on a fee-for-service (FFS) basis to Medi-Cal, OneCare, OneCare Connect and PACE members. A contract is offered to any willing provider meeting credentialing and participation requirements. These provider contracts extend on an annual basis contingent upon approval from the CalOptima Board of Directors.

Extending contracts per Board approval was first approved in 2010. Prior to this all contracts included firm termination dates. In 2012, CalOptima added contract language indicating that contracts will be renewed under the same terms and conditions for an additional one-year term, upon approval by the Board.

The continued renewal of the contracts will support the stability of CalOptima's contracted provider network and allow the Board to preside over contracting directives. Contract language allows for CalOptima and the providers to terminate individual contracts with or without cause.

This staff recommendation impacts all CalOptima FFS PCP contracts except those associated with the University of California-Irvine or St. Joseph Healthcare and its Affiliates.

Fiscal Impact

Management has included expenses associated with the extended contracts in the proposed CalOptima FY 2017-18 Operating Budget. Assuming extension of the contracts under the same terms and conditions, the recommended action to extend CalOptima FFS PCP contracts, except those

associated with the University of California-Irvine or St. Joseph Healthcare and its Affiliates, for one year is a budgeted item with no additional fiscal impact.

Rationale for Recommendation

CalOptima staff recommends this action to maintain and continue the contractual relationship with the provider network and to fulfill regulatory and CalOptima policy requirements.

Concurrence

Gary Crockett, Chief Counsel

Attachments

None

/s/ Michael Schrader *05/25/2017*

Authorized Signature **Date**

Back to Agenda

CalOptima Board Action Agenda Referral

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

Report Item

21. Consider Authorizing Extensions and Amendments of the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Fee-For-Service (FFS) Primary Care Physician (PCP) Contracts Associated with the University of California – Irvine

Contact

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

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to:

1. Extend the Medi-Cal, OneCare, OneCare Connect and PACE fee-for-service (FFS) Primary Care (PCP) contracts through June 30, 2018 associated with the University of California - Irvine, and to:
2. Amend these contracts and revise member rates to the extent authorized by the Board of Directors in a separate Board action; and
3. Amend these contracts' terms to reflect applicable regulatory requirements

Background/Discussion

CalOptima currently contracts with many individual physicians and physicians groups to provide Primary Care services on a fee-for-service (FFS) basis to Medi-Cal, OneCare, OneCare Connect and PACE members. A contract is offered to any willing provider meeting credentialing and participation requirements. These provider contracts extend on an annual basis contingent upon approval from the CalOptima Board of Directors.

Extending contracts per Board approval was first approved in 2010. Prior to this all contracts included firm termination dates. In 2012, CalOptima added contract language indicating that contracts will be renewed under the same terms and conditions for an additional one-year term, upon approval by the Board.

The continued renewal of the contracts will support the stability of CalOptima's contracted provider network and allow the Board to preside over contracting directives. Contract language allows for CalOptima and the providers to terminate individual contracts with or without cause.

This staff recommendation impacts all CalOptima FFS PCP contracts associated with the University of California - Irvine.

Fiscal Impact

Management has included expenses associated with the extended contracts in the proposed CalOptima FY 2017-18 Operating Budget. Assuming extension of the contracts under the same terms and conditions, the recommended action to extend CalOptima FFS PCP contracts associated with the University of California - Irvine, for one year is a budgeted item with no additional fiscal impact.

Back to Agenda

Rationale for Recommendation
CalOptima staff recommends this action to maintain and continue the contractual relationship with the provider network and to fulfill regulatory and CalOptima policy requirements.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader | *05/25/2017*
Authorized Signature | **Date**

Back to Agenda

CalOptima Board Action Agenda Referral

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

Report Item
22. Consider Authorizing Extensions and Amendments of the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Ancillary Contracts that Expire During Fiscal Year 2017-18

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

Recommended Actions
Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to:
1. Extend the Medi-Cal, OneCare, OneCare Connect and PACE fee-for-service (FFS) ancillary services provider contracts through June 30, 2018 and to
2. Amend these contracts' terms to reflect applicable regulatory requirements

Background and Discussion
CalOptima currently contracts with many ancillary providers to provide health care services on a fee-for-service basis to Medi-Cal, OneCare, OneCare Connect and PACE Members. Ancillary services include, but are not limited to, laboratory, imaging, durable medical equipment, home health, and transportation. A contract is offered to any willing provider, as long as they meet credentialing and participation requirements. These provider contracts extend on an annual basis contingent upon Board approval.

Extending contracts per Board approval was first approved in 2010. Prior to this all contracts included firm termination dates. In 2012, CalOptima added contract language indicating that contracts will be renewed under the same terms and conditions for an additional one-year term, upon approval by the CalOptima Board of Directors

The renewal of these contracts with existing providers will support the stability of CalOptima's contracted provider network. Contract language does not guarantee any provider any particular volume or exclusivity, and allows for CalOptima and the providers to terminate the contracts with or without cause.

This staff recommendation impacts fee-for-service ancillary services provider contracts.

Fiscal Impact
Management has included expenses associated with the extended contracts in the proposed CalOptima FY 2017-18 Operating Budget. Assuming extension of the contracts under the same terms and conditions, the recommended action to extend ancillary contracts for one year is a budgeted item with no additional fiscal impact.

Rationale for Recommendation
CalOptima staff recommends this action to maintain and continue the contractual relationship with the provider network and to fulfill regulatory and CalOptima policy requirements.

Back to Agenda

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader *05/25/2017*
Authorized Signature **Date**

Back to Agenda

CalOptima Board Action Agenda Referral

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

Report Item

23. Consider Authorizing Extensions and Amendments of the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Fee-For Service (FFS) Hospital Contracts

Contact

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

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to:

1. Extend the Medi-Cal, OneCare, OneCare Connect and PACE FFS hospital contracts through June 30, 2018;
2. Amend these contracts and revise the fee-for-service (FFS) rates to the extent authorized by the Board in a separate Board action; and
3. Amend these contracts' terms to reflect applicable regulatory requirements.

Background

CalOptima's current Medi-Cal FFS hospital contracts were amended July 1, 2016 to extend the contracts through June 2017.

In support of MCE, the Board on November 7, 2013 approved the distribution of enhanced federal funding received from the Department of Health Care Services (DHCS), to the health networks. CalOptima, in order to maintain the higher funding level for MCE members, was required to demonstrate a Medical Loss Ratio (MLR) of eighty-five percent (85%) or higher. CalOptima's MLR did not support the continued level of funding established in 2014 and DHCS gradually reduced the level of MCE funding to CalOptima. The Board subsequently approved a reduction in hospital FFS rates in a Board action on September 3, 2015.

DHCS further reduced rates for MCE members. As a result, the Board at the May 5, 2016 meeting approved a 15% decrease in capitation rates for MCE members. Contracts were amended to reflect this decrease, revised rates effective through June 30, 2017.

Discussion

Extension of the Contract Term: Staff is requesting authority to extend the Medi-Cal, OneCare, OneCare Connect and PACE FFS hospital contracts through June 30, 2018.

MCE Rates: On April 28, 2017, DHCS released draft rates for CalOptima for Fiscal Year (FY) 2017-18. After evaluation of the new rates, Staff does not recommend revision to the FFS hospital MCE rates at this time. Staff therefore requests authority to extend the existing MCE member rates through June 30, 2018.

Back to Agenda

Regulatory Revisions: In 2016, the Center for Medicare & Medicaid Services (CMS) released a comprehensive revision of the federal Medicaid managed care and Child Health Insurance Program (CHIP) regulations. The intent of the regulations is to align the managed care requirements of Medicaid with those for Medicare. Some of the revised regulations such as those dealing with ownership disclosure and record retention requirements, must be incorporated into CalOptima's contracts with providers. Staff requests authority to amend FFS hospital contracts to include the regulatory requirements as applicable and in accordance with state and federal guidance.

Fiscal Impact

Management has included expenses associated with the extended contracts in the proposed CalOptima FY 2017-18 Operating Budget. Assuming extension of the contracts under the same terms and conditions, the recommended action to extend CalOptima FFS hospital contracts for one year is a budgeted item with no additional fiscal impact.

Rationale for Recommendation

CalOptima staff recommends this action to maintain and continue the contractual relationship with the provider network and to fulfill regulatory and CalOptima policy requirements.

Concurrence

Gary Crockett, Chief Counsel

Attachments

None

/s/ Michael Schrader *05/25/2017*

Authorized Signature **Date**

Back to Agenda

CalOptima Board Action Agenda Referral

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

Report Item

24. Consider Authorizing Extensions and Amendments of the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Fee-For Service (FFS) Specialist Physician Contracts Except Those Associated with the University of California-Irvine, Children's Hospital of Orange County (CHOC) or St. Joseph Healthcare and its Affiliates

Contact

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

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to:

1. Extend the Medi-Cal, OneCare, OneCare Connect and PACE fee-for-service (FFS) specialist physician contracts through June 30, 2018, except those associated with the University of California-Irvine, Children's Hospital of Orange County (CHOC) or St. Joseph Healthcare and its affiliates, and to:
2. Amend these contracts and revise the member rates to the extent authorized by the Board of Directors in a separate Board action; and
3. Amend these contracts' terms to reflect applicable regulatory requirements.

Background

CalOptima currently contracts with many individual physicians and physicians groups to provide Specialist services on a FFS basis to Medi-Cal, OneCare, OneCare Connect and PACE members. A contract is offered to any willing provider, as long as they meet credentialing and participation requirements. These provider contracts extend on an annual basis contingent upon approval from the Board.

Extending contracts per Board approval was first approved in 2010. Prior to this all contracts included firm termination dates. In 2012, CalOptima added contract language indicating that contracts will be renewed under the same terms and conditions for an additional one-year term, upon approval by the Board.

In support of MCE, the Board on November 7, 2013 approved the distribution of enhanced federal funding received from the Department of Health Care Services (DHCS), to specialist physicians. CalOptima, in order to maintain the higher funding level for MCE members, had to demonstrate a Medical Loss Ratio (MLR) of eighty-five percent (85%) or higher. CalOptima's MLR did not support the continued level of funding established in 2014 and DHCS gradually reduced the level of MCE funding to CalOptima. The Board subsequently approved a reduction in specialist physician FFS rates in a Board action on September 3, 2015.

DHCS further reduced rates for MCE members. As a result, the Board at the May 5, 2016 meeting approved a 15% decrease in capitation rates for MCE members. Contracts were amended to reflect this decrease, with revised rates effective through June 30, 2017.

Back to Agenda

Discussion

Extension of the Contract Term: Staff is requesting authority to extend and amend the Medi-Cal, OneCare, OneCare Connect and PACE FFS specialist physician contracts except those associated with the University of California-Irvine, Children's Hospital of Orange County (CHOC) or St. Joseph Healthcare and its affiliates through June 30, 2018.

MCE Rates: On April 28, 2017, DHCS released draft capitation rates for CalOptima for Fiscal Year (FY) 2017-18. After evaluation of the new rates, Staff does not recommend revision to the FFS specialist physician MCE rates at this time. Staff therefore requests authority to extend and amend the FFS specialist physician contracts, except those for the University of California-Irvine, Children's Hospital of Orange County (CHOC) or St. Joseph Healthcare and its affiliates at the existing rates through June 30, 2018.

Regulatory Changes: In 2016, the Center for Medicare & Medicaid Services (CMS) released a comprehensive revision of the federal Medicaid managed care and Child Health Insurance Program (CHIP) regulations. The intent of the regulations is to align the managed care requirements of Medicaid with those for Medicare. Some of the revised regulations such as those dealing with record retention requirements, must be incorporated into CalOptima's contracts with providers. Staff requests authority to amend FFS specialist physician contracts, except those associated with the University of California-Irvine, Children's Hospital of Orange County (CHOC) or St. Joseph Healthcare and its affiliates, to include regulatory requirements as applicable and in accordance with CMS and DHCS guidance.

The continued renewal of the contracts will support the stability of CalOptima's contracted provider network and allow the Board to preside over contracting directives. Contract language allows for CalOptima and the providers to terminate individual contracts with or without cause.

Fiscal Impact

Management has included expenses associated with the extended contracts in the proposed CalOptima FY 2017-18 Operating Budget. Assuming extension of the contracts under the same terms and conditions, the recommended action to extend CalOptima FFS specialist physician contracts, except those associated with the University of California-Irvine, Children's Hospital of Orange County (CHOC) or St. Joseph Healthcare and its affiliates, for one year is a budgeted item with no additional fiscal impact.

Rationale for Recommendation

CalOptima staff recommends these actions to maintain and continue the contractual relationship with the specialist provider network and to fulfill regulatory and CalOptima policy requirements.

Concurrence

Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader *05/25/2017*
Authorized Signature **Date**

Back to Agenda

CalOptima Board Action Agenda Referral

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

Report Item
25. Consider Authorizing Extensions and Amendments of the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Fee-For Service (FFS) Specialist Physician Contracts Associated with the University of California-Irvine

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

Recommended Actions
Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to:
1. Extend the Medi-Cal, OneCare, OneCare Connect and PACE fee-for-service (FFS) specialist physician contracts associated with the University of California-Irvine through June 30, 2018, and to:
2. Amend these contracts and revise the member rates to the extent authorized by the Board of Directors in a separate Board action; and
3. Amend these contracts' terms to reflect applicable regulatory requirements.

Background
CalOptima currently contracts with many individual physicians and physicians groups to provide Specialist services on a FFS basis to Medi-Cal, OneCare, OneCare Connect and PACE members. A contract is offered to any willing provider, as long as they meet credentialing and participation requirements. These provider contracts extend on an annual basis contingent upon approval from the Board.

Extending contracts per Board approval was first approved in 2010. Prior to this all contracts included firm termination dates. In 2012, CalOptima added contract language indicating that contracts will be renewed under the same terms and conditions for an additional one-year term, upon approval by the Board.

In support of MCE, the Board on November 7, 2013 approved the distribution of enhanced federal funding received from the Department of Health Care Services (DHCS), to specialist physicians. CalOptima, in order to maintain the higher funding level for MCE members, had to demonstrate a Medical Loss Ratio (MLR) of eighty-five percent (85%) or higher. CalOptima's MLR did not support the continued level of funding established in 2014 and DHCS gradually reduced the level of MCE funding to CalOptima. The Board subsequently approved a reduction in specialist physician FFS rates in a Board action on September 3, 2015.

DHCS further reduced rates for MCE members. As a result, the Board at the May 5, 2016 meeting approved a 15% decrease in capitation rates for MCE members. Contracts were amended to reflect this decrease, with revised rates effective through June 30, 2017.

Back to Agenda

Discussion

Extension of the Contract Term: Staff is requesting authority to extend and amend the Medi-Cal, OneCare, OneCare Connect and PACE FFS specialist physician contracts associated with the University of California-Irvine, through June 30, 2018.

MCE Rates: On April 28, 2017, DHCS released draft capitation rates for CalOptima for Fiscal Year (FY) 2017-18. After evaluation of the new rates, Staff does not recommend revision to the FFS specialist physician MCE rates at this time. Staff therefore requests authority to extend through June 30, 2018 and amend the FFS specialist physician contracts, for the University of California-Irvine

Regulatory Changes: In 2016, the Center for Medicare & Medicaid Services (CMS) released a comprehensive revision of the federal Medicaid managed care and Child Health Insurance Program (CHIP) regulations. The intent of the regulations is to align the managed care requirements of Medicaid with those for Medicare. Some of the revised regulations such as those dealing with record retention requirements, must be incorporated into CalOptima's contracts with providers. Staff requests authority to amend FFS specialist physician contracts with the University of California-Irvine to include regulatory requirements as applicable and in accordance with CMS and DHCS guidance.

The continued renewal of the contracts will support the stability of CalOptima's contracted provider network and allow the Board to preside over contracting directives. Contract language allows for CalOptima and the providers to terminate individual contracts with or without cause.

Fiscal Impact

Management has included expenses associated with the extended contracts in the proposed CalOptima FY 2017-18 Operating Budget. Assuming extension of the contracts under the same terms and conditions, the recommended action to extend CalOptima FFS specialist physician contracts, associated with the University of California-Irvine, for one year is a budgeted item with no additional fiscal impact.

Rationale for Recommendation

CalOptima staff recommends this action to maintain and continue the contractual relationship with the provider network and to fulfill regulatory and CalOptima policy requirements.

Concurrence

Gary Crockett, Chief Counsel

Attachments

None

/s/ Michael Schrader | *05/25/2017*

Authorized Signature | **Date**

Back to Agenda

CalOptima Board Action Agenda Referral

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

Report Item
26. Consider Authorizing Extensions and Amendments of the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Fee-For Service (FFS) Specialist Physician Contracts Associated with St. Joseph Healthcare and its Affiliates

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

Recommended Actions
Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to:
1. Extend the Medi-Cal, OneCare, OneCare Connect and PACE fee-for-service (FFS) specialist physician contracts associated with St. Joseph Healthcare and its Affiliates through June 30, 2018, and to:
2. Amend these contracts and revise the rates to the extent authorized by the Board of Directors in a separate Board action; and
3. Amend these contracts' terms to reflect applicable regulatory requirements.

Background
CalOptima currently contracts with many individual physicians and physicians groups to provide Specialist services on a FFS basis to Medi-Cal, OneCare, OneCare Connect and PACE members. A contract is offered to any willing provider, as long as they meet credentialing and participation requirements. These provider contracts extend on an annual basis contingent upon approval from the Board.

Extending contracts per Board approval was first approved in 2010. Prior to this all contracts included firm termination dates. In 2012, CalOptima added contract language indicating that contracts will be renewed under the same terms and conditions for an additional one-year term, upon approval by the Board.
In support of MCE, the Board on November 7, 2013 approved the distribution of enhanced federal funding received from the Department of Health Care Services (DHCS), to specialist physicians. CalOptima, in order to maintain the higher funding level for MCE members, had to demonstrate a Medical Loss Ratio (MLR) of eighty-five percent (85%) or higher. CalOptima's MLR did not support the continued level of funding established in 2014 and DHCS gradually reduced the level of MCE funding to CalOptima. The Board subsequently approved a reduction in specialist physician FFS rates in a Board action on September 3, 2015.

DHCS further reduced rates for MCE members. As a result, the Board at the May 5, 2016 meeting approved a 15% decrease in capitation rates for MCE members. Contracts were amended to reflect this decrease, with revised rates effective through June 30, 2017.

Back to Agenda

Discussion

Extension of the Contract Term: Staff is requesting authority to extend and amend the Medi-Cal, OneCare, OneCare Connect and PACE FFS specialist physician contracts associated with St. Joseph Healthcare and its Affiliates, through June 30, 2018.

MCE Rates: On April 28, 2017, DHCS released draft capitation rates for CalOptima for Fiscal Year (FY) 2017-18. After evaluation of the new rates, Staff does not recommend revision to the FFS specialist physician MCE rates at this time. Staff therefore requests authority to extend through June 30, 2018 and amend the FFS specialist physician contracts, for St. Joseph Healthcare and its Affiliates

Regulatory Changes: In 2016, the Center for Medicare & Medicaid Services (CMS) released a comprehensive revision of the federal Medicaid managed care and Child Health Insurance Program (CHIP) regulations. The intent of the regulations is to align the managed care requirements of Medicaid with those for Medicare. Some of the revised regulations such as those dealing with record retention requirements, must be incorporated into CalOptima's contracts with providers. Staff requests authority to amend FFS specialist physician contracts with St. Joseph Healthcare and its Affiliates to include regulatory requirements as applicable and in accordance with CMS and DHCS guidance.

The continued renewal of the contracts will support the stability of CalOptima's contracted provider network and allow the Board to preside over contracting directives. Contract language allows for CalOptima and the providers to terminate individual contracts with or without cause.

Fiscal Impact

Management has included expenses associated with the extended contracts in the proposed CalOptima FY 2017-18 Operating Budget. Assuming extension of the contracts under the same terms and conditions, the recommended action to extend CalOptima FFS specialist physician contracts, associated with St. Joseph Healthcare and its Affiliates, for one year is a budgeted item with no additional fiscal impact.

Rationale for Recommendation

CalOptima staff recommends this action to maintain and continue the contractual relationship with the provider network and to fulfill regulatory and CalOptima policy requirements.

Concurrence

Gary Crockett, Chief Counsel

Attachments

None

/s/ Michael Schrader *05/25/2017*
Authorized Signature **Date**

Back to Agenda

CalOptima Board Action Agenda Referral

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

Report Item

27. Consider Authorizing Extensions and Amendments of the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Fee-For Service (FFS) Specialist Physician Contracts Associated with Children's Hospital of Orange County (CHOC)

Contact

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

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to:

1. Extend the Medi-Cal, OneCare, OneCare Connect and PACE fee-for-service (FFS) specialist physician contracts associated with Children's Hospital of Orange County through June 30, 2018, and to:
2. Amend these contracts and revise the member rates to the extent authorized by the Board of Directors in a separate Board action; and
3. Amend these contracts' terms to reflect applicable regulatory requirements.

Background

CalOptima currently contracts with many individual physicians and physicians groups to provide Specialist services on a FFS basis to Medi-Cal, OneCare, OneCare Connect and PACE members. A contract is offered to any willing provider, as long as they meet credentialing and participation requirements. These provider contracts extend on an annual basis contingent upon approval from the Board.

Extending contracts per Board approval was first approved in 2010. Prior to this all contracts included firm termination dates. In 2012, CalOptima added contract language indicating that contracts will be renewed under the same terms and conditions for an additional one-year term, upon approval by the Board.

In support of MCE, the Board on November 7, 2013 approved the distribution of enhanced federal funding received from the Department of Health Care Services (DHCS), to specialist physicians. CalOptima, in order to maintain the higher funding level for MCE members, had to demonstrate a Medical Loss Ratio (MLR) of eighty-five percent (85%) or higher. CalOptima's MLR did not support the continued level of funding established in 2014 and DHCS gradually reduced the level of MCE funding to CalOptima. The Board subsequently approved a reduction in specialist physician FFS rates in a Board action on September 3, 2015.

DHCS further reduced rates for MCE members. As a result, the Board at the May 5, 2016 meeting approved a 15% decrease in capitation rates for MCE members. Contracts were amended to reflect this decrease, with revised rates effective through June 30, 2017.

Discussion
Extension of the Contract Term: Staff is requesting authority to extend and amend the Medi-Cal, OneCare, OneCare Connect and PACE FFS specialist physician contracts associated with Children's Hospital of Orange County, through June 30, 2018.

MCE Rates: On April 28, 2017, DHCS released draft capitation rates for CalOptima for Fiscal Year (FY) 2017-18. After evaluation of the new rates, Staff does not recommend revision to the FFS specialist physician MCE rates at this time. Staff therefore requests authority to extend through June 30, 2018 and amend the FFS specialist physician contracts, for Children's Hospital of Orange County

Regulatory Changes: In 2016, the Center for Medicare & Medicaid Services (CMS) released a comprehensive revision of the federal Medicaid managed care and Child Health Insurance Program (CHIP) regulations. The intent of the regulations is to align the managed care requirements of Medicaid with those for Medicare. Some of the revised regulations such as those dealing with record retention requirements, must be incorporated into CalOptima's contracts with providers. Staff requests authority to amend FFS specialist physician contracts with Children's Hospital of Orange County to include regulatory requirements as applicable and in accordance with CMS and DHCS guidance.

The continued renewal of the contracts will support the stability of CalOptima's contracted provider network and allow the Board to preside over contracting directives. Contract language allows for CalOptima and the providers to terminate individual contracts with or without cause.

Fiscal Impact
Management has included expenses associated with the extended contracts in the proposed CalOptima FY 2017-18 Operating Budget. Assuming extension of the contracts under the same terms and conditions, the recommended action to extend CalOptima FFS specialist physician contracts, associated with Children's Hospital of Orange County, for one year is a budgeted item with no additional fiscal impact.

Rationale for Recommendation
CalOptima staff recommends this action to maintain and continue the contractual relationship with the provider network and to fulfill regulatory and CalOptima policy requirements.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *05/25/2017*
Authorized Signature — **Date**

CalOptima Board Action Agenda Referral

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

Report Item

28. Consider Authorizing Extension and Amendment of the CalOptima Medi-Cal Full-Risk Health Network Contract with Kaiser Permanente

Contact

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

Recommended Action

Subject to approval of the Department of Health Care Services (DHCS), authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to extend the current Medi-Cal Full-Risk Health Network contract with Kaiser Permanente that currently expires on June 30, 2017 for up to 12 months, and to amend the contract terms to reflect updated regulatory requirements, as applicable.

Background

CalOptima's current Medi-Cal Full-Risk Health Network Contracts were amended July 1, 2016 to extend the Contracts through December 2016. In December of 2016, the Medi-Cal Full-Risk Health Network Contract for Kaiser Permanente was amended to extend the contract through June 30, 2017.

In support of Medi-Cal Expansion, the Board on November 7, 2013 approved the distribution of enhanced federal funding received from the Department of Health Care Services (DHCS), to the Health Networks (HN). CalOptima, in order to maintain the higher funding level for Medi-Cal Expansion (MCE) members, had to demonstrate a Medical Loss Ratio (MLR) of eighty-five percent (85%) or higher. CalOptima's MLR did not support the continued level of funding established in 2014 and DHCS gradually reduced the level of MCE funding to CalOptima.

Kaiser Permanente's compensation is based on terms and conditions outlined in a three way agreement with DHCS, Kaiser Permanente and CalOptima. The compensation is further defined in a two way agreement between Kaiser Permanente and CalOptima. The terms and conditions of the both agreements were specifically defined by the State of California. Compensation to Kaiser is based on a percent of the capitation rates CalOptima receives from the State. Therefore, Kaiser capitation rates adjust in accordance with the rates from the state.

In early May, DHCS issued a letter (attached) indicating that the terms of the three-way agreement had been fulfilled, and indicated that the DHCS does not intend to continue to participate in such agreements.

Discussion

<u>Extension of the Contract Term</u>: Based on this guidance, staff is in the process of conducting analysis on options going forward and seeking clarification from DHCS on the intended timeline for the anticipated termination of the current arrangement. Staff will be working with Kaiser to explore

Back to Agenda

options, such as transitioning Kaiser to CalOptima's standard HMO contract arrangement. In the meantime, to ensure no disruption to member care, staff plans to work with Kaiser and with DHCS to ensure an orderly transition, and will keep the Board apprised of our progress.

MCE Rates: On April 28, 2017, DHCS released draft capitation rates for CalOptima for Fiscal Year (FY) 2017-2018. As noted, capitation rates paid to Kaiser are currently calculated on a percent of premium basis. As proposed, and subject to DHCS approval, staff requests authority to extend the existing structure for up to an additional 12 months, through June 30, 2018.

Regulatory Revisions: In 2016, the Center for Medicare & Medicaid Services (CMS) released a comprehensive revision of the federal Medicaid managed care and Child Health Insurance Program (CHIP) regulations. The intent of the regulations is to align the managed care requirements of Medicaid with those for Medicare. Some of the revised regulations such as those dealing with ownership disclosure and record retention requirements, must be incorporated into CalOptima's contracts with providers. Staff requests authority to amend the Kaiser Permanente contracts to include the regulatory requirements as applicable and in accordance with DHCS guidance.

Fiscal Impact
Management has included expenses associated with the extended contracts in the proposed CalOptima FY 2017-18 Operating Budget. Assuming extension of the contracts under the same terms and conditions, the recommended action to extend the CalOptima contract with Kaiser Permanente for up to 12 additional months is a budgeted item.

Rationale for Recommendation
CalOptima staff recommends this action to maintain and continue the contractual relationship with the provider network and to fulfill regulatory and CalOptima policy requirements.

Concurrence
Gary Crockett, Chief Counsel

Attachments
May 2, 2017 Letter from the California Department of Health Care Services

/s/ Michael Schrader — *05/25/2017*
Authorized Signature — **Date**

Back to Agenda

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

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

May 2, 2017

SENT VIA ELECTRONIC MAIL

Dr. Susan Fleischman
Vice President, Medicaid, CHIP, and Charitable Care
Kaiser Foundation Health Plan, Inc.
3100 Thornton Avenue
Burbank, CA 91504

Dear Dr. Fleischman,

In 2013, the Department of Health Care Services (DHCS) negotiated with Kaiser Foundation Health Plan, Incorporated (Kaiser) and other health plans to enter into 3-way Agreements to transition the Healthy Families Program (HFP) population into Medi-Cal managed care. The HFP transition was completed in 2014.

As of April 2015, DHCS fulfilled the terms of its obligations under the 3-way Agreements, including the:

1) Development of a model contract template.
   - DHCS developed and approved these contracts in January 2013.
2) Creation of a centralized oversight and compliance process utilized by DHCS.
   - In December 2014, DHCS established the Managed Care Quality and Monitoring Division as the centralized oversight process for Medi-Cal managed care.
3) Development of a process to improve enrollment for members and beneficiaries.
   - In January 2014, DHCS approved a continuity of care process, through DHCS' Health Care Options program to improve the enrollment process.
4) Development of an enrollment process in County Organized Health System (COHS) counties to match existing processes for all Medi-Cal members.
   - In April 2015, DHCS approved changes to this enrollment process by allowing eligible members to enroll with Kaiser who have family and/or prior enrollment linkage.

Based on the implementation activities above, DHCS has met its obligations under the original 3-way Agreements. With the HFP population now fully transitioned into the Medi-Cal program for several years, DHCS does not intend to continue to participate in these agreements. Health plans may, at their own discretion and subject to negotiations between the contracting parties, continue to contract with each other to provide services to the populations that were transitioned under the 3-way Agreements as well as any

new populations that are mutually agreed upon. Any current or future agreements between plans and its subcontracting plans must address appropriate clinical and data oversight activities.

Should you have any questions regarding this letter, please contact your Contract Manager.

Sincerely,

Jennifer Kent
Director

cc: Sarah Brooks, Deputy Director
Health Care Delivery Systems
Department of Health Care Services, MS 4050

Javier Portela, Division Chief
Managed Care Operations Division
Department of Health Care Services, MS 4409

Nathan Nau, Division Chief
Managed Care Quality and Monitoring Division
Department of Health Care Services, MS 4400

Michelle Retke, Chief
Managed Care Systems & Support Branch
Managed Care Operations Division,
Department of Health Care Services, MS 4409

Sergio Lopez, Chief
Operations Section
Managed Care Operations Division
Department of Health Care Services, MS 4409

cc: Continued on next page

Gwendolyn Leake-Isaacs
Director, Medi-Cal Strategy
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Christine Tomcala, CEO
Santa Clara Family Health Plan
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Nathaniel Oubre, Vice President
KP Cal, LLC (NorCal)
1800 Harrison Street
Oakland, CA 94612

Back to Agenda

CalOptima Board Action Agenda Referral

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

Report Item

29. Consider Authorizing Amendments of the CalOptima Medi-Cal Full-Risk Health Network Contract with Heritage Provider Network, Inc., Monarch Family Healthcare and Prospect Medical Group

Contact

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

Recommended Actions

Authorize the Chief Executive Officer (CEO) to enter into Medi-Cal full-risk health network contract amendments, with the assistance of legal counsel, with Heritage Provider Network, Inc., Monarch Family Healthcare and Prospect Medical Group that:

1. Extend the contracts expiring on June 30, 2017 through June 30, 2018;
2. Revise the rates for assigned Medi-Cal members effective July 1, 2017, to the extent authorized by the Board in a separate Board action; and
3. Amend the contract terms to reflect applicable new regulatory requirements.

Background

CalOptima's current Medi-Cal full-risk health network contracts were amended July 1, 2016 to extend the contracts through December 2016. At the November 2016 Board meeting, the Medi-Cal full-risk health network contracts for Heritage was amended to extend the contracts through June 30, 2017. Monarch, a shared risk contractor at that time, became a full-risk contractor effective February 1, 2017. The term for the full-risk Monarch Family Healthcare runs through the end of June 2017.

In support of MCE, the Board on November 7, 2013 approved the distribution of enhanced federal funding received from the Department of Health Care Services (DHCS), to the health networks. CalOptima, in order to maintain the higher funding level for MCE members, was required to demonstrate a Medical Loss Ratio (MLR) of eighty-five percent (85%) or higher. CalOptima's MLR did not support the continued level of funding established in 2014, and DHCS gradually reduced the level of MCE funding to CalOptima. The Board subsequently approved a reduction in health network capitation rates in a Board action on September 3, 2015.

DHCS further reduced rates for MCE members. As a result, the Board at the May 5, 2016, meeting approved a 15% decrease in capitation rates for MCE members. Contracts were amended to reflect this decrease, with revised rates effective through June 30, 2017.

Discussion

Extension of the Contract Terms: Staff is requesting authority to extend the referenced Medi-Cal full-risk contracts through June 30, 2018.

MCE Rates: On April 28, 2017, DHCS released draft capitation rates for CalOptima for Fiscal Year (FY) 2017-18. After evaluation of the new rates, Staff recommends amendment of the referenced

Medi-Cal full-risk HMO contracts to reduce the allocated hospital portion of the MCE rates by 29%. This proposed reduction is addressed in Operating Budget presentation and recommended actions. If authorized by the Board in a separate action item, Staff will amend the contracts to reflect this change effective July 1, 2017 through June 30, 2018.

Regulatory Revisions: In 2016, the Center for Medicare & Medicaid Services (CMS) released a comprehensive revision of the federal Medicaid managed care and Child Health Insurance Program (CHIP) regulations. The intent of the regulations is to align the managed care requirements of Medicaid with those for Medicare. Some of the revised regulations, such as those dealing with ownership disclosure and record retention requirements, must be incorporated into CalOptima's contracts with providers. Staff requests authority to amend Medi-Cal full-risk HMO contracts to include the regulatory requirements as applicable and in accordance with DHCS guidance.

Fiscal Impact

The overall fiscal impact to decrease hospital MCE capitation rates for all impacted providers, effective July 1, 2017, through June 30, 2018, is projected to decrease CalOptima Medi-Cal capitation expenses by approximately $83 million. As indicated, Management has included these proposed rate reductions in the CalOptima FY 2017-18 Operating Budget pending Board approval.

Rationale for Recommendation

CalOptima staff recommends this action to maintain and continue the contractual relationship with the provider network and to fulfill regulatory and CalOptima policy requirements.

Concurrence

Gary Crockett, Chief Counsel

Attachments

None

/s/ Michael Schrader | *05/25/2017*
Authorized Signature | **Date**

CalOptima Board Action Agenda Referral

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

Report Item

30. Consider Authorizing Amendments to the CalOptima Medi-Cal Shared Risk (SRG) Health Network Physician Contracts for Alta Med Health Services, Arta Western Health Network, Noble Mid-Orange County, Talbert Medical Group, and United Care Medical Network

Contact

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

Recommended Actions

Authorize the Chief Executive Officer (CEO) to enter into a Medi-Cal SRG health network physician contract amendments, with the assistance of legal counsel, for Alta Med Health Services, Arta Western Health Network, Noble Mid-Orange County, Talbert Medical Group, and United Care Medical Network that:

1. Extend the contracts through June 30, 2018;
2. Revise the capitation rates for assigned members effective July 1, 2017, to the extent authorized by the CalOptima Board of Directors in a separate Board action; and
3. Amend the contracts' terms to reflect applicable regulatory requirements.

Background

CalOptima's current Medi-Cal SRG health network physician contracts were amended July 1, 2016 to extend the contracts through December 2016. In November 2016, the Medi-Cal PHC health network physician contracts were amended to extend the contracts through June 30, 2017.

In support of Medi-Cal expansion (MCE), the Board on November 7, 2013 approved the distribution of enhanced federal funding received from the Department of Health Care Services (DHCS), to the health networks. CalOptima, in order to maintain the higher funding level for MCE members, was required to demonstrate a Medical Loss Ratio (MLR) of eighty-five percent (85%) or higher. CalOptima's MLR did not support the continued level of funding established in 2014, and DHCS gradually reduced the level of MCE funding to CalOptima. The Board subsequently approved a reduction in health network capitation rates in a Board action on September 3, 2015.

DHCS further reduced rates for MCE members. As a result, the Board at the May 5, 2016 meeting approved a 15% decrease in capitation rates for MCE members. Contracts were amended to reflect this decrease, with revised rates effective through June 30, 2017.

Discussion

Extension of the Contract Term: Staff is requesting authority to amend the Medi-Cal SRG physician contracts for Alta Med Health Services, Arta Western Health Network, Noble Mid-Orange County, Talbert Medical Group and United Care Medical Network to extend the Contracts through June 30, 2018.

Back to Agenda

MCE Rates: On April 28, 2017, DHCS released draft capitation rates for CalOptima for Fiscal Year (FY) 2017-18. After evaluation of the new rates, Staff does not recommend revision to the SRG Physician MCE rates at this time. Staff therefore requests authority to amend the SRG physician contracts for Alta Med Health Services, Arta Western Health Network, Noble Mid-Orange County, Talbert Medical Group and United Care Medical Network, to extend the existing Physician rates through June 30, 2018. However, as indicated in Agenda Item 14 (Operating Budget), staff has proposed a 29% reduction in risk pool funding related to Hospital services for MCE members assigned to the SRG health networks.

Regulatory Changes: In 2016, the Center for Medicare & Medicaid Services (CMS) released a comprehensive revision of the federal Medicaid managed care and Child Health Insurance Program (CHIP) regulations. The intent of the regulations is to align the managed care requirements of Medicaid with those for Medicare. Some of the revised regulations such as those dealing with ownership disclosure and record retention requirements, must be incorporated into CalOptima's contracts with providers. Staff requests authority to amend SRG physician contracts as applicable to include the regulatory requirements as applicable and in accordance with CMS and DHCS guidance.

Fiscal Impact

Management has included expenses associated with the extended contracts in the CalOptima FY 2017-18 Operating Budget pending Board approval. Assuming extension of the contracts under the same terms and conditions for professional services capitation, the recommended action to extend CalOptima SRG physician contracts for Alta Med Health Services, Arta Western Health Network, Noble Mid-Orange County, Talbert Medical Group and United Care Medical Network for one year is a budgeted item with no additional fiscal impact specific to professional services capitation. However, 29% reductions to MCE SRG hospital pool funding is included in the proposed FY2017-18 Operating Budget.

Rationale for Recommendation

CalOptima staff recommends this action to maintain and continue the contractual relationship with the provider network and to fulfill regulatory and CalOptima policy requirements.

Concurrence

Gary Crockett, Chief Counsel

Attachments

None

/s/ Michael Schrader — *05/25/2017*

Authorized Signature — **Date**

Back to Agenda

CalOptima Board Action Agenda Referral

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

Report Item

31. Consider Authorizing Amendment of the CalOptima Medi-Cal Physician Hospital Consortium Health Network Physician Contracts for AMVI Care Health Network, Family Choice Network, Orange County Advantage Medical Group, and Fountain Valley Regional Medical Center

Contact

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

Recommended Actions

Authorize the Chief Executive Officer (CEO) to enter into contract amendments, with the assistance of legal counsel, for AMVI Care Health Network, Family Choice Network, and Orange County Advantage Medical Group and Fountain Valley Regional Medical Center Medi-Cal Physician Hospital Consortium (PHC) health network contracts to:

a. Extend contracts through June 30, 2018;
b. Revise the capitation rate for assigned members effective July 1, 2017, to the extent authorized by the Board in a separate action; and
c. Amend the contract terms to reflect applicable regulatory requirements.

Background

CalOptima's current Medi-Cal PHC health network contracts were amended July 1, 2016 to extend the contracts through December 2016. In November 2016, the Medi-Cal PHC health network contracts were amended to extend the contracts through June 30, 2017.

In support of MCE, the Board on November 7, 2013 approved the distribution of enhanced federal funding received from the Department of Health Care Services (DHCS), to the health networks. CalOptima, in order to maintain the higher funding level for MCE members, was required to demonstrate a Medical Loss Ratio (MLR) of eighty-five percent (85%) or higher. CalOptima's MLR did not support the continued level of funding established in 2014 and DHCS gradually reduced the level of MCE funding to CalOptima. The Board subsequently approved a reduction in health network capitation rates in a Board action on September 3, 2015.

DHCS further reduced rates for MCE members. As a result, the Board at the May 5, 2016, meeting approved a 15% decrease in capitation rates for MCE members. Contracts were amended to reflect this decrease, with revised rates effective through June 30, 2017.

Discussion

Extension of the Contract Term: Staff is requesting authority to amend the Medi-Cal physician PHC contracts for AMVI Care Health Network, Family Choice Network, and Orange County Advantage Medical Group and Fountain Valley Regional Medical Center to extend the contracts through June 30, 2018.

Back to Agenda

MCE Rates: On April 28, 2017, DHCS released draft capitation rates for CalOptima for Fiscal Year (FY) 2017-2018. After evaluation of the new rates, Staff does not recommend revision to the PHC physician MCE rates at this time. Staff therefore requests authority to amend the capitated physician contracts to extend the existing rates through June 30, 2018. Based on this evaluation, Staff does recommend a 29% reduction in the PHC hospital MCE rates at this time. Assuming the Staff proposal reflected in Agenda Item 14 (Operating Budget) is approved as recommended, the capitated hospital contracts will reflect this rate change effective July 1, 2017 through June 30, 2018.

Regulatory Changes: In 2016, the Center for Medicare & Medicaid Services (CMS) released a comprehensive revision of the federal Medicaid managed care and Child Health Insurance Program (CHIP) regulations. The intent of the regulations is to align the managed care requirements of Medicaid with those for Medicare. Some of the revised regulations such as those dealing with ownership disclosure and record retention requirements must be incorporated into CalOptima's contracts with providers. Staff requests authority to amend PHC contracts to include the regulatory requirements, as applicable and in accordance with DHCS guidance.

Fiscal Impact

Management has included expenses associated with the extended contracts in the proposed CalOptima FY 2017-18 Operating Budget. Assuming extension of the contracts under the same terms and conditions, the recommended action to extend CalOptima Medi-Cal PHC health network physician contracts for AMVI Care Health Network, Family Choice Network, and Orange County Advantage Medical Group for one year is a budgeted item with no additional fiscal impact specific to professional services capitation. However, proposed 29% reductions to MCE hospital capitation rates are included in the proposed FY2017-18 Operating Budget.

Rationale for Recommendation

CalOptima staff recommends this action to maintain and continue the contractual relationship with the provider network and to fulfill regulatory and CalOptima policy requirements.

Concurrence

Gary Crockett, Chief Counsel

Attachments

None

/s/ Michael Schrader — *05/25/2017*

Authorized Signature — **Date**

Back to Agenda

CalOptima Board Action Agenda Referral

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

Report Item

32. Consider Authorizing Amendment of the CalOptima Medi-Cal Physician Hospital Consortium Health Network Physician Contracts for, CHOC Physicians Network and Children's Hospital of Orange County

Contact

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

Recommended Actions

Authorize the Chief Executive Officer (CEO) to enter into a contract amendments, with the assistance of legal counsel, for CHOC Physicians Network, and Children's Hospital of Orange County Physician Hospital Consortium (PHC) health network contracts to:

a. Extends contracts through June 30, 2018;
b. Revise the capitation rate for assigned Medi-Cal Expansion (MCE) members effective July 1, 2017, to the extent authorized by the Board in a separate action; and
c. Amend the contract terms to reflect applicable regulatory requirements.

Background

CalOptima's current Medi-Cal PHC health network physician contracts were amended July 1, 2016 to extend the contracts through December 2016. In November 2016, the Medi-Cal PHC health network physician contracts were amended to extend the contracts through June 30, 2017.

In support of MCE, the Board on November 7, 2013 approved the distribution of enhanced federal funding received from the Department of Health Care Services (DHCS), to the health networks. CalOptima, in order to maintain the higher funding level for MCE members, was required to demonstrate a Medical Loss Ratio (MLR) of eighty-five percent (85%) or higher. CalOptima's MLR did not support the continued level of funding established in 2014 and DHCS gradually reduced the level of MCE funding to CalOptima. The Board subsequently approved a reduction in health network capitation rates in a Board action on September 3, 2015.

DHCS further reduced rates for MCE members. As a result, the Board at the May 5, 2016, meeting approved a 15% decrease in capitation rates for MCE members. Contracts were amended to reflect this decrease, with revised rates effective through June 30, 2017.

Discussion

Extension of the Contract Term: Staff is requesting authority to amend the Medi-Cal physician PHC contracts for CHOC Physicians Network and Children's Hospital of Orange County to extend the contracts through June 30, 2018.

MCE Rates: On April 28, 2017, DHCS released draft capitation rates for CalOptima for Fiscal Year (FY) 2017-2018. After evaluation of the new rates, Staff does not recommend revision to the PHC

physician MCE rates at this time. Staff therefore requests authority to amend the capitated physician contracts to extend the existing rates through June 30, 2018. Based on this evaluation, Staff does recommend a 29% reduction in the PHC hospital MCE rates at this time. Assuming the Staff proposal reflected in Agenda Item 14 (Operating Budget) is approved as recommended, the capitated hospital contracts will reflect this rate change effective July 1, 2017 through June 30, 2018.

Regulatory Changes: In 2016, the Center for Medicare & Medicaid Services (CMS) released a comprehensive revision of the federal Medicaid managed care and Child Health Insurance Program (CHIP) regulations. The intent of the regulations is to align the managed care requirements of Medicaid with those for Medicare. Some of the revised regulations such as those dealing with ownership disclosure and record retention requirements must be incorporated into CalOptima's contracts with providers. Staff requests authority to amend PHC contracts to include the regulatory requirements, as applicable and in accordance with DHCS guidance.

Fiscal Impact

Management has included expenses associated with the extended contracts in the proposed CalOptima FY 2017-18 Operating Budget. Assuming extension of the contracts under the same terms and conditions, the recommended action to extend CalOptima Medi-Cal PHC health network physician contracts for CHOC Physicians Network, and Children's Hospital of Orange County for one year is a budgeted item with no additional fiscal impact specific to professional services capitation. However, proposed 29% reductions to MCE hospital capitation rates are included in the proposed FY2017-18 Operating Budget.

Rationale for Recommendation

CalOptima staff recommends this action to maintain and continue the contractual relationship with the provider network and to fulfill regulatory and CalOptima policy requirements.

Concurrence

Gary Crockett, Chief Counsel

Attachments

None

/s/ Michael Schrader — *05/25/2017*

Authorized Signature — **Date**

Back to Agenda

CalOptima Board Action Agenda Referral

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

Report Item

33. Consider Authorization of Expenditures Related to Board Membership in the National Association of Corporate Directors

Contact

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

Recommended Actions

1. Authorize expenditures of $9,700 for full board membership in the National Association of Corporate Directors (NACD) for Fiscal Year 2017-18; and
2. Authorize up to $20,300 for additional seminars and related travel expenses.

Background

For more than thirty-five (35) years, NACD has worked with corporate directors to advance exemplary board leadership. It is a recognized authority on leading boardroom practices and currently helps more than 17,000 corporate directors nationwide. NACD enables corporate directors to anticipate risks and opportunities and equip them to make sound decisions based on leading practices and insights from recognized experts. Beginning in July 2015, the CalOptima board of directors signed up for full membership in NACD, with some board members participating in NACD events.

Discussion

NACD recommends that members of the board of directors, members of executive management, and corporate secretaries participate in NACD activities. CalOptima's annual membership renewal fee of $9,700 includes membership for the full Board for the FY 2017-18 fiscal year. The additional proposed expenses of $20,300 are based on prior year CalOptima expenditures for Board member seminar fees, and related travel, lodging, and meals.

Fiscal Impact

The recommended action is a budgeted item under the proposed CalOptima Fiscal Year 2017-18 Operating Budget.

Rationale for Recommendation

CalOptima's continued membership with NACD will assist Board members in remaining current on best practices in board leadership and governance.

Concurrence

Gary Crockett, Chief Counsel

Back to Agenda

Attachments

None

/s/ Michael Schrader | *5/25/2017*
Authorized Signature | **Date**

Back to Agenda

CalOptima Board Action Agenda Referral

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

Report Item

34. Consider Authorizing Extension of License Agreement with the County of Orange for Use of Space at the County Community Service Center

Contact

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

Recommended Actions

1. Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to negotiate an Amendment to the License Agreement compliant with CalOptima's obligations under applicable state and federal laws regarding the privacy of CalOptima members and their protected health information and extend the License Agreement with the County of Orange for up to an additional four years through June 30, 2021, which allows use of approximately 362 square feet of space at the County Community Service Center (CCSC), located at 15496 Magnolia Street, Suite 111, Westminster, CA 92683;
2. Approve allocation of $18,831.76, which has been included in CalOptima's proposed Fiscal Year (FY) 2017-2018 Operating Budget to fund the extension of the License Agreement; and
3. Authorize staff expenditures of $66,230 in FY 2017-18, plus equipment for a full time Customer Service Representative (CSR) at the licensed site.

Background

As a public agency and community health plan that serves the low-income Medi-Cal population in Orange County, CalOptima has been committed to member outreach, health education and engagement since its inception. By actively engaging our members in efforts with our community-based organizations, we increase opportunities for our members to receive information regarding our programs, learn about their benefits and be more proactive participants in their own health care.

Since 2008, CalOptima utilized space at the main CCSC office at no cost to CalOptima to offer monthly education seminars to increase our members' knowledge about CalOptima's programs and services and information to support our members' health care needs. Due to CalOptima's growth in membership and programs and increased interest in the health education seminars, the space at the main office limited the number of members served at the main CCSC office.

In May 2016, Orange County Social Services Agency informed CalOptima of an opportunity to expand our capacity at the CCSC by licensing space located across the parking lot from the main CCSC office. The licensed space provides one dedicated office and access to a shared conference room 50 percent of the time. On August 4, 2016, CalOptima's Board of Directors authorized the CEO to enter into a one-year license agreement with the County of Orange for usage of the space at the CCSC at a cost of approximately $23,000 for removal of a wall and licensing fees through June 30, 2017.

Since September 2016, CalOptima staff has been on-site to provide information and education about CalOptima's programs and services, enhanced customer service support, and additional monthly

Back to Agenda

educational seminars. The satellite office is centrally-located in the county and may be more convenient for certain CalOptima members who reside in the cities of Santa Ana, Garden Grove and Westminster. While visitation has been limited to an average of less than two members per day to date, staff is hopeful that a greater number of members will be receiving information at the site in the future.

Since the CCSC grand opening in September 2016, staff from various CalOptima departments have been on-site to serve members including Behavioral Health Integration, Program of All-Inclusive Care (PACE), OneCare Connect Sales and Marketing, Customer Service and Community Relations Departments. Services offered on-site include information and referrals for our programs and services, information and enrollment in the PACE and OneCare Connect programs, assistance with navigating health care benefits, educational seminars and customer service related issues including provider and health network selection, referrals, and requesting replacementID cards.

Since the opening of the new CCSC site, CalOptima has increased the health education seminars from one Vietnamese health education seminar to three seminars per month to include English and Spanish seminars, expanding our reach to English and Spanish-speaking members. CalOptima collaborated with community-based organization and internal departments to provide 21 educational seminars over the past nine months, or roughly three events per month, at the CCSC site. Topics presented include:

- The Importance of Vaccinations
- Understanding Social Security Programs and Benefits
- Dementia: The Basics: What it is and is not?
- Who is CalOptima? Understanding Your Medi-Cal Benefits
- Good Oral Care: Understanding Your Denti-Cal Benefits and Accessing Dental Services
- Mental Health Wellness: Understanding and Accessing Behavioral Health Benefits and Services

In January 2017, CalOptima started offering New Member Orientations for our Vietnamese-speaking members at the satellite office. A total of six New Member Orientations were conducted for our Medicare/Medi-Cal members and new Medi-Cal members.

Over 350 members have been provided with information and health education at the licensed site through the activities listed above in the nine months since the site's opening in September 2016. Foot traffic has averaged one to two members daily, and staff is hopeful that more members will receive information from the location with increased awareness of the licensed site and additional outreach efforts to members, providers and community-based organizations.

In addition to CalOptima's services, the CCSC offers a variety of health and human services to local residents including resources and referrals, application assistance and education workshops to assist with housing, mental and public health and support services for older adults. Representatives from Health Care Agency, Housing Authority, Family Caregiver Resource Center, and Office on Aging and Council on Aging are available to assist members on designated days.

CalOptima's primary challenge at the licensed site has been the lack of full-time staff available to serve our members on-site. While staff has made many efforts to provide full-time coverage by developing shifts for various departments, we still received feedback from members about the importance of having a full-time Customer Service Representative on-site. Staff has addressed this concern by budgeting for an additional full-time, bi-lingual Customer Service Representative who will begin duties at the CCSC in late May 2017.

To increase awareness of the licensed site in the community, CalOptima is implementing a number of outreach strategies to members, internal departments, health networks, providers and community-based organizations to increase utilization of services available. Activities include mailers to members residing in a two-mile radius of the satellite office, communications to health networks and providers through CalOptima's newsletters and weekly communications, and targeted site visits to providers, health clinics and community-based organizations within a two-mile radius.

Discussion

Staff recommends authorization to negotiate an amendment to the License Agreement to ensure compliance with applicable state and federal privacy laws and to extend the License Agreement with the County of Orange. The licensed site establishes a presence in the community and is available to provide information to members regarding benefits and health education to support their health care needs.

The current License Agreement allows for one dedicated office, shared use of a conference room and use of the common area. The total leased space for the CCSC is comprised of 2,080 square feet with CalOptima's use of 109 square feet for the dedicated office, 253 square feet for the shared conference room, and estimated 21 percent use of the common area. The License Agreement was approved by CalOptima's Board of Directors on August 4, 2016 for the license period of August 5, 2016 through June 30, 2017.

The proposed extension of the License Agreement for the CCSC would include an increase in the license term for an additional four years through June 30, 2021, increase in the monthly license fee from $1,453.02 per month to $1,560.98 per month for the months of July 1, 2017 through June 30, 2021, and the addition of a new standard insurance clause requiring CalOptima to meet all County insurance's requirements. CalOptima would also negotiate additional amendments as necessary to ensure compliance with applicable state and federal privacy requirements.

The Director of Financial Compliance reviewed the insurance requirements in the Amendment with CalOptima's broker and confirmed that CalOptima can meet these requirements; as proposed, this location can be added to CalOptima's General Liability policy at an additional annual premium of no more than $100.

	Total Amount
License Fee (July 2017 - June 2018) • Fee includes leased space, IT services, telephone services, janitorial services, and electrical/utilities	$18,731.76
Standard Insurance	$100.00
Computer and telecommunications equipment	$5,000.00
Full time bilingual customer service representative	$66,230.00
Total	$90,061.76

As proposed, the amended License Agreement would take effect on July 1, 2017, contingent on successful negotiations with the County and the agreement being fully executed and approved by the County of Orange's Board of Supervisors. The contract allows CalOptima to cancel the contract with 30-day's notice at any time.

The County of Orange's proposed extension to the License Agreement is for up to four additional years for the period of July 1, 2017 through June 30, 2021. Staff is proposing approval of the License Agreement for this period.

Fiscal Impact

The fiscal impact to execute a license agreement amendment to extend the term of the contract with the County of Orange for the period of July 2, 2017 through June 30, 2021, is approximately $75,000. Of this amount, $18,831.76 is budgeted under the proposed CalOptima FY 2017-18 Operating Budget pending Board approval for the period of July 1, 2017 through June 30, 2018. In addition, the annual cost of placing a full time bilingual customer service representative at the site is projected to total $66,230 in FY2017-18, plus $5,000 for computer/telework equipment for a total of $90,061.76 for FY 2017-18.

Rationale for Recommendation

As part of CalOptima's mission, staff works toward providing access to health care services for our members. By operating a licensed site in central Orange County, CalOptima is able to expand services to our members and build a presence in the community. The satellite office provides CalOptima with an opportunity to expand services to its members and provide direct support, increasing their ability to access health care.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Fully Executed County of Orange License Agreement-Original
2. CCSC Cost Apply

/s/ Michael Schrader *5/25/2017*
Authorized Signature **Date**

Back to Agenda

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3

LICENSE AGREEMENT

5

This LICENSE AGREEMENT (**"License"**) is made and entered into AUGUST 4, 2016 (**"Effective Date"**), by and between, CALOPTIMA, (hereinafter referred to as **"LICENSEE"**) and COUNTY OF ORANGE, a political subdivision of the State of California (hereinafter referred to as **"COUNTY"**) without regard to number and gender. LICENSEE and COUNTY may individually be referred to herein as a "**Party**," or collectively as the "**Parties**."

RECITALS

I. COUNTY leases that certain real property located at 15496 Magnolia in the City of Westminster, (**"County Property"**) pursuant to a lease dated July 1, 2016 for COUNTY's Social Services Agency's (**"SSA"**) Orange County Community Service Center Annex (**"OCCSCA"**).

II. The Services provided by LICENSEE will include a convenient on-site source while SSA clients are at the SSA Office.

III. COUNTY agrees to provide LICENSEE sufficient office space within the SSA Office for LICENSEE to provide the Services.

NOW THEREFORE, in consideration of the Recitals above, incorporated herein by reference, COUNTY and LICENSEE do hereby agree as follows:

1. DEFINITIONS (AMLC-2.1 S)

The following words in this License have the significance attached to them in this clause, unless otherwise apparent from context:

"Board of Supervisors" means the Board of Supervisors of the County of Orange, a political subdivision of the State of California.

"Chief Real Estate Officer" means the Chief Real Estate Officer, County Executive Office, County of Orange, or designee or upon written notice to LESSOR, such other person or entity as shall be designated by the County Executive Officer.

"County Counsel" means the County Counsel, County of Orange, or designee, or upon written notice to LICENSEE, such other person or entity as shall be designated by the Board of Supervisors.

"County Executive Officer" means the County Executive Officer, County Executive Office, County of Orange, or designee, or upon written notice to LICENSEE, such other person or entity as shall be designated by the Board of Supervisors.

"**Facilities Services Manager**" means the Manager of the Social Services Agency, Facilities Services, County of Orange, or designee, or upon written notice to LICENSEE, such other person or entity as shall be designated by the Director of Social Services Agency.

1
"Risk Manager" means the Manager of County Executive Office, Risk Management, for the County of Orange, or upon written notice to LICENSEE, such entity as shall be designated by the County Executive Officer.
3
5
"SSA Director" means the Director of Social Services Agency, County of Orange, or designee, or upon written notice to LICENSEE, such other person or entity as shall be designated by the County Executive Officer or the Board of Supervisors.
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2. TERM (AMLC-3.1 N)

11
The term of this License shall commence on the Effective Date and terminate on June 30, 2017, unless terminated as provided in Clause 3 (TERMINATION) of this License.
13

15
3. TERMINATION (AMLC-3.3 S)

17
This License shall be revocable by either COUNTY's SSA Director or LICENSEE at any time; however, as a courtesy the Parties will attempt to give thirty (30) days written notice to the other Party upon revocation.

19
4. LICENSE AREA (AMLC-4.2 N)

21
COUNTY grants to LICENSEE the non-exclusive right to use that certain property hereinafter referred to as **"License Area,"** shown on Exhibit A, attached hereto and by reference made a part hereof, for the purposes set forth in Clause 6 (USE) of this License together with non-exclusive, in common use of COUNTY's elevators, stairways, washrooms, hallways, driveways for vehicle ingress and egress, pedestrian walkways, other facilities and common areas appurtenant to LICENSEE's License Area created by this License.
23
25
27
During the term of this License, the dates and times for use of the License Area will be determined by the Facilities Services Manager, and the location of the License Area is subject to relocation at the sole discretion of the Facilities Operations Manager.
29
31

5. PARKING (AMLC-4.4 S)

33
Throughout the term of this License COUNTY shall provide one (1) parking space for LICENSEE's free and non-exclusive use.
35

37
6. USE (AMLC-5.1 N)

39
LICENSEE's use of the License Area shall be limited to general office to provide clients with health related workshops and information regarding their Medi-Cal benefits.
41
LICENSEE agrees not to use the License Area for any other purpose nor to engage in or permit any other activity within or from the License Area without prior written permission from the Facilities Services Manager. LICENSEE further agrees not to conduct or permit to be conducted any public or private nuisance in, on, or from the License Area, not to commit or permit to be committed waste on the License Area, and to comply with all governmental laws and regulations in connection with its use of the License Area.
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1 NO ALCOHOLIC BEVERAGES OR TOBACCO PRODUCTS SHALL BE SOLD OR CONSUMED WITHIN THE LICENSE AREA.

3

7. LICENSE FEE (AMLC-6.1 S)

5

LICENSEE agrees to pay COUNTY from and after the effective date of this License according to the
7 following schedule:

9

MONTH	MONTHLY LICENSE FEE
1	$0.00
2	$361.73
3	$1,453.02
4	$1,453.02
5	$1,453.02
6	$1,453.02
7	$1,453.02
8	$1,453.02
9	$1,453.02
10	$1,453.02
11	$1,453.02
12	$1,453.02

11 13 15 17 19 21 23 25 27 29

The monthly License Fee shall be payable in advance, without prior notice or demand on the first day of
31 each calendar month while this License is in effect without deduction or offset in lawful money of the United States.

33

In the event the obligation to pay the License Fee begins or terminates on some day other than the first day or
35 last day of the month, the License Fee shall be prorated to reflect the actual period of use on the basis of a thirty (30) day month. The fee for any partial calendar month during which this License becomes effective
37 will be payable on such effective date.

39 **8. PAYMENT PROCEDURE (AMLC-7.1 N)**

41 All payments shall be delivered to the County of Orange, Office of the Auditor-Controller, P. O. Box 567 (630 N. Broadway), Santa Ana, California 92702. The designated place of payment may be changed at any
43 time by COUNTY upon ten (10) days written notice to LICENSEE. License Fee payments may be made by check payable to the County of Orange. Said License Fee payment shall include a payment voucher
45 indicating that the payment is for the monthly License Fee for office space at the Orange County Community Service Center Annex in Westminster, California. A duplicate copy of the payment voucher shall be mailed
47 to the County of Orange, Social Services Agency, 500 N. State College Boulevard, Orange, California,

49

1 92868, Attention: Facilities Services Manager. LICENSEE assumes all risk of loss if payments are made by mail.

3

No payment by LICENSEE or receipt by COUNTY of a lesser amount than the payment due shall be
5 deemed to be other than on account of the payment due, nor shall any endorsement or statement on any check or any letter accompanying any check or payment as payment be deemed an accord and satisfaction,
7 and COUNTY shall accept such check or payment without prejudice to COUNTY's right to recover the balance of said payment or pursue any other remedy in this License.

9

9. CHARGE FOR LATE PAYMENT (AMLC-7.2 S)

11

LICENSEE hereby acknowledges that late payment of sums due hereunder will cause COUNTY to incur
13 costs not contemplated by this License, the exact amount of which will be extremely difficult to ascertain. Such costs include but are not limited to costs such as administrative processing of delinquent notices,
15 increased accounting costs, etc.

17 Accordingly, if any payment pursuant to this license is not received by COUNTY by the due date, a late charge of one and one-half percent (1.5%) of the payment due and unpaid plus $100 shall be added to the
19 payment, and the total sum shall become immediately due and payable to the COUNTY. An additional charge of one and one-half percent (1.5%) of said payment, excluding late charges, shall be added for each
21 additional month that said payment remains unpaid.

23 LICENSEE and COUNTY hereby agree that such late charges represent a fair and reasonable estimate of the costs that COUNTY will incur by reason of LICENSEE's late payment.

25

Acceptance of such late charges (and/or any portion of the overdue payment) by COUNTY shall in no event
27 constitute a waiver of LICENSEE's default with respect to such overdue payment, or prevent COUNTY from exercising any of the other rights and remedies granted hereunder.

29

10. UTILITIES, JANITORIAL, MAINTENANCE AND REPAIR (AMLC-9.3 N)

31

COUNTY shall be responsible for all charges for all utilities (water, gas and sewer),. County shall be
33 responsible for all maintenance and repairs (including but not limited to: fire alarm, fire extinguisher, HVAC system, elevator maintenance, landscaping, pest control, and trash). COUNTY shall be responsible for
35 telephone service, internet service and janitorial service. All charges for services provided by COUNTY pursuant to this Clause shall be included in LICENSEE's "MONTHLY LICENSE FEE" pursuant to Clause
37 7. (LICENSE FEE) of the License.

39 **11. CONSTRUCTION AND/OR ALTERATION BY LICENSEE (AMD2.1 S)**

41 COUNTY's Consent. No structures, improvements, or facilities shall be constructed, erected, altered, or made by LICENSEE within the License Area without prior written consent of the Facilities Services Manager. Any
43 conditions relating to the manner, method, design, and construction of said structures, improvements, or facilities fixed by the Facilities Services Manager as a condition to granting such consent, shall be conditions
45 hereof as though originally stated herein. LICENSEE may, at any time and at its sole expense, install and place business fixtures and equipment within License Area.

47

Strict Compliance with Plans and Specifications. All improvements constructed by LICENSEE within the

49

License Area shall be constructed in strict compliance with detailed plans and specifications approved by the Facilities Services Manager.

COUNTY shall contract with a licensed contractor to remove the existing wall between the "Reception Area" and "Room #1" as depicted in Exhibit B, to replace existing carpet, and repair any areas resulting from removing said wall. LICENSEE shall reimburse COUNTY in the amount not to exceed Seven Thousand six hundred forty-five dollars and fifty-five cents ($7,645.55) within twenty (20) business days of COUNTY's submittal to LICENSEE of an invoice from COUNTY.

12. MECHANICS LIENS OR STOP-NOTICES (AMD4.1 S)

LICENSEE shall at all times indemnify, defend with counsel approved in writing by COUNTY and save COUNTY harmless from all claims, losses, demands, damages, cost, expenses, or liability costs for labor or materials in connection with construction, repair, alteration, or installation of structures, improvements, equipment, or facilities within the License Area, and from the cost of defending against such claims, including attorney fees and costs.

In the event a lien or stop-notice is imposed upon the License Area as a result of such construction, repair, alteration, or installation, LICENSEE shall either:

A. Record a valid Release of Lien, or
B. Procure and record a bond in accordance with Section 3143 of the Civil Code, which frees the License Area from the claim of the lien or stop-notice and from any action brought to foreclose the lien.

Should LICENSEE fail to accomplish either of the two optional actions above within fifteen (15) days after the filing of such a lien or stop-notice, the License shall be in default and shall be subject to immediate termination.

13. OWNERSHIP OF IMPROVEMENTS (AMD6.1 N)

All improvements, exclusive of trade fixtures, constructed or placed within the License Area by LICENSEE must, upon completion, be free and clear all liens, claims, or liability for labor or material and at COUNTY's option shall be the property of COUNTY's at the expiration of this License or upon earlier termination hereof. COUNTY retains the right to require LICENSEE, at LICENSEE's cost, to remove all LICENSEE's improvements located on the License Area at the expiration or termination hereof.

14. INSURANCE (AML10.1 N)

LICENSEE agrees to purchase all required insurance at LICENSEE's expense and to deposit with COUNTY certificates of insurance, including all endorsements required herein, necessary to satisfy COUNTY that the insurance provisions of this License have been complied with and to keep such insurance coverage and the certificates and endorsements therefore on deposit with COUNTY during the entire term of this License. This License shall automatically terminate at the same time LICENSEE's insurance coverage is terminated. If within ten (10) business days after termination under this Clause LICENSEE obtains and provides evidence of the required insurance coverage acceptable to Facilities Services Manager, this License may be reinstated at the sole discretion of Facilities Services Manager.

LICENSEE agrees that LICENSEE shall not operate on the License Area at any time the required insurance is not in full force and effect as evidenced by a certificate of insurance and necessary endorsements or, in the interim, an official binder being in the possession of Facilities Services Manager. In no cases shall assurances by LICENSEE, its employees, agents, including any insurance agent, be construed as adequate evidence of insurance. Facilities Services Manager will only accept valid certificates of insurance and

1 endorsements, or in the interim, an insurance binder as adequate evidence of insurance. LICENSEE also agrees that upon cancellation, termination, or expiration of LICENSEE's insurance, COUNTY may take
3 whatever steps are necessary to interrupt any operation from or on the License Area until such time as the Facilities Services Manager reinstates the License.
5
If LICENSEE fails to provide Facilities Services Manager with a valid certificate of insurance and
7 endorsements, or binder at any time during the term of the License, COUNTY and LICENSEE agree that this shall constitute a material breach of the License. Whether or not a notice of default has or has not been
9 sent to LICENSEE, said material breach shall permit COUNTY to take whatever steps necessary to interrupt any operation from or on the License Area, and to prevent any persons, including, but not limited to,
11 members of the general public, and LICENSEE's employees and agents, from entering the License Area until such time as Facilities Services Manager is provided with adequate evidence of insurance required herein.
13 LICENSEE further agrees to hold COUNTY harmless for any damages resulting from such interruption of business and possession, including, but not limited to, damages resulting from any loss of income or business
15 resulting from the COUNTY's action.

17 All contractors performing work on behalf of LICENSEE pursuant to this License shall obtain insurance subject to the same terms and conditions as set forth herein for LICENSEE. LICENSEE shall not allow
19 contractors or subcontractors to work if contractors have less than the level of coverage required by COUNTY from LICENSEE under this License. It is the obligation of LICENSEE to provide written notice
21 of the insurance requirements to every contractor and to receive proof of insurance prior to allowing any contractor to begin work within the License Area. Such proof of insurance must be maintained by
23 LICENSEE through the entirety of this License and be available for inspection by a COUNTY representative at any reasonable time.
25 All self-insured retentions (**"SIRs"**) and deductibles shall be clearly stated on the Certificate of Insurance. If no SIRs or deductibles apply, indicate this on the Certificate of Insurance with a "0" by the appropriate line
27 of coverage. Any **SIR** or deductible in excess of $25,000 ($5,000 for automobile liability), shall specifically be approved by COUNTY's Risk Manager.
29
If LICENSEE fails to maintain insurance acceptable to COUNTY for the full term of this License, COUNTY
31 may terminate this License.

33 **Qualified Insurer**

35 The policy or policies of insurance must be issued by an insurer licensed to do business in the state of California (California Admitted Carrier) or have a minimum rating of A- (Secure A.M. Best's Rating) and
37 VIII (Financial Size Category) as determined by the most current edition of the **Best's key Rating Guide/Property-Casualty/United States or ambest.com**.
39
If the insurance carrier is not an admitted carrier in the state of California and does not have an A.M. Best
41 rating of A-/VIII, COUNTY's Risk Manager retains the right to approve or reject a carrier after a review of the company's performance and financial ratings.
43
The policy or policies of insurance maintained by LICENSEE shall provide the minimum limits and
45 coverage as set forth below:

47
Coverages Minimum Limits
49

Coverages	Minimum Limits
Commercial General Liability	$1,000,000 per occurrence $2,000,000 aggregate
Automobile Liability including coverage for owned, non-owned and hired vehicles	$1,000,000 limit per occurrence
Workers' Compensation	Statutory
Employers' Liability Insurance	$1,000,000 per occurrence

Required Coverage Forms

The Commercial General Liability coverage shall be written on Insurance Services Office (**"ISO"**) form CG 00 01, or a substitute form providing liability coverage at least as broad.
The Business Auto Liability coverage shall be written on ISO form CA 00 01, CA 00 05, CA 00 12, CA 00 20, or a substitute form providing liability coverage as broad.

Required Endorsements

The following endorsements must be submitted with the Certificate of Insurance:

a) The Commercial General Liability policy shall contain an Additional Insured endorsement using ISO form CG 2010 or CG 2033 or a form at least as broad naming the COUNTY, its elected and appointed officials, officers, employees, and agents as Additional Insureds.

b) The Commercial General Liability policy shall contain a primary non-contributing endorsement evidencing that the LESSEE's insurance is primary and any insurance or self-insurance maintained by the COUNTY shall be excess and non-contributing.

c) The Workers' Compensation policy shall contain a waiver of subrogation endorsement waiving all rights of subrogation against the COUNTY, and members of the Board of Supervisors, its elected and appointed officials, officers, agents and employees.

d) The Commercial Property policy shall contain a Loss Payee endorsement naming the COUNTY as respects the COUNTY's financial interest when applicable.

All insurance policies required by this contract shall waive all rights of subrogation against the COUNTY and members of the Board of Supervisors, its elected and appointed officials, officers, agents and employees when acting within the scope of their appointment or employment.

All insurance policies required by this contract shall give COUNTY thirty (30) days notice in the event of cancellation and ten (10) days for non-payment of premium. This shall be evidenced by policy provisions or an endorsement separate from the Certificate of Insurance.

1 The Commercial General Liability policy shall contain a severability of interests' clause, also known as a "separation of insureds" clause (standard in the ISO CG 001 policy).
3
Insurance certificates should be forwarded to COUNTY's address provided in Clause 17 (NOTICES) below
5 or to an address provided by SSA/Facilities Services Manager. LICENSEE has ten (10) business days to provide adequate evidence of insurance or this License may be cancelled.
7
COUNTY expressly retains the right to require LICENSEE to increase or decrease insurance of any of the
9 above insurance types throughout the term of this License. Any increase or decrease in insurance will be as deemed by COUNTY's Risk Manager as appropriate to adequately protect COUNTY.
11
COUNTY shall notify LICENSEE in writing of changes in the insurance requirements. If LICENSEE does
13 not deposit copies of acceptable certificates of insurance and endorsements with COUNTY incorporating such changes within thirty (30) days of receipt of such notice, this License may be in breach without further
15 notice to LICENSEE, and COUNTY shall be entitled to all legal remedies.

17 The procuring of such required policy or policies of insurance shall not be construed to limit LICENSEE's liability hereunder nor to fulfill the indemnification provisions and requirements of this License, nor in any
19 way to reduce the policy coverage and limits available from the insurer.

21 **15. OPERATIONS (AMLC-11.1 N)**

23 LICENSEE shall keep and maintain the License Area and all improvements of any kind in good condition and in substantial repair. COUNTY will, on LICENSEE's behalf, provide all maintenance and repairs to the
25 License Area during the term of the License. LICENSEE is required to notify COUNTY of any and all necessary maintenance and repairs to the License Area on a timely basis.
27
LICENSEE expressly agrees to maintain the License Area in a safe, clean, wholesome, and sanitary
29 condition, to the complete satisfaction of COUNTY and in compliance with all applicable laws. LICENSEE further agrees to keep the License Area free and clear of rubbish and litter. COUNTY shall have the right to
31 enter upon and inspect the License Area at any time for cleanliness and safety.

33 LICENSEE shall designate in writing to COUNTY an on-site representative who shall be responsible for the day to day operation and level of maintenance, cleanliness, and general order.
35
16. LIMITATION OF THE LICENSE (AMLC-13.1 S)
37
This License and the rights and privileges granted LICENSEE in and to the License Area are subject to all
39 covenants, conditions, restrictions, and exceptions of record or apparent from a physical inspection of the License Area. Nothing contained in this License or in any document related hereto shall be construed to
41 imply the conveyance to LICENSEE of rights in the License Area, which exceed those owned by COUNTY.

43 **17. HIPAA NOTICE (N)**

45 LICENSEE acknowledges that the Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA) requires COUNTY to safeguard and maintain the confidentiality of any Protected Health
47 Information (PHI). LICENSEE hereby agrees not to access, remove, destroy, or relocate any property used by COUNTY to safeguard and store PHI. LICENSEE further agrees to use appropriate safeguards and to
49

Back to Agenda

1 take all reasonable steps to prevent access to any PHI stored on the premises, including informing its workforce, contractors and vendors of the confidential nature of the records maintained by COUNTY.
3 LICENSEE agrees to report to COUNTY within ten (10) calendar days any unauthorized use or any disclosure of PHI, which LICENSEE becomes aware. Upon COUNTY's knowledge of any breach,
5 disclosure, or unauthorized use of PHI by LICENSEE, COUNTY shall:

7 a. Provide an opportunity for LICENSEE to cure the breach or end the violation. If LICENSEE does not cure the breach or end the violation within thirty (30) days or shorter period as required by
9 COUNTY, COUNTY shall terminate this Agreement; or

11 b. Immediately terminate this Agreement if cure is not possible.

13 **18. HAZARDOUS MATERIALS (AMLC-16.1 S)**

15 A. Definition of Hazardous Materials. For purposes of this License, the term **"Hazardous Material"** or "Hazardous Materials" shall mean any hazardous or toxic substance, material, product, byproduct, or waste
17 which is or shall become regulated by any governmental entity, including, without limitation, the COUNTY acting in its governmental capacity, the State of California or the United States government.

19

B. Use of Hazardous Materials. LICENSEE or LICENSEE's employees, agents, independent
21 contractors or invitees (collectively **"LICENSEE Parties"**) shall not cause or permit any Hazardous Materials to be brought upon, stored, kept, used, generated, released into the environment or
23 disposed of on, under, from or about the License Area (which for purposes of this clause shall include the subsurface soil and ground water). Notwithstanding the foregoing, LICENSEE may keep
25 on or about the License Area small quantities of Hazardous Materials that are used in the ordinary, customary and lawful cleaning of and business operations on the License Area.

27

C. LICENSEE Obligations. If the presence of any Hazardous Materials on, under or about the License
29 Area caused or permitted by LICENSEE or LICENSEE Parties results in (i) injury to any person, (ii) injury to or contamination of the License Area (or a portion thereof), or (iii) injury to or
31 contamination or any real or personal property wherever situated, LICENSEE, at its sole cost and expense, shall promptly take all actions necessary or appropriate to return the License Area to the
33 condition existing prior to the introduction of such Hazardous Materials to the License Area and to remedy or repair any such injury or contamination. Without limiting any other rights or remedies of
35 COUNTY under this License, LICENSEE shall pay the cost of any cleanup or remedial work performed on, under or about the License Area as required by this License or by applicable laws in
37 connection with the removal, disposal, neutralization or other treatment of such Hazardous Materials caused or permitted by LICENSEE or LICENSEE Parties. Notwithstanding the foregoing,
39 LICENSEE shall not take any remedial action in response to the presence, discharge or release, of any Hazardous Materials on, under or about the License Area caused or permitted by LICENSEE or
41 LICENSEE Parties, or enter into any settlement agreement, consent decree or other compromise with any governmental or quasigovernmental entity without first obtaining the prior written consent
43 of the COUNTY. All work performed or caused to be performed by LICENSEE as provided for above shall be done in good and workmanlike manner and in compliance with plans, specifications,
45 permits and other requirements for such work approved by COUNTY.

47 D. Indemnification for Hazardous Materials. To the fullest extent permitted by law, LICENSEE hereby agrees to indemnify, hold harmless, protect and defend (with attorneys acceptable to COUNTY)
49 COUNTY, its elected officials, officers, employees, agents and independent contractors and the

Back to Agenda

License Area, from and against any and all liabilities, losses, damages (including, but not limited, damages for the loss or restriction on use of rentable or usable space or any amenity of the License Area or damages arising from any adverse impact on marketing of the License Area), diminution in the value of the License Area, judgments, fines, demands, claims, recoveries, deficiencies, costs and expenses (including, but not limited to, reasonable attorneys' fees, disbursements and court costs and all other professional or consultant's expenses), whether foreseeable or unforeseeable, arising directly or indirectly out of the presence, use, generation, storage, treatment, on or off-site disposal or transportation of Hazardous Materials on, into, from, under or about the License Area by LICENSEE or LICENSEE's Parties. The foregoing indemnity shall also specifically include the cost of any required or necessary repair, restoration, clean-up or detoxification of the License Area and the preparation of any closure or other required plans.

19. NOTICES (AMLC-14.1 S)

All notices pursuant to this License shall be addressed as set forth below or as either Party may hereafter designate by written notice and shall be sent through the United States mail in the State of California duly registered or certified with postage prepaid. If any notice is sent by registered or certified mail, as aforesaid, the same shall be deemed served or delivered twenty-four (24) hours after mailing thereof as above provided. Notwithstanding the above, COUNTY may also provide notices to LICENSEE by personal delivery, by regular mail, or by electric mail and any such notice so given shall be deemed to have been given upon receipt.

TO: COUNTY

County of Orange
Social Services Agency
Facilities Services
500 N. State College Boulevard
Orange, CA 92868

With a copy to:

County Executive Office
Attention: Chief Real Estate Officer
333 W. Santa Ana Boulevard, 3rd Floor
Santa Ana, CA 92701

TO: LICENSEE

CalOptima
15496 Magnolia, #111
Westminster, CA 92806
Phil Tsunoda, Executive Director,
Public Policy & Public Affairs
ptsunoda@caloptima.org

20. ATTACHMENTS TO LICENSE (AMLC-15.1 S)

This License includes the following, which are attached hereto and made a part hereof:

I. GENERAL CONDITIONS
II. EXHIBITS
   Exhibit A - License Description
   Exhibit B – Floor Plan

//

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3
WITNESS WHEREOF, the parties have executed this License the day and year first above written
5

APPROVED AS TO FORM:
OFFICE OF COUNTY COUNSEL
ORANGE COUNTY, CALIFORNIA

By___________________
Deputy County Counsel

Date: 8/25/16

LICENSEE
CalOptima

By___________________

Name: Michael Schrader
Title: CEO

RECOMMENDED FOR APPROVAL

Social Services Agency

By___________________
Carol Wiseman, Chief Deputy Director

COUNTY

COUNTY OF ORANGE

By___________________
Scott Mayer, Chief Real Estate Officer
County Executive Office
Per Resolution No. 14-014 of the Board of Supervisors and Minute Order dated January 28, 2014

Date: 8.29.16

CEO Real Estate Services

By___________________
John Bock, Administrative Manager

Back to Agenda

GENERAL CONDITIONS (AMLC-GC I-17 S)

1. PERMITS AND LICENSES (AMLC - GC2 S)

LICENSEE shall be required to obtain any and all permits and/or licenses which may be required in connection with the operation of the License Area as set out herein. No permit, approval, or consent given hereunder by COUNTY, in its governmental capacity, shall affect or limit LICENSEE's obligations hereunder, nor shall any approvals or consents given by COUNTY, as a Party to this License, be deemed approval as to compliance or conformance with applicable governmental codes, laws, rules, or regulations.

2. SIGNS (AMLC-GC3 S)

LICENSEE agrees not to construct, maintain, or allow any signs, banners, flags, etc., upon License Area except as approved by Facilities Operations Manager unapproved signs, banners, flags, etc., may be removed.

3. LICENSE ORGANIZATION (AMLC-GC4 S)

The various headings and numbers herein, the grouping of provisions of this License into separate clauses and paragraphs, and the organization hereof, are for the purpose of convenience only and shall not be considered otherwise.

4. AMENDMENTS (AMLC-GC5 S)

This License is the sole and only agreement between the Parties regarding the subject matter hereof; other agreements, either oral or written, are void. Any changes to this License shall be in writing and shall be properly executed by both Parties.

5. UNLAWFUL USE (AMLC-GC6 S)

LICENSEE agrees no improvements shall be erected, placed upon, operated, nor maintained on the License Area, nor any business conducted or carried on therein or there from, in violation of the terms of this License, or of any regulation, order of law, statute, bylaw, or ordinance of a governmental agency having jurisdiction.

6. INSPECTION (AMLC-GC7 S)

COUNTY or its authorized representative shall have the right at all reasonable times to inspect the operation to determine if the provisions of this License are being complied with.

7. INDEMNIFICATION (AMLC-GC8 S)

LICENSEE hereby waives all claims and recourse against COUNTY including the right of contribution for loss or damage of persons or property arising from, growing out of, or in any way connected with or related to this License except claims arising from the concurrent active or sole negligence of COUNTY, its officers, agents, and employees. LICENSEE hereby agrees to indemnify, hold harmless, and defend with counsel acceptable to COUNTY, its officers, agents, and employees against any and all claims, loss, demands, damages, cost, expenses, or liability costs arising out of the operation, use, or maintenance of the property

described herein, and/or LICENSEE's exercise of the rights under this License, except for liability arising out of the concurrent active or sole negligence of COUNTY, its officers, agents, or employees, including the cost of defense of any lawsuit arising there from.

In the event COUNTY is named as co-defendant, LICENSEE shall notify COUNTY of such fact and shall represent COUNTY with counsel acceptable to COUNTY in such legal action unless COUNTY undertakes to represent itself as co-defendant in such legal action, in which event LICENSEE shall pay to COUNTY its litigation costs, expenses, and attorney's fees. In the event judgment is entered against COUNTY and LICENSEE because of the concurrent active negligence of COUNTY and LICENSEE, their officers, agents, or employees, an apportionment of liability to pay such judgment shall be made by a court of competent jurisdiction. Neither Party shall request a jury apportionment.

8. TAXES AND ASSESSMENTS (AMLC-GC9 S)

Although not anticipated, should this License create a possessory interest which is subject to the payment of taxes levied on such interest, it is understood and agreed that all taxes and assessments (including but not limited to said possessory interest tax) which become due and payable in connection with this License or upon fixtures, equipment, or other property used in connection with this License, shall be the full responsibility of LICENSEE, and LICENSEE shall cause said taxes and assessments to be paid promptly.

9. PARTIAL INVALIDITY (AMLC-GC10 S)

If any term, covenant, condition, or provision of this License is held by a court of competent jurisdiction to be invalid, void, or unenforceable, the remainder of the provisions hereof shall remain in full force and effect and shall in no way be affected, impaired, or invalidated thereby.

10. WAIVER OF RIGHTS (AMLC-GC11 S)

The failure of COUNTY to insist upon strict performance of any of the terms, covenants, or conditions of this License shall not be deemed a waiver of any right or remedy that COUNTY may have, and shall not be deemed a waiver of the right to require strict performance of all the terms, covenants, and conditions of the License thereafter, nor a waiver of any remedy for the subsequent breach or default of any term, covenant, or condition of the License. Any waiver, in order to be effective, must be signed by the Party whose right or remedy is being waived.

11. CONDITION OF LICENSE AREA UPON TERMINATION (AMLC-GC12 S)

Except as otherwise agreed to herein, upon termination of this License, LICENSEE shall redeliver possession of said License Area to COUNTY in substantially the same condition that existed immediately prior to LICENSEE's entry thereon, reasonable wear and tear, flood, earthquakes, and any act of war excepted.

12. DISPOSITION OF ABANDONED PERSONAL PROPERTY (AMLC-GC13 S)

If LICENSEE abandons the License Area or is dispossessed thereof by process of law or otherwise, title to any personal property belonging to LICENSEE and left on the License Area ten (10) days after such event shall be deemed, at COUNTY's option, to have been transferred to COUNTY. COUNTY shall have the

1 right to remove and to dispose of such property without liability there from to LICENSEE or to any person claiming under LICENSEE, and shall have no need to account therefore.
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13. TIME OF ESSENCE (AMLC-GC14 S)
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Time is of the essence of this License. Failure to comply with any time requirements of this License shall
7 constitute a material breach of this License.

9 **14. NO ASSIGNMENT (AMLC-G15 S)**

11 The License granted hereby is personal to LICENSEE and any assignment of said license by LICENSEE, voluntarily or by operation of law, shall automatically terminate the License granted hereby.
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15. CHILD SUPPORT ENFORCEMENT REQUIREMENTS (AMLC-GC16 S)
15

In order to comply with child support requirements of the County of Orange, LICENSEE hereby furnishes
17 COUNTY's Facilities Operations Manager, COUNTY's standard form, Child Support Enforcement Certification Requirements. COUNTY acknowledges receipt of the aforementioned form, which contains the
19 following information:

21 a) In the case where LICENSEE is doing business as an individual, LICENSEE's name, date of birth, Social Security number, and residence address;
23

b) In the case where LICENSEE is doing business in a form other than as an individual, the name,
25 date of birth, Social Security number, and residence address of each individual who owns an interest of ten (10) percent or more in the contracting entity;
27

c) A certification that LICENSEE has fully complied with all applicable federal and state reporting
29 requirements regarding its employees; and

31 d) A certification that LICENSEE has fully complied with all lawfully served Wage and Earnings Assignment Orders and Notices of Assignment and will continue to so comply.
33

Failure of LICENSEE to continuously comply with all federal and state reporting requirements for child
35 support enforcement or to comply with all lawfully served Wage and Earnings Assignment Orders and Notices of Assignment shall constitute a material breach of this License. Failure to cure such breach within
37 sixty (60) calendar days of notice from COUNTY's shall constitute grounds for termination of this License.

39 It is expressly understood that this data will be transmitted to governmental agencies charged with the establishment and enforcement of child support orders and will not be used for any other purpose.
41

16. RIGHT TO WORK AND MINIMUM WAGE LAWS (AMLC-GC17 S)
43

In accordance with the United States Immigration Reform and Control Act of 1986, LICENSEE shall require
45 its employees that directly or indirectly service the License Area or terms and conditions of this License, in any manner whatsoever, to verify their identity and eligibility for employment in the United States.
47 LICENSEE shall also require and verify that its contractors or any other persons servicing the License Area

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1 or terms and conditions of this License, in any manner whatsoever, verify the identity of their employees and their eligibility for employment in the United States.

3

Pursuant to the United States of America Fair Labor Standard Act of 1938, as amended, and State of California Labor Code, Section 1178.5, LICENSEE shall pay no less than the greater of the Federal or California Minimum Wage to all its employees that directly or indirectly service the License Area, in any manner whatsoever. LICENSEE shall require and verify that all its contractors or other persons servicing the License Area on behalf of LICENSEE also pay their employees no less than the greater of the Federal or California Minimum Wage.

LICENSEE shall comply and verify that its contractors comply with all other Federal and State of California laws for minimum wage, overtime pay, record keeping, and child labor standards pursuant to the servicing of the License Area or terms and conditions of this License.

Notwithstanding the minimum wage requirements provided for in this clause, LICENSEE, where applicable, shall comply with the prevailing wage and related requirements pursuant to the provisions of Section 1773 of the Labor Code of the State of California.

17. BEST MANAGEMENT PRACTICES (AMLC 15.1 S)

LICENSEE and all of LICENSEE's, agents, employees and contractors shall conduct operations under this License so as to assure that pollutants do not enter municipal storm drain systems which systems are comprised of, but are not limited to curbs and gutters that are part of the street systems ("**Stormwater Drainage System**"), and to ensure that pollutants do not directly impact "**Receiving Waters**" (as used herein, Receiving Waters include, but are not limited to, rivers, creeks, streams, estuaries, lakes, harbors, bays and oceans).

The Santa Ana and San Diego Regional Water Quality Control Boards have issued National Pollutant Discharge Elimination System ("**NPDES**") permits ("**Stormwater Permits**") to the County of Orange, and to the Orange County Flood Control District and cities within Orange County, as co-permittees (hereinafter collectively referred to as "**County Parties**") which regulate the discharge of urban runoff from areas within the County of Orange, including the License Area. The County Parties have enacted water quality ordinances that prohibit conditions and activities that may result in polluted runoff being discharged into the Stormwater Drainage System.

To assure compliance with the Stormwater Permits and water quality ordinances, the County Parties have developed a Drainage Area Management Plan ("**DAMP**") which includes a Local Implementation Plan ("**LIP**") for each jurisdiction that contains Best Management Practices ("**BMP(s)**") that parties using properties within Orange County must adhere to. As used herein, a BMP is defined as a technique, measure, or structural control that is used for a given set of conditions to manage the quantity and improve the quality of stormwater runoff in a cost effective manner. These BMPs are found within the COUNTY's LIP in the form of Model Maintenance Procedures and BMP Fact Sheets (the Model Maintenance Procedures and BMP Fact Sheets contained in the DAMP/LIP shall be referred to hereinafter collectively as "**BMP Fact Sheets**") and contain pollution prevention and source control techniques to eliminate non-stormwater discharges and minimize the impact of pollutants on stormwater runoff.

The use under this License does not require BMP Fact Sheets.

1 **18. PAYMENT CARD COMPLIANCE (AMLC-G15 S)**

3 Should LICENSEE conduct credit/debit card transactions in conjunction with their business with the COUNTY, on behalf of the COUNTY, or as part of the business that they conduct, LICENSEE covenants
5 and warrants that it is currently Payment Card Industry Data Security Standard (**"PCI DSS"**) and Payment Application Data Security Standards (**"PA DSS"**) compliant and will remain compliant during the entire
7 duration of this License. LICENSEE agrees to immediately notify COUNTY in the event LICENSEE should ever become non-compliant, and will take all necessary steps to return to compliance and shall be
9 compliant within ten (10) days of the commencement of any such interruption.

11 Upon demand by COUNTY, LICENSEE shall provide to COUNTY written certification of LICENSEE's PCI DSS and/or PA DSS compliance.

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Back to Agenda

Back to Agenda

LICENSE DESCRIPTION (10.1 S)

PROJECT NO: GA 1213-236

DATE: 6/29/16

PROJECT: CalOptima
15496 Magnolia, #111
Westminster, CA 92806

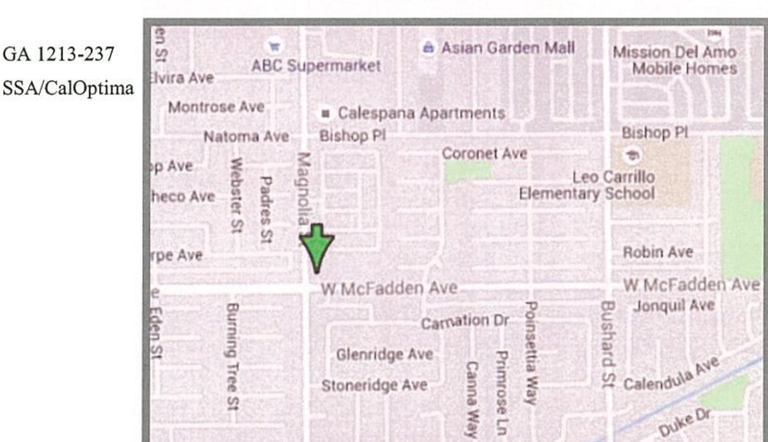
WRITTEN BY: EAS

All the License Area referenced on a Floor Plan marked Exhibit B, attached hereto and made a part hereof, being approximately Three Hundred Sixty Two (362) rentable square feet of COUNTY-designated space for LICENSEE's non-exclusive use, which space may vary from time-to-time based on COUNTY's pre-approval in writing, and being a portion of the Orange County Community Service Center Annex building located at 15496 Magnolia, Suite 111, Rooms 1 and 2 in the City of Westminster, County of Orange, State of California, together with appurtenant right to use common areas located thereon, and the non-exclusive use of one parking space in the adjacent parking lot.

NOT TO BE RECORDED

EXHIBIT A

GA 1213-237
SSA/CalOptima



License Area:
Rooms 1 & 2

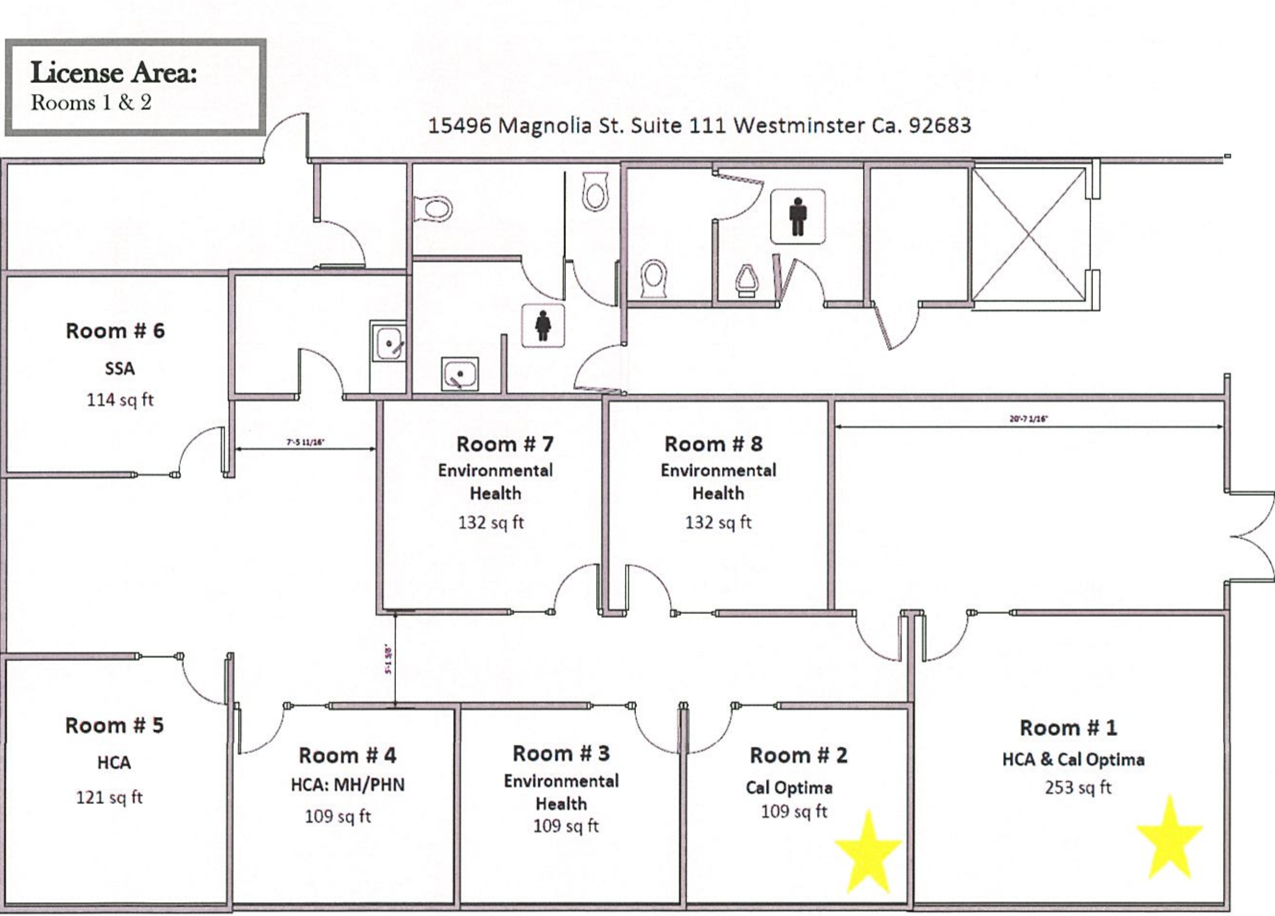


EXHIBIT B

CCSC COST APPLY - 15496 Magnolia Street, Westminster

FY 2017-18 MONTHLY INVOICE CODING SUMMARY

Invoice Coding and Job Number Allocation.

	Fund/Dept/Budget Control Unit/Object/Job No.	July 2017	August 2017	September 2017	October 2017	November 2017	December 2017	January 2018	February 2018	March 2018	April 2018	May 2018	June 2018	Annual Total
CalOptima	100/063/063 2211/2200/S34009	$ 1,560.98	$ 1,560.98	$ 1,560.98	$ 1,560.98	$ 1,560.98	$ 1,560.98	$ 1,560.98	$ 1,560.98	$ 1,560.98	$ 1,560.98	$ 1,560.98	$ 1,560.98	**$ 18,731.77**

LEASED SPACE	Fund/Dept/Budget Control /Unit/Object/Job No	sq ft	Allocation %	July 2017	August 2017	September 2017	October 2017	November 2017	December 2017	January 2018	February 2018	March 2018	April 2018	May 2018	June 2018	Annual Total
Cal Optima	**100/063/063 2211/2200/S34009**	**235.55**	**21.83%**	**$ 1,424.19**	**$ 1,424.19**	**$ 1,424.19**	**$ 1,424.19**	**$ 1,424.19**	**$ 1,424.19**	**$ 1,424.19**	**$ 1,424.19**	**$ 1,424.19**	**$ 1,424.19**	**$ 1,424.19**	**$ 1,424.19**	**$ 17,090.27**

Total leased space: 1079 sq. ft.

Lease rates: Monthly / Fiscal Year total:

Rent: July 1, 2017 - June 30, 2018 $ 6,524.00 $ 78,288.00

Operating Expenses charge by Charles H Manh and Anh Manh	Fund/Dept/Budget Control /Unit/Object/Job No	sq ft	Allocation %	July 2017	August 2017	September 2017	October 2017	November 2017	December 2017	January 2018	February 2018	March 2018	April 2018	May 2018	June 2018	Annual Total
Cal Optima	**100/063/063 2211/1000/S34009**	**235.55**	**21.83%**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**

Total leased space: 1079 sq. ft.

Monthly / Fiscal Year total:

Operating Expenses: July 1 2017 - June 30, 2018 $ - $ -

IT SERVICES - Internet by Time W	Fund/Dept/Budget Control /Unit/Object	# computers	Allocation %	July 2017	August 2017	September 2017	October 2017	November 2017	December 2017	January 2018	February 2018	March 2018	April 2018	May 2018	June 2018	Annual Total
Cal Optima	**100/063/063 2211/1000/S34009**	**1**	**16.67%**	**$ 65.84**	**$ 65.84**	**$ 65.84**	**$ 65.84**	**$ 65.84**	**$ 65.84**	**$ 65.84**	**$ 65.84**	**$ 65.84**	**$ 65.84**	**$ 65.84**	**$ 65.84**	**$ 790.02**

Monthly IT rates $ 395.01 2016-17 Rate + 2.60% CPI

Annual High Speed Internet Service Cost $ 4,740.12

TELEPHONE SERVICES	Fund/Dept/Budget Control /Unit/Object	# phones	Allocation %	July 2017	August 2017	September 2017	October 2017	November 2017	December 2017	January 2018	February 2018	March 2018	April 2018	May 2018	June 2018	Annual Total
Cal Optima	**100/063/063 2211/1000/S34009**	**1**	**12.50%**	**$ 19.27**	**$ 19.27**	**$ 19.27**	**$ 19.27**	**$ 19.27**	**$ 19.27**	**$ 19.27**	**$ 19.27**	**$ 19.27**	**$ 19.27**	**$ 19.27**	**$ 19.27**	**$ 231.25**

Monthly Average Telephone Service Costs $ 154.17 2016-17 Rate + 2.60% CPI

Annual Telephone Service Costs $ 1,850.00

Back to Agenda

JANITORIAL SERVICES	Fund/Dept/Budget Control /Unit/Object	sq ft	Allocation %	July 2017	August 2017	September 2017	October 2017	November 2017	December 2017	January 2018	February 2018	March 2018	April 2018	May 2018	June 2018	Annual Total		
Cal Optima	**100/063/063 2211/1000/S34009**	**235.55**	**21.83%**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**		

Total leased space: 1079 sq. ft.

Monthly Janitorial Costs $ - 2016-17 Rate + 2.60% CPI
12 mo. Annual Janitorial Costs $ -

ELECTRICAL/UTILITIES Acct 3045332860 by Al Pasillas	Fund/Dept/Budget Control /Unit/Object	sq ft	Allocation %	July 2017	August 2017	September 2017	October 2017	November 2017	December 2017	January 2018	February 2018	March 2018	April 2018	May 2018	June 2018	Annual Total		
Cal Optima	**100/063/063 2211/1000/S34009**	**235.55**	**21.83%**	**$ 51.69**	**$ 51.69**	**$ 51.69**	**$ 51.69**	**$ 51.69**	**$ 51.69**	**$ 51.69**	**$ 51.69**	**$ 51.69**	**$ 51.69**	**$ 51.69**	**$ 51.69**	**$ 620.23**		

Total leased space: 1079 sq. ft.

Average Utility Costs $ 236.76 2016-17 Rate + 2.60% CPI
12 mo. Annual Janitorial Costs $ 2,841.17

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item
35. Consider Adoption of Resolution Approving Updated Human Resources Policy GA. 8058: Salary Schedule and Proposed Market Adjustments

Contact
Ladan Khamseh, Chief Operations Officer (714) 246-8400
Vicki Hewlett, Interim Director Human Resources (714) 246-8400

Recommended Actions
1. Adopt Resolution Approving CalOptima's Updated Human Resources Policy GA. 8058: Salary Schedule;
2. Approve proposed market adjustments for various positions.

Background
On November 1, 1994, the Board of Directors delegated authority to the Chief Executive Officer to promulgate employee policies and procedures, and to amend these policies from time to time, subject to annual presentation of the policies and procedures, with specific emphasis on any changes thereto, to the Board of Directors or a committee appointed by the Board of Directors for that purpose. On December 6, 1994, the Board adopted CalOptima's Bylaws, which requires, pursuant to section 13.1, that the Board of Directors adopt by resolution, and from time to time amend, procedures, practices and policies for, among other things, hiring employees and managing personnel.

Pursuant to the California Code of Regulations, Title 2, Section 570.5, CalOptima is required to adopt a publicly available pay schedule that meets the requirements set forth by the California Public Employees' Retirement System (CalPERS) to reflect recent changes, including the addition or deletion of positions and revisions to wage grades for certain positions.

The following table lists an existing Human Resources policy that has been updated and is being presented for review and approval.

	Policy No./Name	Summary of Changes	Reason for Change
1.	GA. 8058: Salary Schedule	• This policy focuses solely on CalOptima's Salary Schedule and requirements under CalPERS regulations. • Attachment 1 – Salary Schedule has been revised in order to reflect recent changes to the Salary Schedule, including the deletion of positions. A summary of the	- Pursuant to CalPERS requirement, 2 CCR §570.5, CalOptima periodically updates the salary schedule to reflect current job titles and pay rates for each job position. - There are changes to two (2) positions indicated on

	Policy No./Name	Summary of Changes	Reason for Change
		changes to the Salary Schedule is included for reference.	the attached revised Salary Schedule. - Remove Position: Elimination of a Job Title typically due to a change in the scope of a current position or the elimination of position in a job family. (2 positions)

Market Adjustments

Staff recommends one (1) market adjustment for Director Customer Service to address recruitment and retention issues, and one (1) market adjustment for Director Grievance & Appeals after the Human Resources Department conducted a market study resulting in the recommendation to adjust target compensation to reflect increased subject matter complexity and job scope.

Fiscal Impact

The total cost for the market adjustments effective on or after the pay period ending June 24, 2017 is $487.58. Unspent budgeted funds for salaries and benefits approved in the CalOptima FY 2016-17 Operating Budget on June 2, 2016, will fund the salary adjustments.

The estimated annual cost is $12,677.12. Funding for the salary adjustments is an unbudgeted item in the CalOptima FY 2017-18 Operating Budget. Staff anticipates that unspent budgeted funds for salaries and benefits in the FY 2017-18 Operating Budget pending Board approval will fund the salary adjustments through June 30, 2018.

Rationale for Recommendation

The recommended market adjustments is retain well qualified staff. Pursuant to the Compensation Administration Guidelines, adopted as part of CalOptima Policy GA. 8057: Compensation Program, approval by the Board of Directors is required as part of the process for market adjustments, which are not part of the regular merit process. Recommendations are made based on extensive review by CalOptima's Resources Workgroup consistent with the market adjustment process to ensure that CalOptima remains competitive with market trends and meets its ongoing obligation to provide structure and clarity on employment matters, consistent with applicable federal, state, and local laws and regulations. These policies serve as a framework for CalOptima's operations.

Concurrence

Gary Crockett, Chief Counsel

Back to Agenda

Attachments

1. Resolution No. 17-0601-03, Approve Updated Human Resources Policy
2. Revised CalOptima Policy:
   a. GA.8058: Salary Schedule – (redlined and clean) with revised Attachment
3. Summary of Changes to the Salary Schedule and Market Adjustments

/s/ Michael Schrader *5/25/2017*
Authorized Signature **Date**

RESOLUTION NO. 17-0601-03

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

APPROVE UPDATED HUMAN RESOURCES POLICY

WHEREAS, section 13.1 of the Bylaws of the Orange County Health Authority, dba CalOptima, provide that the Board of Directors shall adopt by resolution, and may from time to time amend, procedures, practices and policies for, inter alia, hiring employees, and managing personnel; and

WHEREAS, in 1994, the Board of Directors designated the Chief Executive Officer as the Appointing Authority with full power to hire and terminate CalOptima employees at will, to set compensation within the boundaries of the budget limits set by the Board, to promulgate employee policies and procedures, and to amend said policies and procedures from time to time, subject to annual review by the Board of Directors, or a committee appointed by the Board for that purpose; and

WHEREAS, California Code of Regulations, Title 2, Section 570.5, requires CalOptima to adopt a publicly available pay schedule that identifies the position title and pay rate for every employee position, and CalOptima regularly reviews CalOptima's salary schedule accordingly.

NOW, THEREFORE, BE IT RESOLVED:

Section 1. That the Board of Directors hereby approves and adopts the attached updated Human Resources Policy: GA.8058 Salary Schedule.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a., CalOptima this 1st day of June, 2017.

AYES:
NOES:
ABSENT:
ABSTAIN:

/s/___________________________________
Title: Chair, Board of Directors
Printed Name and Title: Paul Yost M.D., Chair, CalOptima Board of Directors

Attest:
/s/_____________________________________
Suzanne Turf, Clerk of the Board

Back to Agenda

Policy #: GA.8058
Title: **Salary Schedule**
Department: Human Resources
Section: Not Applicable

CEO Approval: Michael Schrader ________

Effective Date: 05/01/14
Last Review Date: 06/01/17
Last Revised Date: ~~05/04/17~~
06/01/17
~~05/04/17~~

~~*Board Approved Policy*~~

I. PURPOSE

A. This policy maintains a CalOptima Salary Schedule that lists all active job classifications including job title, salary grade, and salary ranges (minimum, midpoint, and maximum pay rate amounts).

B. This policy ensures the salary schedule is publicly available pursuant to the requirements of Title 2, California Code of Regulations (CCR) §570.5 so that employees who are members of the California Public Employees Retirement System (CalPERS) have their compensation considered qualified for pension calculation under CalPERS regulations.

II. POLICY

A. Pursuant to the requirements under Title 2, California Code of Regulations (CCR) §570.5, CalOptima has established the attached salary schedule for each CalOptima job position. In order for CalPERS member's pay rates to be credited by CalPERS, the Human Resources Department (HR) shall maintain a salary schedule that meets the following eight (8) separate criteria:

1. Approval and adoption by the governing body in accordance with requirements applicable to public meetings laws;

2. Identification of position titles for every employee position;

3. Listing of pay rate for each identified position, which may be stated as a single amount or as multiple amounts with a range;

4. Specifies the time base, including, but not limited to, whether the time base is hourly, daily, bi-weekly, monthly, bi-monthly, or annually;

5. Posted at the employer's office or immediately accessible and available for public review from the employer during normal business hours or posted on the employer's internet website;

6. Indicates the effective date and date of any revisions;

7. Retained by the employer and available for public inspection for not less than five (5) years; and

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1
2 8. Does not reference another document in lieu of disclosing the pay rate.
3
4 B. The Chief Executive Officer (CEO) is authorized and directed to take all steps necessary and proper
5 to implement the salary schedule for all other employees not inconsistent therewith.
6
7 **III. PROCEDURE**
8
9 A. The Human Resources Department (HR) will ensure that the salary schedule, meeting the
10 requirements above, are available at CalOptima's offices and immediately accessible for public
11 review during normal business hours or posted on CalOptima's internet website.
12
13 B. HR shall retain the salary schedule for not less than five (5) years.
14
15 C. HR shall review the salary schedule and provide recommendations to maintain the competitiveness
16 of the salary schedule to market pay levels.
17
18 D. Any adjustments to the salary schedule requires that the Executive Director of HR make a
19 recommendation to the CEO for approval, with the CEO taking the recommendation to the
20 CalOptima Board of Directors for final approval. No changes to the salary schedule, or CEO
21 compensation, shall be effective unless and until approved by the CalOptima Board of Directors.
22
23 **IV. ATTACHMENTS**
24
25 A. CalOptima - Salary Schedule (Revised as of 06/01/1705/04/17)
26
27 **V. REFERENCES**
28
29 A. Title 2, California Code of Regulations, §570.5
30
31 **VI. REGULATORY AGENCY APPROVALS**
32
33 None to Date
34
35 **VII. BOARD ACTIONS**
36
37 A. 06/01/17: Regular Meeting of the CalOptima Board of Directors
38 A.B. 05/04/17: Regular Meeting of the CalOptima Board of Directors
39 B.C. 03/02/17: Regular Meeting of the CalOptima Board of Directors
40 C.D. 12/01/16: Regular Meeting of the CalOptima Board of Directors
41 D.E. 11/03/16: Regular Meeting of the CalOptima Board of Directors
42 E.F. 10/06/16: Regular Meeting of the CalOptima Board of Directors
43 F.G. 09/01/16: Regular Meeting of the CalOptima Board of Directors
44 G.H. 08/04/16: Regular Meeting of the CalOptima Board of Directors
45 H.I. 06/02/16: Regular Meeting of the CalOptima Board of Directors
46 I.J. 03/03/16: Regular Meeting of the CalOptima Board of Directors
47 J.K. 12/03/15: Regular Meeting of the CalOptima Board of Directors
48 K.L. 10/01/15: Regular Meeting of the CalOptima Board of Directors
49 L.M. 06/04/15: Regular Meeting of the CalOptima Board of Directors
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2 **VIII. REVIEW/REVISION HISTORY**
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Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	05/01/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	08/07/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	11/06/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	12/04/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	03/05/2015	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	06/04/2015	GA.8058	Salary Schedule	Administrative
Revised	10/01/2015	GA.8058	Salary Schedule	Administrative
Revised	12/03/2015	GA.8058	Salary Schedule	Administrative
Revised	03/03/2016	GA.8058	Salary Schedule	Administrative
Revised	06/02/2016	GA.8058	Salary Schedule	Administrative
Revised	08/04/2016	GA.8058	Salary Schedule	Administrative
Revised	09/01/2016	GA.8058	Salary Schedule	Administrative
Revised	10/06/2016	GA.8058	Salary Schedule	Administrative
Revised	11/03/2016	GA.8058	Salary Schedule	Administrative
Revised	12/01/2016	GA.8058	Salary Schedule	Administrative
Revised	03/02/2017	GA.8058	Salary Schedule	Administrative
Revised	05/04/2017	GA.8058	Salary Schedule	Administrative
Revised	06/01/2017	GA.8058	Salary Schedule	Administrative

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1 **IX. GLOSSARY**
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3 Not Applicable
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Policy #:	GA.8058
Title:	**Salary Schedule**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	Michael Schrader _______
Effective Date:	05/01/14
Last Review Date:	06/01/17
Last Revised Date:	06/01/17

DRAFT

I. PURPOSE

A. This policy maintains a CalOptima Salary Schedule that lists all active job classifications including job title, salary grade, and salary ranges (minimum, midpoint, and maximum pay rate amounts).

B. This policy ensures the salary schedule is publicly available pursuant to the requirements of Title 2, California Code of Regulations (CCR) §570.5 so that employees who are members of the California Public Employees Retirement System (CalPERS) have their compensation considered qualified for pension calculation under CalPERS regulations.

II. POLICY

A. Pursuant to the requirements under Title 2, California Code of Regulations (CCR) §570.5, CalOptima has established the attached salary schedule for each CalOptima job position. In order for CalPERS member's pay rates to be credited by CalPERS, the Human Resources Department (HR) shall maintain a salary schedule that meets the following eight (8) separate criteria:

1. Approval and adoption by the governing body in accordance with requirements applicable to public meetings laws;

2. Identification of position titles for every employee position;

3. Listing of pay rate for each identified position, which may be stated as a single amount or as multiple amounts with a range;

4. Specifies the time base, including, but not limited to, whether the time base is hourly, daily, bi-weekly, monthly, bi-monthly, or annually;

5. Posted at the employer's office or immediately accessible and available for public review from the employer during normal business hours or posted on the employer's internet website;

6. Indicates the effective date and date of any revisions;

7. Retained by the employer and available for public inspection for not less than five (5) years; and

8. Does not reference another document in lieu of disclosing the pay rate.

B. The Chief Executive Officer (CEO) is authorized and directed to take all steps necessary and proper to implement the salary schedule for all other employees not inconsistent therewith.

III. PROCEDURE

A. The Human Resources Department (HR) will ensure that the salary schedule, meeting the requirements above, are available at CalOptima's offices and immediately accessible for public review during normal business hours or posted on CalOptima's internet website.

B. HR shall retain the salary schedule for not less than five (5) years.

C. HR shall review the salary schedule and provide recommendations to maintain the competitiveness of the salary schedule to market pay levels.

D. Any adjustments to the salary schedule requires that the Executive Director of HR make a recommendation to the CEO for approval, with the CEO taking the recommendation to the CalOptima Board of Directors for final approval. No changes to the salary schedule, or CEO compensation, shall be effective unless and until approved by the CalOptima Board of Directors.

IV. ATTACHMENTS

A. CalOptima - Salary Schedule (Revised as of 06/01/17)

V. REFERENCES

A. Title 2, California Code of Regulations, §570.5

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. 06/01/17: Regular Meeting of the CalOptima Board of Directors
B. 05/04/17: Regular Meeting of the CalOptima Board of Directors
C. 03/02/17: Regular Meeting of the CalOptima Board of Directors
D. 12/01/16: Regular Meeting of the CalOptima Board of Directors
E. 11/03/16: Regular Meeting of the CalOptima Board of Directors
F. 10/06/16: Regular Meeting of the CalOptima Board of Directors
G. 09/01/16: Regular Meeting of the CalOptima Board of Directors
H. 08/04/16: Regular Meeting of the CalOptima Board of Directors
I. 06/02/16: Regular Meeting of the CalOptima Board of Directors
J. 03/03/16: Regular Meeting of the CalOptima Board of Directors
K. 12/03/15: Regular Meeting of the CalOptima Board of Directors
L. 10/01/15: Regular Meeting of the CalOptima Board of Directors
M. 06/04/15: Regular Meeting of the CalOptima Board of Directors

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VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	05/01/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	08/07/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	11/06/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	12/04/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	03/05/2015	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	06/04/2015	GA.8058	Salary Schedule	Administrative
Revised	10/01/2015	GA.8058	Salary Schedule	Administrative
Revised	12/03/2015	GA.8058	Salary Schedule	Administrative
Revised	03/03/2016	GA.8058	Salary Schedule	Administrative
Revised	06/02/2016	GA.8058	Salary Schedule	Administrative
Revised	08/04/2016	GA.8058	Salary Schedule	Administrative
Revised	09/01/2016	GA.8058	Salary Schedule	Administrative
Revised	10/06/2016	GA.8058	Salary Schedule	Administrative
Revised	11/03/2016	GA.8058	Salary Schedule	Administrative
Revised	12/01/2016	GA.8058	Salary Schedule	Administrative
Revised	03/02/2017	GA.8058	Salary Schedule	Administrative
Revised	05/04/2017	GA.8058	Salary Schedule	Administrative
Revised	06/01/2017	GA.8058	Salary Schedule	Administrative

1 **IX. GLOSSARY**
2
3 Not Applicable
4

CalOptima - Annual Base Salary Schedule - Revised June 1, 2017
Effective as of May 1, 2014

	Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
	Accountant	K	39	$47,112	$61,360	$75,504	
	Accountant Int	L	634	$54,288	$70,512	$86,736	
	Accountant Sr	M	68	$62,400	$81,120	$99,840	
	Accounting Clerk	I	334	$37,128	$46,384	$55,640	
	Actuarial Analyst	L	558	$54,288	$70,512	$86,736	
	Actuarial Analyst Sr	M	559	$62,400	$81,120	$99,840	
	Actuary	O	357	$82,576	$107,328	$131,976	
	Administrative Assistant	H	19	$33,696	$42,224	$50,648	
	Analyst	K	562	$47,112	$61,360	$75,504	
	Analyst Int	L	563	$54,288	$70,512	$86,736	
	Analyst Sr	M	564	$62,400	$81,120	$99,840	
	Applications Analyst	K	232	$47,112	$61,360	$75,504	
	Applications Analyst Int	L	233	$54,288	$70,512	$86,736	
	Applications Analyst Sr	M	298	$62,400	$81,120	$99,840	
	Associate Director Customer Service	O	593	$82,576	$107,328	$131,976	
	Associate Director Information Services	Q	557	$114,400	$154,440	$194,480	
	Associate Director Provider Network	O	647	$82,576	$107,328	$131,976	
	Auditor	K	565	$47,112	$61,360	$75,504	
	Auditor Sr	L	566	$54,288	$70,512	$86,736	
	Behavioral Health Manager	N	383	$71,760	$93,184	$114,712	
	Biostatistics Manager	N	418	$71,760	$93,184	$114,712	
	Board Services Specialist	J	435	$40,976	$53,352	$65,624	
	Business Analyst	J	40	$40,976	$53,352	$65,624	
	Business Analyst Sr	M	611	$62,400	$81,120	$99,840	
	Business Systems Analyst Sr	M	69	$62,400	$81,120	$99,840	
	Buyer	J	29	$40,976	$53,352	$65,624	
	Buyer Int	K	49	$47,112	$61,360	$75,504	
	Buyer Sr	L	67	$54,288	$70,512	$86,736	
	Care Transition Intervention Coach (RN)	N	417	$71,760	$93,184	$114,712	
	Certified Coder	K	399	$47,112	$61,360	$75,504	
	Certified Coding Specialist	K	639	$47,112	$61,360	$75,504	
	Certified Coding Specialist Sr	L	640	$54,288	$70,512	$86,736	
	Change Control Administrator	L	499	$54,288	$70,512	$86,736	
	Change Control Administrator Int	M	500	$62,400	$81,120	$99,840	
	Change Management Analyst Sr	N	465	$71,760	$93,184	$114,712	
**	Chief Counsel	T	132	$197,704	$266,968	$336,024	
**	Chief Executive Officer	V	138	$319,740	$431,600	$543,600	
**	Chief Financial Officer	U	134	$237,224	$320,216	$403,312	
**	Chief Information Officer	T	131	$197,704	$266,968	$336,024	
**	Chief Medical Officer	U	137	$237,224	$320,216	$403,312	
**	Chief Operating Officer	U	136	$237,224	$320,216	$403,312	
	Claims - Lead	J	574	$40,976	$53,352	$65,624	
	Claims Examiner	H	9	$33,696	$42,224	$50,648	
	Claims Examiner - Lead	J	236	$40,976	$53,352	$65,624	
	Claims Examiner Sr	I	20	$37,128	$46,384	$55,640	
	Claims QA Analyst	I	28	$37,128	$46,384	$55,640	
	Claims QA Analyst Sr.	J	540	$40,976	$53,352	$65,624	
	Claims Recovery Specialist	I	283	$37,128	$46,384	$55,640	
	Claims Resolution Specialist	I	262	$37,128	$46,384	$55,640	
	Clerk of the Board	O	59	$82,576	$107,328	$131,976	
	Clinical Auditor	M	567	$62,400	$81,120	$99,840	
	Clinical Auditor Sr	N	568	$71,760	$93,184	$114,712	
	Clinical Documentation Specialist (RN)	O	641	$82,576	$107,328	$131,976	
	Clinical Pharmacist	P	297	$95,264	$128,752	$162,032	

Back to Agenda

CalOptima - Annual Base Salary Schedule - Revised June 1, 2017
Effective as of May 1, 2014

	Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
	Clinical Systems Administrator	M	607	$62,400	$81,120	$99,840	
	Clinician (Behavioral Health)	M	513	$62,400	$81,120	$99,840	
	Communications Specialist	J	188	$40,976	$53,352	$65,624	
	Community Partner	K	575	$47,112	$61,360	$75,504	
	Community Partner Sr	L	612	$54,288	$70,512	$86,736	
	Community Relations Specialist	J	288	$40,976	$53,352	$65,624	
	Community Relations Specialist Sr	K	646	$47,112	$61,360	$75,504	
	Compliance Claims Auditor	K	222	$47,112	$61,360	$75,504	
	Compliance Claims Auditor Sr	L	279	$54,288	$70,512	$86,736	
	Contract Administrator	M	385	$62,400	$81,120	$99,840	
	Contracts Manager	N	207	$71,760	$93,184	$114,712	
	Contracts Specialist	K	257	$47,112	$61,360	$75,504	
	Contracts Specialist Int	L	469	$54,288	$70,512	$86,736	
	Contracts Specialist Sr	M	331	$62,400	$81,120	$99,840	
*	Controller	Q	464	$114,400	$154,440	$194,480	
	Credentialing Coordinator	J	41	$40,976	$53,352	$65,624	
	Credentialing Coordinator - Lead	J	510	$40,976	$53,352	$65,624	
	Customer Service Coordinator	J	182	$40,976	$53,352	$65,624	
	Customer Service Rep	H	5	$33,696	$42,224	$50,648	
	Customer Service Rep - Lead	J	482	$40,976	$53,352	$65,624	
	Customer Service Rep Sr	I	481	$37,128	$46,384	$55,640	
	Data Analyst	K	337	$47,112	$61,360	$75,504	
	Data Analyst Int	L	341	$54,288	$70,512	$86,736	
	Data Analyst Sr	M	342	$62,400	$81,120	$99,840	
	Data and Reporting Analyst - Lead	O	TBD	$82,576	$107,328	$131,976	
	Data Entry Tech	F	3	$27,872	$34,840	$41,808	
	Data Warehouse Architect	O	363	$82,576	$107,328	$131,976	
	Data Warehouse Programmer/Analyst	O	364	$82,576	$107,328	$131,976	
	Data Warehouse Project Manager	O	362	$82,576	$107,328	$131,976	
	Data Warehouse Reporting Analyst	N	412	$71,760	$93,184	$114,712	
	Data Warehouse Reporting Analyst Sr	O	522	$82,576	$107,328	$131,976	
	Database Administrator	M	90	$62,400	$81,120	$99,840	
	Database Administrator Sr	O	179	$82,576	$107,328	$131,976	
**	Deputy Chief Counsel	S	160	$164,736	$222,352	$280,072	
**	Deputy Chief Medical Officer	T	561	$197,704	$266,968	$336,024	
*	Director Accounting	P	122	$95,264	$128,752	$162,032	
*	Director Applications Management	R	170	$137,280	$185,328	$233,376	
*	Director Audit & Oversight	Q	546	$114,400	$154,440	$194,480	
*	Director Behavioral Health Services	P	392	$95,264	$128,752	$162,032	
*	Director Budget and Procurement	Q	527	$114,400	$154,440	$194,480	
*	Director Business Development	P	351	$95,264	$128,752	$162,032	
*	Director Business Integration	Q	543	$114,400	$154,440	$194,480	
*	Director Case Management	Q	318	$114,400	$154,440	$194,480	
*	Director Claims Administration	P	112	$95,264	$128,752	$162,032	
*	Director Clinical Outcomes	Q	602	$114,400	$154,440	$194,480	
*	Director Clinical Pharmacy	R	129	$137,280	$185,328	$233,376	
*	Director Coding Initiatives	P	375	$95,264	$128,752	$162,032	
*	Director Communications	P	361	$95,264	$128,752	$162,032	
*	Director Community Relations	P	292	$95,264	$128,752	$162,032	
*	Director Configuration & Coding	Q	596	$114,400	$154,440	$194,480	
*	Director Contracting	P	184	$95,264	$128,752	$162,032	
*	Director COREC	Q	369	$114,400	$154,440	$194,480	
*	Director Customer Service	P	118	$95,264	$128,752	$162,032	
*	Director Electronic Business	P	358	$95,264	$128,752	$162,032	

Back to Agenda

	Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
*	Director Enterprise Analytics	Q	520	$114,400	$154,440	$194,480	
*	Director Facilities	P	428	$95,264	$128,752	$162,032	
*	Director Finance & Procurement	P	157	$95,264	$128,752	$162,032	
*	Director Financial Analysis	R	374	$137,280	$185,328	$233,376	
*	Director Financial Compliance	P	460	$95,264	$128,752	$162,032	
*	Director Fraud Waste & Abuse and Privacy	Q	581	$114,400	$154,440	$194,480	
*	Director Government Affairs	P	277	$95,264	$128,752	$162,032	
*	Director Grievance & Appeals	P	528	$95,264	$128,752	$162,032	
*	Director Health Education & Disease Management	Q	150	$114,400	$154,440	$194,480	
*	Director Health Services	Q	328	$114,400	$154,440	$194,480	
*	Director Human Resources	Q	322	$114,400	$154,440	$194,480	
*	Director Information Services	R	547	$137,280	$185,328	$233,376	
*	Director Long Term Support Services	Q	128	$114,400	$154,440	$194,480	
*	Director Medi-Cal Plan Operations	P	370	$95,264	$128,752	$162,032	
*	Director Network Management	P	125	$95,264	$128,752	$162,032	
*	Director OneCare Operations	P	425	$95,264	$128,752	$162,032	
*	Director Organizational Training & Education	P	579	$95,264	$128,752	$162,032	
*	Director PACE Program	Q	449	$114,400	$154,440	$194,480	
*	Director Process Excellence	Q	447	$114,400	$154,440	$194,480	
*	Director Program Implementation	Q	489	$114,400	$154,440	$194,480	
*	Director Project Management	Q	447	$114,400	$154,440	$194,480	
*	Director Provider Data Quality	Q	TBD	$114,400	$154,440	$194,480	
*	Director Provider Services	P	597	$95,264	$128,752	$162,032	
*	Director Public Policy	P	459	$95,264	$128,752	$162,032	
*	Director Quality (LTSS)	Q	613	$114,400	$154,440	$194,480	
*	Director Quality Analytics	Q	591	$114,400	$154,440	$194,480	
*	Director Quality Improvement	Q	172	$114,400	$154,440	$194,480	
*	Director Regulatory Affairs and Compliance	Q	625	$114,400	$154,440	$194,480	
*	Director Strategic Development	P	121	$95,264	$128,752	$162,032	
*	Director Systems Development	R	169	$137,280	$185,328	$233,376	
*	Director Utilization Management	Q	265	$114,400	$154,440	$194,480	
	Disease Management Coordinator	M	70	$62,400	$81,120	$99,840	
	Disease Management Coordinator - Lead	M	472	$62,400	$81,120	$99,840	
	EDI Project Manager	O	403	$82,576	$107,328	$131,976	
	Enrollment Coordinator (PACE)	K	441	$47,112	$61,360	$75,504	
	Enterprise Analytics Manager	P	582	$95,264	$128,752	$162,032	
	Executive Assistant	K	339	$47,112	$61,360	$75,504	
	Executive Assistant to CEO	L	261	$54,288	$70,512	$86,736	
**	Executive Director Clinical Operations	S	501	$164,736	$222,352	$280,072	
**	Executive Director Compliance	S	493	$164,736	$222,352	$280,072	
**	Executive Director Human Resources	S	494	$164,736	$222,352	$280,072	
**	Executive Director Network Operations	S	632	$164,736	$222,352	$280,072	
**	Executive Director Operations	S	276	$164,736	$222,352	$280,072	
**	Executive Director Program Implementation	S	490	$164,736	$222,352	$280,072	
**	Executive Director Public Affairs	S	290	$164,736	$222,352	$280,072	
**	Executive Director Quality Analytics	S	601	$164,736	$222,352	$280,072	
**	Executive Director, Behavioral Health Integration	S	614	$164,736	$222,352	$280,072	
	Facilities & Support Services Coord - Lead	J	631	$40,976	$53,352	$65,624	
	Facilities & Support Services Coordinator	J	10	$40,976	$53,352	$65,624	
	Facilities Coordinator	J	438	$40,976	$53,352	$65,624	
	Financial Analyst	L	51	$54,288	$70,512	$86,736	
	Financial Analyst Sr	M	84	$62,400	$81,120	$99,840	
	Financial Reporting Analyst	L	475	$54,288	$70,512	$86,736	
	Gerontology Resource Coordinator	M	204	$62,400	$81,120	$99,840	

Back to Agenda

CalOptima - Annual Base Salary Schedule - Revised June 1, 2017
Effective as of May 1, 2014

Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
Graphic Designer	M	387	$62,400	$81,120	$99,840	
Grievance & Appeals Nurse Specialist	N	226	$71,760	$93,184	$114,712	
Grievance Resolution Specialist	J	42	$40,976	$53,352	$65,624	
Grievance Resolution Specialist - Lead	L	590	$54,288	$70,512	$86,736	
Grievance Resolution Specialist Sr	K	589	$47,112	$61,360	$75,504	
Health Coach	M	556	$62,400	$81,120	$99,840	
Health Educator	K	47	$47,112	$61,360	$75,504	
Health Educator Sr	L	355	$54,288	$70,512	$86,736	
Health Network Liaison Specialist (RN)	N	524	$71,760	$93,184	$114,712	
Health Network Oversight Specialist	M	323	$62,400	$81,120	$99,840	
HEDIS Case Manager	N	443	$71,760	$93,184	$114,712	
HEDIS Case Manager (LVN)	M	552	$62,400	$81,120	$99,840	
Help Desk Technician	J	571	$40,976	$53,352	$65,624	
Help Desk Technician Sr	K	573	$47,112	$61,360	$75,504	
HR Assistant	I	181	$37,128	$46,384	$55,640	
HR Business Partner	M	584	$62,400	$81,120	$99,840	
HR Coordinator	J	316	$40,976	$53,352	$65,624	
HR Representative	L	278	$54,288	$70,512	$86,736	
HR Representative Sr	M	350	$62,400	$81,120	$99,840	
HR Specialist	K	505	$47,112	$61,360	$75,504	
HR Specialist Sr	L	608	$54,288	$70,512	$86,736	
HRIS Analyst Sr	M	468	$62,400	$81,120	$99,840	
ICD-10 Project Manager	O	411	$82,576	$107,328	$131,976	
Infrastructure Systems Administrator	J	541	$40,976	$53,352	$65,624	
Infrastructure Systems Administrator Int	K	542	$47,112	$61,360	$75,504	
Inpatient Quality Coding Auditor	L	642	$54,288	$70,512	$86,736	
Intern	E	237	$25,272	$31,720	$37,960	
Investigator Sr	L	553	$54,288	$70,512	$86,736	
IS Coordinator	J	365	$40,976	$53,352	$65,624	
IS Project Manager	O	424	$82,576	$107,328	$131,976	
IS Project Manager Sr	P	509	$95,264	$128,752	$162,032	
IS Project Specialist	M	549	$62,400	$81,120	$99,840	
IS Project Specialist Sr	N	550	$71,760	$93,184	$114,712	
Kitchen Assistant	E	585	$25,272	$31,720	$37,960	
Legislative Program Manager	N	330	$71,760	$93,184	$114,712	
Licensed Clinical Social Worker	L	598	$54,288	$70,512	$86,736	
Litigation Support Specialist	M	588	$62,400	$81,120	$99,840	
LVN (PACE)	M	533	$62,400	$81,120	$99,840	
Mailroom Clerk	E	1	$25,272	$31,720	$37,960	
Manager Accounting	N	98	$71,760	$93,184	$114,712	
Manager Actuary	P	453	$95,264	$128,752	$162,032	
Manager Applications Management	P	271	$95,264	$128,752	$162,032	
Manager Audit & Oversight	O	539	$82,576	$107,328	$131,976	
Manager Behavioral Health	O	633	$82,576	$107,328	$131,976	
Manager Business Integration	O	544	$82,576	$107,328	$131,976	
Manager Case Management	O	270	$82,576	$107,328	$131,976	
Manager Claims	N	92	$71,760	$93,184	$114,712	
Manager Clinic Operations	O	551	$82,576	$107,328	$131,976	
Manager Clinical Pharmacist	Q	296	$114,400	$154,440	$194,480	
Manager Coding Quality	N	382	$71,760	$93,184	$114,712	
Manager Communications	N	398	$71,760	$93,184	$114,712	
Manager Community Relations	M	384	$62,400	$81,120	$99,840	
Manager Contracting	O	329	$82,576	$107,328	$131,976	
Manager Creative Branding	N	430	$71,760	$93,184	$114,712	

Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
Manager Cultural & Linguistic	N	349	$71,760	$93,184	$114,712	
Manager Customer Service	N	94	$71,760	$93,184	$114,712	
Manager Decision Support	O	454	$82,576	$107,328	$131,976	
Manager Disease Management	O	372	$82,576	$107,328	$131,976	
Manager Electronic Business	O	422	$82,576	$107,328	$131,976	
Manager Employment Services	N	420	$71,760	$93,184	$114,712	
Manager Encounters	N	516	$71,760	$93,184	$114,712	
Manager Environmental Health & Safety	N	495	$71,760	$93,184	$114,712	
Manager Facilities	N	209	$71,760	$93,184	$114,712	
Manager Finance	N	148	$71,760	$93,184	$114,712	
Manager Financial Analysis	O	356	$82,576	$107,328	$131,976	
Manager Government Affairs	N	437	$71,760	$93,184	$114,712	
Manager Grievance & Appeals	N	426	$71,760	$93,184	$114,712	
Manager Health Education	N	173	$71,760	$93,184	$114,712	
Manager HEDIS	O	427	$82,576	$107,328	$131,976	
Manager Human Resources	O	526	$82,576	$107,328	$131,976	
Manager Information Services	P	560	$95,264	$128,752	$162,032	
Manager Information Technology	P	110	$95,264	$128,752	$162,032	
Manager Integration Government Liaison	N	455	$71,760	$93,184	$114,712	
Manager Long Term Support Services	O	200	$82,576	$107,328	$131,976	
Manager Marketing & Enrollment (PACE)	O	414	$82,576	$107,328	$131,976	
Manager Medical Data Management	O	519	$82,576	$107,328	$131,976	
Manager Medi-Cal Program Operations	N	483	$71,760	$93,184	$114,712	
Manager Member Liaison Program	N	354	$71,760	$93,184	$114,712	
Manager Member Outreach & Education	N	616	$71,760	$93,184	$114,712	
Manager Member Outreach Education & Provider Relations	O	576	$82,576	$107,328	$131,976	
Manager MSSP	O	393	$82,576	$107,328	$131,976	
Manager OneCare Clinical	O	359	$82,576	$107,328	$131,976	
Manager OneCare Customer Service	N	429	$71,760	$93,184	$114,712	
Manager OneCare Regulatory	N	197	$71,760	$93,184	$114,712	
Manager OneCare Sales	O	248	$82,576	$107,328	$131,976	
Manager Outreach & Enrollment	N	477	$71,760	$93,184	$114,712	
Manager PACE Center	O	432	$82,576	$107,328	$131,976	
~~Manager Payroll & Benefits~~	~~N~~	~~144~~	~~$71,760~~	~~$93,184~~	~~$114,712~~	Remove Position
Manager Process Excellence	O	622	$82,576	$107,328	$131,976	
Manager Program Implementation	O	488	$82,576	$107,328	$131,976	
Manager Project Management	O	532	$82,576	$107,328	$131,976	
Manager Provider Data Management Services	N	TBD	$71,760	$93,184	$114,712	
Manager Provider Network	O	191	$82,576	$107,328	$131,976	
Manager Provider Relations	N	171	$71,760	$93,184	$114,712	
Manager Provider Services	O	TBD	$82,576	$107,328	$131,976	
Manager Purchasing	N	275	$71,760	$93,184	$114,712	
Manager QI Initiatives	N	433	$71,760	$93,184	$114,712	
Manager Quality Analytics	O	617	$82,576	$107,328	$131,976	
Manager Quality Improvement	O	104	$82,576	$107,328	$131,976	
Manager Regulatory Affairs and Compliance	O	626	$82,576	$107,328	$131,976	
Manager Reporting & Financial Compliance	O	572	$82,576	$107,328	$131,976	
Manager Strategic Development	O	603	$82,576	$107,328	$131,976	
Manager Strategic Operations	N	446	$71,760	$93,184	$114,712	
Manager Systems Development	P	515	$95,264	$128,752	$162,032	
Manager Utilization Management	O	250	$82,576	$107,328	$131,976	
Marketing and Outreach Specialist	J	496	$40,976	$53,352	$65,624	
Medical Assistant	H	535	$33,696	$42,224	$50,648	
Medical Authorization Asst	H	11	$33,696	$42,224	$50,648	

Back to Agenda

CalOptima - Annual Base Salary Schedule - Revised June 1, 2017
Effective as of May 1, 2014

	Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
	Medical Case Manager	N	72	$71,760	$93,184	$114,712	
	Medical Case Manager (LVN)	L	444	$54,288	$70,512	$86,736	
*	Medical Director	S	306	$164,736	$222,352	$280,072	
	Medical Records & Health Plan Assistant	G	548	$30,576	$38,272	$45,968	
	Medical Records Clerk	E	523	$25,272	$31,720	$37,960	
	Medical Services Case Manager	K	54	$47,112	$61,360	$75,504	
	Member Liaison Specialist	I	353	$37,128	$46,384	$55,640	
	MMS Program Coordinator	K	360	$47,112	$61,360	$75,504	
	Nurse Practitioner (PACE)	P	635	$95,264	$128,752	$162,032	
	Occupational Therapist	N	531	$71,760	$93,184	$114,712	
	Occupational Therapist Assistant	M	623	$62,400	$81,120	$99,840	
	Office Clerk	C	335	$21,008	$26,208	$31,408	
	OneCare Operations Manager	O	461	$82,576	$107,328	$131,976	
	OneCare Partner - Sales	K	230	$47,112	$61,360	$75,504	
	OneCare Partner - Sales (Lead)	K	537	$47,112	$61,360	$75,504	
	OneCare Partner - Service	I	231	$37,128	$46,384	$55,640	
	OneCare Partner (Inside Sales)	J	371	$40,976	$53,352	$65,624	
	Outreach Specialist	I	218	$37,128	$46,384	$55,640	
	Paralegal/Legal Secretary	K	376	$47,112	$61,360	$75,504	
	Payroll Specialist	J	554	$40,976	$53,352	$65,624	
	Performance Analyst	L	538	$54,288	$70,512	$86,736	
	Personal Care Attendant	E	485	$25,272	$31,720	$37,960	
	Personal Care Attendant - Lead	E	498	$25,272	$31,720	$37,960	
	Personal Care Coordinator	I	525	$37,128	$46,384	$55,640	
	Pharmacy Resident	K	379	$47,112	$61,360	$75,504	
	Pharmacy Services Specialist	I	23	$37,128	$46,384	$55,640	
	Pharmacy Services Specialist Int	J	35	$40,976	$53,352	$65,624	
	Pharmacy Services Specialist Sr	K	507	$47,112	$61,360	$75,504	
	Physical Therapist	N	530	$71,760	$93,184	$114,712	
	Physical Therapist Assistant	M	624	$62,400	$81,120	$99,840	
	Policy Advisor Sr	O	580	$82,576	$107,328	$131,976	
	Privacy Manager	N	536	$71,760	$93,184	$114,712	
	Privacy Officer	P	648	$95,264	$128,752	$162,032	
	Process Excellence Manager	O	529	$82,576	$107,328	$131,976	
	Program Assistant	I	24	$37,128	$46,384	$55,640	
	Program Coordinator	I	284	$37,128	$46,384	$55,640	
	Program Development Analyst Sr	M	492	$62,400	$81,120	$99,840	
	Program Manager	M	421	$62,400	$81,120	$99,840	
	Program Manager Sr	O	594	$82,576	$107,328	$131,976	
	Program Specialist	J	36	$40,976	$53,352	$65,624	
	Program Specialist Int	K	61	$47,112	$61,360	$75,504	
	Program Specialist Sr	L	508	$54,288	$70,512	$86,736	
	Program/Policy Analyst	K	56	$47,112	$61,360	$75,504	
	Program/Policy Analyst Sr	M	85	$62,400	$81,120	$99,840	
	Programmer	L	43	$54,288	$70,512	$86,736	
	Programmer Int	N	74	$71,760	$93,184	$114,712	
	Programmer Sr	O	80	$82,576	$107,328	$131,976	
	Project Manager	M	81	$62,400	$81,120	$99,840	
	Project Manager - Lead	M	467	$62,400	$81,120	$99,840	
	Project Manager Sr	O	105	$82,576	$107,328	$131,976	
	Project Specialist	K	291	$47,112	$61,360	$75,504	
	Project Specialist Sr	L	503	$54,288	$70,512	$86,736	
	Projects Analyst	K	254	$47,112	$61,360	$75,504	
	Provider Enrollment Data Coordinator	I	12	$37,128	$46,384	$55,640	

Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
Provider Enrollment Data Coordinator Sr	J	586	$40,976	$53,352	$65,624	
Provider Enrollment Manager	K	190	$47,112	$61,360	$75,504	
Provider Network Rep Sr	L	391	$54,288	$70,512	$86,736	
Provider Network Specialist	K	44	$47,112	$61,360	$75,504	
Provider Network Specialist Sr	L	595	$54,288	$70,512	$86,736	
Provider Office Education Manager	L	300	$54,288	$70,512	$86,736	
Provider Relations Rep	K	205	$47,112	$61,360	$75,504	
Provider Relations Rep Sr	L	285	$54,288	$70,512	$86,736	
Publications Coordinator	J	293	$40,976	$53,352	$65,624	
QA Analyst	L	486	$54,288	$70,512	$86,736	
QA Analyst Sr	N	380	$71,760	$93,184	$114,712	
QI Nurse Specialist	N	82	$71,760	$93,184	$114,712	
QI Nurse Specialist (LVN)	M	445	$62,400	$81,120	$99,840	
Receptionist	F	140	$27,872	$34,840	$41,808	
Recreational Therapist	L	487	$54,288	$70,512	$86,736	
Recruiter	L	406	$54,288	$70,512	$86,736	
Recruiter Sr	M	497	$62,400	$81,120	$99,840	
Registered Dietitian	L	57	$54,288	$70,512	$86,736	
Regulatory Affairs and Compliance Analyst	K	628	$47,112	$61,360	$75,504	
Regulatory Affairs and Compliance Analyst Sr	L	629	$54,288	$70,512	$86,736	
Regulatory Affairs and Compliance Lead	M	630	$62,400	$81,120	$99,840	
RN (PACE)	N	480	$71,760	$93,184	$114,712	
Security Analyst Int	N	534	$71,760	$93,184	$114,712	
Security Analyst Sr	O	474	$82,576	$107,328	$131,976	
Security Officer	F	311	$27,872	$34,840	$41,808	
SharePoint Developer/Administrator Sr	O	397	$82,576	$107,328	$131,976	
Social Worker	K	463	$47,112	$61,360	$75,504	
* Special Counsel	R	317	$137,280	$185,328	$233,376	
Sr Manager Human Resources	P	649	$95,264	$128,752	$162,032	
Sr Manager Information Services	Q	650	$114,400	$154,440	$194,480	
Sr Manager Government Affairs	O	451	$82,576	$107,328	$131,976	
Sr Manager Provider Network	O	651	$82,576	$107,328	$131,976	
Staff Attorney	P	195	$95,264	$128,752	$162,032	
Supervisor Accounting	M	434	$62,400	$81,120	$99,840	
Supervisor Audit and Oversight	N	618	$71,760	$93,184	$114,712	
Supervisor Budgeting	M	466	$62,400	$81,120	$99,840	
Supervisor Case Management	N	86	$71,760	$93,184	$114,712	
Supervisor Claims	K	219	$47,112	$61,360	$75,504	
Supervisor Coding Initiatives	M	502	$62,400	$81,120	$99,840	
Supervisor Customer Service	K	34	$47,112	$61,360	$75,504	
Supervisor Data Entry	K	192	$47,112	$61,360	$75,504	
Supervisor Day Center (PACE)	K	619	$47,112	$61,360	$75,504	
Supervisor Dietary Services (PACE)	M	643	$62,400	$81,120	$99,840	
Supervisor Disease Management	N	644	$71,760	$93,184	$114,712	
Supervisor Encounters	L	253	$54,288	$70,512	$86,736	
Supervisor Facilities	L	162	$54,288	$70,512	$86,736	
Supervisor Finance	N	419	$71,760	$93,184	$114,712	
Supervisor Grievance and Appeals	M	620	$62,400	$81,120	$99,840	
Supervisor Health Education	M	381	$62,400	$81,120	$99,840	
Supervisor Information Services	N	457	$71,760	$93,184	$114,712	
Supervisor Long Term Support Services	N	587	$71,760	$93,184	$114,712	
~~Supervisor Member Outreach and Education~~	~~L~~	~~592~~	~~$54,288~~	~~$70,512~~	~~$86,736~~	Remove Position
Supervisor MSSP	N	348	$71,760	$93,184	$114,712	
Supervisor OneCare Customer Service	K	408	$47,112	$61,360	$75,504	

Back to Agenda

CalOptima - Annual Base Salary Schedule - Revised June 1, 2017
Effective as of May 1, 2014

Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
Supervisor Payroll	M	517	$62,400	$81,120	$99,840	
Supervisor Pharmacist	P	610	$95,264	$128,752	$162,032	
Supervisor Provider Enrollment	K	439	$47,112	$61,360	$75,504	
Supervisor Provider Relations	M	652	$62,400	$81,120	$99,840	
Supervisor Quality Analytics	M	609	$62,400	$81,120	$99,840	
Supervisor Quality Improvement	N	600	$71,760	$93,184	$114,712	
Supervisor Regulatory Affairs and Compliance	N	627	$71,760	$93,184	$114,712	
Supervisor Social Work (PACE)	L	636	$54,288	$70,512	$86,736	
Supervisor Systems Development	O	456	$82,576	$107,328	$131,976	
Supervisor Therapy Services (PACE)	N	645	$71,760	$93,184	$114,712	
Supervisor Utilization Management	N	637	$71,760	$93,184	$114,712	
Systems Manager	N	512	$71,760	$93,184	$114,712	
Systems Network Administrator Int	M	63	$62,400	$81,120	$99,840	
Systems Network Administrator Sr	N	89	$71,760	$93,184	$114,712	
Systems Operations Analyst	J	32	$40,976	$53,352	$65,624	
Systems Operations Analyst Int	K	45	$47,112	$61,360	$75,504	
Technical Analyst Int	L	64	$54,288	$70,512	$86,736	
Technical Analyst Sr	M	75	$62,400	$81,120	$99,840	
Technical Writer	L	247	$54,288	$70,512	$86,736	
Technical Writer Sr	M	470	$62,400	$81,120	$99,840	
Therapy Aide	J	521	$40,976	$53,352	$65,624	
Training Administrator	L	621	$54,288	$70,512	$86,736	
Training Program Coordinator	K	471	$47,112	$61,360	$75,504	
Translation Specialist	G	241	$30,576	$38,272	$45,968	
Web Architect	O	366	$82,576	$107,328	$131,976	

* These positions are identified for the purposes of CalOptima Policy GA. 8042: Supplemental Compensation as Director level and above positions for which eligible employees may qualify for Employer-Paid Member Contribution.

** These positions are identified for the purposes of CalOptima Policy GA. 8042: Supplemental Compensation as Director level and above positions for which eligible employees may qualify for Employer-Paid Member Contribution and are also Chief or Executive Director level positions.

Text in red indicates new changes to the salary schedule proposed for Board approval.

Summary of Changes to Salary Schedule

For June 2017 Board Meeting:

Title	Old Wage Grade	New Job Code / Wage Grade	Notes / Reason	Salary Adjustment (% Increase)	Month Added/Changed
Manager Payroll & Benefits	N	N/A	Remove title from salary schedule. Position is being eliminated.	N/A	June 2017
Supervisor Member Outreach and Education	L	N/A	Remove title from salary schedule. Position is being eliminated.	N/A	June 2017

Back to Agenda

Summary of Market Adjustments

For June 2017 Board Meeting:

Title	Old Wage Grade	New Job Code / Wage Grade	Notes / Reason	Salary Adjustment (% Increase)	Month Added / Changed
Director Customer Service	P	N/A	A market adjustment is requested to address recruiting and retention issues.	1 Director Customer Service will receive a 5.00% adjustment. The total impact for the current fiscal year is $243.79. The annual cost is $6,338.56.	June 2017
Director Grievance & Appeals	P	N/A	A market adjustment is requested due to the addition of staff and greater scope of responsibility.	1 Director Grievance & Appeals will receive a 5.00% adjustment. The total impact for the current fiscal year is $243.79. The annual cost is $6,338.56.	June 2017

Back to Agenda

CalOptima Board Action Agenda Referral

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

Report Item
36. Consider Authorizing the Chief Executive Officer (CEO) to Approve New and Revised Credentialing Policies, and to Retire Those No Longer Needed

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

Recommended Actions
Authorize the CEO to:
1. Approve new policies: GG.1650: Credentialing & Re-Credentialing of Practitioners and GG.1651: Credentialing and Re-Credentialing of Health Delivery Organizations (HDOs) (formerly GG.1609: Credentialing and Re-Credentialing and GG.1606: Credentialing & Re-Credentialing of Mid-Levels, with proposed changes);
2. Approve proposed revisions to: GG.1616: Fair Hearing; GG.1607: Monitoring of Adverse Activity; GG.1633: Board Certification; and
3. Retire: GG.1609: Credentialing & Re-Credentialing and GG.1606: Credentialing & Re-Credentialing of Mid-Levels.

Background
Over the last 16 months, CalOptima has been reviewing its procedures relating to initial and re-credentialing of practitioners and HDOs for effectiveness and efficiencies. This included a close evaluation of current processes and workflows within the Quality Improvement department as well as intersections with other areas including provider contracting, provider relations, network management, GARS, and audit & oversight. The attached policies and procedures have been updated with these revisions. The proposed policy changes were presented and approved by the Credentialing and Peer Review Committee on April 20, 2017.

Discussion
Certain technical language and substantive issues required modification or clarification for all of the following policies.

- GG. 1650: Credentialing & Re-Credentialing of Practitioners (formerly GG:1609 and GG: 1606):
    - Removed HDO references and created a new policy for Credentialing & Re-credentialing of HDOs (GG.1651);
    - Aligned requirements to new Department of Health Care Services (DHCS) All Plan Letter (APL) for:
        - Provider types (Physicians vs. Non-Physician Medical Practitioners)
        - Categorizing Practitioners by risk-level;
    - Merged Credentialing of Mid-levels into this policy, retiring GG.1606; strengthened language regarding supervising physician must be credentialed with CalOptima;
    - Clarified types of practitioners that are credentialed and not credentialed;

    - Added language to the Policy Section regarding final decisions being rendered within 180 days from date of licensure verification;
    - Added reference to GG.1643: Minimum Physician Standards;
    - Added language regarding work history verification (including all post-graduate activity in the last five years).

- GG. 1651: Credentialing and Re-Credentialing of Health Delivery Organizations:
    - Developed a credentialing policy specific to Health Delivery Organizations, which includes but is not limited to, hospitals, home health agencies, skilled nursing facilities, and free standing surgical centers;
    - Aligned requirements to meet new DHCS APL for:
        - Provider types (non-practitioner);
        - Categorizing of providers by risk-level;
        - Additional requirements for moderate and high risk providers;
    - Added HDO credentialing requirements:
        - Requires confirmation that a provider is in good standing;
        - Requires documentation of review and approval by an accredited body;
        - Requires on-site quality assessment if HDO is not accredited.

- GG. 1616: Fair Hearing;
    - Added language to describe the process CalOptima uses to provide a fair procedure to Practitioners when adverse actions are proposed or taken by CalOptima;
    - Updated language to differentiate CalOptima-initiated actions vs. practitioner-initiated actions vs. other disciplinary actions;
    - Clearly delineated actions as a result of medical disciplinary versus administrative cause or reason, and the handling of fair hearing rights specific to medical disciplinary cause or reason.

- GG. 1607: Monitoring of Adverse Activity:
    - Added a description of the monthly monitoring of adverse activities for practitioners, HDOs and other contracted and non-contracted providers;
    - Specifies the various entities that are monitored, including but not limited to OIG, SAM, NPDB, Medi-care Opt-Out, Medi-Cal Provider Suspended and Ineligible list, Medical Board of California;
    - Updated reporting requirements to DHCS and Health Networks when adverse activities are identified.

- GG. 1633: Board Certification:
    - Updated language that describes the requirements for board certification of contracted physicians;
    - Added language to address board certification requirements for certain specialties where shorter or longer time periods may apply, such as podiatric physicians;
    - Added language to clarify exemption for certain contracted physicians who meet specific requirements;

- Added language to align policy with Minimum Physician Standards policy GG.1643 effective July 1, 2016.

Staff also recommends retiring two policies, GG.1609: Credentialing & Re-Credentialing and GG.1606: Credentialing & Re-Credentialing of Mid-Levels, as the provisions included in these policies were incorporated into the new Policy GG.1650: Credentialing and Re-credentialing of Practitioners and Policy GG.1651: Credentialing and Re-credentialing of HDOs.

Fiscal Impact
There is no anticipated fiscal impact for the recommended actions to revise and retire specified internal credentialing policies.

Rationale for Recommendation
The proposed changes better align with revised workflows, differentiate requirements for practitioners and HDOs, and clarify processes for adverse activity monitoring, the fair hearing process, and board certification requirements.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. PowerPoint Presentation, Credentialing Policy Updates
2. Proposed Revised Policy GG.1650: Credentialing and Re-Credentialing of Practitioners;
3. Proposed Revised Policy GG. 1651: Credentialing and Re-Credentialing of Health Delivery Organizations;
4. Proposed Revised Policy GG.1616: Fair Hearing;
5. Proposed Revised Policy GG.1607: Monitoring of Adverse Activity;
6. Proposed Revised Policy GG. 1633: Board Certification;
7. Proposed Retirement of Policy GG.1609: Credentialing and Re-Credentialing (Retire); and
8. Proposed Retirement of GG.1606: Credentialing and Re-Credentialing of Mid-Levels (Retire).

/s/ Michael Schrader — *5/25/2017*
Authorized Signature — **Date**

Back to Agenda

Credentialing Policy Updates

Board of Directors Meeting
June 1, 2017

Richard Bock, Deputy Chief Medical Officer,
Caryn Ireland, Executive Director, Quality and Analytics

Back to Agenda

NEW BUSINESS

- Updates on Credentialing Policies:
  - GG.1650 Credentialing & Re-Credentialing of Practitioners (Formerly GG.1609)
  - GG.1651 Credentialing & Re-Credentialing of Health Delivery Organizations (New)
  - GG.1633 Board Certification
  - GG.1616 Fair Hearing
  - GG.1607 Monitoring of Adverse Activity
  - GG.1609 Credentialing & Re-Credentialing (Retire)
  - GG.1606 Credentialing & Re-Credentialing of Mid-Levels (Retire)

Back to Agenda

Summary of Changes

Policy No./ Name	Summary of Changes	Reason for Change
GG.1650 Credentialing and Re-Credentialing of Practitioners (New number, formerly GG.1609)	• Removed HDO references and created new Credentialing/Re-Credentialing for HDO policy GG.1651 ▪ Aligned to new DHCS APL for: ▪ Provider types (Physicians vs. Non-Physician Medical Practitioners) ▪ Categorizing Practitioners by Risk-level ▪ Merged Credentialing of Mid-levels into the policy, retiring GG.1606. Supervising physician must be credentialed with CalOptima.	• Requirements for HDO's are different • Alignment to DHCS APL 16-012 for Credentialing • Credentialing of Mid-Levels are similar to Physicians

Back to Agenda

Summary of Changes - Continued

Policy No./ Name	Summary of Changes	Reason for Change
GG.1650 Credentialing and Re-credentialing of Practitioners (continued)	▪ Clarified types of practitioners that are credentialed and not credentialed. ▪ Final decisions will be rendered within 180 days from date of licensure verification. ▪ Added reference to GG.1643: Minimum Physician Standards. ▪ Work history verified including all post-graduate activity in the last five years.	•Alignment to DHCS APL • Per NCQA standards • Reference to new policy added 7/1/2016 • Process follows industry business practice

Back to Agenda

Summary of Changes - Continued

Policy No./ Name	Summary of Changes	Reason for Change
GG.1651 Credentialing and Re-credentialing of Health Delivery Organizations (HDOs) (New Policy)	▪ Policy specific to HDOs such as hospitals, home health agencies, skilled nursing facilities, and free standing surgical centers. ▪ Aligns to new DHCS APL for: ▪ Provider types (non-practitioner) ▪ Categorizing providers by risk-level ▪ Additional requirements for moderate and high risk providers ▪ HDO credentialing requirements: ▪ Confirms if provider is in good standing ▪ Confirms review and approved by accredited body ▪ Conducts on-site quality assessment if not accredited	• Credentialing specific to HDO's • Alignment with DHCS APL 16-012 • Alignment to NCQA Standard CR7

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Back to Agenda

Summary of Changes - Continued

Policy No./ Name	Summary of Changes	Reason for Change
GG.1607 Monitoring of Adverse Activities	▪ Describes the monthly monitoring of adverse activities for practitioners, HDO's and other contracted and non-contracted providers. ▪ Specifies the various activities that are monitored, including but not limited to OIG, SAM, NPDB, Medicare Opt-Out, Medi-Cal Provider Suspended and Ineligible list, Medical Board of California ▪ Updated reporting requirements to DHCS and Health Networks when adverse activities are identified	• Align with current business practices. • Added SAM requirement for Medicare • Align with DHCS APL

Back to Agenda

Summary of Changes - Continued

Policy No./ Name	Summary of Changes	Reason for Change
GG.1616 Fair Hearing	▪Describes the process CalOptima uses to provide a fair procedure to Practitioners when adverse actions are proposed or taken by CalOptima. ▪Differentiates CalOptima initiated actions vs. practitioner initiated actions vs. other disciplinary actions ▪Delineates actions as a result of medical disciplinary versus administrative cause or reason, and handles fair hearing rights specific to medical disciplinary cause or reason.	• Added more specificity and appropriate legal language to the fair hearing procedure and policy

Back to Agenda

Summary of Changes - Continued

Policy No./ Name	Summary of Changes	Reason for Change
GG.1633 Board Certification Requirements for Physicians	▪Describes the requirements for board certification of contracted physicians ▪ Added specific language to address specialties with shorter or longer board certification time periods, such as podiatric physician board certification ▪Added language to align~~ed~~ with Minimum Physician Standards policy GG.1643 effective July 1, 2016 ▪ Added language to clarify exemption and grandfathering for certain contracted physicians who meet specific requirements	• Updated policy to include board certification requirements for Podiatrists • Added Reference to GG.1643 Minimum Physician Standards

Back to Agenda

Policy #:	GG.1650Δ
Title:	**Credentialing and Recredentialing of Practitioners**
Department:	Medical Affairs
Section:	Quality Improvement

CEO Approval: Michael Schrader _______

Effective Date:	06/01/17
Last Review Date:	Not Applicable
Last Revised Date:	Not Applicable

Applicable to:
☒ Medi-Cal
☒ OneCare
☒ OneCare Connect
☒ PACE

DRAFT

I. PURPOSE

This policy defines the process by which CalOptima evaluates and determines whether to approve or decline practitioners (as described in Section II. of this Policy ("Practitioners")) for participation in CalOptima programs.

II. POLICY

A. CalOptima shall establish guidelines by which CalOptima shall evaluate and select Practitioners to participate in CalOptima, in accordance with Title 42, Code of Federal Regulations, Section 422.204(a) and other applicable laws, regulations, and guidance.

B. CalOptima may delegate Credentialing and Recredentialing activities to a Health Network in accordance with CalOptima Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities.

   1. A Health Network shall establish policies and procedures to evaluate and approve Practitioners to participate in CalOptima programs that, at minimum, meet the requirements as outlined in this policy.

C. The Chief Medical Officer (CMO), or his or her physician Designee, shall have direct responsibility over and actively participate in the Credentialing program.

D. The CalOptima Credentialing Peer Review Committee (CPRC) shall be responsible for reviewing a Practitioner's Credentialing information and determining such Practitioner's participation in CalOptima.

E. CalOptima shall Credential and Recredential the following Practitioners as provided in this Policy Physicians, Non-Physicians Medical Practitioners, Behavioral Health Practitioners, Substance Use Disorder (SUD) Practitioners, and Long Term Services and Supports (LTSS) Practitioners that provide care to CalOptima program Members, and are:

   1. Licensed, certified, or registered by the state of California to practice independently and;

   2. Contracted with CalOptima including physicians practicing at Federally Qualified Health Centers (FQHC) and community clinics that perform Primary and Specialty Care services.

F. CalOptima shall credential Non-Physician Medical Practitioners (NMP) who do not have an independent relationship with CalOptima, as follows:

1. For NMPs who provide services under the supervision of a practicing, licensed, and credentialed Physician Practitioner who has executed a signed Delegation Services Agreement with the NMP; or

2. Under the employment agreement of a credentialed Provider.

G. An NMP shall notify CalOptima immediately if the supervising Physician Practitioner no longer meets the CalOptima Credentialing requirements, or if there is a change in the supervising Physician Practitioner, or employment with the entity.

H. CalOptima does not Credential or Recredential:

1. Practitioners that practice exclusively within the inpatient setting (e.g., Hospitalist) and provide care for a Member only as a result of the Member being directed to the hospital, or inpatient, setting;

2. Practitioners that practice exclusively within freestanding facilities, and provide care for a Member only as a result of the Member being directed to the facility (e.g. Diagnostic Radiologists, Urgent Care, Emergency Medicine);

3. Pharmacists who work for a Pharmacy Benefit Manager (PBM) to which CalOptima delegates utilization management (UM) functions (Credentialing of Pharmacies and its professional and technical staff shall be conducted by the PBM, in accordance with CalOptima Policy GG.1406: Pharmacy Network Credentialing and Access.);

4. Covering Practitioners (e.g., locum tenens) who do not have an independent relationship with CalOptima;

5. Practitioners who do not provide care for a Member in a treatment setting (e.g., External Physician Reviewer); and

I. CalOptima shall categorize Practitioners into the three (3) Fraud, Waste, and Abuse risk levels established by the Centers for Medicare & Medicaid Services: limited, moderate, and high, and will screen Practitioners for the appropriate risk level in accordance with Department of Health Care Services (DHCS) All Plan Letter (APL) 16-012: Provider Credentialing and Recredentialing, Title 42, CFR, Section 455, and as described Sections III.A. and III.B. of this Policy.

J. CalOptima shall Recredential a Practitioner at least every three (3) years, utilizing a thirty-six (36)-month cycle to the month, not to the day.

K. CalOptima shall ensure that all Practitioners maintain current California licensure, Drug Enforcement Agency (DEA) certification, and medical malpractice insurance in the interval between Credentialing cycles and shall provide evidence of monthly review of the Medical Board of California and Office of Inspector General (OIG) exclusion, or suspension, list in accordance with CalOptima Policy GG.1607Δ: Monitoring Adverse Activities.

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L. If CalOptima declines to include a Practitioner in the CalOptima network, CalOptima shall notify, in writing, such Practitioner within sixty (60) calendar days of the reason for its decision.

M. CalOptima shall not discriminate, in terms of participation, reimbursement, or indemnification, against any Practitioner who is acting within the scope of his or her license, certification, or registration under federal and state law, solely on the basis of the license, or certification. This prohibition shall not preclude CalOptima from:

1. Refusing to grant participation to a Practitioner in excess of the number necessary to meet the needs of Members;

2. Using different reimbursement amounts for different specialties, or for different Practitioners in the same specialty; and

3. Implementing measures designed to maintain quality and control costs consistent with CalOptima's responsibilities.

N. CalOptima shall not discriminate against a Practitioner that serves high-risk populations, or specializes in the treatment of costly conditions.

O. CalOptima shall not make, or decline, Credentialing and Recredentialing decisions based on a Practitioner's race, ethnicity, national identity, gender, age, sexual orientation, or the type of procedure, or patient, in which the Practitioner specializes.

P. CalOptima shall monitor and prevent discriminatory Credentialing decisions as follows:

1. Periodic audits of Credentialing files (in-process, denied, and approved files) to ensure Practitioners are not discriminated against at least annually;

2. Periodic audits of Practitioner complaints to determine if there are complaints alleging discrimination, including a review by the CPRC of quarterly reports of complaints, including discrimination at least annually;

3. Maintaining a heterogeneous Credentialing committee membership; and

4. Requiring those responsible for Credentialing and Recredentialing decisions to sign a statement affirming that they do not discriminate when making decisions.

Q. CalOptima shall maintain the confidentiality of Credentialing files, in accordance with CalOptima Policy GG.1604Δ: Confidentiality of Credentialing Files.

R. CalOptima shall maintain Credentialing files that include documentation of required elements, as described in this Policy.

S. CalOptima shall render a final decision within one hundred eighty (180) calendar days from the date of licensure verification.

1. If CalOptima is unable to render a decision within one hundred eighty (180) calendar days from the date of licensure verification for any Practitioner, during the Practitioner's Credentialing, or Recredentialing process, the application shall be considered expired.

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T. Except as provided in CalOptima Policy GG.1608Δ: Full Scope Site Reviews, CalOptima does not delegate the Facility Site Review and Medical Record Review (MRR) processes to a Health Network. CalOptima assumes all authority, responsibility, and coordination of FSRs, MRRs, and Physical Accessibility Review Surveys (PARS) and reports its findings to Health Networks to incorporate the documents to support review prior to Credentialing decisions.

U. On an annual basis, the CalOptima Board of Directors shall review and approve this Policy.

III. PROCEDURE

A. Practitioner Initial Credentialing

1. In conjunction with the CalOptima Provider Relations and Contracting Departments, a Practitioner shall initiate the Credentialing process with CalOptima.

a. Upon receipt of the request from the Practitioner, CalOptima shall send a notification electronically, explaining the expectations for completion and submission of the credentialing application and required documents.

b. Physician Practitioners shall meet the Minimum Physician Standards as outlined in CalOptima Policy GG.1643Δ: Minimum Physician Standards and CalOptima will verify that the Physician Practitioner meets the minimum standards as provided in this Policy.

c. Practitioners shall submit a current, signed, and dated application with attestation to CalOptima that attests to:

i. Any work history gap that exceeds six (6) months, including written clarification;

ii. The essential functions of the position that the Practitioner cannot perform, with or without accommodation (i.e., health status);

iii. Lack of present illegal drug use that impairs current ability to practice;

iv. History of any loss of license and history of felony convictions;

v. History of any loss, or limitation, of licensure, or privileges, or disciplinary activity;

vi. Current malpractice insurance coverage; and

vii. The correctness and completeness of the application;

d. All credentialing applications shall be signed. Faxed, digital, electronic, scanned, or photocopied signatures are acceptable; however, signature stamps are not acceptable.

e. A Practitioner shall ensure that all information included in a Credentialing application is no more than six (6) months old.

f. CalOptima shall return an incomplete application to a Practitioner, and such incomplete application will not be processed until the Practitioner submits all the required information.

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g. An NMP who does not have an individual relationship with CalOptima, and is supervised by a Physician Practitioner, must include a signed Delegation Services Agreement indicating name of supervising Physician Practitioner who is practicing, licensed and credentialed by CalOptima, or provide a copy of the employment agreement with the credentialed provider.

2. Upon receipt of a complete Credentialing application, CalOptima shall verify the information provided through primary verification using industry-recognized verification sources or a Credentialing Verification Organization. This information includes, but is not limited to:

   a. A current, valid California license to practice in effect at the time of the Credentialing decision;

   b. Board Certification, as applicable, unless exempt from the Board Certification requirement pursuant to CalOptima Policy GG.1633Δ: Board Certification Requirements for Physicians; and

   c. Education and training, including evidence of graduation from an appropriate professional school, continuing education requirements and if applicable, completion of residency, and specialty training.

3. CalOptima shall also collect and verify the following information from each Provider as applicable, but need not verify this information through a primary source. This information includes, but is not limited to:

   a. Work history, including all post-graduate activity in the last five (5) years (on initial Credentialing). The Practitioner shall provide, in writing, an explanation of any gaps of six (6) months, or more;

   b. Written, or verbal, confirmation from the Practitioner's primary inpatient admitting facility that the Practitioner has privileges in good standing, or confirmation that the Practitioner refers patients to hospital-based Practitioners (Hospitalist), as applicable;

   c. Any alternative admitting arrangements must be documented in the Credentialing file;

   d. A valid DEA, or Controlled Dangerous Substances (CDS), certificate obtained through confirmation by National Technical Information Service (NTIS), if applicable, in effect at the time of the Credentialing decision;

   e. A valid National Provider Identifier (NPI) number;

   f. Current malpractice insurance or self-insurance (e.g., trust, escrow accounts coverage) in the minimum amounts of one million dollars ($1,000,000.00) per occurrence and three million dollars ($3,000,000.00) aggregate per year at the time of the Credentialing decision;

   g. Practitioner information entered into the National Practitioner Data Bank (NPDB), if applicable;

   h. No exclusion, suspension, or ineligibility to participate in any state and federal health care program at the time of the Credentialing decision;

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i. A review of any Grievances, or quality, cases filed against a Practitioner in the last three (3) years;

j. No exclusion from participation at any time in federal, or state, health care programs based on conduct within the last ten (10) years that supports a mandatory exclusion under the Medicare program, as set forth in Title 42, United States Code, Section 1320a-7(a), as follows:

   i. A conviction of a criminal offense related to the delivery of an item, or service, under federal, or state, health care programs;

   ii. A felony conviction related to neglect, or abuse, of patients in connection with the delivery of a health care item, or service;

   iii. A felony conviction related to health care Fraud; or

   iv. A felony conviction related to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

k. History of professional liability claims that resulted in settlements or judgments, paid by, or on behalf of, the Practitioner;

l. Human Immunodeficiency Virus (HIV) specialist attestation, if applicable;

m. Current IRS Form W-9;

n. Current (within last three (3) years) Full Scope FSR/MRR, and PARS, as applicable, pursuant to CalOptima Policy GG.1608Δ: Full Scope Site Reviews; and

o. Active enrollment status with Medi-Cal

   i. The CMO, or his or her physician Designee, has the ability to make exceptions with respect to Medi-Cal enrollment status in order to satisfy access and continuity of care requirements; and

   ii. The CMO, or his or her physician Designee, may also make exceptions to Providers outside of Orange, Los Angeles, San Bernardino, Riverside, and San Diego Counties, on a case-by-case basis.

p. Active enrollment status with Medicare for OneCare, or OneCare Connect, Practitioners.

B. Practitioner Recredentialing

1. CalOptima shall Recredential a Practitioner at least every three (3) years after initial Credentialing. At the time of Recredentialing, CalOptima shall:

   a. Collect and verify, at a minimum, all of the information required for initial credentialing, as set forth in Section III.A of this policy, including any change in work history, except historical data already verified at the time of the initial credentialing of the Practitioner; and

   b. Incorporate the following data in the decision-making process:

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i. Member Grievances and Appeals, including number and type during the past three (3) years;

ii. Information from quality review activities;

iii. Board Certification, if applicable;

iv. Member satisfaction, if applicable;

v. Medical Record Reviews, if applicable;

vi. Facility Site Review (FSR) results and Physical Accessibility Review Survey (PARS) results, if applicable; and

vii. Compliance with the terms of the Practitioner's contract.

c. All Recredentialing applications shall be signed. Faxed, digital, electronic, scanned, or photocopied signatures are acceptable; however, signature stamps are not acceptable.

2. Current (within the last three (3) years) Full Scope FSR/MRR and PARS, as applicable, pursuant to CalOptima Policy GG.1608Δ: Full Scope Site Reviews.

3. CalOptima shall ensure that all Practitioners maintain current California licensure, Drug Enforcement Agency (DEA) certification, and medical malpractice insurance in the interval between Credentialing cycles.

4. If CalOptima terminates a Practitioner during the Recredentialing process for administrative reasons (i.e., the Practitioner failed to provide complete credentialing information) and not for quality reasons (i.e., medical disciplinary cause or reason), it may reinstate the Practitioner within thirty (30) calendar days of termination and is not required to perform initial credentialing. However, CalOptima must re-verify credentials that are no longer within the verification time limit. If the reinstatement would be more than thirty (30) calendar days after termination, CalOptima must perform initial credentialing of such Practitioner.

C. Practitioner Rights

1. New applicants for Credentialing will receive Practitioner Rights attached to the CPPA as Addendum A, describing the following:

a. Right to review information

i. Practitioners will be notified of their right to review information CalOptima has obtained to evaluate their credentialing application, attestation, or curriculum vitae. This includes non-privileged information obtained from any outside source (e.g., malpractice insurance carriers, state licensing boards), but does not extend to review of information, references, or recommendations protected by law from disclosure.

b. Right to correct erroneous information

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i. All Practitioners will be notified by certified mail when Credentialing information obtained from other sources varies substantially from that provided by the Practitioner;

ii. All Practitioners have the right to correct erroneous information, as follows:

a) The Practitioner has forty-eight (48) hours, excluding weekends, from date of notification to correct erroneous information;

b) Requests for correction of erroneous information must be submitted by certified mail on the Practitioner's letterhead with a detailed explanation regarding erroneous information, as well as copy(ies) of corrected information; and

c) All submissions will be mailed to CalOptima's Quality Improvement Department using the following address:

Attention: Quality Improvement Department – Credentialing
CalOptima
505 City Parkway West
Orange, CA 92868

iii. CalOptima is not required to reveal the source of information, if the information is not obtained to meet CalOptima's Credentialing verification requirements, or if federal or state law prohibits disclosure.

2. Documentation of receipt of corrections

a. A Practitioner shall be notified within thirty (30) calendar days via a letter to document CalOptima's receipt of the identified erroneous information.

3. Right to be notified of application status

a. Practitioners may receive the status of their Credentialing, or Recredentialing, application, upon request.

b. Practitioners can contact the Quality Improvement Department by phone, e-mail, or facsimile requesting the status of their application. The Quality Improvement Department will respond within one (1) business day of the status of the Practitioner's application with respect to outstanding information required to complete the application process.

D. Credentialing Peer Review Committee (CPRC)

1. CalOptima shall designate a CPRC that uses a peer-review process to make recommendations and decisions regarding Credentialing and Recredentialing.

2. Such CPRC shall include representation from a range of Practitioners participating in the organization's network, and shall be responsible for reviewing a Practitioner's Credentialing and Recredentialing files, and determining the Practitioner's participation in CalOptima programs.

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3. Completed Credentialing and Recredentialing files will either be presented to the CMO, or his or her physician Designee, on a clean file list for signature, or will be presented at CPRC for review and approval.

   a. A clean file consists of a complete application with a signed attestation and consent form, supporting documents, and verification of no professional review or malpractice claim(s) that resulted in settlements or judgments paid by, or on behalf of, the Practitioner within the last seven (7) years from the date of the Credentialing, or Recredentialing, review

      i. A clean file shall be considered approved and effective on the date that the CMO, or his or her physician Designee, review and approve a Practitioner's Credentialing, or Recredentialing, file, and deem the file clean.

      ii. Approved, clean file lists shall be presented at the CPRC and reflected in the meeting minutes.

   b. Files that do not meet the clean file review process and require further review by CPRC include but are not limited to those files that include a history of malpractice claim(s) that resulted in settlements or judgments paid by, or on behalf of, the Practitioner, identification of Practitioner, or OIG exclusion list, Medi-Cal Suspended and Ineligible Provider List, or NPDB query identifying Medical Board investigations, or other actions.

      i. Non-clean list files will be reviewed by CPRC for determination to accept, or deny, the application.

      ii. CPRC minutes shall reflect thoughtful consideration of information presented in the credentialing file.

      iii. CPRC meetings and decisions may take in real-time, as a virtual meeting, but may not be conducted through e-mail.

4. The CPRC shall make recommendations based on the Practitioners' ability to deliver care based on the Credentialing information collected from the file review process, and shall be verified prior to making a Credentialing decision.

   a. The Quality Improvement Department shall send the Practitioner a decision letter, within sixty (60) calendar days of the decision:

      i. Acceptance;

      ii. Acceptance with Restrictions along with appeal rights information, in accordance with CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners; or

      iii. Denial of the application along with appeal rights information, in accordance with CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners, with a letter of explanation forwarded to the applicant.

   b. CalOptima shall render a final decision within one hundred eighty (180) calendar days from the date of licensure verification.

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i. If CalOptima is unable to render a decision within one hundred eighty (180) calendar days from the date of licensure verification for any Practitioner, during the Practitioner's Credentialing, or Recredentialing process, the application shall be considered expired.

E. CalOptima shall monitor and prevent discriminatory practices, to include, but not be limited to:

a. Monitoring:

i. CalOptima shall conduct periodic audits of Credentialing files (in-process, denied, and approved files) to ensure that Practitioners are not discriminated against; and

ii. Review Practitioner complaints to determine if there are complaints alleging discrimination.

iii. On a quarterly basis, the QI Department shall review grievances, appeals, and potential quality of care issues for complaints alleging discrimination, and will report outcomes to the CPRC for review and determination.

b. Prevention:

i. The QI Department shall maintain a heterogeneous Credentialing committee, and will require those responsible for Credentialing decisions to sign a statement affirming that they do not discriminate.

F. Upon acceptance of the Credentialing application, the CalOptima Quality Improvement Department shall generate a Provider profile and forward the Provider profile to the Contracting and Provider Data Management Service (PDMS) Departments. The PDMS Department will enter the contract and Credentialing data into CalOptima's core business system, which updates pertinent information into the online Provider directory.

IV. ATTACHMENTS

A. California Participating Physician Application (CPPA)
B. CalOptima Primary Source Verification Table
C. Ongoing Monitoring Website Information Matrix

V. REFERENCES

A. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima PACE Program Agreements
D. CalOptima Contract for Health Care Services2017 NCQA Standards and Guidelines
E. CalOptima Policy GG.1406: Pharmacy Network Credentialing and Access
F. CalOptima Policy GG.1604Δ: Confidentiality of Credentialing Files
G. CalOptima Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities
H. CalOptima Policy GG.1606Δ: Credentialing and Recredentialing of Mid-Level Practitioners
I. CalOptima Policy GG.1607Δ: Monitoring Adverse Activities
J. CalOptima Policy GG.1608Δ: Full Scope Site Reviews

K. CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners
L. CalOptima Policy GG.1633Δ: Board Certification Requirements for Physicians
M. CalOptima Policy GG.1643Δ: Minimum Physician Standards
N. CalOptima Policy GG.1651Δ: Credentialing and Recredentialing of a Healthcare Delivery Organization (HDO)
O. CalOptima Policy HH.1101: CalOptima Provider Compliant
P. CalOptima Policy MA.9006: Provider Complaint Process
Q. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
R. Department of Health Care Services All Plan Letter (APL) 16-009: Adult Immunizations as a Pharmacy Benefit
U. Department of Health Care Services All Plan Letter (APL) 16-012: Provider Credentialing and Recredentialing
S. Title 42, Code of Federal Regulations, §§422.204(a), 422.205, 438.12, 438.214, 460.64 and 460.71
T. Title 45, Code of Federal Regulations, §455, Subpart E
U. Title 42, United States Code, §1320a-7(a)
V. Title XVIII and XIV of the Social Security Act
W. California Business and Professions Code, Section 805
X. California Evidence Code, Section 1157

VI. REGULATORY AGENCY APPROVALS

A. 04/28/15: Department of Health Care Services

VII. BOARD ACTIONS

A. 06/01/17: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	10/1995	GG.1609	Health Network Practitioner Credentialing Program Standards	Medi-Cal
Revised	12/1995	GG.1609	Health Network Practitioner Credentialing Program Standards	Medi-Cal
Revised	12/1996	GG.1609	Health Network Practitioner Credentialing Program Standards	Medi-Cal
Revised	02/1998	GG.1609	Health Network Practitioner Credentialing Program Standards	Medi-Cal
Revised	01/1999	GG.1609	Credentialing and Recredentialing	Medi-Cal
Revised	08/2000	GG.1609	Credentialing and Recredentialing	Medi-Cal
Revised	02/2001	GG.1609	Credentialing and Recredentialing	Medi-Cal
Revised	01/01/2006	MA.7009	Credentialing and Recredentialing	OneCare
Revised	07/01/2007	GG.1609	Credentialing and Recredentialing	Medi-Cal
Revised	07/01/2009	GG.1609	Credentialing and Recredentialing	Medi-Cal
Revised	09/01/2011	GG.1609	Credentialing and Recredentialing	Medi-Cal
Revised	03/01/2012	MA.7009	Credentialing and Recredentialing	OneCare
Revised	02/01/2013	GG.1609	Credentialing and Recredentialing	Medi-Cal
Revised	06/01/2014	GG.1609	Credentialing and Recredentialing	Medi-Cal

DRAFT

Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	02/01/2015	MA.1609	Credentialing and Recredentialing	OneCare OneCare Connect PACE
Revised	03/01/2015	GG.1609Δ	Credentialing and Recredentialing	Medi-Cal OneCare OneCare Connect PACE
Effective	06/01/2017	GG.1650Δ	Credentialing and Recredentialing	Medi-Cal OneCare OneCare Connect PACE

1

1 **IX. GLOSSARY**
2

Term	Definition
Abuse	Actions that may, directly or indirectly, result in: unnecessary costs to a CalOptima Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.
Appeal	A request by the Member or the Member's Authorized Representative for review of any decision to deny, modify, or discontinue a Covered Service.
Behavioral Health Provider	A licensed practitioner including, but not limited to, physicians, nurse specialists, psychiatric nurse practitioners, licensed psychologists (PhD or PsyD), licensed clinical social worker (LCSW), marriage and family therapist (MFT or MFCC), professional clinical counselors and qualified autism service providers, furnishing covered services.
Board Certification/Certified	Certification of a physician by one (1) of the boards recognized by the American Board of Medical Specialties (ABMS), or American Osteopathic Association (AOA), as meeting the requirements of that board for certification.
Continuity of Care	Services provided to a Member rendered by an out-of-network provider with whom the Member has pre-existing provider relationship.
Credentialing	The process of obtaining, verifying, assessing, and monitoring the qualifications of a practitioner to provide quality and safe patient care services.
Credentialing Peer Review Committee	Peer review body who reviews all recommendations and decisions regarding Credentialing and Recredentialing
Credentialing Verification Organization	An organization that collects and verifies credentialing information.
Delegation Services Agreement	Mutually agreed upon document, signed by both parties, which includes, without limit: 1. CalOptima responsibilities; 2. Duration of the agreement; 3. Termination of the agreement; 4. Delegated Entity responsibilities and Delegated Services; 5. Types and frequency of reporting to the Delegated Entity; 6. Process by which the CalOptima evaluates the Delegated Entity's performance (Performance Measurements); 7. Use of confidential CalOptima information including Member Protected Health Information (PHI) by the Delegated Entity; and 8. Remedies available to the CalOptima if the Delegated Entity does not fulfill its obligations.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.

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Term	Definition
Fraud	Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. (18 U.S.C. § 1347).
Full Scope Site Review	An onsite inspection to evaluate the capacity or continuing capacity of a PCP Site to support the delivery of quality health care services using the Site Review Survey and Medical Record Review Survey.
Grievance	An oral or written expression of dissatisfaction, including any Complaint, dispute, request for reconsideration, or Appeal made by a Member.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Long Term Support Services (LTSS) Provider	A licensed practitioner such as physicians, Non-Physician Medical Practitioners (NMP), social workers, and nurse managers.
Medical Record Review (MRR)	A DHCS tool utilized to audit PCP medical records for format, legal protocols, and documented evidence of the provision of preventive care and coordination and continuity of care services.
Member	An enrollee-beneficiary of a CalOptima program.
Minimum Physician Standards	Minimum standards that must be met in order for a Physician to be credentialed and contracted for participation in CalOptima programs.
Non-Physician Medical Practitioner (NMP)	A licensed practitioner, including but not limited to, a Nurse Practitioner (NP), Certified Nurse Midwife (CNM), Certified Nurse Specialists (CNS), Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), Speech Therapist (ST), or Audiologist furnishing covered services.
Pharmacy Benefit Manager (PBM)	The entity that performs certain functions and tasks including, but not limited to, pharmacy credentialing, contracting, and claims processing in accordance with the terms and conditions of the PBM Services Agreement.
Physical Accessibility Review Survey (PARS)	A DHCS tool used to assess the level of physical accessibility of provider sites, including specialist and ancillary service providers.
Physician Practitioner	A licensed practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), furnishing covered services.
Primary Care	For purposes of this policy, a basic level of health care usually rendered in an ambulatory setting by a Primary Care Provider (PCP).
Recredentialing	The process by which the qualifications of Practitioners is verified in order to make determinations relating to their continued eligibility for participation in the CalOptima program.
Specialty Care	For purposes of this policy, Specialty Care given to Members by referral by other than a Primary Care Provider (PCP).

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Term	Definition
Substance Use Disorder (SUD) Providers	Licensed, certified or registered by one (1) of the following: a physician licensed by the Medical Board of California, a psychologist licensed by the Board of Psychology, a clinical social worker or marriage and family therapist licensed by California Board of Behavioral Sciences, or an intern registered with California Board of Psychology or California Board of Behavioral sciences.
Utilization Management (UM)	Requirements or limits on coverage. Utilization management may include, but is not limited to, prior authorization, quantity limit, or step therapy restrictions.
Waste	The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

1

California Participating Practitioner Application

I. Instructions

This form should be typed. If more space is needed than provided on original, attach additional sheets and reference the question being answered. Please refer to cover page for a list of the required documents to be submitted with this application.

II. Identifying Information

Last Name: First Name: Middle:

Is there any other name under which you have been known? Name(s):

Home Mailing Address:

City: State: Zip Code:

Home Phone Number: Fax Number: Cell Number: Pager Number:

Practitioner Email: Citizenship (If not a U.S. citizen, please provide a copy of Alien Registration Card):

Birth Date: Social Security Number:

Birth Place: Gender ◯ Male ◯ Female

Driver's License State/Number: Race/Ethnicity (optional):

Your intent is to serve as a(n):

☐ Primary Care Provider ☐ Specialist ☐ Urgent Care ☐ Hospitalist ☐ Hospital Based

Specialty:

Subspecialties:

III. Practice Information

Practice Name (if applicable): Department Name (if hospital based):

Primary Office Address:

City: State: Zip Code:

Telephone Number: Fax Number: Website (if applicable):

Office Administrator/Manager: Office Administrator/Manager Telephone Number:

Office Administrator/Manager Email: Office Administrator/Manager Fax Number:

Federal Tax ID Number: Name Associated with Tax ID:

Back to Agenda

III. Practice Information (Continued)

Please identify the physical accessibility of this office. ◯ Basic ◯ Limited ◯ None

Type of practice (check all that apply): ☐ Solo Practice ☐ Group Practice ☐ Urgent Care

☐ Single Specialty Group

☐ Multi Specialty Group

Primary Office Hours of Operation

Languages spoken by Staff:

Languages spoken by Provider:

Group Medicare PTAN/UPIN #:

Group NPI #:

Secondary Practice Information

Practice Name (if applicable):

Department Name (if hospital based):

Secondary Office Address:

City:

State:

Zip Code:

Telephone Number:

Fax Number:

Website (if applicable):

Office Administrator/Manager:

Office Administrator/Manager Telephone Number:

Office Administrator/Manager Email:

Office Administrator/Manager Fax Number:

Federal Tax ID Number:

Name Associated with Tax ID:

Please identify the physical accessibility of this office. ◯ Basic ◯ Limited ◯ None

Type of practice (check all that apply): ☐ Solo Practice ☐ Group Practice ☐ Urgent Care

☐ Single Specialty Group

☐ Multi Specialty Group

Secondary Office Hours of Operation

Languages spoken by Staff:

Languages spoken by Provider:

Group Medicare PTAN/UPIN #:

Group NPI #:

Back to Agenda

Tertiary Practice Information

Practice Name (if applicable): | Department Name (if hospital based):

Tertiary Office Address:

City: | State: | Zip Code:

Telephone Number: | Fax Number: | Website (if applicable):

Office Administrator/Manager: | Office Administrator/Manager Telephone Number:

Office Administrator/Manager Email: | Office Administrator/Manager Fax Number:

Federal Tax ID Number: | Name Associated with Tax ID:

Please identify the physical accessibility of this office. ◯ Basic ◯ Limited ◯ None

Type of practice (check all that apply): ☐ Solo Practice ☐ Group Practice ☐ Urgent Care

☐ Single Specialty Group

☐ Multi Specialty Group

Tertiary Office Hours of Operation

Languages spoken by Staff:

Languages spoken by Provider:

Group Medicare PTAN/UPIN #: | Group NPI #:

Mailing Address

Which of your practices is your primary mailing address? ◯ Primary ◯ Secondary ◯ Tertiary ◯ Other

If your mailing address is different from your practice address, please provide it:

IV. Billing Information

Which of your practices handles your billing? ◯ Primary ◯ Secondary ◯ Tertiary If none, please provide billing information:

Billing Company

Billing Company Mailing Address:

City: | State: | Zip Code:

Contact Person: | Telephone Number:

Federal Tax ID Number: | Name Associated with Tax ID:

Back to Agenda

V. Practice Description

Do you employ any allied health professionals (e.g. nurse practitioners, physician assistants, psychologist, etc.)? ◯ Yes ◯ No
If so, please list:

Name	Type of Provider	License Number

Physician Assistant Supervisor Name: ______ License Number: ______

Do you personally employ any physicians (do not include physicians who are employed by the medical group)? ◯ Yes ◯ No
If so, please list:

Name	**California Medical License Number**	**Primary/Secondary/Tertiary Practice**
		☐ Primary ☐ Secondary ☐ Tertiary
		☐ Primary ☐ Secondary ☐ Tertiary
		☐ Primary ☐ Secondary ☐ Tertiary
		☐ Primary ☐ Secondary ☐ Tertiary

Please list any clinical services you perform that are not typically associated with your specialty:

______

Which offices does this applies to: ☐ Primary ☐ Secondary ☐ Tertiary

Please list any clinical services you do **not** perform that are typically associated with your specialty:

______

Which offices does this applies to: ☐ Primary ☐ Secondary ☐ Tertiary

Is your practice limited to certain ages? ◯ Yes ◯ No If yes, specify limitation: ______

Which offices does this applies to: ☐ Primary ☐ Secondary ☐ Tertiary

Coverage of Practice

List your answering service and covering physicians by name. Attach additional sheets if necessary.

Answering Service Company ______

Answering Service Mailing Address: ______

City: ______ State: ______ Zip Code: ______ Email: ______

Covering Physician's Name(s) / Phone Number / Which practices does their coverage apply (Primary, Secondary, Tertiary):

______

______

______

Back to Agenda

VI. Education, Training and Experience

Medical/Professional Education

NOT REQUIRED FOR RE-CREDENTIALING

Medical School/Professional: ______ Degree Received: ______ Graduation Date: ______

Mailing Address: ______ Website (if applicable): ______

City: ______ State: ______ Zip Code: ______ Registrar's Phone Number: ______

Internship/PGY-1

NOT REQUIRED FOR RE-CREDENTIALING

Institution: ______ Program Director: ______

Address ______ City ______ State ______ Zip ______

Telephone Number: ______ Fax Number: ______ Website (if applicable): ______

Type of Internship: ______ From (mm/yyyy): ______ To (mm/yyyy): ______

Did you successfully complete the program? ◯ Yes ◯ No (If No, please explain on a separate sheet.)

Residencies/Fellowships

For Re-Credentialing, please add any new Residencies or Fellowships in the last three (3) years.

Institution: ______ Program Director: ______

Address ______ City ______ State ______ Zip ______

Telephone Number: ______ Fax Number: ______ Website (if applicable): ______

Type of Training: ______ Specialty: ______ From (mm/yy): ______

Did you successfully complete the program? ◯ Yes ◯ No (Please explain on a separate sheet.) To(mm/yy): ______

Institution: ______ Program Director: ______

Address ______ City ______ State ______ Zip ______

Telephone Number: ______ Fax Number: ______ Website (if applicable): ______

Type of Training: ______ Specialty: ______ From (mm/yy): ______

Did you successfully complete the program? ◯ Yes ◯ No (Please explain on a separate sheet.) To(mm/yy): ______

Institution: ______ Program Director: ______

Address ______ City ______ State ______ Zip ______

Telephone Number: ______ Fax Number: ______ Website (if applicable): ______

Type of Training: ______ Specialty: ______ From (mm/yy): ______

Did you successfully complete the program? ◯ Yes ◯ No (Please explain on a separate sheet.) To(mm/yy): ______

VII. Medical Licensure & Certifications

California State Medical License Number	Issue Date	Expiration Date

Drug Enforcement Agency (DEA) Registration Number	Schedules	Expiration Date

Controlled Dangerous Substances Certificate (CDS) (if applicable)	Expiration Date

ECFMG Number (applicable to foreign medical graduates)	Issue Date

Individual National Physician Identifier (NPI)	Medi-Cal/Medicaid Number	Individual Medicare PTAN Number

All Other State Medical Licenses

State	License Number	Issue Date	Expiration Date

Other Certifications (e.g., Fluoroscopy, Radiography, ACLS/BLS/PALS, etc.)

Type of Certification	License Number	Expiration Date

Board Certification(s)

Include certifications by board(s) which are duly organized and recognized by:

- a member board of the American Board of Medical Specialties
- a member board of the American Osteopathic Association
- a board or association with equivalent requirements approved by the Medical Board of California
- a board or association with an Accreditation Council for Graduate Medical Education or American Osteopathic Association approved postgraduate training that provides complete training in that specialty or subspecialty.

Name of Issuing Board	Certificate Number	Date Certified/Recertified	Expiration Date (if any)

Back to Agenda

Board Certification(s) (Continued)

Have you applied for board certification other than those indicated on the prior page? ◯ Yes ◯ No

If so, list board(s) and date(s):

If not certified, describe your intent for certification, if any, and date of eligibility for certification below or in a separate sheet.

Specialty:

Board Name:

Exam Date:

Describe here:

VIII. Current Hospital and Other Institutional Affiliations

Please list in reverse chronological order (with the current affiliation(s) first) all institutions where you have current affiliations (A) and have had previous hospital privileges (B). This includes hospitals, surgery centers, institutions, corporations, military assignments, or government agencies. If more space is needed, attach additional sheet(s).

A. Current Affiliations

Hospital Name: | Department Name : | Status (active, provisional, courtesy, temporary, etc.):

Primary Hospital Address:

City: | State: | Zip Code: | From (mm/yy):

Medical Staff Phone: | Medical Staff Fax: | To (mm/yy):

Hospital Name: | Department Name : | Status (active, provisional, courtesy, temporary, etc.):

Secondary Hospital Address:

City: | State: | Zip Code: | From (mm/yy):

Medical Staff Phone: | Medical Staff Fax: | To (mm/yy):

Hospital Name: | Department Name : | Status (active, provisional, courtesy, temporary, etc.):

Other Institution Address:

City: | State: | Zip Code: | From (mm/yy):

Medical Staff Phone: | Medical Staff Fax: | To (mm/yy):

Hospital Name: | Department Name : | Status (active, provisional, courtesy, temporary, etc.):

Other Institution Address:

City: | State: | Zip Code: | From (mm/yy):

Medical Staff Phone: | Medical Staff Fax: | To (mm/yy):

Back to Agenda

A. Current Affiliations (continued)

If you do not have hospital privileges, please explain (physicians without hospital privileges must provide written plan for continuity of care):

B. Previous Hospital and Other Institution Affiliations

Name and Address of Affiliation:

Department:

From (mm/yy):

To (mm/yy):

Reason for leaving:

Name and Address of Affiliation:

Department:

From (mm/yy):

To (mm/yy):

Reason for leaving:

Name and Address of Affiliation:

Department:

From (mm/yy):

To (mm/yy):

Reason for leaving:

Name and Address of Affiliation:

Department:

From (mm/yy):

To (mm/yy):

Reason for leaving:

Name and Address of Affiliation:

Department:

From (mm/yy):

To (mm/yy):

Reason for leaving:

Back to Agenda

IX. Peer References

List three professional references, preferably from your specialty area, not including relatives, current partners or associates in practice. If possible, include at least one member from the Medical Staff of each facility at which you have privileges.

NOTE: References must be from individuals who are directly familiar with your work, either via direct clinical observation or through close working relations. **At least one reference must be from someone with the same credentials, for example, a MD must list a reference from another MD or a DPM must list one reference from another DPM.**

Name of Reference: Specialty:

Address City State Zip

Telephone Number: Fax Number: Email Address:

Name of Reference: Specialty:

Address City State Zip

Telephone Number: Fax Number: Email Address:

Name of Reference: Specialty:

Address City State Zip

Telephone Number: Fax Number: Email Address:

X. Work History

For Re-Credentialing, check box if no changes in the last three (3) years. ☐

Chronologically list all work history activities since completion of postgraduate training (use extra sheets if necessary). This information must be complete. Curriculum vitae are not sufficient. Please explain any gaps on a separate page.

Current Practice: Contact Name:

Address City State Zip

Telephone Number: Fax Number: From (mm/yy): To (mm/yy):

Name of Practice/Employer: Contact Name:

Address City State Zip

Telephone Number: Fax Number: From (mm/yy): To (mm/yy):

Name of Practice/Employer: Contact Name:

Address City State Zip

Telephone Number: Fax Number: From (mm/yy): To (mm/yy):

XI. Professional Liability

Please list all of your professional liability carriers for the past five years, listing the most recent first. If more space is needed, attach additional sheet(s).

Name of Current Insurance Carrier: Policy Number:

Address City State Zip

Telephone Number: Fax Number: Website (if applicable):

Email Address: Tail Coverage? Yes No Per Claim Amount:

Original Effective Date: Expiration Date: Aggregate Amount:

Name of Carrier: Policy Number:

Address City State Zip

Telephone Number: Fax Number: Website (if applicable):

Email Address: Tail Coverage? Yes No Per Claim Amount:

Original Effective Date: Expiration Date: Aggregate Amount:

Name of Carrier: Policy Number:

Address City State Zip

Telephone Number: Fax Number: Website (if applicable):

Email Address: Tail Coverage? Yes No Per Claim Amount:

Original Effective Date: Expiration Date: Aggregate Amount:

XII. Professional and Practice Services

Are you a Certified Qualified Medical Examiner (QME) of the State Industrial Medical Council? Yes No

What type of anesthesia do you provide in your group/office?

Local Regional Conscious Sedation General None Other (please specify)

If you provide direct laboratory services, please indicate the TIN utilized and provide Clinical Laboratory Information Act (CLIA) information. Attach a copy of your CLIA certificate or waiver.

Federal Tax ID: Type of Service Provided: Do you have a CLIA certificate? Yes No

Billing Name: Do you have a CLIA waiver? Yes No

CLIA Certificate Number: CLIA Certificate Expiration Date:

Back to Agenda

XII. Professional and Practice Services (continued)

Have you or your office received any of the following accreditations, certificates or licensures?

- [ ] American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF)
- [ ] Institute for Medical Quality-Accreditation Association for Ambulatory Health Care (IMQ-AAAHC)
- [ ] Medicare Certification
- [ ] Child Health and Disability Prevention Program (CHDP)
- [ ] California Children Services (CCS)
- [ ] The Medical Quality Commission (TMQC)
- [ ] Comprehensive Perinatal Services Program (CPSP)
- [ ] Family Planning
- [ ] Other ______________________

Please list international, state and/or national medical societies or other professional organizations or societies of which you are a member or applicant. Use the drop-down list to select your membership status.

Organization Name	Membership Status

Do you participate in electronic data interchange (EDI)? (Yes (No If so, which Network? ______________________

Do you use a practice management system/software? (Yes (No If so, which one? ______________________

Continue to the Next Page for HIV/AIDS Specialist Designation

HIV/AIDS SPECIALIST DESIGNATION

This legislation requires standing referrals to HIV/AIDS specialists for patients who need continued care for their HIV/AIDS. The Department of Managed Health Care (DMHC) recently defined an HIV/AIDS specialist under Regulation LS - 34 -01.

In order to comply with this regulation, we need to identify appropriately qualified specialists within our network who meet the definition of an HIV/AIDS specialist.

We will use your information for internal referral procedures and for publication listing in the Provider Directory.

As always, if information about your practice changes, please notify us promptly.

☐ No, I do not wish to be designated as an HIV/AIDS specialist.

☐ Yes, I do wish to be designated as an HIV/AIDS specialist based on the below criteria:

- ☐ I am credentialed as an "HIV Specialist" by the American Academy of HIV Medicine. **OR**
- ☐ I am board certified in HIV Medicine or have earned a Certificate of Added Qualification in the field of HIV Medicine granted by a member board of the American Board of Medical Specialties. **OR**
- ☐ I am board certified in Infectious Disease by a member board of the American Board of Medical Specialties and meet the following qualifications:
  1. In the immediately preceding 12 months, I have clinically managed medical care to a minimum of 25 patients who are infected with HIV; **AND**
  2. In the immediately preceding 12 months, I have successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment or both of HIV-infected patients, including a minimum of 5 hours related to antiretroviral therapy per year; **OR**
- ☐ In the immediately preceding 24 months, I have clinically managed medical care to a minimum of 20 patients who are infected with HIV; **AND**
  1. In the immediately preceding 12 months, I have obtained board certification or re-certification in the field of Infectious Disease from a member board of the American Board of Medical Specialties; **OR**
  2. In the immediately preceding 12 months, I have successfully completed a minimum of 30 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment or both, of HIV-infected patients; **OR**
  3. In the immediately preceding 12 months, I have successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment or both, of HIV-infected patients Medicine and successfully completed the HIV Medicine Competency Maintenance Examination administered by the American Academy of HIV Medicine.

Continue to the Next Page for Attestation

Back to Agenda

ATTESTATION QUESTIONS

INSTRUCTIONS: Please answer the following questions "Yes" or "No". If your answer to any of the following questions is "**Yes**", please provide full details on a separate sheet of paper.

1. Has your license to practice medicine, Drug Enforcement Administration (DEA) registration or an applicable narcotic registration in any jurisdiction ever been denied, limited, restricted, suspended, revoked, not renewed, or subject to probationary conditions, or have you voluntarily or involuntarily relinquished any such license or registration or voluntarily or involuntarily accepted any such actions or conditions or have you been fined or received a letter of reprimand or is such action pending? ◯ Yes ◯ No

2. Have you ever been charged, suspended, fined, disciplined, or otherwise sanctioned, subjected to probationary conditions, restricted or excluded, or have you voluntarily or involuntarily relinquished eligibility to provide services or accepted conditions on your eligibility to provide services, for reasons relating to possible incompetence or improper professional conduct, or breach of contract or program conditions by Medicare, Medicaid, or any federal program or is any such action pending? ◯ Yes ◯ No

3. Have your clinical privileges, membership, contractual participation or employment by any medical organization (e.g., hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), private payer (including those that contract with (public) federal programs), or other health delivery entity or system), ever been denied, suspended, restricted, reduced, subject to probationary conditions, revoked or not renewed for possible incompetence, improper professional conduct or breach of contract, or is any such action pending? ◯ Yes ◯ No

4. Have you ever surrendered, allowed to expire, voluntarily or involuntarily withdrawn a request for membership or clinical privileges, terminated contractual participation or employment, or resigned from any medical organization (e.g., hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), or other health delivery entity or system) while under investigation for possible incompetence or improper professional conduct, or breach of contract, or in return for such an investigation not being conducted, or is any such action pending? ◯ Yes ◯ No

5. Have you ever surrendered, voluntarily withdrawn, or been requested or compelled to relinquish your status as a student in good standing in any internship, residency, fellowship, preceptorship, or other clinical education program? ◯ Yes ◯ No

6. Have you ever been denied certification/recertification by a specialty board? ◯ Yes ◯ No

7. Have you ever chosen not to recertify or voluntarily surrender your board certification while under investigation? ◯ Yes ◯ No

8. a. Have you ever been convicted of, or pled guilty to a criminal offense (e.g., felony or misdemeanor) and/or placed on deferred adjudication or probation for a criminal offense other than a misdemeanor traffic offense? ◯ Yes ◯ No
   b. Are any such actions pending? ◯ Yes ◯ No

9. Have any judgments been entered against you, or settlements been agreed to by you within the last seven (7) years, in professional liability cases? If **YES**, please complete Addendum B. ◯ Yes ◯ No

10. Are there any professional liability lawsuits/arbitrations against you that have been dismissed or currently pending? If **YES**, please complete Addendum B. ◯ Yes ◯ No

11. Has your professional liability insurance ever been terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged), or have you ever been denied professional liability insurance, or has any professional liability carrier provided you with written notice of any intent to deny, cancel, not renew, or limit your professional liability insurance or its coverage of any procedures? ◯ Yes ◯ No

12. Do you have any physical or mental condition which would prevent or limit your ability to perform the essential functions of the position and/or privileges for which your qualifications are being evaluated in accordance with accepted standards of professional performance, with or without reasonable accommodations? If **YES**, please describe on a separate sheet any accommodations that could reasonably be made to facilitate your performance of such functions without risk of compromise. ◯ Yes ◯ No

Continue to the Next Page for Additional Attestation

Back to Agenda

ATTESTATION QUESTIONS (Continued)

INSTRUCTIONS: Please answer the following questions "Yes" or "No". If your answer to any of the following questions is "**Yes**", please provide full details on a separate sheet of paper.

13. Have you ever rendered professional medical services as an employee of a staff model HMO, an entity insured by the federal government (such as the military or a Federally Qualified Health Center) or an academic institution. ◯ Yes ◯ No

    If **YES**, have you, in the past seven (7) years, been named as a defendant in a lawsuit (whether or not you were later dismissed from the matter)? ◯ Yes ◯ No

14. Is your current ability to practice impaired by chemical dependency or substance abuse, including present use of illegal drugs? ◯ Yes ◯ No

15. Within the last two (2) years, has your membership, privileges, participation or affiliation with any healthcare organization (e.g., a hospital or HMO), been terminated, suspended or restricted; or have you taken a leave of absence from a health care organization for reasons related to the abuse of, or dependency on, alcohol or drugs? ◯ Yes ◯ No

I hereby affirm that the information submitted in this Section, Attestation Questions, Application, and any addenda thereto is current, correct, and complete to the best of my knowledge and belief and in good faith. I understand that material omissions or misrepresentations may result in denial of my application or termination of my privileges, employment or physician participation agreement.

APPLICANT SIGNATURE (Stamp is Not Acceptable)	**PRINTED NAME**	**DATE**

Continue to the Next Page for Information Release/

INFORMATION RELEASE/ACKNOWLEDGEMENTS

I hereby consent to the disclosure, inspection and copying of information and documents relating to my credentials and qualifications and performance ("credentialing information") by and between "this Healthcare Organization" and other Healthcare Organizations (e.g., hospital medical staffs, medical groups, independent practice associations (IPAs), health care service plans, health maintenance organizations (HMOs), preferred provider organizations (PPOs), other health delivery systems or entities, medical societies, professional associations, medical school faculty positions, training programs, professional liability insurance companies {with respect to certification of coverage and claims history}, licensing authorities, and businesses and individuals acting as their agents - collectively "Healthcare Organizations,") for the purpose of evaluating this application and any recredentialing application regarding my professional training, experience, character, conduct and judgment, ethics, and ability to work with others. In this regard, the utmost care shall be taken to safeguard the privacy of patients and the confidentiality of peer records, and to protect peer review information from being further disclosed.

I am informed and acknowledge that federal and state laws provide immunity protections to certain individuals and entities for their acts and/or communications in connection with evaluating the qualifications of healthcare providers. I hereby release all persons and entities, including this Healthcare Organization, engaged in quality assessment, peer review and credentialing on behalf of this Healthcare Organization, and all persons and entities providing credentialing information to such representatives of this Healthcare Organization, from any liability they might incur for their acts and/or communications in connection with evaluation of my qualifications for participation in this Healthcare Organization, to the extent that those acts and/or communications are protected by state or federal law.

I understand that I shall be afforded such fair procedures with respect to my participation in this Healthcare Organization as may be required by state and federal law and regulation, including, but not limited to, California Business and Professions Code Section 809 et seq., if applicable.

I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubt about such qualifications.

During such time as this application is being processed, I agree to update the application should there be any change in the information provided.

In addition to any notice required by any contract with a Healthcare Organization, I agree to notify this Healthcare Organization immediately in writing of the occurrence of any of the following: (i) the unstayed suspension, revocation or nonrenewal of my license to practice medicine in California; (ii) any suspension, revocation or nonrenewal of my DEA or other controlled substances registration; or (iii) any cancellation or nonrenewal of my professional liability insurance coverage.

I further agree to notify this Healthcare Organization in writing, within fourteen (14) days from the occurrence of any of the following: (i) receipt of written notice of any adverse action against me, by the Medical Board of California taken or pending, including, but not limited to, any accusation filed, temporary restraining order or imposition of any interim suspension, probation or limitations affecting my license to practice medicine; or (ii) any adverse action against me by any Healthcare Organization, which has resulted in the filing of a Section 805 report (or any subsections) with the Medical Board of California, appropriate licensing board or a report with the National Practitioner Data Bank; or (iii) the denial, revocation, suspension, reduction limitation, nonrenewal or voluntary relinquishment by resignation of my medical staff membership or clinical privileges at any Healthcare Organization; or (iv) any material reduction in my professional liability insurance coverage; or (v) my receipt of written notice of any legal action against me, including, without limitation, any filed and served malpractice suit or arbitration action; or (vi) my conviction of any crime (excluding any minor traffic violations); or (vii) my receipt of written notice of any adverse action against me under the Medicare or Medicaid programs, including, but not limited to, fraud and abuse proceedings or convictions.

I pledge to provide continuous care for my patients.

I hereby affirm that the information submitted in this application and any addenda thereto (including my curriculum vitae if attached) is true, current, correct, and complete to the best of my knowledge and belief and is furnished in good faith. I understand that material omissions or misrepresentations may result in denial of my application or termination of my privileges, employment or physician participation agreement.

A photocopy of this document shall be as effective as the original.

APPLICANT SIGNATURE (Stamp is Not Acceptable)	**PRINTED NAME**	**DATE**

Addenda Submitting :

☐ Addendum B: Professional Liability Action Explanation

This application and Addenda A and B were created and are endorsed by:
- California Association of Health Plans (916) 552-2910
- California Association of Physician Groups (916) 443-2274

The CPPA has been completed. Please be sure you have signed the last two pages (pages 15 and 16) before submission.

Back to Agenda

California Participating Practitioner Application

Addendum A

Practitioner Rights

Right to Review

The practitioner has the right to review information obtained by the Healthcare Organization for the purpose of evaluating that practitioner's credentialing or recredentialing application. This includes non-privileged information obtained from any outside source (e.g., malpractice insurance carriers, state licensing boards), but does not extend to review of information, references or recommendations protected by law from disclosure.

The practitioner may request to review such information at any time by sending a written request, via certified letter, to the Credentialing Department at the Healthcare Organization's offices. The Credentialing Department of the Healthcare Organization's offices, will notify the practitioner within 72 hours of the date and time when such information will be available for review at the Credentialing Department office.

Right to be Informed of the Status of Credentialing/Recredentialing Application

Practitioners may request to be informed of the status of their credentialing/recredentialing application. The practitioner may request this information by sending a written request by letter, email or fax to the Credentialing Department of the Healthcare Organization's offices.

The provider will be notified in writing by fax, email or letter no more than seven working days of the current status of your application with respect to outstanding information required to complete the application process.

Notification of Discrepancy

Practitioners will be notified in writing via fax, email or certified letter, when information obtained by primary sources varies substantially from information provided on the practitioner's application. Examples of information at substantial variance include reports of practitioner's malpractice claims history, actions taken against a practitioner's license/certificate, suspension or termination of hospital privileges or board certification expiration when one or more of these examples have not been self-reported by the practitioner on his/her application form. Practitioners will be notified of the discrepancy at the time of primary source verification. Sources will not be revealed if information obtained is not intended for verification of credentialing elements or is protected from disclosure by law.

Correction of Erroneous Information

If a practitioner believes that erroneous information has been supplied to Healthcare Organization by primary sources, the practitioner may correct such information by submitting written notification to the Credentialing Department. Practitioners must submit a written notice, via certified letter, along with a detailed explanation to the Credentialing Department at the Healthcare Organization, within 48 hours of the Healthcare Organization's notification to the practitioner of a discrepancy or within 24 hours of a practitioner's review of his/her credentials file.

Upon receipt of notification from the practitioner, the Healthcare Organization will re-verify the primary source information in dispute. If the primary source information has changed, correct will be made immediately to the practitioner's credentials file. The practitioner will be notified in writing, via certified letter, that the correction has been made to his/her credentials file. If, upon review, primary source information remains inconsistent with practitioner's notification, the Credentialing Department will so notify the practitioner via certified letter. The practitioner may then provide proof of correction by the primary source body to Healthcare Organization's Credentialing Department via certified letter at the address below within 10 working days. The Credentialing Department will re-verify primary source information if such documentation is provided.

Healthcare Organization's Credentialing Department Address:

Address: 505 City Parkway West

City: Orange ST: CA Zip: 92868

APPLICANT SIGNATURE

PRINTED NAME

DATE

California Participating Practitioner Application

Addendum B

Professional Liability Action Explained

This Addendum is submitted to ______ herein, this Healthcare Organization

Please complete this form for each pending, settled or otherwise conclude professional liability lawsuit or arbitration filed and served against you, in which you were named a party in the past seven (7) years, whether the lawsuit or arbitration is pending, settled or otherwise concluded, and whether or not any payment was made on your behalf by any insurer, company, hospital or other entity. All questions must be answered completely in order to avoid delay in expediting your application. If there is more than one professional liability lawsuit or arbitration action, please photocopy this Addendum B prior to completing, and complete a separate form for each lawsuit.

☐ *Please check here if there are no pending/settled claims to report (and sign below to attest).*

I. Practioner Identifying Information

Last Name: ______ First Name: ______ Middle: ______

II. Case Information

Patient's Name: ______ Patient Gender ◯ Male ◯ Female Patient DOB: ______

City, County, State where lawsuit filed: ______

Court Case number, if known: ______

Date of alleged incident serving as basis for the lawsuit/ arbitration: ______

Date suit filed: ______

Location of incident:
☐ Hospital ☐ My Office ☐ Other doctor's office ☐ Surgery Center ☐ Other (specify) ______

Relationship to patient (Attending physician, Surgeon, Assistant, Consultant, etc.) ______

Allegation

______

Is/was there an insurance company or other liability protection company or organization providing coverage/defense of the lawsuit or arbitration action? ◯ Yes ◯ No

If yes, please provide company name, contact person, phone number, location and carrier's claim identification number, or other liability protection company or organization.

______

If you would like us to contact your attorney regarding any of the above, please provide attorney(s) name(s) and phone number(s). Please fax this document to your attorney as this will serve as your authorization:

Name: ______ Telephone Number: ______ Fax Number: ______

III. Status of Lawsuit/Arbitration (check one)

- [ ] Lawsuit/arbitration still ongoing, unresolved.
- [ ] Judgment rendered and payment was made on my behalf. Amount paid on my behalf: $
- [ ] Judgment rendered and I was found not liable.
- [ ] Lawsuit/arbitration settled and payment made on my behalf. Amount paid on my behalf: $
- [ ] Lawsuit/arbitration settled/dismissed, no judgment rendered, no payment made on my behalf.

Summarize the circumstances giving rise to the action. If the action involves patient care, provide a narrative, with adequate clinical detail, including your description of your care and treatment of the patient. If more space is needed, attach additional sheets.

Please include:

1. Condition and diagnosis at the time of incident,
2. Dates and description of treatment rendered, and
3. Condition of patient subsequent to treatment.

SUMMARY

I certify that the information in this document and any attached documents is true and correct. I agree that "this Healthcare Organization", its representatives, and any individuals or entities providing information to this Healthcare Organization in good faith shall not be liable, to the fullest extent provided by law, for any act or occasion related to the evaluation or verification contained in this document, which is part of the California Participating Practitioner Application. In order for the participating healthcare organizations to evaluate my application for participation in and/or my continued participation in those organizations, I hereby give permission to release to this Healthcare Organization about my medical malpractice insurance coverage and malpractice claims history. This authorization is expressly contingent upon my understanding that the information provided will be maintained in a confidential manner and will be shared only in the context of legitimate credentialing and peer review activities. This authorization is valid unless and until it is revoked by me in writing. I authorize the attorney(s) listed on Page 1 to discuss any information regarding this case with "this Healthcare Organization".

APPLICANT SIGNATURE **PRINTED NAME** **DATE**

CalOptima Primary Source Verification Table

Primary Source Verification – Licensure

Licensure	Source of Verification	Method of Documentation
MD – Medical Board of California	www.mbc.ca.gov AIM screen with Facility log-in	Full print out indicating "data current as of" and the accessed date at bottom of the print out
DO- Osteopathic Board of California	www.ombc.ca.gov	Full print out indicating "data current as of" and the accessed date at bottom of the print out
DC- California Board of Chiropractic	www.chiro.ca.gov	Full print out indicating "data current as of" and the accessed date at bottom of the print out
DDS- Dental Board of California	www.dbc.ca.gov	Full print out indicating "data current as of" and the accessed date at bottom of the print out
DPM- California Board of Podiatric Medicine	www.bpm.ca.gov	Full print out indicating "data current as of" and the accessed date at bottom of the print out
California Board of Psychology	http://www.psychology.ca.gov	Full print out indicating "data current as of" and the accessed date at bottom of the print out
California Board of Behavioral Sciences	http://www.bbs.ca.gov	Full print out indicating "data current as of" and the accessed date at bottom of the print out
Department of Consumer Affairs Acupuncture Board	http://www.acupuncture.ca.gov	Full print out indicating "data current as of" and the accessed date at bottom of the print out
Department of Consumer Affairs CA State Board of Optometry	http://www.optometry.ca.gov	Full print out indicating "data current as of" and the accessed date at bottom of the print out

CalOptima Primary Source Verification Table

Primary Source Verification- DEA

DEA	Source of Verification	Method of Documentation
DEA	NTIS https://www.deanumber.com	Full print out indicating "data current as of"
	https://www.deadiversion.usdoj.gov (or)	Print out
	AMA Physician Master File Copy of current DEA certificate	Visual inspection/ print out

Primary Source Verification – Board Certification

Board Certification	Source of Verification	Method of Documentation
Board Certification	www.Boardcertifieddocs.com (or)	Print out
	https://www.doprofiles.org/	Print out
	American Board of Podiatric Surgery http://www.abps.org/	Print out

Primary Source Verification- Education & Training

Education & Training	Source of Verification	Method of Documentation
Education & Training	Board certification by ABMS or AOA in practicing specialty	Print out certificate
	AMA Physician Master File http://profiles.ama-assn.org	Print out of AMA with education "verified" not "being verified" or "being re-verified" ; Print out
	(or)	
	AOA Official Osteopathic Physician Profile Report https://www.doprofiles.org/	AOA Profile
	(or) Contact the training institution to verify the highest level of training. State Licensing Agency, as applicable	Letter from institution stating that practitioner successfully completed the training in good standing or provide an explanation if the practitioner was ever disciplined.

Back to Agenda

CalOptima Primary Source Verification Table

Primary Source Verification – Malpractice History

Malpractice History	NPDB-HIPDB Http://www.npdb-hippdb.hrsa.gov	Print out of report

Primary Source Verification- Medicare/Medicaid Sanctions

Sanction Information	Source of Verification	Method of Documentation
State & Federal Sanctions	NPDB-HIPDB Http://www.npdb-hippdb.hrsa.gov (and)	Print out of report
	System for Award Management http://www.sam.gov (and)	Information entered in Credentialing Data Base and print out included in the credentialing packet
	Office of Inspector General http://oig.hhs.gov (and)	Information entered in Credentialing Data Base and print out included in the credentialing packet
	Medi-Cal Suspended & Ineligible List http://files.medi-cal.ca.gov/	Information entered in Credentialing Data Base and print out included in the credentialing packet
	AMA Physician Master File AOA Physician Profile report	In credentialing file (if used for verification of another element)
	State Licensing agencies	In Credentialing file

Back to Agenda

Ongoing Monitoring Website Information 01-25-2017

Licensing Board, Address and Phone Numbers	Practitioner Types	Website/links	Instructions and Comments	Report Frequency
Medical Board of California 2005 Evergreen Street, Suite 1200 Sacramento, CA 95815 PH:(916) 263-2382 or (800) 633-2322 Enforcement Central File Room PH: (916) 263-2525 FAX: (916) 263-2420 805's Discipline Coord. (916) 263-2449	MD	www.mbc.ca.gov **All communications for disciplinary actions will be done by e-mail to subscribers.** **Link to subscribe for actions:** **http://www.mbc.ca.gov/Subscribers/** **Link for all Disciplinary Actions/License Alerts distributed:** **http://www.mbc.ca.gov/Publications/Disciplinary_Actions/** **Enforcement Public Document Search (Search by Name or Lic:** **http://www2.mbc.ca.gov/PDL/Search.aspx**	You must signup to subscribe for E-mail notifications of accusations, license suspensions, restrictions, revocations, or surrenders for physicians and surgeons licensed by the MBOC. Disciplinary action documents are obtainable via the web-site by: • Link to Enforcement Public Document Search (on the left side of page under check your doctor online) or in the • License verification section; Under Public Documents – Top Right	Bi-Monthly subscribers will be sent information regarding Accusations. Decisions will be sent on a daily basis as the decisions become final
Osteopathic Medical Board of CA 1300 National Drive, Suite #150 Sacramento, CA 95834-1991 (916) 928-8390 Office (916) 928-8392 Fax E-mail:osteopathic@dca.ca.gov Enforcement/Disciplines(916)-928-8390 Ext. 6	DO	www.ombc.ca.gov **Direct Link To Enforcement Actions:** **http://www.ombc.ca.gov/consumers/enforce_action.shtml** **Subscribe to e-mail Alerts** **http://www.ombc.ca.gov/consumers/enforce_action.shtml**	▪ Link to Consumers Tab at the top ▪ Link to Enforcement Action Can get on a distribution list by e-mailing J. Corey Sparks, Lead Enforcement Analyst E-mail: Corey.Sparks@dca.ca.gov 916-928-8393 (PH) 916-928-8392 (FAX) The board is behind in updating the website. You can subscribe or send an e-mail to get on the distribution list. 01/18/17 – 2nd Quarter 2016 is the last posted report. E-mails distribution is current	Quarterly via the Website E-Mail Distribution list:

Revised 01-25-2017
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Back to Agenda

Ongoing Monitoring Website Information 01-25-2017

Licensing Board, Address and Phone Numbers	Practitioner Types	Website/links	Instructions and Comments	Report Frequency
Medical Board of California **Board of Podiatric Medicine** 2005 Evergreen Street, Ste. 1300 Sacramento, CA 95815-3831 PH: (916) 263-2647 Fax:(916) 263-2651 Email: BPM@dca.ca.gov Enforcement Program Central File Room Medical Board of California 2005 Evergreen Street, Suite 1200 Sacramento, CA 95815 FAX: (916) 263-2420	DPM	**www.bpm.ca.gov** **Direct Link toEnforcement Resources:** **http://www.bpm.ca.gov/consumers/index.shtml** **Subscribers list** **http://www.mbc.ca.gov/Subscribers/** .	▪ Consumers ▪ Link to Enforcement Resources ▪ Link to Recent Disciplinary Actions(Categorized by the following): ➢ Decisions ➢ Accusations Filed ➢ Accusation and Petition to Revoke Probation filed ➢ Accusations and/or Statement of Issues Withdrawn or Dismissed ➢ Statement of Issues Listed alphabetically by category: Decision, Accusation, etc. 9/21/16 was the latest update on 12/15/16 and no reports were available. Updated01/17/17	Board of Podiatric Medicine: Changes to viewing information. On the website go to recent Disciplinary Actions, separated into categories, Decisions, Accusations filed, etc. History not available only current accusations and decisions latest one year from effective date. You can subscribe to actions related to licenses
Acupuncture Board 1747 N. Market Blvd Suite 180 Sacramento, CA 95834 PH: (916) 515-5200 Fax: (916) 928-2204 Email: acupuncture@dca.ca.gov To order copies of actions send to Attn of Consumer Protection Program	LAC/AC	**www.acupuncture.ca.gov** **Direct Link to Disciplinary Actions:** **www.acupuncture.ca.gov/consumers/board_actions.shtml** **Sign up for subscribers list for disciplinary actions:** **https://www.dca.ca.gov/webapps/acupuncture/subscribe.php**	▪ Link to Consumer at the top ▪ Link to DisciplinaryActions Last update January 5, 2017	Monthly running report listed Alpha Newer actions highlighted with date in blue. Note: Board meetings are held quarterly.

Revised 01-25-2017
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Ongoing Monitoring Website Information 01-25-2017

Licensing Board, Address and Phone Numbers	Practitioner Types	Website/links	Instructions and Comments	Report Frequency
Board of Behavioral Sciences 1625 N Market Blvd., Suite S-200 Sacramento, CA 95834 PH: (916) 574-7830 Fax: (916) 574-8625 E-Mail: BBSWebmaster@bbs.ca.gov	Licensee Licensed Clinical Social Workers (LCSW) Licensed Marriage and Family Therapists (LMFT) Licensed Professional Clinical Counselors (LPCC) Licensed Educational Psychologists (LEP)	**www.bbs.ca.gov** **Sign up for subscribers list for disciplinary actions.** **https://www.dca.ca.gov/webapps/bbs/subscribe.php**	You must sign up for Subscriber list to obtain Enforcement Actions. E-mail will be sent to you. If you don't sign up as a subscriber, the News Letters will provide disciplinary actions.	**Via Subscriptions Only** Information must be obtained via subscription. For Subscribers: E-mail reports were sent:
CA Board of Chiropractic Examiners Board of Chiropractic Examiners 901 P Street, Suite 142A Sacramento, CA 95814 PH (916) 263-5355 FAX (916) 327-0039 Email: chiro.info@dca.ca.gov	DC	**www.chiro.ca.gov** **Monthly Reports** **http://www.chiro.ca.gov/enforcement/actions.shtml**	Note monthly disciplinary actions reports ▪ Link to Enforcement at the top right side (next to Contact Us) ▪ Link to Disciplinary Actions ▪ Actions listed by month and year Last report December 2016	Monthly
Dental Board of California 2005 Evergreen Street, Suite 1550 Sacramento, CA 95815 PH: (916) 263-2300 PH: (877)729-7789 Toll Free Fax #: (916) 263-2140 Email:dentalboard@dca.ca.gov Enforcement Unit PH: 916-274-6326	DDS, DMD	**www.dbc.ca.gov** **Direct Link to Disciplinary Actions:** **http://www.dbc.ca.gov/consumers/hotsheets.shtml**	▪ Link Home Page ▪ Under Highlights at the bottom of the page-Link to Hot Sheet! Dental Disciplinary Action ▪ Actions listed by month and year Or ▪ Link to Consumer ▪ Hot Sheets (Summary of Administrative Actions Last report December 2016	Monthly Note: At the end of the list it provides a date posted. As of 12/31/2016

Revised 01-25-2017

This document is for informational purposes only and subject to change.

Please visit the individual websites listed for the most current up-to-date information.

Back to Agenda

Ongoing Monitoring Website Information 01-25-2017

Licensing Board, Address and Phone Numbers	Practitioner Types	Website	Instructions and Comments	Report Frequency
California Board of Occupational Therapy (CBOT) 2005 Evergreen St. Suite 2250 Sacramento, CA 95815 PH: (916) 263-2294 Fax: (916) 263-2701 Email: cbot@dca.ca.gov Email: EnfPrg@dca.ca.gov	OT, OTA	**www.bot.ca.gov** **Direct Link To Enforcement Actions:** **http://www.bot.ca.gov/consumers/disciplinary_action.shtml** **Sign up for subscribers list for disciplinary actions:** **https://www.dca.ca.gov/webapps/bot/subscribe.php**	▪ Link to Consumer at the top ▪ Link to Disciplinary Action Practitioners are listed under: Revocations, Surrenders and Other Disciplinary Orders: A – L and M – Z. **Sign up to receive a monthly Hot Sheet List of disciplinary actions via e-mail to:** EnfPrg.Enfprg@dca.ca.gov Will need to send a written request to obtain the information, which may be sent back to you via e-mail.	Update as needed (whenever they have an update). Depends on when there is an OT placed on probation or revoked. Listed Alpha by type of action. E-Mail Submission
California State Board of Optometry 2450 Del Paso Road, Suite 105 Sacramento, CA 95834 PH:(916) 575-7170 Fax (916) 575-7292 Email: optometry@dca.ca.gov	OD	**www.optometry.ca.gov** **Direct Link To Enforcement Actions:** **http://www.optometry.ca.gov/consumers/disciplinary.shtml**	▪ Link to Consumer at the top ▪ Link to Citations and Disciplinary Actions ▪ Bottom of page actions are posted by year Practitioners are listed by year, type of action and then alphabetically Note: Report provides a Last Updated date at the top of the report. Last update12/22/2016	Listed by year, in Alpha Order by type of Action Website will be updated as actions are adopted. Recommend monthly review. The Board typically adopts formal disciplinary actions during regularly scheduled quarterly meetings.

Revised 01-25-2017
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Please visit the individual websites listed for the most current up-to-date information.

Back to Agenda

Ongoing Monitoring Website Information 01-25-2017

Licensing Board, Address and Phone Numbers	Practitioner Types	Website	Instructions and Comments	Report Frequency
Physical Therapy Board of California 2005 Evergreen St. Suite 1350 Sacramento, CA 95815 PH: (916) 561-8200 Fax: (916) 263-2560	PT	**www.ptb.ca.gov** **Sign up for subscribers list for disciplinary actions:** **https://www.dca.ca.gov/webapps/ptbc/interested_parties.php**	Disciplinary action and license reinstatement information may be obtained by checking the Board's online license verification system. Last update 9/28/15	**None** – This entity does not release sanction information reports, organizations are required to conduct individual queries every 12-18 months on credentialed practitioners.
Physician AssistantBoard (PAB) 2005 Evergreen Street Suite 1100 Sacramento, CA 95815 PH: (916) 561-8780 FAX(916) 263-2671 Email:pacommittee@mbc.ca.gov	PA/PAC	**www.pac.ca.gov** **Direct Link To Enforcement Actions:** **www.pac.ca.gov/forms_pubs/disciplinaryactions.shtml**	▪ Link to Consumers ▪ Link to Disciplinary Action ▪ Link to Month within the year at bottom of the page Practitioners listed via month, then Alpha Last report listed December 2016	Monthly Note Reports for December 2014 – July 2015 were all posted at the same time, between 8/25/15 and 8/31/15.
Board of Psychology 1625 North Market Blvd, Suite N-215 Sacramento, CA 95834 bopmail@dca.ca.gov Office Main Line (916)-574-7720 **Toll Free Number: 1-866-503-3221.**	PhD, PsyD	**www.psychboard.ca.gov** **Sign up for subscribers list for disciplinary actions:** **https://www.dca.ca.gov/webapps/psychboard/subscribe.php**	**Monthly reports are no longer available on the website. (change took place around September or October 2014)** You must sign up for Subscriber list to obtain Enforcement Actions. E-mail will be sent to you. If you don't sign up as a subscriber, the News Letters will provide disciplinary actions. To order copies documents, send your written request, including the name and license number of the licensee, to the attention of the Enforcement Program at the Board's offices in Sacramento. A fee is charged for these documents.	**Via Subscriptions Only** Information must be obtained via subscription. For Subscribers: E-mail

Revised 01-25-2017
This document is for informational purposes only and subject to change.
Please visit the individual websites listed for the most current up-to-date information.

Back to Agenda

Ongoing Monitoring Website Information 01-25-2017

Licensing Board, Address and Phone Numbers	Practitioner Types	Website	Instructions and Comments	Report Frequency
CA Board of Registered Nursing 1747 North Market Blvd, Suite 150 Sacramento, CA 95834 Mailing Address: Board of Registered Nursing P.O. Box 944210 Sacramento, CA 94244-2100 Phone: (916) 322-3350 FAX (916) 574-7693. Email: enforcement_brn@dca.ca.gov	Certified Nurse Midwife (CNM) Certified Nurse Anesthetist (CRNA) Clinical Nurse Specialist (CNS) Critical Care Nurse (CCRN) Nurse Practitioner (NP) Registered Nurse (RN) Psychiatric Mental Health Nursing (PMHN) Public Health Nurse (PHN)	**www.rn.ca.gov** **Unlicensed Practice/Nurse Imposter Citations:** **http://www.rn.ca.gov/enforcement/unlicprac.shtml**	Disciplinary action and license reinstatement information may be obtained by checking the Board's online license verification system. Photocopies of this information may be requested by faxing the Board's Enforcement Program at (916) 574-7693. Or You can subscribe to the National Council of State Board of Nursing (BCSBN) Nursys e-Notify system. **See website information below.**	**None**–This entity does not release sanction information reports, organizations are required to conduct individual queries every 12-18 months on credentialed practitioners.
National Council of State Board of Nursing (BCSBN) 111 East Wacker Drive, Suite 2900 Chicago, IL 60601-4277 Phone:(312) 525-3600 Fax: (312) 279-1032 Email: info@ncsbn.org .	Additional information for RN/LVN/NP/CNM	**www.nursys.com** To subscribe for daily, weekly or monthly (depending on how often you want to be updated) updates on license status, expirations and disciplinary actions. **https://www.nursys.com/EN/ENDefault.aspx**	Nursys e-Notify informs you if you employed RNs or LPN/VNs and Advance Practice Nurses (APRN in the categories of Nurse Practitioner (NP), Certified Registered Nurse Anesthetist (CRNA), Certified Nurse Midwife (CNM) and Clinical Nurse Specialist (CNS) have received public discipline or alerts from their licensing jurisdiction(s).	.
Speech-Language Pathology & Audiology Board 2005 Evergreen Street, Suite 2100 Sacramento, CA 95815 Email: speechandhearing@dca.ca.gov Main Phone Line: (916) 263-2666 Main Fax Line: (916) 263-2668	SP, AU	**http://www.speechandhearing.ca.gov/** **Direct Link to Accusations Pending and Disciplinary Actions:** **http://www.speechandhearing.ca.gov/consumers/enforcement.shtml** As of1/18/2017the information represents disciplinary action taken by the Board from:7/1/07 – 09/30/2016.	▪ Link to Consumer ▪ Link to Enforcement ▪ Link to Accusations pending or Disciplinary Actions 1. For actions pending Board decisions select "SP/AU" For Speech-Language Pathology & Audiology 2. For Board decisions select "Disciplinary Actions". Last report listed FY 2016-2017 Action Taken	**Quarterly** Disciplinary Actions are listed by fiscal year. Pending Actions are listed alphabetically by first name.

Revised 01-25-2017

This document is for informational purposes only and subject to change.

Please visit the individual websites listed for the most current up-to-date information.

Back to Agenda

Ongoing Monitoring Website Information 01-25-2017

Site Name, Address and Phone Numbers	Service	Website	Instructions and Comments	Report Frequency
HHS Officer of Inspector General Office of Investigations Health Care Administrative Sanctions Room N2-01-26 7500 Security Blvd. Baltimore, MD21244-1850	OIG - List of Excluded Individuals and Entities (LEIE) excluded from Federal Health Care Programs: Medicare /Medicaidsanction &exclusions	**www.oig.hhs.gov** **Direct Link for individuals:** **http://exclusions.oig.hhs.gov/** **Direct Link to exclusion database** **http://oig.hhs.gov/exclusions/exclusions_list.asp**	▪ Link to Exclusions ▪ Link to LEIE Downloadable Databases under the Exclusion Program tab ▪ Link to the various reports, exclusions, reinstatements or databases. To subscribe for notifications follow instructions: Get Email updates	**Monthly** (see note under instructions regarding subscribing notifications)
Noridian Healthcare Solutions Medicare Opt-Out Physicians JE MAC **1855-609-9960 Select Provider Enrollment** **https://med.noridianmedicare.com/web/jeb**	Medicare Opt-Out	**https://www.noridianmedicare.com** Link to JE Part B **https://med.noridianmedicare.com/web/jeb** **Direct Link to Opt-Out Reports:** **https://med.noridianmedicare.com/web/jeb/enrollment/opt-out/opt-out-listing**	Under Medicare Contracts: ▪ Jurisdiction E Part B ▪ Link to Enrollment ▪ Opt Out of Medicare ▪ Opt Out Listing ▪ Link to Opt Out Listing by State: • Excel Listing or • HTML Listing On 01/20/17 Listing as follows: Excel Listing or (Last update 01/19/17) HTML Listing (Last update 01/19/17) However the HTML update noted the incorrect year 1/19/2016. Correction was made on 2/3/2017	**Quarterly** Last update: 01/19/17(updated 1/20/17) 08/15/16 06/13/16 (6/10/16) 12/23/15 10/30/15 Northern 10/08/15 Southern 08/14/15 07/07/15 04/13/15 03/11/15 01/28/15
CMS.gov **Centers for Medicare & Medicaid Services**	Medicare Opt-Out Affidavits	**https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/OptOutAffidavits.html** For a listing of all physicians and practitioners that are currently opted out of Medicare: **https://data.cms.gov/dataset/Opt-Out-Affidavits/7yuw-754z**	This link will provide information regarding Opt Out Affidavits and Opt Providers from Data.CMS.gov.	

Revised 01-25-2017
This document is for informational purposes only and subject to change.
Please visit the individual websites listed for the most current up-to-date information.

Back to Agenda

Ongoing Monitoring Website Information 01-25-2017

Site Name, Address and Phone Numbers	Service	Website	Instructions and Comments	Report Frequency
Department of Health Care Services (DHCS) **Medi-Cal Provider Suspended and Ineligible List** Office of Investigations Health Care Administrative Sanctions Room N2-01-26 7500 Security Blvd. Baltimore, MD21244-1850	Medi-Cal Reports exclusions and reinstatements from the State Medi-Cal Program	www.medi-cal.ca.gov **DirectLink to Suspended and Ineligible Provider List**: http://files.medi-cal.ca.gov/pubsdoco/SandILanding.asp	From Home Page: ▪ Link to References ▪ Suspended and Ineligible Provider List ▪ Under Download the S&I List is the list for the month. (Bottom of the page) Or ▪ Link to References ▪ Provider Enrollment ▪ Suspended and Ineligible Provider List ▪ Under Download the S&I List is the list for the month. (Bottom of the page) Last published 1/13/17	**Monthly**
SAM (System for Award Management) formerly known as Excluded Parties List System (EPLS)	Individuals and Organizations debarred from participating in government contracts or receiving government benefits or financial assistance	https://www.sam.gov/portal/SAM/#1 SAM Registration https://uscontractorregistration.com/ Note: The SAM website has a user guide: Link to SAM User Guide- v1.8.3 of 350:	Select Search Records at the top ▪ Under: Advanced Search ▪ Select Advance Search - Exclusion ▪ Select Single Search ▪ Scroll down and enter the Active Date to and from for the month you are reviewing ▪ Click search ▪ Export Results	**Monthly**
DEA Office of Diversion Control **800-882-9539** **deadiversionwebmaster@usdoj.gov**	**DEA Verification**	www.deadiversion.usdoj.gov/ **Direct Link to Validation Form** https://www.deadiversion.usdoj.gov/webforms/validateLogin.jsp	On the right side under Links: Link to Registration Validation Need DEA #, Name as it appears on your registration and SSN or TIN provided on application. **Note**: Please does not use the Duplicate Certification Link as it is for Physicians, use the Registration Validation Link.	**NA**

Revised 01-25-2017
This document is for informational purposes only and subject to change.
Please visit the individual websites listed for the most current up-to-date information.

Back to Agenda

Additional Websites

Site Name, Address and Phone Numbers	Service	Website	Instructions and Comments
The Licensed Facility Information system (LFIS) The Automated Licensing Information and Report Tracking System (ALIRTS) Contains license and utilization data information of healthcare facilities in California. The Licensed Facility Information system (LFIS) is maintained by the Office of Statewide Health Planning and Development to collect and display licensing and other basic information about California's hospitals, long-term care facilities, primary care and specialty clinics, home health agencies and hospices.	**Organizational Providers License Verification:** Hospitals Long-term care facilities Home Health Agencies Hospices Primary care and Specialty clinics	**www.alirts.oshpd.ca.gov/Default.aspx** **Direct Link:** **www.alirts.oshpd.ca.gov/LFIS/LFISHome.aspx**	The main source of the information in LFIS is the licenses issued by the Department of Health Services (DHS) Licensing and Certification District Offices. Contact information for these District Offices is available at: www.dhs.ca.gov/LNC/default.htm **To search for a facility** • Enter name in box that is found in top right corner Search or • Link to Advance Search on the left under Login. **LFIS Home** **Alirts Home** **Advanced Search** You may search by using the following four search categories, Facility Name, Facility Number, License and Legal Entity. Enter your search parameters within the one category you selected and click the Search button to the right.
The California Department of Public Health (CDPH) General Information (916) 558-1784	**Organizational Providers License Verification:** Hospitals Surgery Centers Home Health Agencies Hospices Dialysis Centers Others	http://www.cdph.ca.gov/Pages/DEFAULT.aspx Licensed Facility Report http://hfcis.cdph.ca.gov/Reports/GenerateReport.aspx?rpt=FacilityListing Health Facilities Search http://hfcis.cdph.ca.gov/search.aspx	Health Information Health Facilities Consumer Information System Find a facility Public Inquiry/Reports Type of Facility Select Excel or PDF format Health Facilities Search To check a particular facility, check the applicable box for the type (e.g. SNF or Hospital) then enter the Name or zip code and the facility will appear for you to select. You will be able to obtain copies of site visits for SNFs at this site.

Revised 01-25-2017
This document is for informational purposes only and subject to change.
Please visit the individual websites listed for the most current up-to-date information.

Back to Agenda

Additional Websites

Site Name, Address and Phone Numbers	Service	Website	Instructions and Comments
National Plan and Provider Enumeration System (NPPES) NPI Enumerator PO Box 6059 Fargo, ND 58108-6059 800-465-3203 customerservice@npienumerator.com The Centers for Medicare & Medicaid Services (CMS) has developed the National Plan and Provider Enumeration System (NPPES) to assign these unique identifiers. The NPI Registry enables you to search for a provider's NPPES information. All information produced by the NPI Registry is provided in accordance with the NPPES Data Dissemination Notice. Information in the NPI Registry is updated daily. You may run simple queries to retrieve this read-only data.	**Organizational Providers and Practitioners Numbers for the following:** • NPI • Medicare • Medi-Cal	https://nppes.cms.hhs.gov/NPPES/Welcome.do Search NPI Records https://npiregistry.cms.hhs.gov/ **Search the NPI Registry** • Search for an **Individual Provider** • Search for an **Organizational Provider**	Source for obtaining NPI Numbers, Medicare PIN and UPIN Numbers and Medicaid provider numbers Select Search the NPI Registry Complete the appropriate sections for Individual or for Organizations for individuals First Name Last Name for organizations Organization Name

Revised 01-25-2017
This document is for informational purposes only and subject to change.
Please visit the individual websites listed for the most current up-to-date information.

Back to Agenda

Additional Websites

Site Name, Address and Phone Numbers	Service	Website	Instructions and Comments
Social Security Death Master File (DMF). National Technical Information Services (NTIS) is the only authorized official distributor of the Death Master file on the web. Final Rule Establishing Certification Program for Access to Death Master File in Effect The National Technical Information Service (NTIS) established a certification program for subscribers to the Limited Access Death Master File (LADMF) through a Final Rule (FR), pursuant to Section 203 of the Bipartisan Budget Act of 2013 (Pub. L. 113-67) which also requires NTIS to recoup the cost of the certification program through processing fees. The FR was published in the Federal Register Wednesday, June 1, 2016, and became effective Monday, November 28, 2016. The FR may be reviewed at **https://www.gpo.gov/fdsys/pkg/FR-2016-06-01/html/2016-12479.htm**.	**Subscription to the Limited Access Death Master File (LADMF)**	**Social Security Death Master File (DMF) Website** https://www.ssdmf.com/FolderID/1/SessionID/%7B17B93F37-71E0-433B-B3F2-B9BA03D721A6%7D/PageVars/Library/InfoManage/Guide.htm **National Technical Information Services (NTIS)** https://classic.ntis.gov/products/ssa-dmf/#	You must register to obtain information and there are several fees associated with the service.

Revised 01-25-2017
This document is for informational purposes only and subject to change.
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Additional Websites

Board Certification, Address and Phone Numbers	Practitioner Types	Website	Instructions and Comments	Verification Type
Nursing Board Certification for Nurse Practitioners/Advance Practice Nurses **- American Academy of Nurse Practitioners Certification Board (AANPCB) (1/2017) (Formerly the American Academy of Nurse Practitioners Certification Program (AANPCP)** **- American Nurses Credentialing Center** (ANCC) **- National Certification Corporation for the Obstetrics, Gynecology and Neonatal Nursing Specialties**(ncc) **- Pediatric Nursing Certification Board** (PNCB) **- American Association of Critical-Care Nurses** (AACN)	NP	AANPCB - www.aanpcert.org/ ANCC -**www.nursecredentialing.org** ncc - **www.nccwebsite.org** PNCB - **www.pncb.org** AACN -**www.aacn.org**	Informational only to verify board certification	**Board Certification**
National Commission on Certification of PA's (NCCPA)	PAC	**http://www.nccpa.net/**	Informational only to verify board certification	**Board Certification**
American Midwifery Certification Board (amcb) 849 International Drive, Suite 120 Linthicum, MD 21090 Phone 410-694-9424	CNM and CM	**http://www.amcbmidwife.org/**	Under the Verify AMCB Certification ▪ Click Search button ▪ Enter last Name, First Name and Certification Number ▪ Click Search Button	**Board Certification** Informational only to verify board certification needed

Revised 01-25-2017

This document is for informational purposes only and subject to change.

Please visit the individual websites listed for the most current up-to-date information.

Back to Agenda

Additional Websites

Board Certification, Address and Phone Numbers	Practitioner Types	Website	Instructions and Comments	Verification Type
American Board of Professional Psychology (ABPP) 600 Market Street Suite 201 Chapel Hill, NC 27516 Phone 919-537-8031 email: office@abpp.org	PhD, PsyD	**http://www.abpp.org/**	Under Find a Board Certified Psychologists ▪ Click Verification Note there is a $25 charge, credits much be purchased prior to your verification search.	**Board Certification** Informational only to verify board certification if needed
Three specialty certifying boards are currently approved under California law for DPMs: – **American Board of Foot and Ankle Surgery** (formerly The American Board of Podiatric Surgery 7/1/14) (Also includes the following certifications: Foot Surgery and Reconstruction Rear foot/Ankle Surgery (RRA)). – **The American Board of Podiatric Medicine**(Conducts the certification process in Podiatric Orthopedics and Primary Podiatric Medicine – **American Board of Multiple Specialties in Podiatry.** (Includes Certification for Primary Care, Foot and ankle Surgery, diabetic wound care and limb salvage	DPM	• American Board of Foot and Ankle Surgery. https://www.abfas.org/ • The American Board of Podiatric Medicine conducts the certification process in Podiatric Orthopedics and Primary Podiatric Medicine. https://www.abpmed.org/ • American Board of Multiple Specialties in Podiatry. http://abmsp.org/	Informational only to verify board certification	**Board Certification**

Revised 01-25-2017
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Please visit the individual websites listed for the most current up-to-date information.

Back to Agenda

Policy #:	GG.1651Δ
Title:	**Credentialing and Recredentialing of Healthcare Delivery Organizations**
Department:	Medical Affairs
Section:	Quality Improvement

CEO Approval: Michael Schrader _______

Effective Date:	06/01/17
Last Review Date:	Not Applicable
Last Revised Date:	Not Applicable

Applicable to: ☒ Medi-Cal
☒ OneCare
☒ OneCare Connect
☒ PACE

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1 **I. PURPOSE**
2
3 This policy evaluates and determines whether to approve or decline Healthcare Delivery Organizations
4 (HDOs) participation in CalOptima programs.
5
6 **II. POLICY**
7
8 A. CalOptima shall establish guidelines by which CalOptima shall evaluate and select HDOs to
9 participate in CalOptima, in accordance with Title 42, Code of Federal Regulations, Section
10 422.204 and other applicable laws, regulations, and guidance.
11
12 B. CalOptima may delegate Credentialing and Recredentialing activities to a Health Network in
13 accordance with CalOptima Policy GG.1605: Delegation and Oversight of Credentialing and
14 Recredentialing Activities.
15
16 1. A Health Network shall establish policies and procedures to evaluate and approve HDOs to
17 participate in CalOptima programs that, at minimum, meet the requirements as outlined in this
18 policy.
19
20 C. The Chief Medical Officer (CMO), or his or her physician Designee, shall have direct responsibility
21 over and actively participate in the Credentialing program.
22
23 D. The CalOptima Credentialing and Peer Review Committee (CPRC) shall be responsible for
24 reviewing an HDO's Credentialing information and determining such HDO's participation in
25 CalOptima.
26
27 E. Prior to contracting with an HDO, CalOptima shall require that the HDO be successfully
28 credentialed, as applicable, including confirming that the HDO is in good standing with state and
29 federal regulatory agencies.
30
31 F. CalOptima shall categorize HDOs into three (3) risk levels: limited, moderate, and high, for
32 committing Fraud, Waste and Abuse, and will screen HDOs for the appropriate risk level in
33 accordance with Department of Health Care Services (DHCS) All Plan Letter (APL) 16-012:
34 Provider Credentialing and Recredentialing, Title 42, CFR, Section 455, and as described Section
35 III.A. of this Policy.
36

G. CalOptima shall Recredential an HDO at least every three (3) years, utilizing a thirty-six (36)-month cycle to the month, not to the day.

H. On a monthly basis, CalOptima shall monitor the Medicare and Medi-Cal Sanction Lists, which include OIG, SAM, and Medi-Cal. CalOptima shall immediately suspend any HDO identified on the Sanction Lists in accordance with CalOptima Policy GG.1607Δ: Monitoring Adverse Activities.

I. If CalOptima declines to include an HDO in the CalOptima network, CalOptima shall notify, in writing, such HDO within sixty (60) calendar days of the reason for its decision. An HDO shall have the right to file a complaint about the decision in accordance with CalOptima Policies HH.1101: CalOptima Provider Compliant and MA.9006: Provider Complaint Process, as applicable.

J. CalOptima shall monitor and prevent discriminatory Credentialing decisions as follows:

1. Periodic audits of Credentialing files (in-process, denied, and approved files) to ensure providers are not discriminated against;

2. Periodic audits of HDO complaints to determine if there are complaints alleging discrimination, including a review by the CPRC of quarterly reports of complaints, including discrimination;

3. Maintaining a heterogeneous Credentialing committee membership; and

4. Requiring that those responsible for Credentialing and Recredentialing decisions sign a statement affirming that they do not discriminate when making decisions.

K. CalOptima shall maintain the confidentiality of Credentialing files, in accordance with CalOptima Policy GG.1604Δ: Confidentiality of Credentialing Files.

L. On an annual basis, the CalOptima Board of Directors shall review and approve this Policy.

III. PROCEDURE

A. HDO Initial Credentialing

1. Prior to contracting with a Medical HDO, CalOptima shall initiate the Credentialing process and confirm that the Medical HDO is in good standing with state and federal regulatory agencies.

2. The HDO shall submit a signed and dated application and include the following attachments:

a. A current, valid license to operate in California, and confirmation that the HDO is in compliance with any other applicable state or federal requirement, and/or business license (or business tax certificate), as applicable;

b. Accreditation certificate, as applicable. Accrediting bodies include, but are not limited to:

i. Joint Commission: A copy of the certificate of accreditation by the Joint Commission, or another Centers for Medicare & Medicaid Services (CMS)-deemed accreditation organization;

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ii. Accreditation Association for Ambulatory Health Care (AAAHC);

iii. Commission on Accreditation of Rehabilitation Facilities (CARF);

iv. Community Health Accreditation Program (CHAP);

v. Continuing Care Accreditation Commission (CCAC); and

vi. Clinical Laboratory Improvement Amendments (CLIA).

c. If an HDO is not accredited, the HDO may submit evidence of an onsite quality review by the state, CMS, or similar agency, or CalOptima must provide evidence of onsite quality review. The onsite quality review must include the criteria used for the assessment, and the process for ensuring that the providers Credential their Practitioners.

d. Certificate of current liability insurance of at least the minimum amounts required by the Contract for Health Care Services, as follows:

i. General/Professional liability at one million ($1,000,000) per occurrence and three million ($3,000,000) aggregate; and

ii. Non-facilities liability at one million ($1,000,000) per occurrence and two million ($2,000,000) aggregate;

e. A copy of any history of sanctions or suspensions from Medicare and/or Medi-Cal; providers terminated from either Medicare or Medi-Cal or on the Suspended and Ineligible Provider list, as applicable.

f. Active enrollment in Medi-Cal and Medicare and a copy of exemptions if applicable;

g. A copy of the organization's Quality Programs, if applicable;

h. Staff roster and copy of all staff certifications, or licensure, if applicable;

i. A valid National Provider Identifier (NPI) number; and

j. A current W-9.

3. CalOptima shall conduct and communicate the results of a Facility Site Review (FSR) for Community Clinics and Free Standing Urgent Care centers providing services to CalOptima Members pursuant to CalOptima Policy GG.1608Δ: Full Scope Site Reviews to incorporate the documents to support review prior to Credentialing decisions.

4. All Credentialing applications shall be signed. Faxed, digital, electronic, scanned, or photocopied signatures are acceptable; however, signature stamps are not acceptable.

5. HDO Screening

a. If CalOptima identifies an HDO as moderate or high-risk, CalOptima will conduct a pre-enrollment site visit prior to contracting.

DRAFT

b. If CalOptima identifies an HDO as high-risk, CalOptima shall also require verification of a completed criminal background check and fingerprinting for prospective (newly credentialed) home health agencies and suppliers of Durable Medical Equipment and prosthetic and orthotic supplies and any individual with a five percent (5%), or greater, ownership.

B. HDO Recredentialing

1. CalOptima shall Recredential a Medical or Service HDO at least every three (3) years after initial Credentialing. At the time of Recredentialing, CalOptima shall:

   a. Collect and verify, at a minimum, all of the information required for initial credentialing, as set forth in Section III.A. of this Policy; and

   b. Incorporate the following data in the decision-making process:

      i. Quality review activities, including but not limited to, information from:

         a) DHCS, CMS, or other agency, as applicable;

         b) CalOptima quality review results, as applicable;

         c) Review of FSR results, as applicable; and

         d) Review of Grievance, Appeal, and potential quality issue (PQI) case reviews.

      ii. Review of the HDO's compliance with the terms of its contract with CalOptima.

      iii. Member satisfaction, if applicable;

      iv. Medical Record Reviews, if applicable;

      v. FSR results and Physical Accessibility Review Survey (PARS) results, if applicable; and

      vi. Compliance with the terms of the Provider's contract.

2. CalOptima shall ensure that an HDO has current California licensure, accreditation (if applicable), and insurance at all times during such HDO's participation in CalOptima.

3. If CalOptima terminates an HDO during the Recredentialing process for administrative reasons (e.g., the HDO failed to provide complete credentialing information) and not for quality reasons, it may reinstate the HDO within thirty (30) calendar days of termination and is not required to perform initial credentialing. However, CalOptima must re-verify credentials that are no longer within the verification time limit. If the reinstatement would be more than thirty (30) calendar days after termination, CalOptima must perform initial Credentialing of such HDO.

DRAFT

4. All Recredentialing applications shall be signed. Faxed, digital, electronic, scanned, or photocopied signatures are acceptable; however, signature stamps are not acceptable.

C. HDO Rights

1. CalOptima shall maintain Credentialing files that include documentation of required elements, as described in this Policy.

2. An HDO shall have the right to file a complaint about the decision in accordance with CalOptima Policies HH.1101: CalOptima Provider Compliant and MA.9006: Provider Complaint Process, as applicable.

D. Credentialing Peer Review Committee (CPRC)

1. CalOptima shall designate a CPRC that uses a peer-review process to make recommendations and decisions regarding Credentialing and Recredentialing.

2. Completed Credentialing and Recredentialing files will either be presented to the CMO, or his or her physician Designee, on a clean file list for signature, or will be presented at CPRC for review and approval.

   a. A clean file consists of a complete application with a signed attestation and consent form, supporting documents, and verification of no liability claim(s) that resulted in settlements or judgments paid by, or on behalf of, the HDO within the last seven (7) years from the date of the Credentialing or Recredentialing review

      i. A clean file shall be considered approved and effective on the date that the CMO, or his or her physician Designee, review and approve a HDO's Credentialing or Recredentialing file, and deem the file clean.

      ii. Approved, clean file lists shall be presented at the CPRC and reflected in the meeting minutes.

   b. Files that do not meet the clean file review process and require further review by CPRC include but are not limited to those files that include a history of liability claim(s) that resulted in settlements, or judgments, paid by or on behalf of the HDO, or files of HDOs that have a history of being included on the Medi-Cal Suspended and Ineligible Provider List.

      i. Non-clean list files will be reviewed by CPRC for determination to accept, or deny, the application. Files that are incomplete will not be processed until the Provider submits all the required information.

      ii. CPRC minutes shall reflect thoughtful consideration of information presented in the credentialing file.

      iii. CPRC meetings and decisions may take place in real-time, as a virtual meeting via telephone or video conferencing, but may not be conducted through e-mail.

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3. The CPRC shall make recommendations based on the HDO's ability to deliver care based on the Credentialing information collected from the file review process.

   a. The CalOptima Quality Improvement Department shall send the HDO, or applicant, a decision letter, within sixty (60) calendar days of the decision:

      i. Acceptance;

      ii. Approved with Restrictions; or

      iii. Denial of the application, along with information regarding the right to file a complaint, with a letter of explanation forwarded to the applicant.

   b. CalOptima shall render a final decision within one hundred eighty (180) calendar days from the date of licensure verification.

   c. If CalOptima is unable to render a decision within one hundred eighty (180) calendar days from the date of licensure verification for any HDO, during the HDO's Credentialing, or Recredentialing process, the application shall be considered expired.

4. Upon acceptance of the Credentialing application, the CalOptima Quality Improvement Department shall generate a Provider profile and forward the Provider profile to the Contracting and Provider Data Management Service (PDMS) Departments. The PDMS Department will enter the contract and Credentialing data into CalOptima's core business system, which updates pertinent information into the online Provider directory.

IV. ATTACHMENTS

A. Ongoing Monitoring Website Information Matrix

V. REFERENCES

A. 2017 NCQA Standards and Guidelines
B. California Evidence Code, §1157
C. CalOptima Contract for Health Care Services
D. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
E. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
F. CalOptima PACE Program Agreement
G. CalOptima Policy GG.1604Δ: Confidentiality of Credentialing Files
H. CalOptima Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities
I. CalOptima Policy GG.1607Δ: Monitoring Adverse Activities
J. CalOptima Policy GG.1608Δ: Full Scope Site Reviews
K. CalOptima Policy HH.1101: CalOptima Provider Compliant
L. CalOptima Policy MA.9006: Provider Complaint Process
M. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
A. Department of Health Care Services All Plan Letter (APL) 16-012: Provider Credentialing and Recredentialing

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1 N. Title 42, Code of Federal Regulations, §§422.204(a), 422.205, 424, 431 and 455.450
2 O. Title 45, Code of Federal Regulations, §455
3 P. Title 42, United States Code, §1320a-7(a)
4 Q. Title XVIII and XIV of the Social Security Act
5
6 **VI. REGULATORY AGENCY APPROVALS**
7
8 None to Date
9
10 **VII. BOARD ACTIONS**
11
12 A. 06/01/17: Regular Meeting of the CalOptima Board of Directors
13
14 **VIII. REVIEW/REVISION HISTORY**
15

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	06/01/2017	GG.1651Δ	Credentialing and Recredentialing	Medi-Cal OneCare OneCare Connect PACE

16

DRAFT

1 **IX. GLOSSARY**
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Term	Definition
Abuse	Actions that may, directly or indirectly, result in: unnecessary costs to a CalOptima Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.
Appeal	A request by the Member or the Member's Authorized Representative for review of any decision to deny, modify, or discontinue a Covered Service.
Credentialing	The process of obtaining, verifying, assessing, and monitoring the qualifications of a provider to provide quality and safe patient care services.
Credentialing Peer Review Committee	Peer review body who reviews provider information and files and makes recommendations and decisions regarding Credentialing and Recredentialing
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Facility Site Review	An onsite inspection to evaluate the capacity or continuing capacity of a site to support the delivery of quality health care services using the Facility Site Review (FSR), Medical Record Review (MRR) or Physical Accessibility Review Survey (PARS), DHCS provided tools.
Fraud	Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program. (18 U.S.C. § 1347).
Grievance	An oral or written expression of dissatisfaction, including any Complaint, dispute, request for reconsideration, or Appeal made by a Member.
Health Network	A Physician Hospital Consortium (PHC), Physician Medical Group, physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Medical Health Delivery Organizations (HDOs)	Organizations that are contracted to provide medical services such as hospitals, home health agencies, skilled nursing facilities, free standing surgical centers, extended care facilities (LTC), nursing homes (assisted living), hospice, community clinic, urgent care centers, dialysis centers, Residential Care Facility for the Elderly (RCFE), Community Based Adult Services (CBAS), durable medical equipment suppliers, radiology centers, clinical laboratories, rehabilitation facilities.
Medical Record Review (MRR)	A DHCS tool utilized to audit PCP medical records for format, legal protocols, and documented evidence of the provision of preventive care and coordination and continuity of care services.
Member	An enrollee-beneficiary of a CalOptima program.

DRAFT

Term	Definition
Physical Accessibility Review Survey (PARS)	A DHCS tool used to assess the level of physical accessibility of provider sites, including PCPs, high volume specialists and ancillary service providers, and CBAS centers
Practitioner	A licensed independent practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services.
Provider	Any person or institution that furnishes Covered Services.
Recredentialing	The process by which provider qualifications or status is verified in order to make determinations relating to their continued eligibility for participation in the CalOptima program.
Service Health Delivery Organizations (HDOs)	Organizations that are contracted to provide services that support Member needs such as ambulance, non-emergency medical transportation (NEMT) providers, and providers of other Member-facing services such as, other transportation, meal, and homecare services.
Waste	The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

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Ongoing Monitoring Website Information 01-25-2017

Licensing Board, Address and Phone Numbers	Practitioner Types	Website/links	Instructions and Comments	Report Frequency
Medical Board of California 2005 Evergreen Street, Suite 1200 Sacramento, CA 95815 PH:(916) 263-2382 or (800) 633-2322 Enforcement Central File Room PH: (916) 263-2525 FAX: (916) 263-2420 805's Discipline Coord. (916) 263-2449	MD	**www.mbc.ca.gov** **All communications for disciplinary actions will be done by e-mail to subscribers.** **Link to subscribe for actions:** **http://www.mbc.ca.gov/Subscribers/** **Link for all Disciplinary Actions/License Alerts distributed:** **http://www.mbc.ca.gov/Publications/Disciplinary_Actions/** **Enforcement Public Document Search (Search by Name or Lic:** **http://www2.mbc.ca.gov/PDL/Search.aspx**	You must signup to subscribe for E-mail notifications of accusations, license suspensions, restrictions, revocations, or surrenders for physicians and surgeons licensed by the MBOC. Disciplinary action documents are obtainable via the web-site by: • Link to Enforcement Public Document Search (on the left side of page under check your doctor online) or in the • License verification section; Under Public Documents – Top Right	Bi-Monthly subscribers will be sent information regarding Accusations. Decisions will be sent on a daily basis as the decisions become final
Osteopathic Medical Board of CA 1300 National Drive, Suite #150 Sacramento, CA 95834-1991 (916) 928-8390 Office (916) 928-8392 Fax E-mail:osteopathic@dca.ca.gov Enforcement/Disciplines(916)-928-8390 Ext. 6	DO	**www.ombc.ca.gov** **Direct Link To Enforcement Actions:** **http://www.ombc.ca.gov/consumers/enforce_action.shtml** **Subscribe to e-mail Alerts** **http://www.ombc.ca.gov/consumers/enforce_action.shtml**	▪ Link to Consumers Tab at the top ▪ Link to Enforcement Action Can get on a distribution list by e-mailing J. Corey Sparks, Lead Enforcement Analyst E-mail: Corey.Sparks@dca.ca.gov 916-928-8393 (PH) 916-928-8392 (FAX) The board is behind in updating the website. You can subscribe or send an e-mail to get on the distribution list. 01/18/17 – 2nd Quarter 2016 is the last posted report. E-mails distribution is current	Quarterly via the Website E-Mail Distribution list:

Revised 01-25-2017
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Back to Agenda

Ongoing Monitoring Website Information 01-25-2017

Licensing Board, Address and Phone Numbers	Practitioner Types	Website/links	Instructions and Comments	Report Frequency
Medical Board of California Board of Podiatric Medicine 2005 Evergreen Street, Ste. 1300 Sacramento, CA 95815-3831 PH: (916) 263-2647 Fax:(916) 263-2651 Email: BPM@dca.ca.gov Enforcement Program Central File Room Medical Board of California 2005 Evergreen Street, Suite 1200 Sacramento, CA 95815 FAX: (916) 263-2420	DPM	**www.bpm.ca.gov** **Direct Link toEnforcement Resources:** **http://www.bpm.ca.gov/consumers/index.shtml** **Subscribers list** **http://www.mbc.ca.gov/Subscribers/** .	▪ Consumers ▪ Link to Enforcement Resources ▪ Link to Recent Disciplinary Actions(Categorized by the following): ➢ Decisions ➢ Accusations Filed ➢ Accusation and Petition to Revoke Probation filed ➢ Accusations and/or Statement of Issues Withdrawn or Dismissed ➢ Statement of Issues Listed alphabetically by category: Decision, Accusation, etc. 9/21/16 was the latest update on 12/15/16 and no reports were available. Updated01/17/17	Board of Podiatric Medicine: Changes to viewing information. On the website go to recent Disciplinary Actions, separated into categories, Decisions, Accusations filed, etc. History not available only current accusations and decisions latest one year from effective date. You can subscribe to actions related to licenses
Acupuncture Board 1747 N. Market Blvd Suite 180 Sacramento, CA 95834 PH: (916) 515-5200 Fax: (916) 928-2204 Email: acupuncture@dca.ca.gov To order copies of actions send to Attn of Consumer Protection Program	LAC/AC	**www.acupuncture.ca.gov** **Direct Link to Disciplinary Actions:** **www.acupuncture.ca.gov/consumers/board_actions.shtml** **Sign up for subscribers list for disciplinary actions:** **https://www.dca.ca.gov/webapps/acupuncture/subscribe.php**	▪ Link to Consumer at the top ▪ Link to DisciplinaryActions Last update January 5, 2017	Monthly running report listed Alpha Newer actions highlighted with date in blue. Note: Board meetings are held quarterly.

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Back to Agenda

Ongoing Monitoring Website Information 01-25-2017

Licensing Board, Address and Phone Numbers	Practitioner Types	Website/links	Instructions and Comments	Report Frequency
Board of Behavioral Sciences 1625 N Market Blvd., Suite S-200 Sacramento, CA 95834 PH: (916) 574-7830 Fax: (916) 574-8625 E-Mail: BBSWebmaster@bbs.ca.gov	Licensee Licensed Clinical Social Workers (LCSW) Licensed Marriage and Family Therapists (LMFT) Licensed Professional Clinical Counselors (LPCC) Licensed Educational Psychologists (LEP)	**www.bbs.ca.gov** **Sign up for subscribers list for disciplinary actions.** **https://www.dca.ca.gov/webapps/bbs/subscribe.php**	You must sign up for Subscriber list to obtain Enforcement Actions. E-mail will be sent to you. If you don't sign up as a subscriber, the News Letters will provide disciplinary actions.	**Via Subscriptions Only** Information must be obtained via subscription. For Subscribers: E-mail reports were sent:
CA Board of Chiropractic Examiners Board of Chiropractic Examiners 901 P Street, Suite 142A Sacramento, CA 95814 PH (916) 263-5355 FAX (916) 327-0039 Email: chiro.info@dca.ca.gov	DC	**www.chiro.ca.gov** **Monthly Reports** **http://www.chiro.ca.gov/enforcement/actions.shtml**	Note monthly disciplinary actions reports ▪ Link to Enforcement at the top right side (next to Contact Us) ▪ Link to Disciplinary Actions ▪ Actions listed by month and year Last report December 2016	Monthly
Dental Board of California 2005 Evergreen Street, Suite 1550 Sacramento, CA 95815 PH: (916) 263-2300 PH: (877)729-7789 Toll Free Fax #: (916) 263-2140 Email:dentalboard@dca.ca.gov Enforcement Unit PH: 916-274-6326	DDS, DMD	**www.dbc.ca.gov** **Direct Link to Disciplinary Actions:** **http://www.dbc.ca.gov/consumers/hotsheets.shtml**	▪ Link Home Page ▪ Under Highlights at the bottom of the page-Link to Hot Sheet! Dental Disciplinary Action ▪ Actions listed by month and year Or ▪ Link to Consumer ▪ Hot Sheets (Summary of Administrative Actions Last report December 2016	Monthly Note: At the end of the list it provides a date posted. As of 12/31/2016

Revised 01-25-2017
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Please visit the individual websites listed for the most current up-to-date information.

Ongoing Monitoring Website Information 01-25-2017

Licensing Board, Address and Phone Numbers	Practitioner Types	Website	Instructions and Comments	Report Frequency
California Board of Occupational Therapy (CBOT) 2005 Evergreen St. Suite 2250 Sacramento, CA 95815 PH: (916) 263-2294 Fax: (916) 263-2701 Email: cbot@dca.ca.gov Email: EnfPrg@dca.ca.gov	OT, OTA	**www.bot.ca.gov** **Direct Link To Enforcement Actions:** **http://www.bot.ca.gov/consumers/disciplinary_action.shtml** **Sign up for subscribers list for disciplinary actions:** **https://www.dca.ca.gov/webapps/bot/subscribe.php**	▪ Link to Consumer at the top ▪ Link to Disciplinary Action Practitioners are listed under: Revocations, Surrenders and Other Disciplinary Orders: A – L and M – Z. **Sign up to receive a monthly Hot Sheet List of disciplinary actions via e-mail to:** EnfPrg.Enfprg@dca.ca.gov Will need to send a written request to obtain the information, which may be sent back to you via e-mail.	Update as needed (whenever they have an update). Depends on when there is an OT placed on probation or revoked. Listed Alpha by type of action. E-Mail Submission
California State Board of Optometry 2450 Del Paso Road, Suite 105 Sacramento, CA 95834 PH:(916) 575-7170 Fax (916) 575-7292 Email: optometry@dca.ca.gov	OD	**www.optometry.ca.gov** **Direct Link To Enforcement Actions:** **http://www.optometry.ca.gov/consumers/disciplinary.shtml**	▪ Link to Consumer at the top ▪ Link to Citations and Disciplinary Actions ▪ Bottom of page actions are posted by year Practitioners are listed by year, type of action and then alphabetically Note: Report provides a Last Updated date at the top of the report. Last update12/22/2016	Listed by year, in Alpha Order by type of Action Website will be updated as actions are adopted. Recommend monthly review. The Board typically adopts formal disciplinary actions during regularly scheduled quarterly meetings.

Revised 01-25-2017
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Back to Agenda

Ongoing Monitoring Website Information 01-25-2017

Licensing Board, Address and Phone Numbers	Practitioner Types	Website	Instructions and Comments	Report Frequency
Physical Therapy Board of California 2005 Evergreen St. Suite 1350 Sacramento, CA 95815 PH: (916) 561-8200 Fax: (916) 263-2560	PT	**www.ptb.ca.gov** **Sign up for subscribers list for disciplinary actions:** **https://www.dca.ca.gov/webapps/ptbc/interested_parties.php**	Disciplinary action and license reinstatement information may be obtained by checking the Board's online license verification system. Last update 9/28/15	**None** – This entity does not release sanction information reports, organizations are required to conduct individual queries every 12-18 months on credentialed practitioners.
Physician AssistantBoard (PAB) 2005 Evergreen Street Suite 1100 Sacramento, CA 95815 PH: (916) 561-8780 FAX(916) 263-2671 Email:pacommittee@mbc.ca.gov	PA/PAC	**www.pac.ca.gov** **Direct Link To Enforcement Actions:** **www.pac.ca.gov/forms_pubs/disciplinaryactions.shtml**	▪ Link to Consumers ▪ Link to Disciplinary Action ▪ Link to Month within the year at bottom of the page Practitioners listed via month, then Alpha Last report listed December 2016	Monthly Note Reports for December 2014 – July 2015 were all posted at the same time, between 8/25/15 and 8/31/15.
Board of Psychology 1625 North Market Blvd, Suite N-215 Sacramento, CA 95834 bopmail@dca.ca.gov Office Main Line (916)-574-7720 **Toll Free Number: 1-866-503-3221.**	PhD, PsyD	**www.psychboard.ca.gov** **Sign up for subscribers list for disciplinary actions:** **https://www.dca.ca.gov/webapps/psychboard/subscribe.php**	**Monthly reports are no longer available on the website. (change took place around September or October 2014)** You must sign up for Subscriber list to obtain Enforcement Actions. E-mail will be sent to you. If you don't sign up as a subscriber, the News Letters will provide disciplinary actions. To order copies documents, send your written request, including the name and license number of the licensee, to the attention of the Enforcement Program at the Board's offices in Sacramento. A fee is charged for these documents.	**Via Subscriptions Only** Information must be obtained via subscription. For Subscribers: E-mail

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Please visit the individual websites listed for the most current up-to-date information.

Back to Agenda

Ongoing Monitoring Website Information 01-25-2017

Licensing Board, Address and Phone Numbers	Practitioner Types	Website	Instructions and Comments	Report Frequency
CA Board of Registered Nursing 1747 North Market Blvd, Suite 150 Sacramento, CA 95834 Mailing Address: Board of Registered Nursing P.O. Box 944210 Sacramento, CA 94244-2100 Phone: (916) 322-3350 FAX (916) 574-7693. Email: enforcement_brn@dca.ca.gov	Certified Nurse Midwife (CNM) Certified Nurse Anesthetist (CRNA) Clinical Nurse Specialist (CNS) Critical Care Nurse (CCRN) Nurse Practitioner (NP) Registered Nurse (RN) Psychiatric Mental Health Nursing (PMHN) Public Health Nurse (PHN)	**www.rn.ca.gov** **Unlicensed Practice/Nurse Imposter Citations:** **http://www.rn.ca.gov/enforcement/unlicprac.shtml**	Disciplinary action and license reinstatement information may be obtained by checking the Board's online license verification system. Photocopies of this information may be requested by faxing the Board's Enforcement Program at (916) 574-7693. Or You can subscribe to the National Council of State Board of Nursing (BCSBN) Nursys e-Notify system. **See website information below.**	**None**–This entity does not release sanction information reports, organizations are required to conduct individual queries every 12-18 months on credentialed practitioners.
National Council of State Board of Nursing (BCSBN) 111 East Wacker Drive, Suite 2900 Chicago, IL 60601-4277 Phone:(312) 525-3600 Fax: (312) 279-1032 Email: info@ncsbn.org .	Additional information for RN/LVN/NP/CNM	**www.nursys.com** To subscribe for daily, weekly or monthly (depending on how often you want to be updated) updates on license status, expirations and disciplinary actions. **https://www.nursys.com/EN/ENDefault.aspx**	Nursys e-Notify informs you if you employed RNs or LPN/VNs and Advance Practice Nurses (APRN in the categories of Nurse Practitioner (NP), Certified Registered Nurse Anesthetist (CRNA), Certified Nurse Midwife (CNM) and Clinical Nurse Specialist (CNS) have received public discipline or alerts from their licensing jurisdiction(s).	.
Speech-Language Pathology & Audiology Board 2005 Evergreen Street, Suite 2100 Sacramento, CA 95815 Email: speechandhearing@dca.ca.gov Main Phone Line: (916) 263-2666 Main Fax Line: (916) 263-2668	SP, AU	**http://www.speechandhearing.ca.gov/** **Direct Link to Accusations Pending and Disciplinary Actions:** **http://www.speechandhearing.ca.gov/consumers/enforcement.shtml** As of1/18/2017the information represents disciplinary action taken by the Board from:7/1/07 – 09/30/2016.	▪ Link to Consumer ▪ Link to Enforcement ▪ Link to Accusations pending or Disciplinary Actions 1. For actions pending Board decisions select "SP/AU" For Speech-Language Pathology & Audiology 2. For Board decisions select "Disciplinary Actions". Last report listed FY 2016-2017 Action Taken	**Quarterly** Disciplinary Actions are listed by fiscal year. Pending Actions are listed alphabetically by first name.

Revised 01-25-2017

This document is for informational purposes only and subject to change.

Please visit the individual websites listed for the most current up-to-date information.

Back to Agenda

Ongoing Monitoring Website Information 01-25-2017

Site Name, Address and Phone Numbers	Service	Website	Instructions and Comments	Report Frequency
HHS Officer of Inspector General Office of Investigations Health Care Administrative Sanctions Room N2-01-26 7500 Security Blvd. Baltimore, MD21244-1850	OIG - List of Excluded Individuals and Entities (LEIE) excluded from Federal Health Care Programs: Medicare /Medicaidsanction &exclusions	**www.oig.hhs.gov** **Direct Link for individuals:** **http://exclusions.oig.hhs.gov/** **Direct Link to exclusion database** **http://oig.hhs.gov/exclusions/exclusions_list.asp**	▪ Link to Exclusions ▪ Link to LEIE Downloadable Databases under the Exclusion Program tab ▪ Link to the various reports, exclusions, reinstatements or databases. To subscribe for notifications follow instructions: Get Email updates	**Monthly** (see note under instructions regarding subscribing notifications)
Noridian Healthcare Solutions Medicare Opt-Out Physicians JE MAC **1855-609-9960 Select Provider Enrollment** **https://med.noridianmedicare.com/web/jeb**	Medicare Opt-Out	**https://www.noridianmedicare.com** Link to JE Part B **https://med.noridianmedicare.com/web/jeb** **Direct Link to Opt-Out Reports:** **https://med.noridianmedicare.com/web/jeb/enrollment/opt-out/opt-out-listing**	Under Medicare Contracts: ▪ Jurisdiction E Part B ▪ Link to Enrollment ▪ Opt Out of Medicare ▪ Opt Out Listing ▪ Link to Opt Out Listing by State: • Excel Listing or • HTML Listing On 01/20/17 Listing as follows: Excel Listing or (Last update 01/19/17) HTML Listing (Last update 01/19/17) However the HTML update noted the incorrect year 1/19/2016. Correction was made on 2/3/2017	**Quarterly** Last update: 01/19/17(updated 1/20/17) 08/15/16 06/13/16 (6/10/16) 12/23/15 10/30/15 Northern 10/08/15 Southern 08/14/15 07/07/15 04/13/15 03/11/15 01/28/15
CMS.gov **Centers for Medicare & Medicaid Services**	Medicare Opt-Out Affidavits	**https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/OptOutAffidavits.html** For a listing of all physicians and practitioners that are currently opted out of Medicare: **https://data.cms.gov/dataset/Opt-Out-Affidavits/7yuw-754z**	This link will provide information regarding Opt Out Affidavits and Opt Providers from Data.CMS.gov.	

Revised 01-25-2017
This document is for informational purposes only and subject to change.
Please visit the individual websites listed for the most current up-to-date information.

Back to Agenda

Ongoing Monitoring Website Information 01-25-2017

Site Name, Address and Phone Numbers	Service	Website	Instructions and Comments	Report Frequency
Department of Health Care Services (DHCS) **Medi-Cal Provider Suspended and Ineligible List** Office of Investigations Health Care Administrative Sanctions Room N2-01-26 7500 Security Blvd. Baltimore, MD21244-1850	Medi-Cal Reports exclusions and reinstatements from the State Medi-Cal Program	www.medi-cal.ca.gov **DirectLink to Suspended and Ineligible Provider List**: http://files.medi-cal.ca.gov/pubsdoco/SandILanding.asp	From Home Page: ▪ Link to References ▪ Suspended and Ineligible Provider List ▪ Under Download the S&I List is the list for the month. (Bottom of the page) Or ▪ Link to References ▪ Provider Enrollment ▪ Suspended and Ineligible Provider List ▪ Under Download the S&I List is the list for the month. (Bottom of the page) Last published 1/13/17	**Monthly**
SAM (System for Award Management) formerly known as Excluded Parties List System (EPLS)	Individuals and Organizations debarred from participating in government contracts or receiving government benefits or financial assistance	https://www.sam.gov/portal/SAM/#1 SAM Registration https://uscontractorregistration.com/ Note: The SAM website has a user guide: Link to SAM User Guide- v1.8.3 of 350:	Select Search Records at the top ▪ Under: Advanced Search ▪ Select Advance Search - Exclusion ▪ Select Single Search ▪ Scroll down and enter the Active Date to and from for the month you are reviewing ▪ Click search ▪ Export Results	**Monthly**
DEA Office of Diversion Control **800-882-9539** deadiversionwebmaster@usdoj.gov	**DEA Verification**	www.deadiversion.usdoj.gov/ **Direct Link to Validation Form** https://www.deadiversion.usdoj.gov/webforms/validateLogin.jsp	On the right side under Links: Link to Registration Validation Need DEA #, Name as it appears on your registration and SSN or TIN provided on application. **Note**: Please does not use the Duplicate Certification Link as it is for Physicians, use the Registration Validation Link.	**NA**

Revised 01-25-2017
This document is for informational purposes only and subject to change.
Please visit the individual websites listed for the most current up-to-date information.

Back to Agenda

Additional Websites

Site Name, Address and Phone Numbers	Service	Website	Instructions and Comments
The Licensed Facility Information system (LFIS) The Automated Licensing Information and Report Tracking System (ALIRTS) Contains license and utilization data information of healthcare facilities in California. The Licensed Facility Information system (LFIS) is maintained by the Office of Statewide Health Planning and Development to collect and display licensing and other basic information about California's hospitals, long-term care facilities, primary care and specialty clinics, home health agencies and hospices.	**Organizational Providers License Verification:** Hospitals Long-term care facilities Home Health Agencies Hospices Primary care and Specialty clinics	**www.alirts.oshpd.ca.gov/Default.aspx** **Direct Link:** **www.alirts.oshpd.ca.gov/LFIS/LFISHome.aspx**	The main source of the information in LFIS is the licenses issued by the Department of Health Services (DHS) Licensing and Certification District Offices. Contact information for these District Offices is available at: www.dhs.ca.gov/LNC/default.htm **To search for a facility** • Enter name in box that is found in top right corner Search or • Link to Advance Search on the left under Login. **LFIS Home** **Alirts Home** **Advanced Search** You may search by using the following four search categories, Facility Name, Facility Number, License and Legal Entity. Enter your search parameters within the one category you selected and click the Search button to the right.
The California Department of Public Health (CDPH) General Information (916) 558-1784	**Organizational Providers License Verification:** Hospitals Surgery Centers Home Health Agencies Hospices Dialysis Centers Others	http://www.cdph.ca.gov/Pages/DEFAULT.aspx Licensed Facility Report http://hfcis.cdph.ca.gov/Reports/GenerateReport.aspx?rpt=FacilityListing Health Facilities Search http://hfcis.cdph.ca.gov/search.aspx	Health Information Health Facilities Consumer Information System Find a facility Public Inquiry/Reports Type of Facility Select Excel or PDF format Health Facilities Search To check a particular facility, check the applicable box for the type (e.g. SNF or Hospital) then enter the Name or zip code and the facility will appear for you to select. You will be able to obtain copies of site visits for SNFs at this site.

Revised 01-25-2017
This document is for informational purposes only and subject to change.
Please visit the individual websites listed for the most current up-to-date information.

Back to Agenda

Additional Websites

Site Name, Address and Phone Numbers	Service	Website	Instructions and Comments
National Plan and Provider Enumeration System (NPPES) NPI Enumerator PO Box 6059 Fargo, ND 58108-6059 800-465-3203 customerservice@npienumerator.com The Centers for Medicare & Medicaid Services (CMS) has developed the National Plan and Provider Enumeration System (NPPES) to assign these unique identifiers. The NPI Registry enables you to search for a provider's NPPES information. All information produced by the NPI Registry is provided in accordance with the NPPES Data Dissemination Notice. Information in the NPI Registry is updated daily. You may run simple queries to retrieve this read-only data.	**Organizational Providers and Practitioners Numbers for the following:** • NPI • Medicare • Medi-Cal	https://nppes.cms.hhs.gov/NPPES/Welcome.do Search NPI Records https://npiregistry.cms.hhs.gov/ **Search the NPI Registry** • Search for an **Individual Provider** • Search for an **Organizational Provider**	Source for obtaining NPI Numbers, Medicare PIN and UPIN Numbers and Medicaid provider numbers Select Search the NPI Registry Complete the appropriate sections for Individual or for Organizations for individuals First Name Last Name for organizations Organization Name

Revised 01-25-2017
This document is for informational purposes only and subject to change.
Please visit the individual websites listed for the most current up-to-date information.

Additional Websites

Site Name, Address and Phone Numbers	Service	Website	Instructions and Comments
Social Security Death Master File (DMF). National Technical Information Services (NTIS) is the only authorized official distributor of the Death Master file on the web. Final Rule Establishing Certification Program for Access to Death Master File in Effect The National Technical Information Service (NTIS) established a certification program for subscribers to the Limited Access Death Master File (LADMF) through a Final Rule (FR), pursuant to Section 203 of the Bipartisan Budget Act of 2013 (Pub. L. 113-67) which also requires NTIS to recoup the cost of the certification program through processing fees. The FR was published in the Federal Register Wednesday, June 1, 2016, and became effective Monday, November 28, 2016. The FR may be reviewed at **https://www.gpo.gov/fdsys/pkg/FR-2016-06-01/html/2016-12479.htm**.	**Subscription to the Limited Access Death Master File (LADMF)**	**Social Security Death Master File (DMF) Website** https://www.ssdmf.com/FolderID/1/SessionID/%7B17B93F37-71E0-433B-B3F2-B9BA03D721A6%7D/PageVars/Library/InfoManage/Guide.htm **National Technical Information Services (NTIS)** https://classic.ntis.gov/products/ssa-dmf/#	You must register to obtain information and there are several fees associated with the service.

Revised 01-25-2017
This document is for informational purposes only and subject to change.
Please visit the individual websites listed for the most current up-to-date information.

Additional Websites

Board Certification, Address and Phone Numbers	Practitioner Types	Website	Instructions and Comments	Verification Type
Nursing Board Certification for Nurse Practitioners/Advance Practice Nurses **- American Academy of Nurse Practitioners Certification Board (AANPCB) (1/2017) (Formerly the American Academy of Nurse Practitioners Certification Program (AANPCP)** **- American Nurses Credentialing Center** (ANCC) **- National Certification Corporation for the Obstetrics, Gynecology and Neonatal Nursing Specialties**(ncc) **- Pediatric Nursing Certification Board** (PNCB) **- American Association of Critical-Care Nurses** (AACN)	NP	AANPCB - www.aanpcert.org/ ANCC -**www.nursecredentialing.org** ncc - **www.nccwebsite.org** PNCB - **www.pncb.org** AACN -**www.aacn.org**	Informational only to verify board certification	**Board Certification**
National Commission on Certification of PA's (NCCPA)	PAC	**http://www.nccpa.net/**	Informational only to verify board certification	**Board Certification**
American Midwifery Certification Board (amcb) 849 International Drive, Suite 120 Linthicum, MD 21090 Phone 410-694-9424	CNM and CM	**http://www.amcbmidwife.org/**	Under the Verify AMCB Certification ▪ Click Search button ▪ Enter last Name, First Name and Certification Number ▪ Click Search Button	**Board Certification** Informational only to verify board certification needed

Revised 01-25-2017
This document is for informational purposes only and subject to change.
Please visit the individual websites listed for the most current up-to-date information.

Back to Agenda

Additional Websites

Board Certification, Address and Phone Numbers	Practitioner Types	Website	Instructions and Comments	Verification Type
American Board of Professional Psychology (ABPP) 600 Market Street Suite 201 Chapel Hill, NC 27516 Phone 919-537-8031 email: office@abpp.org	PhD, PsyD	**http://www.abpp.org/**	Under Find a Board Certified Psychologists ▪ Click Verification Note there is a $25 charge, credits much be purchased prior to your verification search.	**Board Certification** Informational only to verify board certification if needed
Three specialty certifying boards are currently approved under California law for DPMs: – **American Board of Foot and Ankle Surgery** (formerly The American Board of Podiatric Surgery 7/1/14) (Also includes the following certifications: Foot Surgery and Reconstruction Rear foot/Ankle Surgery (RRA)). – **The American Board of Podiatric Medicine**(Conducts the certification process in Podiatric Orthopedics and Primary Podiatric Medicine – **American Board of Multiple Specialties in Podiatry.** (Includes Certification for Primary Care, Foot and ankle Surgery, diabetic wound care and limb salvage	DPM	• American Board of Foot and Ankle Surgery. https://www.abfas.org/ • The American Board of Podiatric Medicine conducts the certification process in Podiatric Orthopedics and Primary Podiatric Medicine. https://www.abpmed.org/ • American Board of Multiple Specialties in Podiatry. http://abmsp.org/	Informational only to verify board certification	**Board Certification**

Revised 01-25-2017
This document is for informational purposes only and subject to change.
Please visit the individual websites listed for the most current up-to-date information.

Back to Agenda

Policy #: GG.1616Δ
Title: **Fair Hearing Plan for Practitioners**
Department: Medical Affairs
Section: Quality Improvement

CEO Approval: Michael Schrader ______

Effective Date: 4/96
Last Review Date: 06/01/17
Last Revised Date: 06/01/17

~~This policy shall apply to the following CalOptima line of business (LOB)~~Applicable to:

- Medi-Cal
- OneCare
- OneCare Connect
- PACE

~~edi-Cal~~ ~~neCare Connect~~ ~~neCare~~ ~~ACE~~

I. PURPOSE

This policy~~o~~ defines the process that CalOptima~~, or a Health Network (HN), or a Physician Medical Group (PMG)~~ shall use to provide a fair ~~review of decisions that affect CalOptima, HN or PMG,~~procedure to Practitioners ~~or applicants,~~when adverse actions are proposed to be taken or are taken by CalOptima and ~~protect peer review participants from liability.~~for which a report is required to be filed under California Business and Professions Code S~~s~~ection 805 of the -and/or with the National Practitioner Data Bank (NPDB).

~~DEFINITIONS~~

II. POLICY

A. CalOptima~~, HN, or PMG~~ shall offer Practitioners ~~and applicants~~ the procedural rights ~~as described~~set forth in this P~~p~~olicy.

B. A Peer Review investigation may be initiated by CalOptima whenever reliable information indicates a Practitioner ~~or applicant~~may have engaged in actions which adversely affect or could adversely affect the health or welfare of a CalOptima Member and may call into question his or her competence or professional conduct.

C. ~~,~~In the event CalOptima believes an adverse action is warranted, as a result of the peer review investigation, CalOptima shall provide written notice to the Practitioner, within thirty (30) calendar days of the decision of the adverse recommendation and the right to request a hearing as provided in this P~~p~~olicy.

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1 B.D. A Practitioner may request a hearing if CalOptima,
2 HN, or PMG takes or recommends any of the following actions, and if CalOptima, HN, or PMG
3 would be required to file a report pursuant to Section 805 of the California Business and Professions
4 Code and Section 1370 of the California Health and Safety Code, if the appeal body determines
5 that such action is based on medical disciplinary cause or reason:and/or National Practitioner Data
6 Bank requirements based on one (1) or more of the following actions::
7
8 1. CalOptima Initiated Actions:
9
10 1.a. Denial of an applicant's a Practitioner's application for CalOptima, HN or PMG
11 participation for a medical disciplinary cause or reason;
12
13 2.b. Non-renewal of a Practitioner's CalOptima, HN or PMG participation for a medical
14 disciplinary cause or reason;
15
16 3.c. Restriction on a Practitioner's CalOptima, HN or PMG participation for a cumulative total
17 of thirty (30) calendar days or more for any twelve (12) month period for a medical
18 disciplinary cause or reason;
19
20 d. Termination of a Practitioner's CalOptima participation for a medical disciplinary cause or
21 reason; and
22
23 e. Imposition of summary suspension of a Practitioner's CalOptima participation for a medical
24 disciplinary cause or reason if the summary suspension remains in effect for more than
25 fourteen (14) calendar days.
26
27 2. Practitioner-Initiated Actions:
28
29 4. Resignation or leave of absence by a Practitioner from CalOptima, HN or PMG participation
30 after receiving: (i) notice of an investigation;
31
32 a. Withdrawal or abandonment of an applicant's initiated for a medical disciplinary cause or
33 reason; or (ii) notice that his or her application is denied or will be denied for a medical
34 disciplinary cause or reason;
35
36 5.b. Withdrawal or abandonment of a Practitioner's application for CalOptima, HN or PMG
37 participation after: (i) notice of an investigation or the impending denial of an
38 applicationinitiated for a medical disciplinary cause or reason; or (ii) notice that his or her
39 application is denied or will be denied for a medical disciplinary cause or reason;
40
41 6.c. Withdrawal or abandonment of a Practitioner's request for renewal of CalOptima, HN or
42 PMG participation; participation after: (i) notice of an investigation initiated for a medical
43 disciplinary cause or reason; or (ii) notice that his or her application is denied or will be
44 denied for a medical disciplinary cause or reason.
45
46 7. Summary suspension of a Practitioner from providing Covered Services for more than fourteen
47 (14) consecutive calendar days; and
48
49 8. Termination of a Practitioner's CalOptima, HN or PMG participation.

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3. ~~A~~Other Disciplinary Actions

~~C.~~ Any other disciplinary action or recommendation that must be reported to the Medical Board and/or the National Practitioner~~, applicant, or agency whose decision prompted the hearing may Appeal the Judicial Review Committee's decision if:~~

~~1. There was substantial noncompliance with the requirements of fair procedure, which has created demonstrable prejudice;~~

~~2. The decision was arbitrary or capricious, or was not supported by the evidence, based upon the hearing record or such additional information as may be permitted pursuant to the Appeals procedure; or~~

~~3.~~a. ~~A rule or procedure relied on by the Judicial Hearing Committee in arriving at its decision was not reasonable or warranted~~ Data Bank.

~~D.~~E. Except as otherwise provided in this ~~p~~Policy, no Practitioner ~~or applicant~~ shall be entitled, as a matter of right, to more than one (1) ~~Judicial Review Committee~~ hearing ~~and one (1) Appeal~~ on any matter ~~that may be the subject of a hearing and Appeal~~.

~~E.~~F. With respect to the entirety of this process, technical, insignificant, or non-prejudicial deviations from the procedures set forth in this process shall not be grounds for invalidating the action taken.

~~F. Exhaustion of internal administrative remedies~~

~~1. A Practitioner~~If adverse action, as described in CalOptima Policy GG.1607Δ: Monitoring Adverse Activities, is taken or ~~applicant~~ recommended, a Practitioner shall exhaust all remedies afforded by this ~~p~~Policy before resorting to legal action.

~~2.~~ If a Practitioner ~~or applicant~~ fails to exhaust all remedies afforded by this ~~p~~Policy, CalOptima~~, HN or PMG~~ shall deem such Practitioner ~~or applicant~~ to~~:~~

~~a. Waive~~ have waived all hearing and ~~Appeal~~appeal requirements~~;~~ and

~~b.~~G. ~~Accept CalOptima, HN or PMG's~~ to have accepted CalOptima's action or recommendation.

H. This policy does not apply to the imposition of administrative restrictions, suspensions, or terminations resulting from the Practitioner's failure to meet specific credentialing and contractual obligations including, without limitation, the failure to meet Minimum Physician Standards, or where restrictions, suspensions, or terminations are not based on a medical disciplinary cause or reason.

I. The hearing process described in this policy may not be used to challenge any established law, rule, regulation, policy, or requirement and the Judicial Review Committee has no authority to make

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findings or decisions to modify, limit, or overrule any established law, rule, regulation, policy, or requirement and it shall not entertain any such challenge.

J. Unless a summary suspension is imposed, if the Practitioner waives his or her procedural rights, then the recommendation of CalOptima shall be submitted for final action, as provided in Section III~~V~~.A.20~~1~~.f.

K. Health Networks shall have policies and procedures consistent with this policy that provide Practitioners with formal appeal rights when the Health Network takes or proposes adverse action for which a report is required to be filed under Section 805 of the California Business and Professions Code and/or with the NPDB.

III. PROCEDURE

A. Hearing Procedure

1. Notice of Action

a. If CalOptima~~, HN or PMG~~ takes or recommends any of the final actions described in Section ~~II.B~~III.D. of this P~~p~~olicy, CalOptima~~, HN or PMG~~ shall provide written notice as soon as possible after CalOptima takes or recommends the action but not later than thirty (30) calendar days thereafter to the Practitioner ~~or applicant~~ of the action or recommendation, and the Practitioner's ~~or applicant's~~ right to a hearing.

b. ~~CalOptima, HN or PMG's~~The notice shall include:

i. The action or recommendation against the Practitioner ~~or applicant~~;

ii. CalOptima's~~, HN's or PMG's~~ obligation to report such action, if adopted, in accordance with Section 805 of the California Business and Professions Code and/or National Practitioner Data Bank requirements;

iii. A brief ~~indication~~statement of the reasons for the action or recommendation;

~~iv.~~ The Practitioner's ~~or applicant's~~ right to request a hearing~~:~~

~~1) Regardless of whether or not CalOptima, HN or PMG takes or recommends such action based on medical disciplinary cause or reason; and~~

~~2)~~iv. ~~Within~~ within thirty (30) calendar days after the date of the notice~~.~~; and

v. ~~All other hearing rights as described in~~ A copy of this Fair Hearing Plan P~~p~~olicy.

2. Request for Hearing

a. A Practitioner ~~or applicant~~ shall request a hearing by a Judicial Review Committee within thirty (30) calendar days after the date of receipt of the notice described in Section ~~III~~III~~V~~.A.1 of this P~~p~~olicy.

~~b.~~ The Practitioner ~~or applicant~~ shall request such hearing in writing to the CalOptima~~, HN or PMG~~ Chief Medical Officer (CMO~~).~~

~~c.~~b. ~~The Practitioner has the right to be represented by an attorney or another person of their choice~~), or designee, as applicable.

~~d.~~c. If the Practitioner ~~or applicant~~ fails to request a hearing in accordance with Sections ~~III~~IIII~~V~~.A.2.a and ~~III~~IIII~~V~~.A.2.b of this policy, CalOptima~~, HN or PMG~~ shall deem such Practitioner ~~or applicant~~ to:

i. ~~Waive~~Have waived the right to a hearing and to any appellate review for which he or she may have been eligible under this policy; and

ii. ~~Accept CalOptima, HN or PMG's~~Have accepted CalOptima's action or ~~recommendation~~final proposed action, which shall thereupon become effective immediately.

3. Hearing Schedule

a. Upon receipt of a Practitioner's ~~or applicant's~~ written request for a hearing, ~~the CMO~~CalOptima shall deliver such request to the ~~agency~~peer review committee whose decision prompted the hearing.

~~b. The agency whose decision prompted the hearing shall schedule and arrange for a hearing within thirty (30) calendar days after receipt of the Practitioner's or applicant's request from the CMO.~~

~~c.~~b. ~~The hearing shall take place~~The hearing shall commence not less than thirty (30) calendar days and not more than sixty (60) calendar days after the date the CMO receives the Practitioner's ~~or applicant's~~ request for a hearing. ~~CalOptima, HN, or PMG may delay the hearing if:~~

i. CalOptima~~, HN,~~ may extend the time for commencement of the hearing, but in the event the request is received from a Practitioner who is under summary suspension, the hearing shall be held as soon as arrangements may be reasonably made, so long as the Practitioner has at least thirty (30) calendar days from the date of the notice to prepare for the hearing or ~~PMG~~provides written waiver of this right;

~~i.~~ii. CalOptima and the Practitioner ~~or applicant~~may agree, in writing, to delay the hearing~~, in writing~~; or

~~ii.~~iii. The ~~Hearing Officer issues~~hearing officer may issue a written decision to delay the hearing on a showing of good cause.

~~4. If CalOptima, HN or PMG summarily suspends, in whole or in part, a Practitioner's participation in CalOptima, HN, or PMG and such Practitioner requests a hearing, CalOptima, HN or PMG shall hold the hearing as soon as arrangement may reasonably be made.~~.

~~5.~~4. Notice of Hearing (Charges)

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1
2 a. CalOptima, HN, or PMGIf the Practitioner makes a request for a hearing on a timely basis,
3 CalOptima shall provide written notice of the hearing to the Practitioner or applicant at least
4 thirty (30) calendar days prior to the date of the hearing.
5
6 b. Such notice shall include:
7
8 i. The time, date, and location of the hearing;
9
10 ii. A notice of charges that includes:
11
12 1) The reason(s) for the final proposed action taken or recommendationrecommended,
13 including acts or omissions with which the Practitioner or applicant is charged;
14
15 2) List of charts and a list of the patients whose care is in question, ifwhere
16 applicable; and
17
18 3) List of witnesses expected to testify at the hearing on behalf of CalOptima, HN or
19 PMG.
20
21 iii.ii. Reason for or, if the action involves denial, if the hearing is a result of a denial
22 of an applicant'sPractitioner's application. for participation, the reason(s) for the denial;
23 and
24
25 iii. A summary of the Practitioner's rights and the hearing process.
26
27 c. CalOptima may amend the Notice of Hearing at any time so long as the Practitioner has
28 reasonable opportunity to prepare for and present a defense to the amended charges.
29
30 6.5. Judicial Review Committee
31
32 a. Upon receipt of a request for a hearing, the CalOptima CMO shall appoint a Judicial
33 Review Committee, at least a majority of whom shall be peers of the Practitioner or
34 applicant, and shall designate a chairperson. The Judicial Review Committee shall be
35 composed of not less than three (3) members.
36
37 b. The chairperson shall hear all pre-hearing matters until the selection of a hearing officer.
38
39 c. All members of the Judicial Review Committee shall be present during the entire hearingat
40 each hearing session, Judicial Review Committee meeting, and deliberation session unless
41 both parties agree that any one (1) member need not attend a particular session or meeting.
42
43 d. The decision of the Judicial Review Committee shall be by a majority vote of the members.
44 The numerical vote shall be recorded.
45
46 6. Arbitrator
47
48 a. CalOptima may propose that an arbitrator be selected in lieu of a Judicial Review
49 Committee. The use of an arbitrator shall be subject to mutual agreement by CalOptima and

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the Practitioner. If an arbitrator is used, the process described in Section III~~n IV~~.A.6~~7~~.b. of this policy will apply.

b. The arbitrator shall meet the same qualifications as the hearing officer and will be selected using a process mutually acceptable to CalOptima and the Practitioner. If the parties are unable to agree, the arbitrator will be selected pursuant to JAMS Comprehensive Arbitration Rules & Procedures. If an arbitrator is selected, no separate Judicial Review Committee or hearing officer shall be appointed and all references in this P~~p~~olicy to the Judicial Review Committee or hearing officer duties and responsibilities shall be read as applicable to the arbitrator.

7. Hearing Officer

a. The CalOptima CMO shall appoint a hearing officer to preside at the hearing.

i. The hearing officer shall be an attorney at law qualified to preside over a hearing, and preferably shall have experience in medical staff disciplinary matters.

ii. The hearing officer shall:

a) Not be biased for or against the Practitioner ~~or applicant~~;

b) Gain no direct financial benefit from the outcome; and

c) Not act as a prosecuting officer or as an advocate for any party.

b. The hearing officer shall participate in the deliberations, and act as a legal advisor to the Judicial Review Committee, but shall not be entitled to vote.

c. The hearing officer shall ensure that all participants in the hearing have a reasonable opportunity to be heard and to present all relevant oral and documentary evidence, and that proper decorum is maintained.

d. The hearing officer shall be entitled to determine the order of, or procedure for, presenting evidence and argument during the hearing.

e. The hearing officer shall have the authority and discretion, in accordance with this policy, to:

i. Grant continuances;

ii. Determine when attorneys may be permitted;

~~iii. Rule on disputed discovery requests;~~

~~iv. Decide when evidence may or may not be introduced;~~

~~v.~~ iii. Rule on challenges to Judicial Review Committee members;

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iv. Rule on challenges to himself or herself serving as the hearing officer;

v. Rule on questions raised prior to, or during, the hearing pertaining to matters of law, procedures, or the admissibility of evidence;

vi. Exercise discretion in limiting the number of witnesses and the overall amount of evidence introduced at the hearing;

vii. Impose any safeguards for the protection of the Peer Review process and, as justice requires, pursuant to Business and Professions Code Section 809.2;

viii. If requested by the Judicial Review Committee, assist in preparation of the Judicial Review Committee's report and recommendations; and

ix. Take such action as may be warranted by the circumstances if the hearing officer determines that either side in a hearing is not proceeding in an efficient and expeditious manner.

8. Failure to Appear

a. A Practitioner's failure to appear and proceed at the hearing, absent good cause, shall be deemed voluntary acceptance of the recommendation or action. In such cases, the matter will be forwarded for final action as provided in Section III.A.20.f of this Policy.

9. Postponements and Extensions

a. Once a request for hearing is initiated, postponements and extensions of time beyond the times permitted under this policy may be allowed by the hearing officer on a showing of good cause or upon agreement of parties.

b. Extensions of time necessary to appoint a Judicial Review Committee, hearing officer, and/or arbitrator shall be deemed good cause as long as both parties proceed in good faith.

10. Representation

a. The hearings provided for in this policy are for the purpose of intra-professional resolution of matters related to professional conduct, professional competency, or character. Accordingly, the Practitioner is entitled to representation at the hearing as follows:

i. If the Practitioner wishes to be accompanied at the hearing by an attorney, he or she shall provide written notice as soon as possible after CalOptima takes or recommends the action but not later than thirty (30) calendar days when requesting a hearing.

ii. CalOptima shall not be accompanied by an attorney if the Practitioner is not accompanied by an attorney. The foregoing shall not be deemed to deprive any party of its right to assistance of legal counsel for the purpose of preparing for a hearing.

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iii. If the Practitioner chooses not to be represented at the hearing by an attorney, he or she may be represented at the hearing by a licensed health care provider who is not also an attorney.

~~8.~~11. Pre-hearing Procedure

a. The Practitioner ~~or applicant~~ and the ~~agency~~peer review committee whose decision prompted the hearing shall exercise reasonable diligence in notifying the hearing officer of any pending or anticipated procedural irregularities, as far in advance of the scheduled hearing as possible.

b. The Practitioner~~, applicant,~~ or ~~agency~~peer review committee whose decision prompted the hearing may raise ~~objectives~~objections to any pre-hearing decision at the hearing.

i. Such objections shall be preserved for consideration at any appellate review hearing.

ii. If the Practitioner~~, applicant,~~ or ~~agency~~peer review committee whose decision prompted the hearing fails to raise any objections at the hearing, such objections shall be deemed to have been waived.

~~9.~~12. Discovery

~~a.~~ The ~~affected Practitioner or applicant~~parties may inspect and copy, at his or her expense, any ~~documentary~~documents or other information relevant to the charges ~~that CalOptima, HN or PMG~~which the other party has in its possession or under its control~~.~~

~~b. The agency whose decision prompted the hearing may inspect and copy, at its expense, any documentary information relevant to the charges that the affected Practitioner or applicant has in his or her possession or under his or her control.~~

~~a. CalOptima, a HN's a PMG, a Practitioner, and an applicant shall fulfill a request for discovery,~~ as soon as practicable~~.~~ after receipt of a request for the same.

~~c.~~b. Failure to comply with reasonable discovery requests at least thirty (30) calendar days prior to the hearing shall be good cause for a continuance of the hearing.

~~d.~~c. The hearing officer, at the request of either party to the hearing, may deny a discovery request if:

i. The information refers solely to individually identifiable Practitioners other than the affected Practitioner;

ii. The denial is justified to protect peer review; or

iii. The denial is justified ~~to project~~in the interest of justice.

~~e.~~d. In ruling on discovery disputes, the factors that may be considered include:

i. The information sought may be introduced to support or defend the charges;

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ii. The information is "exculpatory~~",~~," in that it would dispute or cast doubt upon the charges, or "inculpatory~~",~~," in that it would help support the charges or recommendation;

iii. The burden on the party of producing the requested information; and

iv. Other discovery requests made by the party.

~~10.~~13. Objections to the introduction of evidence previously not produced ~~for~~to CalOptima~~, HN or PMG~~.

a. ~~The agency whose decision prompted the hearing~~CalOptima may object to the introduction of evidence that was not provided during an application review, or during a peer review investigation conducted pursuant to policy, despite the requests of the ~~agency~~peer review committee whose decision prompted the hearing for the information.

b. The hearing officer shall bar such information from the hearing unless the Practitioner ~~or applicant~~ is able to prove that he or she previously acted diligently and could not have submitted the information.

~~11.~~14. Pre-hearing ~~Document~~Evidentiary Exchange

a. At the request of either party, the parties shall exchange a list of witnesses expected to testify, and copies of all documents that each party plans to introduce at the hearing.

b. The parties shall identify witnesses and exchange documents at least ten (10) calendar days prior to the hearing.

i. Failure to comply is good cause for the hearing officer to grant a continuance.

ii. This provision shall not affect the initial responsibility of the parties to make all relevant documents available for copying at least thirty (30) calendar days prior to the commencement of the hearing.

c. Failure to comply shall be good cause for the hearing officer to limit introduction of any documents not provided, or witnesses not identified, by the other party in a timely manner.

~~12.~~15. Record of Hearing

a. ~~The Judicial Review Committee shall maintain a record of the hearing by using a~~A certified shorthand reporter shall be present to make a record of the hearing proceedings. The pre-hearing proceedings may be placed on the record if deemed appropriate by the hearing officer. The cost of attendance of the shorthand reporter shall be borne by CalOptima.

b. The Practitioner~~, applicant,~~ or ~~agency~~peer review committee whose decision prompted the hearing shall be entitled to receive a copy of the transcript or recording upon paying the reasonable cost for preparing the record. In such cases, both parties shall receive a copy of the transcript.

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~~c. The hearing officer may order that oral evidence be taken only if administered by a person designated by the Judicial Review Committee and entitled to notarize documents in California, or by affirmation under penalty of perjury to the hearing officer.~~

~~13.~~16. Rights of Parties

a. At the hearing, both parties shall have the right to:

i. Ask members of the Judicial Review Committee or the hearing officer questions directly related to determining if the members or the hearing officer meet the qualifications as set forth in Section ~~III~~III~~V~~.A.5~~6~~ and Section ~~III~~III~~V~~.A.~~7~~7~~8~~ of this P~~p~~olicy, and to challenge the members or the hearing officer;

ii. Call and examine witnesses;

iii. Introduce exhibits and other relevant documents;

iv. Cross-examine or otherwise attempt to impeach any witness who testified orally on any matter relevant to the issues, and otherwise rebut any evidence;

v. Provide a written statement at the close of the hearing; and

vi. Be provided with all information made available to the Judicial Review Committee and to have a record made of the proceedings.

b. The ~~agency~~peer review committee whose decision prompted the hearing shall have the right to call and examine a Practitioner ~~or applicant~~ as if under cross-examination.

c. The hearing officer shall rule on any challenge directed at a member of the Judicial Review Committee or the hearing officer prior to the continuation of the proceedings.

~~14.~~17. Admissibility of Evidence

a. The hearing shall not be conducted according to rules of law relating to the examination of witnesses or presentation of evidence.

b. Any relevant evidence, including hearsay, shall be admitted by the hearing officer if it is the type of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law.

c. The Judicial Review Committee members may question the witnesses, and may request that additional witnesses be called, if they deem it appropriate.

~~15.~~18. Burden of Going Forward and Burden of Proof

a. CalOptima~~, HN or PMG~~ shall have the initial duty to present evidence that supports the charge or recommended action. CalOptima is not required to prove each and every charge

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or issue before the Judicial Review Committee in order for its actions and/or recommendation(s) to be found reasonable and warranted.

b. ~~The~~An initial applicant Practitioner shall bear the burden of persuading the Judicial Review Committee, by a preponderance of the evidence, that he or she possesses the requisite qualifications, experience, and competency to participate in CalOptima~~, HN or PMG~~ programs.

i. An initial applicant Practitioner shall provide information that allows for adequate evaluation and resolution of reasonable doubts concerning his or her current qualifications to participate~~ in CalOptima, HN or PMG~~.

ii. An initial applicant Practitioner shall not introduce information not produced upon ~~CalOptima, HN or PMG's~~CalOptima's request during the application process, unless the applicant Practitioner establishes that the information could not have been produced previously in the exercise of reasonable diligence.

~~iii.~~c. ~~In all other cases~~Except as provided above for initial applicants, CalOptima~~, HN or PMG~~ shall bear the burden of persuading the Judicial Review Committee, by a preponderance of the evidence, that its action or recommendation is reasonable and warranted.

~~16.~~19. Adjournment and Conclusion

a. The Hearing Officer may adjourn and reconvene the hearing at the convenience of the participants without special notice.

b. The hearing shall be concluded within a reasonable time, and the hearing officer may set guidelines for introduction of evidence to achieve a timely conclusion.

c. The parties may submit a written statement at the close of the hearing, within guidelines as to length, format, and submission dates as decided by the hearing officer, in consultation with the Judicial Review Committee.

~~c.~~d. Upon conclusion of the presentation of oral and written evidence and argument, the hearing shall be closed. The Judicial Review Committee shall thereupon, outside the presence of the parties, conduct its deliberations and render a decision and accompanying report.

~~d.~~e. Final adjournment shall not occur until the Judicial Review Committee has completed its deliberations.

~~17.~~20. Decision of the Judicial Review Committee

a. The Judicial Review Committee shall base its decision on all the evidence produced at the hearing, ~~and~~including all logical and reasonable inferences from the evidence as well as any written statements submitted to the Judicial Review Committee.

b. Within thirty (30) calendar days after final adjournment of the hearing, the Judicial Review Committee shall render a decision accompanied by a written report that contains findings of

DRAFT

fact and a conclusion articulating the connection between the evidence produced at the hearing and the decision. If the Practitioner is under summary suspension, the time for the decision and report shall be within fifteen (15) days. The report shall be in sufficient detail to enable the parties and any appellate review body to determine the basis for the Judicial Review Committee's decision on each matter contained in the Notice of Charges. Such decision shall also contain an explanation of the procedure for appealing the decision.

c. The Judicial Review Committee shall forward the decision promptly but in not more than thirty (30) calendar days from the date the decision is rendered to the ~~agency~~peer review committee whose decision prompted the hearing, the CalOptima CMO, and ~~to~~ the affected Practitioner~~ or applicant~~.

d. The Judicial Review Committee shall deliver the Practitioner's copy of the report by registered or certified mail, return receipt requested, and first class mail.

e. The decision of the Judicial Review Committee shall be considered final~~, subject only to the~~. There shall be no right ~~of~~to appeal ~~to~~the decision following the ~~appeal body~~formal hearing.

~~B. Appeals to the Appeal Agency~~

~~1. A Practitioner, applicant, or agency whose decision prompted the hearing may Appeal the Judicial Review Committee's decision within thirty (30) calendar days after receipt of the decision.~~

~~a. The Practitioner, applicant, or agency whose decision prompted the Hearing shall deliver the request by written notice, to the CMO, with a brief statement as to the grounds for Appeal.~~

~~b. If no appellate review is requested within such period, both sides shall be deemed to have accepted the action involved, and it shall become the final decision in the matter.~~

~~2. The appeal body shall schedule and arrange for an appellate review within forty (40) calendar days after receipt of a request for an Appeal.~~

~~a. The appeal body shall notify the Practitioner or applicant and the agency whose decision prompted the hearing of the time, place, and date of the appellate review.~~

~~b. The date shall be not less than forty (40) calendar days, or more than ninety (90) calendar days, from the date of receipt of the request for appellate review. However, if a Practitioner who is under suspension requests appellate review, the appeal body shall hold the appellate review as soon as arrangements may reasonably be made.~~

~~c. The appellate Hearing Officer may extend the time for appellate review by the appeal body for good cause.~~

~~3. The Quality Improvement Committee (QIC) may sit as the appeal body, or it may appoint an appeal board, which shall be composed of not fewer than three (3) members of the QIC.~~

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a. ~~The appeal body shall designate a member as appeal chairperson. Knowledge of the matter involved shall not preclude any person from serving as a member of the Appeal body, so long as that person did not participate in the matter at a previous level (i.e., as accuser, investigator, initial decision-maker or panel member).~~

b. ~~For purposes of this section, participation in an initial decision to recommend an investigation shall not be deemed to constitute participation at a previous level on this matter. If, however, a QIC member is disqualified by this section from serving as an appeal body member, he or she shall recuse him or herself from the Appeal.~~

c. ~~The appeal body shall select an attorney to assist in the proceeding. He or she shall act as an appellate Hearing Officer and shall have all of the authority of, and carry out all of the duties assigned to, a hearing officer, as described in Section III.G of this policy. The attorney shall not be entitled to vote with respect to the Appeal.~~

d. ~~The appeal body shall have such powers as are necessary to discharge its responsibilities.~~

e. ~~The decision of the appeal body shall be a final decision of CalOptima, HN or PMG.~~

4. ~~The proceedings by the appeal body shall be in the nature of a review of the record of the hearing before the Judicial Review Committee.~~

a. ~~The appeal body shall exercise its independent judgment in determining if:~~

i. ~~The Practitioner or applicant received a fair hearing;~~

ii. ~~The decision is reasonable and warranted, and supported by the weight of the evidence; and~~

iii. ~~Any provision of this policy, rule, or regulation relied on by the Judicial Review Committee in reaching its decision is reasonable and warranted.~~

b. ~~The appeal body may accept additional oral or written evidence, subject to a foundational showing that such evidence could not be made available to the Judicial Review Committee in the exercise of reasonable diligence, and subject to the same rights of cross examination or confrontation provided at the Judicial Review Committee hearing.~~

c. ~~The appeal body also may remand the matter to the Judicial Review Committee for the taking of further evidence and for a decision.~~

d. ~~The appeal body shall give great weight to the recommendation of the agency whose action prompted the hearing. It shall not act arbitrarily or capriciously.~~

e. ~~Each party shall have the right to present a written statement in support of his or her position on Appeal, the right to appear and present oral argument, the right to be represented by an attorney or any other representatives designated by the party, and the right to personally appear and respond.~~

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f. At the conclusion of oral argument, if requested, the appeal body may thereupon conduct, at a time convenient to itself, deliberations outside the presence of the parties and their representatives.

g. The appeal body shall decide whether to affirm, modify, or reverse the Judicial Review Committee decision, or remand the matter to the Judicial Review Committee for further review and decision. Each party shall have the right to receive the written decision of the appeal body.

5. During the Appeals procedure, either party may request postponements and extensions of time beyond the times expressly permitted in this policy may. Such postponements and extensions may be permitted by the appeal body, its chairperson, or the appellate Hearing Officer acting upon its behalf, on a showing of good cause.

6. Decision

a. Within thirty (30) calendar days after the conclusion of the proceedings before the appeal body, the appeal body shall render a final decision in writing, and shall deliver copies in person or by certified mail, return receipt requested, and first class mail to the Practitioner or applicant, the CMO, and to the agency whose decision prompted the hearing.

b. Except for the matters referred for further review, the final decision of the appeal body following the Appeal procedure set forth in this Fair Hearing Plan shall be effective immediately and shall not be subject to further review. If the matter is remanded to the Judicial Review Committee, the Judicial Review Committee shall promptly conduct its review and make its recommendations to the appeal body, in accord with the instructions given by the appeal body. This further process and the report back to the appeal body shall in no event exceed thirty (30) calendar days in duration, except as the parties may otherwise stipulate.

c. The appeal body shall maintain a record of any additional review proceedings through use of a court reporter present to make a record of the hearing. The cost of preparation of a transcript of the proceedings shall be borne by the party requesting it. In such cases, both parties shall receive a copy of the transcript. The appeal body may, but shall not be required to, order that oral evidence be taken only on oath or affirmation administered by a person designated by such body and entitled to notarize such documents in the State of California.

f. The decision of the Judicial Review Committee shall be transmitted to the CalOptima CMO. If the CalOptima CMO, in consultation with Legal Counsel, is satisfied that the Judicial Hearing Committee's decision follows from a fair hearing and is consistent with the applicable burden of proof as described above, it shall adopt that decision as the final action of CalOptima and the decision shall be effective immediately. If the CalOptima CMO, in consultation with Legal Counsel, concludes that the Judicial Hearing Committee's decision does not follow from a fair hearing and/or is inconsistent with the applicable burden of proof as described above, then the CMO, in consultation with Legal Counsel, shall proceed as it deems necessary and appropriate to address any unfairness and render a decision that is consistent.

21. Reporting

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a. CalOptima shall comply with the reporting requirements of Business and Professions Code and the National Practitioner Data Bank in accordance with CalOptima policy.

IV. ATTACHMENTS

Not Applicable

A. Notice of Hearing

V. REFERENCES

A. California Business and Professions Code, §§805 and 809
B. California Health and Safety Code, §1370
C. California Welfare and Institutions Code, §14000 et seq.
D. CalOptima Contract for Health Care Services
A.E. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B.F. CalOptima Contract with Department of Health Care Services (DHCS) for Medi-Cal
G. CalOptima PACE Program Agreement
H. CalOptima Policy AA.1000: Glossary of Terms
I. CalOptima Policy CMC.1001: Glossary of Terms
J. CalOptima Policy GG.1607Δ: Monitoring Adverse Activities
K. CalOptima Policy MA.1001: Glossary of Terms
L. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
M. NCQA Health Plan Standards and Guidelines: Credentialing and Recredentialing (2015)
C. California Welfare and Institutions Code, Section 14000 et seq.
D. California Business and Professions Code, Sections 805 and 809
E. California Health and Safety Code Section 1370
N. Title 42, Code of Federal Regulations (C.F.R.), Section §422.202
Title 42, Code of Federal Regulations (C.F.R.) Section §422.204
O. NCQA Health Plan Standards and Guidelines: Credentialing and Recredentialing (2015)
F. CalOptima Policy AA.1000: Glossary of Terms
OneCare CalOptima Policy CMC.1001: Glossary of Terms
G. CalOptima Policy GG.1607Δ: Monitoring Adverse Activities CalOptima Policy MA.1001: Glossary of Terms

VI. REGULATORY AGENCY APPROVALS OR

None to Date

VI.VII. BOARD ACTIONS

Not Applicable

None to DateA. 06/01/17: Regular Meeting of the CalOptima Board of Directors

VII.VIII. REVIEW/REVISION HISTORY

~~A. 6/1/14: GG.1616: Fair Hearing Plan for Practitioners (Review)~~
~~B. 2/1/13: GG.1616: Fair Hearing Plan for CalOptima Direct Practitioners~~
~~C. 11/1/11: GG.1616: Fair Hearing Plan for CalOptima Direct Practitioners~~
~~D. 4/1/07: GG.1616: Fair Hearing Plan for CalOptima Direct Practitioners~~
~~E. 3/1/07: MA.7016: Fair Hearing Plan for Practitioners~~
~~F. 10/1/05: MA.7016: Fair Hearing Plan for Practitioners~~
~~G. 2/03: GG.1616: Fair Hearing Plan for CalOptima Direct Practitioners~~
~~H. 3/99: GG.1616: Fair Hearing Plan for CalOptima Direct Practitioners~~
~~I. 4/96: GG.1616: Fair Hearing Plan for CalOptima Direct Practitioners~~

Version	**~~Version~~ Date**	**Policy Number**	**Policy Title**	**Line(s) of Business**
~~Original Date~~Effective	04/1996	GG.1616	Fair Hearing Plan for CalOptima Direct Practitioners	Medi-Cal
~~Revision Date 1~~Revised	03/1999	GG.1616	Fair Hearing Plan for CalOptima Direct Practitioners	Medi-Cal
Revised~~Revision Date 2~~	02/2003	GG.1616	Fair Hearing Plan for CalOptima Direct Practitioners	Medi-Cal
Revised~~Revision Date 3~~	10/01/2005	MA.7016	Fair Hearing Plan for Practitioners	OneCare
Revised~~Revision Date 4~~	03/01/2007	MA.7016	Fair Hearing Plan for Practitioners	OneCare
Revised~~Revision Date 5~~	04/01/2007	GG.1616	Fair Hearing Plan for CalOptima Direct Practitioners	Medi-Cal
Revised~~Revision Date 6~~	11/01/2011	GG.1616	Fair Hearing Plan for CalOptima Direct Practitioners	Medi-Cal
Revised~~Revision Date 7~~	02/01/2013	GG.1616	Fair Hearing Plan for CalOptima Direct Practitioners	Medi-Cal
Review~~-Date 1~~ed	06/01/2014	GG.1616	Fair Hearing Plan for Practitioners	Medi-Cal
Revised~~Revision Date 8~~	06/01/2017	GG.1616Δ	Fair Hearing Plan for Practitioners	Medi-Cal OneCare OneCare Connect PACE

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1 ## ~~VIII.~~IX. ~~DEFINITIONS~~GLOSSARY
2

Term	Definition
Health Network	For purpose of this policy, 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.
Judicial Review Committee	The committee appointed to conduct a hearing based on a request for hearing by a Practitioner as described in this policy.
Minimum Physician Standards	The standards that must be met in order to submit an application for credentialing, the successful approval of which is a prerequisite to contracting with CalOptima or Health Networks in accordance with CalOptima Policy GG.1643: Minimum Physician Standards.
Peer Review	The process of reviewing whether a Practitioner is qualified, on an initial and ongoing basis, to participate in health care programs administered by CalOptima (including through delegated Health Networks) and taking actions, as appropriate, based on such review.
Practitioner	For the purposes of this Policy, "Practitioner" shall have the same meaning as "Licentiate" as that term is defined in Section 805 of the California Business and Professions Code and specifically a physician and surgeon, doctor of podiatric medicine, clinical psychologist, marriage and family therapist, clinical social worker, professional clinical counselor, dentist, physician assistant and persons authorized to practice medicine pursuant to Business and Professions Code Section 2113 or 2168.

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Policy #:	GG.1616Δ
Title:	**Fair Hearing Plan for Practitioners**
Department:	Medical Affairs
Section:	Quality Improvement

CEO Approval: Michael Schrader ______

Effective Date:	4/96
Last Review Date:	06/01/17
Last Revised Date:	06/01/17

Applicable to:
☒ Medi-Cal
☒ OneCare
☒ OneCare Connect
☒ PACE

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I. PURPOSE

This policy defines the process that CalOptima shall use to provide a fair procedure to Practitioners when adverse actions are proposed to be taken or are taken by CalOptima and for which a report is required to be filed under California Business and Professions Code Section 805 of the and/or with the National Practitioner Data Bank (NPDB).

II. POLICY

A. CalOptima shall offer Practitioners the procedural rights set forth in this Policy.

B. A Peer Review investigation may be initiated by CalOptima whenever reliable information indicates a Practitioner may have engaged in actions which adversely affect or could adversely affect the health or welfare of a CalOptima Member and may call into question his or her competence or professional conduct.

C. In the event CalOptima believes an adverse action is warranted, as a result of the peer review investigation, CalOptima shall provide written notice to the Practitioner, within thirty (30) calendar days of the decision of the adverse recommendation and the right to request a hearing as provided in this Policy.

D. A Practitioner may request a hearing if CalOptima would be required to file a report pursuant to Section 805 of the California Business and Professions Code and/or National Practitioner Data Bank requirements based on one (1) or more of the following actions:

1. CalOptima Initiated Actions:

   a. Denial of a Practitioner's application for CalOptima participation for a medical disciplinary cause or reason;

   b. Non-renewal of a Practitioner's CalOptima participation for a medical disciplinary cause or reason;

c. Restriction on a Practitioner's CalOptima participation for a cumulative total of thirty (30) calendar days or more for any twelve (12) month period for a medical disciplinary cause or reason;

d. Termination of a Practitioner's CalOptima participation for a medical disciplinary cause or reason; and

e. Imposition of summary suspension of a Practitioner's CalOptima participation for a medical disciplinary cause or reason if the summary suspension remains in effect for more than fourteen (14) calendar days.

2. Practitioner-Initiated Actions:

a. Resignation or leave of absence by a Practitioner from CalOptima participation after: (i) notice of an investigation initiated for a medical disciplinary cause or reason; or (ii) notice that his or her application is denied or will be denied for a medical disciplinary cause or reason;

b. Withdrawal or abandonment of a Practitioner's application for CalOptima participation after: (i) notice of an investigation initiated for a medical disciplinary cause or reason; or (ii) notice that his or her application is denied or will be denied for a medical disciplinary cause or reason;

c. Withdrawal or abandonment of a Practitioner's request for renewal of CalOptima participation after: (i) notice of an investigation initiated for a medical disciplinary cause or reason; or (ii) notice that his or her application is denied or will be denied for a medical disciplinary cause or reason.

3. Other Disciplinary Actions

a. Any other disciplinary action or recommendation that must be reported to the Medical Board and/or the National Practitioner Data Bank.

E. Except as otherwise provided in this Policy, no Practitioner shall be entitled, as a matter of right, to more than one (1) hearing on any matter.

F. With respect to the entirety of this process, technical, insignificant, or non-prejudicial deviations from the procedures set forth in this process shall not be grounds for invalidating the action taken.

G. If adverse action, as described in CalOptima Policy GG.1607Δ: Monitoring Adverse Activities, is taken or recommended, a Practitioner shall exhaust all remedies afforded by this Policy before resorting to legal action. If a Practitioner fails to exhaust all remedies afforded by this Policy, CalOptima shall deem such Practitioner to have waived all hearing and appeal requirements and to have accepted CalOptima's action or recommendation.

H. This policy does not apply to the imposition of administrative restrictions, suspensions, or terminations resulting from the Practitioner's failure to meet specific credentialing and contractual obligations including, without limitation, the failure to meet Minimum Physician Standards, or where restrictions, suspensions, or terminations are not based on a medical disciplinary cause or reason.

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I. The hearing process described in this policy may not be used to challenge any established law, rule, regulation, policy, or requirement and the Judicial Review Committee has no authority to make findings or decisions to modify, limit, or overrule any established law, rule, regulation, policy, or requirement and it shall not entertain any such challenge.

J. Unless a summary suspension is imposed, if the Practitioner waives his or her procedural rights, then the recommendation of CalOptima shall be submitted for final action, as provided in Section III.A.20.f.

K. Health Networks shall have policies and procedures consistent with this policy that provide Practitioners with formal appeal rights when the Health Network takes or proposes adverse action for which a report is required to be filed under Section 805 of the California Business and Professions Code and/or with the NPDB.

III. PROCEDURE

A. Hearing Procedure

1. Notice of Action

a. If CalOptima takes or recommends any of the final actions described in Section II.D. of this Policy, CalOptima shall provide written notice as soon as possible after CalOptima takes or recommends the action but not later than thirty (30) calendar days thereafter to the Practitioner of the action or recommendation, and the Practitioner's right to a hearing.

b. The notice shall include:

i. The action or recommendation against the Practitioner;

ii. CalOptima's obligation to report such action, if adopted, in accordance with Section 805 of the California Business and Professions Code and/or National Practitioner Data Bank requirements;

iii. A brief statement of the reasons for the action or recommendation;

iv. The Practitioner's right to request a hearing within thirty (30) calendar days after the date of the notice; and

v. A copy of this Fair Hearing Plan Policy.

2. Request for Hearing

a. A Practitioner shall request a hearing by a Judicial Review Committee within thirty (30) calendar days after the date of receipt of the notice described in Section III.A.1 of this Policy.

b. The Practitioner shall request such hearing in writing to the CalOptima Chief Medical Officer (CMO), or designee, as applicable.

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c. If the Practitioner fails to request a hearing in accordance with Sections III.A.2.a and III.A.2.b of this policy, CalOptima shall deem such Practitioner to:

i. Have waived the right to a hearing and to any appellate review for which he or she may have been eligible under this policy; and

ii. Have accepted CalOptima's action or final proposed action, which shall thereupon become effective immediately.

3. Hearing Schedule

a. Upon receipt of a Practitioner's written request for a hearing, CalOptima shall deliver such request to the peer review committee whose decision prompted the hearing.

b. The hearing shall commence not less than thirty (30) calendar days and not more than sixty (60) calendar days after the date the CMO receives the Practitioner's request for a hearing.

i. CalOptima may extend the time for commencement of the hearing, but in the event the request is received from a Practitioner who is under summary suspension, the hearing shall be held as soon as arrangements may be reasonably made, so long as the Practitioner has at least thirty (30) calendar days from the date of the notice to prepare for the hearing or provides written waiver of this right;

ii. CalOptima and the Practitioner may agree, in writing, to delay the hearing; or

iii. The hearing officer may issue a written decision to delay the hearing on a showing of good cause.

4. Notice of Hearing (Charges)

a. If the Practitioner makes a request for a hearing on a timely basis, CalOptima shall provide written notice of the hearing to the Practitioner at least thirty (30) calendar days prior to the date of the hearing.

b. Such notice shall include:

i. The time, date, and location of the hearing;

ii. The reason(s) for the final proposed action taken or recommended, including acts or omissions with which the Practitioner is charged and a list of the patients whose care is in question, where applicable; or, if the action involves denial of a Practitioner's application for participation, the reason(s) for the denial; and

iii. A summary of the Practitioner's rights and the hearing process.

c. CalOptima may amend the Notice of Hearing at any time so long as the Practitioner has reasonable opportunity to prepare for and present a defense to the amended charges.

5. Judicial Review Committee

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a. Upon receipt of a request for a hearing, the CalOptima CMO shall appoint a Judicial Review Committee, at least a majority of whom shall be peers of the Practitioner, and shall designate a chairperson. The Judicial Review Committee shall be composed of not less than three (3) members.

b. The chairperson shall hear all pre-hearing matters until the selection of a hearing officer.

c. All members of the Judicial Review Committee shall be present at each hearing session, Judicial Review Committee meeting, and deliberation session unless both parties agree that any one (1) member need not attend a particular session or meeting.

d. The decision of the Judicial Review Committee shall be by a majority vote of the members. The numerical vote shall be recorded.

6. Arbitrator

a. CalOptima may propose that an arbitrator be selected in lieu of a Judicial Review Committee. The use of an arbitrator shall be subject to mutual agreement by CalOptima and the Practitioner. If an arbitrator is used, the process described in Section III.A.6.b. of this policy will apply.

b. The arbitrator shall meet the same qualifications as the hearing officer and will be selected using a process mutually acceptable to CalOptima and the Practitioner. If the parties are unable to agree, the arbitrator will be selected pursuant to JAMS Comprehensive Arbitration Rules & Procedures. If an arbitrator is selected, no separate Judicial Review Committee or hearing officer shall be appointed and all references in this Policy to the Judicial Review Committee or hearing officer duties and responsibilities shall be read as applicable to the arbitrator.

7. Hearing Officer

a. The CalOptima CMO shall appoint a hearing officer to preside at the hearing.

i. The hearing officer shall be an attorney at law qualified to preside over a hearing, and preferably shall have experience in medical staff disciplinary matters.

ii. The hearing officer shall:

a) Not be biased for or against the Practitioner;

b) Gain no direct financial benefit from the outcome; and

c) Not act as a prosecuting officer or as an advocate for any party.

b. The hearing officer shall participate in the deliberations, and act as a legal advisor to the Judicial Review Committee, but shall not be entitled to vote.

c. The hearing officer shall ensure that all participants in the hearing have a reasonable opportunity to be heard and to present all relevant oral and documentary evidence, and that proper decorum is maintained.

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d. The hearing officer shall be entitled to determine the order of, or procedure for, presenting evidence and argument during the hearing.

e. The hearing officer shall have the authority and discretion, in accordance with this policy, to:

i. Grant continuances;

ii. Determine when attorneys may be permitted;

iii. Rule on challenges to Judicial Review Committee members;

iv. Rule on challenges to himself or herself serving as the hearing officer;

v. Rule on questions raised prior to, or during, the hearing pertaining to matters of law, procedures, or the admissibility of evidence;

vi. Exercise discretion in limiting the number of witnesses and the overall amount of evidence introduced at the hearing;

vii. Impose any safeguards for the protection of the Peer Review process and, as justice requires, pursuant to Business and Professions Code Section 809.2;

viii. If requested by the Judicial Review Committee, assist in preparation of the Judicial Review Committee's report and recommendations; and

ix. Take such action as may be warranted by the circumstances if the hearing officer determines that either side in a hearing is not proceeding in an efficient and expeditious manner.

8. Failure to Appear

a. A Practitioner's failure to appear and proceed at the hearing, absent good cause, shall be deemed voluntary acceptance of the recommendation or action. In such cases, the matter will be forwarded for final action as provided in Section III.A.20.f of this Policy.

9. Postponements and Extensions

a. Once a request for hearing is initiated, postponements and extensions of time beyond the times permitted under this policy may be allowed by the hearing officer on a showing of good cause or upon agreement of parties.

b. Extensions of time necessary to appoint a Judicial Review Committee, hearing officer, and/or arbitrator shall be deemed good cause as long as both parties proceed in good faith.

10. Representation

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a. The hearings provided for in this policy are for the purpose of intra-professional resolution of matters related to professional conduct, professional competency, or character. Accordingly, the Practitioner is entitled to representation at the hearing as follows:

i. If the Practitioner wishes to be accompanied at the hearing by an attorney, he or she shall provide written notice as soon as possible after CalOptima takes or recommends the action but not later than thirty (30) calendar days when requesting a hearing.

ii. CalOptima shall not be accompanied by an attorney if the Practitioner is not accompanied by an attorney. The foregoing shall not be deemed to deprive any party of its right to assistance of legal counsel for the purpose of preparing for a hearing.

iii. If the Practitioner chooses not to be represented at the hearing by an attorney, he or she may be represented at the hearing by a licensed health care provider who is not also an attorney.

11. Pre-hearing Procedure

a. The Practitioner and the peer review committee whose decision prompted the hearing shall exercise reasonable diligence in notifying the hearing officer of any pending or anticipated procedural irregularities, as far in advance of the scheduled hearing as possible.

b. The Practitioner or peer review committee whose decision prompted the hearing may raise objections to any pre-hearing decision at the hearing.

i. Such objections shall be preserved for consideration at any appellate review hearing.

ii. If the Practitioner or peer review committee whose decision prompted the hearing fails to raise any objections at the hearing, such objections shall be deemed to have been waived.

12. Discovery

a. The parties may inspect and copy, at his or her expense, any documents or other information relevant to the charges which the other party has in its possession or under its control, as soon as practicable after receipt of a request for the same.

b. Failure to comply with reasonable discovery requests at least thirty (30) calendar days prior to the hearing shall be good cause for a continuance of the hearing.

c. The hearing officer, at the request of either party to the hearing, may deny a discovery request if:

i. The information refers solely to individually identifiable Practitioners other than the affected Practitioner;

ii. The denial is justified to protect peer review; or

iii. The denial is justified in the interest of justice.

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d. In ruling on discovery disputes, the factors that may be considered include:

i. The information sought may be introduced to support or defend the charges;

ii. The information is "exculpatory," in that it would dispute or cast doubt upon the charges, or "inculpatory," in that it would help support the charges or recommendation;

iii. The burden on the party of producing the requested information; and

iv. Other discovery requests made by the party.

13. Objections to the introduction of evidence previously not produced to CalOptima.

a. CalOptima may object to the introduction of evidence that was not provided during an application review, or during a peer review investigation conducted pursuant to policy, despite the requests of the peer review committee whose decision prompted the hearing for the information.

b. The hearing officer shall bar such information from the hearing unless the Practitioner is able to prove that he or she previously acted diligently and could not have submitted the information.

14. Pre-hearing Evidentiary Exchange

a. At the request of either party, the parties shall exchange a list of witnesses expected to testify, and copies of all documents that each party plans to introduce at the hearing.

b. The parties shall identify witnesses and exchange documents at least ten (10) calendar days prior to the hearing.

i. Failure to comply is good cause for the hearing officer to grant a continuance.

ii. This provision shall not affect the initial responsibility of the parties to make all relevant documents available for copying at least thirty (30) calendar days prior to the commencement of the hearing.

c. Failure to comply shall be good cause for the hearing officer to limit introduction of any documents not provided, or witnesses not identified, by the other party in a timely manner.

15. Record of Hearing

a. A certified shorthand reporter shall be present to make a record of the hearing proceedings. The pre-hearing proceedings may be placed on the record if deemed appropriate by the hearing officer. The cost of attendance of the shorthand reporter shall be borne by CalOptima.

b. The Practitioner or peer review committee whose decision prompted the hearing shall be entitled to receive a copy of the transcript or recording upon paying the reasonable cost for preparing the record. In such cases, both parties shall receive a copy of the transcript.

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16. Rights of Parties

    a. At the hearing, both parties shall have the right to:

        i. Ask members of the Judicial Review Committee or the hearing officer questions directly related to determining if the members or the hearing officer meet the qualifications as set forth in Section III.A.5 and Section III.A.7 of this Policy, and to challenge the members or the hearing officer;

        ii. Call and examine witnesses;

        iii. Introduce exhibits and other relevant documents;

        iv. Cross-examine or otherwise attempt to impeach any witness who testified orally on any matter relevant to the issues, and otherwise rebut any evidence;

        v. Provide a written statement at the close of the hearing; and

        vi. Be provided with all information made available to the Judicial Review Committee and to have a record made of the proceedings.

    b. The peer review committee whose decision prompted the hearing shall have the right to call and examine a Practitioner as if under cross-examination.

    c. The hearing officer shall rule on any challenge directed at a member of the Judicial Review Committee or the hearing officer prior to the continuation of the proceedings.

17. Admissibility of Evidence

    a. The hearing shall not be conducted according to rules of law relating to the examination of witnesses or presentation of evidence.

    b. Any relevant evidence, including hearsay, shall be admitted by the hearing officer if it is the type of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law.

    c. The Judicial Review Committee members may question the witnesses, and may request that additional witnesses be called, if they deem it appropriate.

18. Burden of Going Forward and Burden of Proof

    a. CalOptima shall have the initial duty to present evidence that supports the charge or recommended action. CalOptima is not required to prove each and every charge or issue before the Judicial Review Committee in order for its actions and/or recommendation(s) to be found reasonable and warranted.

    b. An initial applicant Practitioner shall bear the burden of persuading the Judicial Review Committee, by a preponderance of the evidence, that he or she possesses the requisite qualifications, experience, and competency to participate in CalOptima programs.

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1 i. An initial applicant Practitioner shall provide information that allows for adequate
2 evaluation and resolution of reasonable doubts concerning his or her current
3 qualifications to participate.
4
5 ii. An initial applicant Practitioner shall not introduce information not produced upon
6 CalOptima's request during the application process, unless the applicant Practitioner
7 establishes that the information could not have been produced previously in the exercise
8 of reasonable diligence.
9
10 c. Except as provided above for initial applicants, CalOptima shall bear the burden of
11 persuading the Judicial Review Committee, by a preponderance of the evidence, that its
12 action or recommendation is reasonable and warranted.
13
14 19. Adjournment and Conclusion
15
16 a. The Hearing Officer may adjourn and reconvene the hearing at the convenience of the
17 participants without special notice.
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19 b. The hearing shall be concluded within a reasonable time, and the hearing officer may set
20 guidelines for introduction of evidence to achieve a timely conclusion.
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22 c. The parties may submit a written statement at the close of the hearing, within guidelines as
23 to length, format, and submission dates as decided by the hearing officer, in consultation
24 with the Judicial Review Committee.
25
26 d. Upon conclusion of the presentation of oral and written evidence and argument, the hearing
27 shall be closed. The Judicial Review Committee shall thereupon, outside the presence of the
28 parties, conduct its deliberations and render a decision and accompanying report.
29
30 e. Final adjournment shall not occur until the Judicial Review Committee has completed its
31 deliberations.
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33 20. Decision of the Judicial Review Committee
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35 a. The Judicial Review Committee shall base its decision on all the evidence produced at the
36 hearing, including all logical and reasonable inferences from the evidence as well as any
37 written statements submitted to the Judicial Review Committee.
38
39 b. Within thirty (30) calendar days after final adjournment of the hearing, the Judicial Review
40 Committee shall render a decision accompanied by a written report that contains findings of
41 fact and a conclusion articulating the connection between the evidence produced at the
42 hearing and the decision. If the Practitioner is under summary suspension, the time for the
43 decision and report shall be within fifteen (15) days. The report shall be in sufficient detail
44 to enable the parties and any appellate review body to determine the basis for the Judicial
45 Review Committee's decision on each matter contained in the Notice of Charges. Such
46 decision shall also contain an explanation of the procedure for appealing the decision.
47
48 c. The Judicial Review Committee shall forward the decision promptly but in not more than
49 thirty (30) calendar days from the date the decision is rendered to the peer review

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committee whose decision prompted the hearing, the CalOptima CMO, and the affected Practitioner.

d. The Judicial Review Committee shall deliver the Practitioner's copy of the report by registered or certified mail, return receipt requested, and first class mail.

e. The decision of the Judicial Review Committee shall be considered final. There shall be no right to appeal the decision following the formal hearing.

f. The decision of the Judicial Review Committee shall be transmitted to the CalOptima CMO. If the CalOptima CMO, in consultation with Legal Counsel, is satisfied that the Judicial Hearing Committee's decision follows from a fair hearing and is consistent with the applicable burden of proof as described above, it shall adopt that decision as the final action of CalOptima and the decision shall be effective immediately. If the CalOptima CMO, in consultation with Legal Counsel, concludes that the Judicial Hearing Committee's decision does not follow from a fair hearing and/or is inconsistent with the applicable burden of proof as described above, then the CMO, in consultation with Legal Counsel, shall proceed as it deems necessary and appropriate to address any unfairness and render a decision that is consistent.

21. Reporting

a. CalOptima shall comply with the reporting requirements of Business and Professions Code and the National Practitioner Data Bank in accordance with CalOptima policy.

IV. ATTACHMENTS

A. Notice of Hearing

V. REFERENCES

A. California Business and Professions Code, §§805 and 809
B. California Health and Safety Code, §1370
C. California Welfare and Institutions Code, §14000 et seq.
D. CalOptima Contract for Health Care Services
E. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
F. CalOptima Contract with Department of Health Care Services (DHCS) for Medi-Cal
G. CalOptima PACE Program Agreement
H. CalOptima Policy AA.1000: Glossary of Terms
I. CalOptima Policy CMC.1001: Glossary of Terms
J. CalOptima Policy GG.1607Δ: Monitoring Adverse Activities
K. CalOptima Policy MA.1001: Glossary of Terms
L. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
M. NCQA Health Plan Standards and Guidelines: Credentialing and Recredentialing
N. Title 42, Code of Federal Regulations (C.F.R.), §422.202
O. Title 42, Code of Federal Regulations (C.F.R.) §422.204

VI. REGULATORY AGENCY APPROVALS

1
2 None to Date
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4 **VII. BOARD ACTIONS**
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6 A. 06/01/17: Regular Meeting of the CalOptima Board of Directors
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8 **VIII. REVIEW/REVISION HISTORY**
9

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	04/1996	GG.1616	Fair Hearing Plan for CalOptima Direct Practitioners	Medi-Cal
Revised	03/1999	GG.1616	Fair Hearing Plan for CalOptima Direct Practitioners	Medi-Cal
Revised	02/2003	GG.1616	Fair Hearing Plan for CalOptima Direct Practitioners	Medi-Cal
Revised	10/01/2005	MA.7016	Fair Hearing Plan for Practitioners	OneCare
Revised	03/01/2007	MA.7016	Fair Hearing Plan for Practitioners	OneCare
Revised	04/01/2007	GG.1616	Fair Hearing Plan for CalOptima Direct Practitioners	Medi-Cal
Revised	11/01/2011	GG.1616	Fair Hearing Plan for CalOptima Direct Practitioners	Medi-Cal
Revised	02/01/2013	GG.1616	Fair Hearing Plan for CalOptima Direct Practitioners	Medi-Cal
Reviewed	06/01/2014	GG.1616	Fair Hearing Plan for Practitioners	Medi-Cal
Revised	06/01/2017	GG.1616Δ	Fair Hearing Plan for Practitioners	Medi-Cal OneCare OneCare Connect PACE

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1 **IX. GLOSSARY**
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Term	Definition
Health Network	For purpose of this policy, 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.
Judicial Review Committee	The committee appointed to conduct a hearing based on a request for hearing by a Practitioner as described in this policy.
Minimum Physician Standards	The standards that must be met in order to submit an application for credentialing, the successful approval of which is a prerequisite to contracting with CalOptima or Health Networks in accordance with CalOptima Policy GG.1643: Minimum Physician Standards.
Peer Review	The process of reviewing whether a Practitioner is qualified, on an initial and ongoing basis, to participate in health care programs administered by CalOptima (including through delegated Health Networks) and taking actions, as appropriate, based on such review.
Practitioner	For the purposes of this Policy, "Practitioner" shall have the same meaning as "Licentiate" as that term is defined in Section 805 of the California Business and Professions Code and specifically a physician and surgeon, doctor of podiatric medicine, clinical psychologist, marriage and family therapist, clinical social worker, professional clinical counselor, dentist, physician assistant and persons authorized to practice medicine pursuant to Business and Professions Code Section 2113 or 2168.

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[Date]

[Recipient Name]
[Street Address]
[City, ST ZIP Code]

Dear [Recipient Name]:

The purpose of this letter is to provide you with notice that the CalOptima Credentialing and Peer Review Committee (CPRC) has reviewed concerns regarding the quality of your care and has subject to fair hearing rights, determined to deny your credentialing application for CalOptima participation for a medical disciplinary cause or reason, per CalOptima Policy GG.1616 (a copy of this policy is enclosed for your reference).

In reaching its decision, the CPRC has reviewed and considered, by way of example, the following: [ADD DETAIL]

Notice of Procedural Rights:

Please be advised that you are entitled to the procedural rights set forth in CalOptima's Corrective Action Plan for Practitioners Policy No. GG.1615 and Fair Hearing Plan for Practitioners Policy No. GG.1616.

PLEASE BE ADVISED THAT YOU HAVE THIRTY (30) DAYS FROM THE DATE OF RECEIPT OF THIS LETTER TO REQUEST A HEARING. YOUR REQUEST SHALL BE MADE IN WRITING AND DIRECTED TO: RICHARD HELMER, MD, CALOPTIMA CHIEF MEDICAL OFFICER. FAILURE TO REQUEST A HEARING WITHIN THIRTY (30) DAYS WILL RESULT IN A WAIVER OF YOUR RIGHT TO A HEARING AND ANY APPELLATE REVIEW AND THE RECOMMENDATIONS OF THE CPRC SHALL BE DEEMED ACCEPTED AND FINAL

If you timely elect to exercise your right to challenge the recommended restriction, you will have a right to a written notice of the time, date and place of the hearing, to a notice of the charges, the

right to inspect and copy documentary information, to ask questions and challenge the qualifications of Judicial Review Committee members or the hearing officer, to submit documents in your defense, to call and examine witnesses, to introduce exhibits and other relevant documents, to cross-examine and impeach witnesses, to testify on your behalf, to rebut evidence, to provide a written statement at the close of the hearing, to be provided with information made available to the Judicial Review Committee and have a record made of the proceedings, to be provided with a copy of the decision, and to appeal any decision.

Very Truly yours,

Richard Bock, MD, MBA
Deputy Chief Medical Officer

cc: Richard Helmer, MD, Chief Medical Officer
Michael Schrader, Chief Executive Officer
CalOptima Quality Improvement Committee
CalOptima Credentialing and Peer Review Committee

Enclosure

Back to Agenda

Policy #: GG.1607Δ
Title: **Monitoring Adverse** ~~Activity Process~~**Activities**
Department: Medical Affairs
Section: Quality Improvement
CEO Approval: Michael Schrader ______

Effective Date: 12/95
Last Review Date: 06/01/17
Last Revised Date: 06/01/17

Applicable to: ☒ Medi-Cal
☒ OneCare
☒ OneCare Connect
☒ PACE

~~CEO Approval:~~ ~~Michael Schrader~~

~~Effective Date:~~ ~~12/95~~ ~~Revised: 8/98, 11/99, 3/1/07, 4/1/07, 11/1/11, 2/1/13, 6/1/14~~

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~~**I.**~~

I. PURPOSE

~~**To establish**~~This policy establishes a process for ongoing monitoring of ~~**Practitioners**~~contracted or non-contracted practitioners and Healthcare Delivery Organization's (~~**HDO's**~~HDOs) Adverse Activity ~~**during the interval between formal Credentialing and any action taken against Practitioner or HDOs for adverse actions, including, quality issues.**~~.

II. POLICY

A. ~~A.~~ CalOptima shall perform ongoing monitoring of ~~Practitioner~~practitioner or HDO ~~Sanctions, Complaints~~sanctions, complaints, and quality issues between ~~R~~recredentialing cycles.

B. A Health Network shall perform ongoing monitoring of practitioner or HDO sanctions, complaints, and quality issues between Recredentialing cycles~~.~~ that at a minimum, is in accordance with this ~~P~~policy.

C. ~~B.~~ CalOptima shall take appropriate action against ~~Practitioners~~practitioners or HDOs when the CalOptima Quality Improvement (QI) Department identifies ~~occurrences of poor quality.~~ adverse activity.

D. CalOptima shall notify practitioners and HDOs if limiting practice, in writing, within thirty (30) calendar days.

~~A.~~E. Adverse Activities include ~~any of~~, but are not limited to the following:

1. Any adverse action by the Medical Board of California, taken or pending, including, but not limited to, an accusation filed, temporary restraining order or interim suspension order sought or obtained, public letter of reprimand, or any formal restriction, probation, suspension, or revocation of licensure, or cease of practice with charges pending;

2. An ~~adverse~~ action taken by ~~any health care organization or~~ a Peer Review Body (as defined in State or Federal law), or other organizations, that ~~has resulted~~results in the filing of a ~~Section 805~~report under Business & Professions Code Sections 805 or 805.01 report with the Medical Board of California ~~(within fifteen (15) calendar days),~~ and/or a report with the National Practitioner Data Bank (NPDB~~) (within thirty (30) calendar days);~~);

    ~~a. Outcomes which may require reporting to authorities are based on California Business and Professions Code section 805.01.~~

        ~~i. Incompetence, or gross or repeated deviation from the standard of care involving death or serious bodily injury to one or more patients, to the extent or in such a manner as to be dangerous or injurious to any person or to the public.~~

        ~~ii. The use of, or prescribing for or administering to himself or herself, any controlled substance; or the use of any dangerous drug, as defined in Section 4022 of the Business and Professions code, or of alcoholic beverages, to the extent or in such a manner as to be dangerous or injurious to the licentiate, any other person, or the public, or to the extent that such use impairs the ability of the licentiate to practice safely.~~

        ~~iii. Repeated acts of clearly excessive prescribing, furnishing, or administering of controlled substances or repeated acts of prescribing, dispensing, or furnishing of controlled substances without a good faith effort prior examination of the patient and medical reason therefore; and~~

        ~~iv. Sexual misconduct with one or more patients during a course of treatment or an examination;~~

3. A revocation of a Drug Enforcement Agency (DEA) license;

4. A conviction of a felony or misdemeanor of moral turpitude;

5. Any action against a certification under the Medicare or Medicaid programs;

6. A cancellation, non-renewal, or material reduction in medical liability insurance policy coverage;

7. Any action taken by the California Department of Public Health ~~Care Services~~, Division of Licensing and Certification;

8. Any action taken by the Health and Human Services Office of the Inspector General (OIG); ~~and~~

9. Any action taken by System for Award Management (SAM); or~~and;~~

~~9.~~10. A pattern or trend concerning quality of care issues and ~~Complaints~~ complaints that have been identified through the CalOptima Quality Improvement Department.

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~~D. **CalOptima shall inform Practitioners or HDOs of the formal appeal process through the mailing of written notification within thirty (30) calendar days, in accordance with CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners and this policy.**~~

III. PROCEDURE

~~i.~~ CalOptima ~~Practitioners~~monitors practitioners and HDOs ~~shall be subject to~~ on an ongoing ~~monitoring as a result of CalOptima's identification of~~ basis to identify Adverse Activities~~, as described~~ that may affect participation in ~~Section III.B.1of this policy.~~

A. CalOptima ~~shall monitor~~program.

~~ii.~~B. CalOptima monitors various State ~~Licensing Boards, and State~~ and Federal ~~Agencies in order to timely identify any Practitioners or HDOs with~~boards, agencies, and databanks for Adverse Activity(ies~~),:~~) including:

1. OIG exclusion list: ~~monthly, as well as during the time of initial~~upon Credentialing and Recredentialing and ongoing on a monthly basis;

2. SAM list:~~;~~ upon Credentialing and Recredentialing and ongoing on a monthly basis;

3. Business & Professions Code Sections 805 and 805.01, and continuous monitoring NPDB reports;

~~2.~~4. Medicare Opt-Out Physicians: ~~monitored~~upon Credentialing and Recredentialing and ongoing on a quarterly ~~during the time of initial Credentialing and Recredentialing~~basis;

~~3.~~5. Medi-Cal Provider Suspended and Ineligible list: ~~monthly~~upon Credentialing and Recredentialing and ongoing on a monthly basis~~.~~; and

~~4.~~6. Medical Board of California notifications: as published via e-mail notifications of license suspensions, restrictions, revocations, surrenders and disciplinary actions~~.;; and~~.

~~5. State Licensing Boards for all practitioners credentialed and contracted with CalOptima: monthly and quarterly as reports are published;~~

~~6.~~C. CalOptima shall review all information ~~gathered from the specified Websites~~ within thirty (30) calendar days of its release~~; and~~.

D. Any adverse activity that limits or removes a practitioner's right to practice will be reported via Provider Alert to the Quality Medical Director for approval. Once approved, the Provider Relations or Health Network Relations Departments will be notified. In addition, Provider Data Management Services (PDMS) will be notified and will enter an alert in Facets™ which will also be captured in Guiding Care for the UM staff's notification.

E. Any adverse activities identified shall be tracked in the adverse activity database.

F. Upon credentialing and recredentialing, adverse activities identified in the tracking database will be summarized and added to the practitioner and HDO file in Credentialing database.

~~7.~~G. On a ~~quarterly~~bi-monthly basis~~, the~~ or earlier, depending on the nature of the adverse activity and CalOptima requirements, the QI Department shall report, in a confidential manner, all findings to the Credentialing ~~and~~ Peer Review Committee (CPRC).

~~8.~~H. On a quarterly basis, CalOptima's Grievance & Appeals Resolution Services (GARS) Department shall report to the Quality Improvement Committee (QIC) all complaints, including a summary of data analysis, regarding service, attitude, and access, in accordance with CalOptima ~~Policy 1608Δ: Full Scope Site Reviews~~Policies CMC.9001: Member Complaint Process, CMC.9002: Member Grievance Process, HH.1102: CalOptima Member Complaint, MA.9002: Member Grievance Process.

~~C.~~I. The QI Department shall ~~monitor~~forward all ~~Practitioners~~ Practitioner and ~~HDOs~~HDO potential quality issues ~~(PQI) as~~ received from internal and external sources~~,~~ to a CalOptima Medical Director for review and potential action, in accordance with CalOptima Policy GG.1611: Potential Quality ~~Improvement Case~~Issue Review Process~~.~~.

~~B. The QI Department~~ CalOptima shall ~~investigate PQI by compiling Medical Records and responses to Complaints from Providers and HDOs.~~

~~C.~~

J. ~~A physician reviewer or~~ inform affected practitioners or HDOs of the ~~CPRC shall review~~ appeal process through the mailing of written notification within thirty (30) calendar days, in accordance with CalOptima Policies HH.1101: CalOptima Provider Complaint and MA.9006: Provider Complaint Process.

~~D.~~ ~~case and determine if any quality of care issues are identified.~~

~~E.~~

~~D. The QI Department shall enter into the Quality Improvement database, and note on the Practitioner's or HDO's credentialing file, a Practitioner or HDO with Adverse Activity.~~

~~E. The CPRC shall review information concerning Practitioners and HDOs with Adverse Activity and implement actions accordingly:~~

~~1. Upon conclusion of the investigation, the CPRC shall determine whether any corrective action is necessary, and whether the corrective action, is recommended as a result of a "medical disciplinary cause or reason."~~

~~2. In accordance with CalOptima Policy GG.1611: Quality Improvement Case Review Process, the summary of the corrective action(s) recommended by the CPRC shall include, without limitation, the following:~~

~~a. Determination of whether a quality issue exists;~~

~~b. If no quality issue is identified, no further action regarding the review process shall occur, and CalOptima shall forward the case summary to the Practitioner or HDO for closure;~~

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~~c. If a potential quality issue is identified, the CPRC shall review the findings, and may recommend:~~

~~i. Review of the case by a multidisciplinary team of Practitioners s or HDOs; and/or~~

~~ii. Peer review of the case by a medical specialist, when required, relevant to the Practitioner or HDO issue involved in the case;~~

~~d. If a quality issue is identified, the CPRC shall take the following action:~~

~~i. Request corrective action from a specific CalOptima Department, Health Network, or Practitioner or HDO;~~

~~ii. Require the Health Network or CalOptima to perform additional educational training; or~~

~~iii. Other appropriate action as defined by the CPRC.~~

~~F.~~K. CalOptima's Quality Improvement Department shall maintain Credentialing information in a Credentialing file, in accordance with CalOptima Policy ~~GG1604Δ~~GG.1604Δ: Confidentiality of Credentialing Files, and shall ensure that all Credentialing files are up-to-date~~.~~.

~~G. Practitioner and HDO Appeal Rights~~

~~1. CalOptima shall inform affected Practitioners and HDOs of the Appeal process through the mailing of written notification within thirty (30) calendar days, in accordance with CalOptima Policy GG1616Δ: Fair Hearing Plan for Practitioners. The written notification shall inform Practitioners and HDOs of:~~

~~a. Any professional review action taken against the Practitioner or HDO, as well as reasons for the action, and a summary of the appeal rights and process;~~

~~b. The Practitioner or HDO's right to request a hearing, and the specific time period for submitting the request;~~

~~c. The Practitioners or HDO's right to request a hearing after thirty (30) days of receipt of the notification;~~

~~d. The Practitioners or HDO's right to representation by an attorney or another person of the Practitioner or HDO's choosing; and~~

~~e. The CalOptima Chief Medical Officer's right to appoint a hearing officer or a panel of individuals to review the appeal.~~

L. All suspensions and~~,~~ terminations from any licensing or regulating agency will be reported through the Regulatory Affairs & Compliance Department to the Department of Health Care Services (DHCS) within ten (10) days of final notification to CalOptima.

a. The report to DHCS shall include the following:

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i. Contract status (by delegated entity, if applicable) with the named provider.

ii. The number of beneficiaries receiving services from the provider by all lines of business including any delegated entity, LTSS, or OneCare Connect.

M. Any alert affecting Health Networks will be communicated through the Health Network Relations Department, as applicable.

N. Any alert that may affect provider directories will follow processes outlined in CalOptima Policy EE.1101: Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-Based Directory.

IV. ATTACHMENTS

A. Ongoing Monitoring Website Information Matrix

V. REFERENCES

A. California Business and Professions Code, §§805 and 805.01
B. California Business and Professions Code, §4022
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
D. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
CalOptima PACE Program AgreementsCalifornia Business and Professions Code, §§ 805 and 805.01
A. California Business and Professions Code, Sections 805 and §4022
B. CalOptima PACE Program Agreement
E. Title 42 United States Code §11101 et seq.
C.F. CalOptima Policy AA.1000: Glossary of TermsCMC.9001: Member Complaint Process
G. CalOptima Policy CMC.9002: Member Grievance Process
D.H. CalOptima Policy GG.1604Δ: Confidentiality of Credentialing Files
E. CalOptima Policy GG.1608Δ: Full Scope Site Reviews
F.I. CalOptima Policy GG.1611: Potential Quality Improvement CaseIssue Review Process
G.J. CalOptima Policy GG.1615: CalOptima Direct Corrective Action Plan for Practitioners
H.K. CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners
L. OneCareCalOptima Policy HH.1101: CalOptima Provider Complaint
M. CalOptima Policy HH.1102: CalOptima Member Complaint
N. CalOptima Policy EE.1101: Additions, Changes and Terminations to CalOptima Providers Information, CalOptima Providers Directory, and Web-based Directory.
I.O. CalOptima Policy MA.1001: Glossary of Terms 9002: Member Grievance Process

VI. REGULATORY APPROVALS

P. 6/1/15: CalOptima Policy MA.9006: Provider Complaint Process

1 J.Q.CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the
2 Department of Health Care Services (DHCS) for Cal MediConnect
3 A.R. Department of Health Care Services All Plan Letter 16-001:Medi-Cal Provider and Subcontract
4 Suspensions, Terminations and Decertifications
5 K. Title 42 United States Code §11101 et seq.
6 A.S.
7
8 **VI. REGULATORY AGENCY APPROVALS**
9
10 None to Date
11
12 **VII. BOARD ACTION**
13
14 Not Applicable
15
16 None to DateA. 06/01/17: Regular Meeting of the CalOptima Board of Directors
17
18 **VIII. REVIEW/REVISION HISTORY**
19
20 A. 6/1/14: GG.1607: Adverse Activity Process
21 B. 2/1/13: GG.1607: Adverse Activity Process
22 C. 11/1/11: MA.7009b: Adverse Activity Process
23 D. 11/1/11: GG.1607: Adverse Activity Process
24 E. 4/1/07: GG.1607: Credentialing, Adverse Activity Files
25 F. 3/1/07: MA.7009b: Credentialing, Adverse Activity Files
26 G. 11/99: GG.1607: Credentialing, Adverse Activity Files
27 H. 8/98: GG.1607: Credentialing, Adverse Activity Files
28 12/95: GG.1607: Credentialing, Adverse Activity File

Version	Version Date	Policy Number	Policy Title	Line(s) of Business
Effective	12/1995	GG.1607	Credentialing, Adverse Activity Files	Medi-Cal
Revised	08/1998	GG.1607	Credentialing, Adverse Activity Files	Medi-Cal
Revised	11/1999	GG.1607	Credentialing, Adverse Activity Files	Medi-Cal
Revised	03/01/2007	MA.7009b	Credentialing, Adverse Activity Files	Medi-Cal
Revised	04/01/2007	GG.1607	Credentialing, Adverse Activity Files	Medi-Cal
Revised	11/01/2011	GG.1607	Adverse Activity Process	Medi-Cal
Revised	11/01/2011	MA.7009b	Adverse Activity Process	OneCare
Revised	02/01/2013	GG.1607	Adverse Activity Process	Medi-Cal OneCare

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Version	Version Date	Policy Number	Policy Title	Line(s) of Business
Revised	06/01/2014	GG.1607	Adverse Activity Process	Medi-Cal OneCare OneCare Connect
Revised	06/01/2017	GG.1607Δ	Monitoring Adverse Activities	Medi-Cal OneCare OneCare Connect PACE

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IX. GLOSSARY

Term	Definition
Behavioral Health Providers	A licensed practitioner including, but not limited to, physicians, nurse specialists, psychiatric nurse practitioners, licensed psychologists (PhD or PsyD), licensed clinical social worker (LCSW), marriage and family therapist (MFT or MFCC), professional clinical counselors and qualified autism service providers, furnishing covered services.
Behavioral Health Providers	A licensed practitioner including, but not limited to, physicians, nurse specialists, psychiatric nurse practitioners, licensed psychologists (PhD or PsyD), licensed clinical social worker (LCSW), marriage and family therapist (MFT or MFCC), professional clinical counselors and qualified autism service providers, furnishing covered services.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Long Term Support Services (LTSS) Providers	A licensed practitioner such as physicians, NMP's, social workers, and nurse managers
Medical Health Delivery Organizations (HDOs)	Organizations that are contracted to provide medical services such as hospitals, home health agencies, skilled nursing facilities, free standing surgical centers, extended care facilities (LTC), nursing homes (assisted living), hospice, community clinic, urgent care centers, dialysis centers, Residential Care Facility for the Elderly (RCFE), Community Based Adult Services (CBAS), radiology centers, clinical laboratories, rehabilitation facilities.
Non-Physician Medical Practitioner (NMP)	A licensed practitioner who practices independently under state law, including but not limited to, a Nurse Practitioner (NP), Certified Nurse Midwife (CNM), Certified Nurse Specialists (CNS), Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), Speech Therapist (ST), Audiologist furnishing covered services.
Physician Practitioner	A licensed practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), furnishing covered services.
Service Health Delivery Organizations (HDOs)	Organizations that are contracted to provide services that support member needs such as ambulance, non-emergency medical transportation, durable medical equipment and providers of other member facing services such as, transportation services, meal services, and homecare services.
Substance Use Disorder (SUD) Providers	Licensed, certified or registered by one of the following: a physician licensed by the Medical Board of California, a psychologist licensed by the Board of Psychology, a clinical social worker or marriage and family therapist licensed by California Board of Behavioral Sciences, or an intern registered with California Board of Psychology or California Board of Behavioral sciences.

4 I.

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Policy #: GG.1607Δ
Title: **Monitoring Adverse Activities**
Department: Medical Affairs
Section: Quality Improvement

CEO Approval: Michael Schrader ______

Effective Date: 12/95
Last Review Date: 06/01/17
Last Revised Date: 06/01/17

Applicable to:
☒ Medi-Cal
☒ OneCare
☒ OneCare Connect
☒ PACE

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I. PURPOSE

This policy establishes a process for ongoing monitoring of contracted or non-contracted practitioners and Healthcare Delivery Organization's (HDOs) Adverse Activity.

II. POLICY

A. CalOptima shall perform ongoing monitoring of practitioner or HDO sanctions, complaints, and quality issues between Recredentialing cycles.

B. A Health Network shall perform ongoing monitoring of practitioner or HDO sanctions, complaints, and quality issues between Recredentialing cycles that at a minimum, is in accordance with this Policy.

C. CalOptima shall take appropriate action against practitioners or HDOs when the CalOptima Quality Improvement (QI) Department identifies adverse activity.

D. CalOptima shall notify practitioners and HDOs if limiting practice, in writing, within thirty (30) calendar days.

E. Adverse Activities include , but are not limited to the following:

1. Any adverse action by the Medical Board of California, taken or pending, including, but not limited to, an accusation filed, temporary restraining order or interim suspension order sought or obtained, public letter of reprimand, or any formal restriction, probation, suspension, or revocation of licensure, or cease of practice with charges pending;

2. An action taken by a Peer Review Body (as defined in State or Federal law), or other organizations, that results in the filing of a report under Business & Professions Code Sections 805 or 805.01 report with the Medical Board of California and/or a report with the National Practitioner Data Bank (NPDB);

3. A revocation of a Drug Enforcement Agency (DEA) license;

4. A conviction of a felony or misdemeanor of moral turpitude;

5. Any action against a certification under the Medicare or Medicaid programs;

6. A cancellation, non-renewal, or material reduction in medical liability insurance policy coverage;

7. Any action taken by the California Department of Public Health, Division of Licensing and Certification;

8. Any action taken by the Health and Human Services Office of the Inspector General (OIG);

9. Any action taken by System for Award Management (SAM); or

10. A pattern or trend concerning quality of care issues and complaints that have been identified through the CalOptima Quality Improvement Department.

III. PROCEDURE

A. CalOptima monitors practitioners and HDOs on an ongoing basis to identify Adverse Activities that may affect participation in CalOptima program.

B. CalOptima monitors various State and Federal boards, agencies, and databanks for Adverse Activity(ies) including:

1. OIG exclusion list: upon Credentialing and Recredentialing and ongoing on a monthly basis;

2. SAM list: upon Credentialing and Recredentialing and ongoing on a monthly basis;

3. Business & Professions Code Sections 805 and 805.01, and continuous monitoring NPDB reports;

4. Medicare Opt-Out Physicians: upon Credentialing and Recredentialing and ongoing on a quarterly basis;

5. Medi-Cal Provider Suspended and Ineligible list: upon Credentialing and Recredentialing and ongoing on a monthly basis; and

6. Medical Board of California notifications: as published via e-mail notifications of license suspensions, restrictions, revocations, surrenders and disciplinary actions.

C. CalOptima shall review all information within thirty (30) calendar days of its release.

D. Any adverse activity that limits or removes a practitioner's right to practice will be reported via Provider Alert to the Quality Medical Director for approval. Once approved, the Provider Relations or Health Network Relations Departments will be notified. In addition, Provider Data Management Services (PDMS) will be notified and will enter an alert in Facets™ which will also be captured in Guiding Care for the UM staff's notification.

E. Any adverse activities identified shall be tracked in the adverse activity database.

F. Upon credentialing and recredentialing, adverse activities identified in the tracking database will be summarized and added to the practitioner and HDO file in Credentialing database.

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G. On a bi-monthly basis or earlier, depending on the nature of the adverse activity and CalOptima requirements, the QI Department shall report, in a confidential manner, all findings to the Credentialing Peer Review Committee (CPRC).

H. On a quarterly basis, CalOptima's Grievance & Appeals Resolution Services (GARS) Department shall report to the Quality Improvement Committee (QIC) all complaints, including a summary of data analysis, regarding service, attitude, and access, in accordance with CalOptima Policies CMC.9001: Member Complaint Process, CMC.9002: Member Grievance Process, HH.1102: CalOptima Member Complaint, MA.9002: Member Grievance Process.

I. The QI Department shall forward all Practitioner and HDO potential quality issues received from internal and external sources to a CalOptima Medical Director for review and potential action, in accordance with CalOptima Policy GG.1611: Potential Quality Issue Review Process.

J. CalOptima shall inform affected practitioners or HDOs of the appeal process through the mailing of written notification within thirty (30) calendar days, in accordance with CalOptima Policies HH.1101: CalOptima Provider Complaint and MA.9006: Provider Complaint Process.

K. CalOptima's Quality Improvement Department shall maintain Credentialing information in a Credentialing file, in accordance with CalOptima Policy GG.1604Δ: Confidentiality of Credentialing Files, and shall ensure that all Credentialing files are up-to-date.

L. All suspensions and terminations from any licensing or regulating agency will be reported through the Regulatory Affairs & Compliance Department to the Department of Health Care Services (DHCS) within ten (10) days of final notification to CalOptima.

   a. The report to DHCS shall include the following:

      i. Contract status (by delegated entity, if applicable) with the named provider.

      ii. The number of beneficiaries receiving services from the provider by all lines of business including any delegated entity, LTSS, or OneCare Connect.

M. Any alert affecting Health Networks will be communicated through the Health Network Relations Department, as applicable.

N. Any alert that may affect provider directories will follow processes outlined in CalOptima Policy EE.1101: Additions, Changes, and Terminations to CalOptima Provider Information, CalOptima Provider Directory, and Web-Based Directory.

IV. ATTACHMENTS

A. Ongoing Monitoring Website Information Matrix

V. REFERENCES

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B. California Business and Professions Code, §4022
C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage

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E. CalOptima PACE Program Agreement
F. CalOptima Policy CMC.9001: Member Complaint Process
G. CalOptima Policy CMC.9002: Member Grievance Process
H. CalOptima Policy GG.1604Δ: Confidentiality of Credentialing Files
I. CalOptima Policy GG.1611: Potential Quality Issue Review Process
J. CalOptima Policy GG.1615: CalOptima Direct Corrective Action Plan for Practitioners
K. CalOptima Policy GG.1616Δ: Fair Hearing Plan for Practitioners
L. CalOptima Policy HH.1101: CalOptima Provider Complaint
M. CalOptima Policy HH.1102: CalOptima Member Complaint
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O. CalOptima Policy MA.9002: Member Grievance Process
P. CalOptima Policy MA.9006: Provider Complaint Process
Q. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
R. Department of Health Care Services All Plan Letter 16-001:Medi-Cal Provider and Subcontract Suspensions, Terminations and Decertifications
S. Title 42 United States Code §11101 et seq.

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTION

A. 06/01/17: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	12/1995	GG.1607	Credentialing, Adverse Activity Files	Medi-Cal
Revised	08/1998	GG.1607	Credentialing, Adverse Activity Files	Medi-Cal
Revised	11/1999	GG.1607	Credentialing, Adverse Activity Files	Medi-Cal
Revised	03/01/2007	MA.7009b	Credentialing, Adverse Activity Files	Medi-Cal
Revised	04/01/2007	GG.1607	Credentialing, Adverse Activity Files	Medi-Cal
Revised	11/01/2011	GG.1607	Adverse Activity Process	Medi-Cal
Revised	11/01/2011	MA.7009b	Adverse Activity Process	OneCare
Revised	02/01/2013	GG.1607	Adverse Activity Process	Medi-Cal OneCare
Revised	06/01/2014	GG.1607	Adverse Activity Process	Medi-Cal OneCare OneCare Connect

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Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	06/01/2017	GG.1607Δ	Monitoring Adverse Activities	Medi-Cal OneCare OneCare Connect PACE

1
2

1 **IX. GLOSSARY**
2

Term	Definition
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Service Health Delivery Organizations (HDOs)	Organizations that are contracted to provide services that support member needs such as ambulance, non-emergency medical transportation, durable medical equipment and providers of other member facing services such as, transportation services, meal services, and homecare services.
Substance Use Disorder (SUD) Providers	Licensed, certified or registered by one of the following: a physician licensed by the Medical Board of California, a psychologist licensed by the Board of Psychology, a clinical social worker or marriage and family therapist licensed by California Board of Behavioral Sciences, or an intern registered with California Board of Psychology or California Board of Behavioral sciences.

3

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Ongoing Monitoring Website Information 01-25-2017

Licensing Board, Address and Phone Numbers	Practitioner Types	Website/links	Instructions and Comments	Report Frequency
Medical Board of California 2005 Evergreen Street, Suite 1200 Sacramento, CA 95815 PH:(916) 263-2382 or (800) 633-2322 Enforcement Central File Room PH: (916) 263-2525 FAX: (916) 263-2420 805's Discipline Coord. (916) 263-2449	MD	www.mbc.ca.gov **All communications for disciplinary actions will be done by e-mail to subscribers.** **Link to subscribe for actions:** **http://www.mbc.ca.gov/Subscribers/** **Link for all Disciplinary Actions/License Alerts distributed:** **http://www.mbc.ca.gov/Publications/Disciplinary_Actions/** **Enforcement Public Document Search (Search by Name or Lic:** **http://www2.mbc.ca.gov/PDL/Search.aspx**	You must signup to subscribe for E-mail notifications of accusations, license suspensions, restrictions, revocations, or surrenders for physicians and surgeons licensed by the MBOC. Disciplinary action documents are obtainable via the web-site by: • Link to Enforcement Public Document Search (on the left side of page under check your doctor online) or in the • License verification section; Under Public Documents – Top Right	Bi-Monthly subscribers will be sent information regarding Accusations. Decisions will be sent on a daily basis as the decisions become final
Osteopathic Medical Board of CA 1300 National Drive, Suite #150 Sacramento, CA 95834-1991 (916) 928-8390 Office (916) 928-8392 Fax E-mail:osteopathic@dca.ca.gov Enforcement/Disciplines(916)-928-8390 Ext. 6	DO	www.ombc.ca.gov **Direct Link To Enforcement Actions:** **http://www.ombc.ca.gov/consumers/enforce_action.shtml** **Subscribe to e-mail Alerts** **http://www.ombc.ca.gov/consumers/enforce_action.shtml**	▪ Link to Consumers Tab at the top ▪ Link to Enforcement Action Can get on a distribution list by e-mailing J. Corey Sparks, Lead Enforcement Analyst E-mail: Corey.Sparks@dca.ca.gov 916-928-8393 (PH) 916-928-8392 (FAX) The board is behind in updating the website. You can subscribe or send an e-mail to get on the distribution list. 01/18/17 – 2nd Quarter 2016 is the last posted report. E-mails distribution is current	Quarterly via the Website E-Mail Distribution list:

Revised 01-25-2017
<u>This document is for informational purposes only and subject to change.</u>
<u>Please visit the individual websites listed for the most current up-to-date information.</u>

Back to Agenda

Ongoing Monitoring Website Information 01-25-2017

Licensing Board, Address and Phone Numbers	Practitioner Types	Website/links	Instructions and Comments	Report Frequency
Medical Board of California **Board of Podiatric Medicine** 2005 Evergreen Street, Ste. 1300 Sacramento, CA 95815-3831 PH: (916) 263-2647 Fax:(916) 263-2651 Email: BPM@dca.ca.gov Enforcement Program Central File Room Medical Board of California 2005 Evergreen Street, Suite 1200 Sacramento, CA 95815 FAX: (916) 263-2420	DPM	**www.bpm.ca.gov** **Direct Link toEnforcement Resources:** **http://www.bpm.ca.gov/consumers/index.shtml** **Subscribers list** **http://www.mbc.ca.gov/Subscribers/** .	▪ Consumers ▪ Link to Enforcement Resources ▪ Link to Recent Disciplinary Actions(Categorized by the following): ➢ Decisions ➢ Accusations Filed ➢ Accusation and Petition to Revoke Probation filed ➢ Accusations and/or Statement of Issues Withdrawn or Dismissed ➢ Statement of Issues Listed alphabetically by category: Decision, Accusation, etc. 9/21/16 was the latest update on 12/15/16 and no reports were available. Updated01/17/17	Board of Podiatric Medicine: Changes to viewing information. On the website go to recent Disciplinary Actions, separated into categories, Decisions, Accusations filed, etc. History not available only current accusations and decisions latest one year from effective date. You can subscribe to actions related to licenses
Acupuncture Board 1747 N. Market Blvd Suite 180 Sacramento, CA 95834 PH: (916) 515-5200 Fax: (916) 928-2204 Email: acupuncture@dca.ca.gov To order copies of actions send to Attn of Consumer Protection Program	LAC/AC	**www.acupuncture.ca.gov** **Direct Link to Disciplinary Actions:** **www.acupuncture.ca.gov/consumers/board_actions.shtml** **Sign up for subscribers list for disciplinary actions:** **https://www.dca.ca.gov/webapps/acupuncture/subscribe.php**	▪ Link to Consumer at the top ▪ Link to DisciplinaryActions Last update January 5, 2017	Monthly running report listed Alpha Newer actions highlighted with date in blue. Note: Board meetings are held quarterly.

Revised 01-25-2017
This document is for informational purposes only and subject to change.
Please visit the individual websites listed for the most current up-to-date information.

Back to Agenda

Ongoing Monitoring Website Information 01-25-2017

Licensing Board, Address and Phone Numbers	Practitioner Types	Website/links	Instructions and Comments	Report Frequency
Board of Behavioral Sciences 1625 N Market Blvd., Suite S-200 Sacramento, CA 95834 PH: (916) 574-7830 Fax: (916) 574-8625 E-Mail: BBSWebmaster@bbs.ca.gov	Licensee Licensed Clinical Social Workers (LCSW) Licensed Marriage and Family Therapists (LMFT) Licensed Professional Clinical Counselors (LPCC) Licensed Educational Psychologists (LEP)	**www.bbs.ca.gov** **Sign up for subscribers list for disciplinary actions.** **https://www.dca.ca.gov/webapps/bbs/subscribe.php**	You must sign up for Subscriber list to obtain Enforcement Actions. E-mail will be sent to you. If you don't sign up as a subscriber, the News Letters will provide disciplinary actions.	**Via Subscriptions Only** Information must be obtained via subscription. For Subscribers: E-mail reports were sent:
CA Board of Chiropractic Examiners Board of Chiropractic Examiners 901 P Street, Suite 142A Sacramento, CA 95814 PH (916) 263-5355 FAX (916) 327-0039 Email: chiro.info@dca.ca.gov	DC	**www.chiro.ca.gov** **Monthly Reports** **http://www.chiro.ca.gov/enforcement/actions.shtml**	Note monthly disciplinary actions reports ▪ Link to Enforcement at the top right side (next to Contact Us) ▪ Link to Disciplinary Actions ▪ Actions listed by month and year Last report December 2016	Monthly
Dental Board of California 2005 Evergreen Street, Suite 1550 Sacramento, CA 95815 PH: (916) 263-2300 PH: (877)729-7789 Toll Free Fax #: (916) 263-2140 Email:dentalboard@dca.ca.gov Enforcement Unit PH: 916-274-6326	DDS, DMD	**www.dbc.ca.gov** **Direct Link to Disciplinary Actions:** **http://www.dbc.ca.gov/consumers/hotsheets.shtml**	▪ Link Home Page ▪ Under Highlights at the bottom of the page-Link to Hot Sheet! Dental Disciplinary Action ▪ Actions listed by month and year Or ▪ Link to Consumer ▪ Hot Sheets (Summary of Administrative Actions Last report December 2016	Monthly Note: At the end of the list it provides a date posted. As of 12/31/2016

Revised 01-25-2017
This document is for informational purposes only and subject to change.
Please visit the individual websites listed for the most current up-to-date information.

Back to Agenda

Ongoing Monitoring Website Information 01-25-2017

Licensing Board, Address and Phone Numbers	Practitioner Types	Website	Instructions and Comments	Report Frequency
California Board of Occupational Therapy (CBOT) 2005 Evergreen St. Suite 2250 Sacramento, CA 95815 PH: (916) 263-2294 Fax: (916) 263-2701 Email: cbot@dca.ca.gov Email: EnfPrg@dca.ca.gov	OT, OTA	**www.bot.ca.gov** **Direct Link To Enforcement Actions:** **http://www.bot.ca.gov/consumers/disciplinary_action.shtml** **Sign up for subscribers list for disciplinary actions:** **https://www.dca.ca.gov/webapps/bot/subscribe.php**	▪ Link to Consumer at the top ▪ Link to Disciplinary Action Practitioners are listed under: Revocations, Surrenders and Other Disciplinary Orders: A – L and M – Z. **Sign up to receive a monthly Hot Sheet List of disciplinary actions via e-mail to:** EnfPrg.Enfprg@dca.ca.gov Will need to send a written request to obtain the information, which may be sent back to you via e-mail.	Update as needed (whenever they have an update). Depends on when there is an OT placed on probation or revoked. Listed Alpha by type of action. E-Mail Submission
California State Board of Optometry 2450 Del Paso Road, Suite 105 Sacramento, CA 95834 PH:(916) 575-7170 Fax (916) 575-7292 Email: optometry@dca.ca.gov	OD	**www.optometry.ca.gov** **Direct Link To Enforcement Actions:** **http://www.optometry.ca.gov/consumers/disciplinary.shtml**	▪ Link to Consumer at the top ▪ Link to Citations and Disciplinary Actions ▪ Bottom of page actions are posted by year Practitioners are listed by year, type of action and then alphabetically Note: Report provides a Last Updated date at the top of the report. Last update12/22/2016	Listed by year, in Alpha Order by type of Action Website will be updated as actions are adopted. Recommend monthly review. The Board typically adopts formal disciplinary actions during regularly scheduled quarterly meetings.

Revised 01-25-2017

This document is for informational purposes only and subject to change.

Please visit the individual websites listed for the most current up-to-date information.

Back to Agenda

Ongoing Monitoring Website Information 01-25-2017

Licensing Board, Address and Phone Numbers	Practitioner Types	Website	Instructions and Comments	Report Frequency
Physical Therapy Board of California 2005 Evergreen St. Suite 1350 Sacramento, CA 95815 PH: (916) 561-8200 Fax: (916) 263-2560	PT	**www.ptb.ca.gov** **Sign up for subscribers list for disciplinary actions:** **https://www.dca.ca.gov/webapps/ptbc/interested_parties.php**	Disciplinary action and license reinstatement information may be obtained by checking the Board's online license verification system. Last update 9/28/15	**None** – This entity does not release sanction information reports, organizations are required to conduct individual queries every 12-18 months on credentialed practitioners.
Physician AssistantBoard (PAB) 2005 Evergreen Street Suite 1100 Sacramento, CA 95815 PH: (916) 561-8780 FAX(916) 263-2671 Email:pacommittee@mbc.ca.gov	PA/PAC	**www.pac.ca.gov** **Direct Link To Enforcement Actions:** **www.pac.ca.gov/forms_pubs/disciplinaryactions.shtml**	▪ Link to Consumers ▪ Link to Disciplinary Action ▪ Link to Month within the year at bottom of the page Practitioners listed via month, then Alpha Last report listed December 2016	Monthly Note Reports for December 2014 – July 2015 were all posted at the same time, between 8/25/15 and 8/31/15.
Board of Psychology 1625 North Market Blvd, Suite N-215 Sacramento, CA 95834 bopmail@dca.ca.gov Office Main Line (916)-574-7720 **Toll Free Number: 1-866-503-3221.**	PhD, PsyD	**www.psychboard.ca.gov** **Sign up for subscribers list for disciplinary actions:** **https://www.dca.ca.gov/webapps/psychboard/subscribe.php**	**Monthly reports are no longer available on the website. (change took place around September or October 2014)** You must sign up for Subscriber list to obtain Enforcement Actions. E-mail will be sent to you. If you don't sign up as a subscriber, the News Letters will provide disciplinary actions. To order copies documents, send your written request, including the name and license number of the licensee, to the attention of the Enforcement Program at the Board's offices in Sacramento. A fee is charged for these documents.	**Via Subscriptions Only** Information must be obtained via subscription. For Subscribers: E-mail

Revised 01-25-2017
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Ongoing Monitoring Website Information 01-25-2017

Licensing Board, Address and Phone Numbers	Practitioner Types	Website	Instructions and Comments	Report Frequency
CA Board of Registered Nursing 1747 North Market Blvd, Suite 150 Sacramento, CA 95834 Mailing Address: Board of Registered Nursing P.O. Box 944210 Sacramento, CA 94244-2100 Phone: (916) 322-3350 FAX (916) 574-7693. Email: enforcement_brn@dca.ca.gov	Certified Nurse Midwife (CNM) Certified Nurse Anesthetist (CRNA) Clinical Nurse Specialist (CNS) Critical Care Nurse (CCRN) Nurse Practitioner (NP) Registered Nurse (RN) Psychiatric Mental Health Nursing (PMHN) Public Health Nurse (PHN)	**www.rn.ca.gov** **Unlicensed Practice/Nurse Imposter Citations:** **http://www.rn.ca.gov/enforcement/unlicprac.shtml**	Disciplinary action and license reinstatement information may be obtained by checking the Board's online license verification system. Photocopies of this information may be requested by faxing the Board's Enforcement Program at (916) 574-7693. Or You can subscribe to the National Council of State Board of Nursing (BCSBN) Nursys e-Notify system. **See website information below.**	**None**–This entity does not release sanction information reports, organizations are required to conduct individual queries every 12-18 months on credentialed practitioners.
National Council of State Board of Nursing (BCSBN) 111 East Wacker Drive, Suite 2900 Chicago, IL 60601-4277 Phone:(312) 525-3600 Fax: (312) 279-1032 Email: info@ncsbn.org .	Additional information for RN/LVN/NP/CNM	**www.nursys.com** To subscribe for daily, weekly or monthly (depending on how often you want to be updated) updates on license status, expirations and disciplinary actions. **https://www.nursys.com/EN/ENDefault.aspx**	Nursys e-Notify informs you if you employed RNs or LPN/VNs and Advance Practice Nurses (APRN in the categories of Nurse Practitioner (NP), Certified Registered Nurse Anesthetist (CRNA), Certified Nurse Midwife (CNM) and Clinical Nurse Specialist (CNS) have received public discipline or alerts from their licensing jurisdiction(s).	.
Speech-Language Pathology & Audiology Board 2005 Evergreen Street, Suite 2100 Sacramento, CA 95815 Email: speechandhearing@dca.ca.gov Main Phone Line: (916) 263-2666 Main Fax Line: (916) 263-2668	SP, AU	**http://www.speechandhearing.ca.gov/** **Direct Link to Accusations Pending and Disciplinary Actions:** **http://www.speechandhearing.ca.gov/consumers/enforcement.shtml** As of1/18/2017the information represents disciplinary action taken by the Board from:7/1/07 – 09/30/2016.	▪ Link to Consumer ▪ Link to Enforcement ▪ Link to Accusations pending or Disciplinary Actions 1. For actions pending Board decisions select "SP/AU" For Speech-Language Pathology & Audiology 2. For Board decisions select "Disciplinary Actions". Last report listed FY 2016-2017 Action Taken	**Quarterly** Disciplinary Actions are listed by fiscal year. Pending Actions are listed alphabetically by first name.

Revised 01-25-2017

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Back to Agenda

Ongoing Monitoring Website Information 01-25-2017

Site Name, Address and Phone Numbers	Service	Website	Instructions and Comments	Report Frequency
HHS Officer of Inspector General Office of Investigations Health Care Administrative Sanctions Room N2-01-26 7500 Security Blvd. Baltimore, MD21244-1850	OIG - List of Excluded Individuals and Entities (LEIE) excluded from Federal Health Care Programs: Medicare /Medicaidsanction &exclusions	**www.oig.hhs.gov** **Direct Link for individuals:** **http://exclusions.oig.hhs.gov/** **Direct Link to exclusion database** **http://oig.hhs.gov/exclusions/exclusions_list.asp**	▪ Link to Exclusions ▪ Link to LEIE Downloadable Databases under the Exclusion Program tab ▪ Link to the various reports, exclusions, reinstatements or databases. To subscribe for notifications follow instructions: Get Email updates	**Monthly** (see note under instructions regarding subscribing notifications)
Noridian Healthcare Solutions Medicare Opt-Out Physicians JE MAC **1855-609-9960 Select Provider Enrollment** **https://med.noridianmedicare.com/web/jeb**	Medicare Opt-Out	**https://www.noridianmedicare.com** Link to JE Part B **https://med.noridianmedicare.com/web/jeb** **Direct Link to Opt-Out Reports:** **https://med.noridianmedicare.com/web/jeb/enrollment/opt-out/opt-out-listing**	Under Medicare Contracts: ▪ Jurisdiction E Part B ▪ Link to Enrollment ▪ Opt Out of Medicare ▪ Opt Out Listing ▪ Link to Opt Out Listing by State: • Excel Listing or • HTML Listing On 01/20/17 Listing as follows: Excel Listing or (Last update 01/19/17) HTML Listing (Last update 01/19/17) However the HTML update noted the incorrect year 1/19/2016. Correction was made on 2/3/2017	**Quarterly** Last update: 01/19/17(updated 1/20/17) 08/15/16 06/13/16 (6/10/16) 12/23/15 10/30/15 Northern 10/08/15 Southern 08/14/15 07/07/15 04/13/15 03/11/15 01/28/15
CMS.gov **Centers for Medicare & Medicaid Services**	Medicare Opt-Out Affidavits	**https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/OptOutAffidavits.html** For a listing of all physicians and practitioners that are currently opted out of Medicare: **https://data.cms.gov/dataset/Opt-Out-Affidavits/7yuw-754z**	This link will provide information regarding Opt Out Affidavits and Opt Providers from Data.CMS.gov.	

Revised 01-25-2017
This document is for informational purposes only and subject to change.
Please visit the individual websites listed for the most current up-to-date information.

Back to Agenda

Ongoing Monitoring Website Information 01-25-2017

Site Name, Address and Phone Numbers	Service	Website	Instructions and Comments	Report Frequency
Department of Health Care Services (DHCS) **Medi-Cal Provider Suspended and Ineligible List** Office of Investigations Health Care Administrative Sanctions Room N2-01-26 7500 Security Blvd. Baltimore, MD21244-1850	Medi-Cal Reports exclusions and reinstatements from the State Medi-Cal Program	**www.medi-cal.ca.gov** **DirectLink to Suspended and Ineligible Provider List**: **http://files.medi-cal.ca.gov/pubsdoco/SandILanding.asp**	From Home Page: ▪ Link to References ▪ Suspended and Ineligible Provider List ▪ Under Download the S&I List is the list for the month. (Bottom of the page) Or ▪ Link to References ▪ Provider Enrollment ▪ Suspended and Ineligible Provider List ▪ Under Download the S&I List is the list for the month. (Bottom of the page) Last published 1/13/17	**Monthly**
SAM (System for Award Management) formerly known as Excluded Parties List System (EPLS)	Individuals and Organizations debarred from participating in government contracts or receiving government benefits or financial assistance	**https://www.sam.gov/portal/SAM/#1** SAM Registration **https://uscontractorregistration.com/** Note: The SAM website has a user guide: Link to SAM User Guide- v1.8.3 of 350:	Select Search Records at the top ▪ Under: Advanced Search ▪ Select Advance Search - Exclusion ▪ Select Single Search ▪ Scroll down and enter the Active Date to and from for the month you are reviewing ▪ Click search ▪ Export Results	**Monthly**
DEA Office of Diversion Control **800-882-9539** **deadiversionwebmaster@usdoj.gov**	**DEA Verification**	**www.deadiversion.usdoj.gov/** **Direct Link to Validation Form** **https://www.deadiversion.usdoj.gov/webforms/validateLogin.jsp**	On the right side under Links: Link to Registration Validation Need DEA #, Name as it appears on your registration and SSN or TIN provided on application. **Note**: Please does not use the Duplicate Certification Link as it is for Physicians, use the Registration Validation Link.	**NA**

Revised 01-25-2017
This document is for informational purposes only and subject to change.
Please visit the individual websites listed for the most current up-to-date information.

Back to Agenda

Additional Websites

Site Name, Address and Phone Numbers	Service	Website	Instructions and Comments
The Licensed Facility Information system (LFIS) The Automated Licensing Information and Report Tracking System (ALIRTS) Contains license and utilization data information of healthcare facilities in California. The Licensed Facility Information system (LFIS) is maintained by the Office of Statewide Health Planning and Development to collect and display licensing and other basic information about California's hospitals, long-term care facilities, primary care and specialty clinics, home health agencies and hospices.	**Organizational Providers License Verification:** Hospitals Long-term care facilities Home Health Agencies Hospices Primary care and Specialty clinics	**www.alirts.oshpd.ca.gov/Default.aspx** **Direct Link:** **www.alirts.oshpd.ca.gov/LFIS/LFISHome.aspx**	The main source of the information in LFIS is the licenses issued by the Department of Health Services (DHS) Licensing and Certification District Offices. Contact information for these District Offices is available at: www.dhs.ca.gov/LNC/default.htm **To search for a facility** • Enter name in box that is found in top right corner Search or • Link to Advance Search on the left under Login. **LFIS Home** **Alirts Home** **Advanced Search** You may search by using the following four search categories, Facility Name, Facility Number, License and Legal Entity. Enter your search parameters within the one category you selected and click the Search button to the right.
The California Department of Public Health (CDPH) General Information (916) 558-1784	**Organizational Providers License Verification:** Hospitals Surgery Centers Home Health Agencies Hospices Dialysis Centers Others	http://www.cdph.ca.gov/Pages/DEFAULT.aspx Licensed Facility Report http://hfcis.cdph.ca.gov/Reports/GenerateReport.aspx?rpt=FacilityListing Health Facilities Search http://hfcis.cdph.ca.gov/search.aspx	Health Information Health Facilities Consumer Information System Find a facility Public Inquiry/Reports Type of Facility Select Excel or PDF format Health Facilities Search To check a particular facility, check the applicable box for the type (e.g. SNF or Hospital) then enter the Name or zip code and the facility will appear for you to select. You will be able to obtain copies of site visits for SNFs at this site.

Additional Websites

Site Name, Address and Phone Numbers	**Service**	**Website**	**Instructions and Comments**
National Plan and Provider Enumeration System (NPPES) NPI Enumerator PO Box 6059 Fargo, ND 58108-6059 800-465-3203 customerservice@npienumerator.com The Centers for Medicare & Medicaid Services (CMS) has developed the National Plan and Provider Enumeration System (NPPES) to assign these unique identifiers. The NPI Registry enables you to search for a provider's NPPES information. All information produced by the NPI Registry is provided in accordance with the NPPES Data Dissemination Notice. Information in the NPI Registry is updated daily. You may run simple queries to retrieve this read-only data.	**Organizational Providers and Practitioners Numbers for the following:** • NPI • Medicare • Medi-Cal	https://nppes.cms.hhs.gov/NPPES/Welcome.do Search NPI Records https://npiregistry.cms.hhs.gov/ **Search the NPI Registry** • Search for an**Individual Provider** • Search for an **Organizational Provider**	Source for obtaining NPI Numbers, Medicare PIN and UPIN Numbers and Medicaid provider numbers Select Search the NPI Registry Complete the appropriate sections for Individual or for Organizations for individuals First Name Last Name for organizations Organization Name

Revised 01-25-2017
This document is for informational purposes only and subject to change.
Please visit the individual websites listed for the most current up-to-date information.

Back to Agenda

Additional Websites

Site Name, Address and Phone Numbers	Service	Website	Instructions and Comments
Social Security Death Master File (DMF). National Technical Information Services (NTIS) is the only authorized official distributor of the Death Master file on the web. Final Rule Establishing Certification Program for Access to Death Master File in Effect The National Technical Information Service (NTIS) established a certification program for subscribers to the Limited Access Death Master File (LADMF) through a Final Rule (FR), pursuant to Section 203 of the Bipartisan Budget Act of 2013 (Pub. L. 113-67) which also requires NTIS to recoup the cost of the certification program through processing fees. The FR was published in the Federal Register Wednesday, June 1, 2016, and became effective Monday, November 28, 2016. The FR may be reviewed at **https://www.gpo.gov/fdsys/pkg/FR-2016-06-01/html/2016-12479.htm**.	**Subscription to the Limited Access Death Master File (LADMF)**	**Social Security Death Master File (DMF) Website** https://www.ssdmf.com/FolderID/1/SessionID/%7B17B93F37-71E0-433B-B3F2-B9BA03D721A6%7D/PageVars/Library/InfoManage/Guide.htm **National Technical Information Services (NTIS)** https://classic.ntis.gov/products/ssa-dmf/#	You must register to obtain information and there are several fees associated with the service.

Revised 01-25-2017
This document is for informational purposes only and subject to change.
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Additional Websites

Board Certification, Address and Phone Numbers	Practitioner Types	Website	Instructions and Comments	Verification Type
Nursing Board Certification for Nurse Practitioners/Advance Practice Nurses **- American Academy of Nurse Practitioners Certification Board (AANPCB) (1/2017) (Formerly the American Academy of Nurse Practitioners Certification Program (AANPCP)** **- American Nurses Credentialing Center** (ANCC) **- National Certification Corporation for the Obstetrics, Gynecology and Neonatal Nursing Specialties**(ncc) **- Pediatric Nursing Certification Board** (PNCB) **- American Association of Critical-Care Nurses** (AACN)	NP	AANPCB - www.aanpcert.org/ ANCC -**www.nursecredentialing.org** ncc - **www.nccwebsite.org** PNCB - **www.pncb.org** AACN -**www.aacn.org**	Informational only to verify board certification	**Board Certification**
National Commission on Certification of PA's (NCCPA)	PAC	**http://www.nccpa.net/**	Informational only to verify board certification	**Board Certification**
American Midwifery Certification Board (amcb) 849 International Drive, Suite 120 Linthicum, MD 21090 Phone 410-694-9424	CNM and CM	**http://www.amcbmidwife.org/**	Under the Verify AMCB Certification ▪ Click Search button ▪ Enter last Name, First Name and Certification Number ▪ Click Search Button	**Board Certification** Informational only to verify board certification needed

Revised 01-25-2017

This document is for informational purposes only and subject to change.

Please visit the individual websites listed for the most current up-to-date information.

Back to Agenda

Additional Websites

Board Certification, Address and Phone Numbers	Practitioner Types	Website	Instructions and Comments	Verification Type
American Board of Professional Psychology (ABPP) 600 Market Street Suite 201 Chapel Hill, NC 27516 Phone 919-537-8031 email: office@abpp.org	PhD, PsyD	**http://www.abpp.org/**	Under Find a Board Certified Psychologists ▪ Click Verification Note there is a $25 charge, credits much be purchased prior to your verification search.	**Board Certification** Informational only to verify board certification if needed
Three specialty certifying boards are currently approved under California law for DPMs: – **American Board of Foot and Ankle Surgery** (formerly The American Board of Podiatric Surgery 7/1/14) (Also includes the following certifications: Foot Surgery and Reconstruction Rear foot/Ankle Surgery (RRA)). – **The American Board of Podiatric Medicine**(Conducts the certification process in Podiatric Orthopedics and Primary Podiatric Medicine – **American Board of Multiple Specialties in Podiatry.** (Includes Certification for Primary Care, Foot and ankle Surgery, diabetic wound care and limb salvage	DPM	• American Board of Foot and Ankle Surgery. https://www.abfas.org/ • The American Board of Podiatric Medicine conducts the certification process in Podiatric Orthopedics and Primary Podiatric Medicine. https://www.abpmed.org/ • American Board of Multiple Specialties in Podiatry. http://abmsp.org/	Informational only to verify board certification	**Board Certification**

Policy #: GG.1633Δ
Title: **Board Certification Requirements for Physicians**
Department: Medical Affairs
Section: Quality Improvement

CEO Approval: Michael Schrader ________

Effective Date: 01/01/08
Last Review Date: 8/1/1506/01/17
Last Revised Date: 8/1/1506/01/17

Applicable to:
- Medi-Cal
- OneCare
- OneCare Connect
- ☒ PACE

I. PURPOSE

To describeThis policy describes CalOptima's requirement for Board Certification of contracted physicians.

II. DEFINITIONS

Term	Definition
Credentialing	The process of obtaining, verifying, assessing, and monitoring the qualifications of a Practitioner to provide quality and safe patient care services.
Health Network (HN)	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 Provider Group.
Physician Medical Group (PMG)	A California professional medical corporation that employs or has entered into contracts with physicians who are licensed to practice medicine in the State of California that has entered into contract with CalOptima to arrange for the provision of Covered Services to Members assigned to that Provider Group.

III.II. POLICY

A. A contracted physician shall be Board Certifiedboard certified within five (5) years following the date upon which that contracted physician completes his or her residency., with the exception of any contracted physician whose board certification time requirement is shorter or longer than the foregoing in which case such shorter or longer period shall apply. For example, a contracted podiatric physician shall be board certified within seven (7) years following the date upon which that contracted podiatric physician completes his or her residency..

B. A ~~contracted~~ physician ~~who is~~may be grandfathered and exempt from the requirements of this Policy if all of the following apply:

a. The physician was first licensed to practice medicine in a United States jurisdiction before January 1, 2008~~,~~; and

b. The physician was a contracted physician with CalOptima or a Health Network prior to July 1, 2016; and

c. The physician's contract with CalOptima or the Health Network did not lapse or terminate for any reason.

~~B.~~C. If a physician's contract with CalOptima or a Health Network lapsed or terminated for any reason, as set forth in Section II.B.~~iii~~ above, then the physician is considered a new physician and is ~~exempt from the requirements of this policy.~~not grandfathered for board certification purposes. In these cases, the physician must apply for a new contract and credentialed status and must meet all the requirements of CalOptima Policy GG.1643: Minimum Physician Standards, including without limitation, the board certification requirement.

~~C.~~D. Except as provided in Section ~~IV~~II.B. of this ~~policy~~Policy, a contracted physician who is required to be board certified shall, at all times, maintain ~~Board Certification~~that status in order to participate in ~~the~~ CalOptima ~~program.~~ programs.

~~D.~~E. A contracted physician shall meet Credentialing and Recredentialing requirements, in accordance with CalOptima Policy GG.~~1609Δ~~1650Δ: Credentialing and Recredentialing.

A Health Network shall establish policies and procedures for Board Certification of contracted physicians that, at minimum, meet and verify compliance with the requirements as outlined in this Policy.

F.

~~IV.~~III. PROCEDURE

A. A contracted physician shall indicate his or her Board Certification status as part of the Credentialing and Recredentialing process.

B. ~~CalOptima, a Health Network (HN) or a Physician Medical Group (PMG)~~CalOptima shall independently verify that a contracted physician is either currently Board Certified, or exempt from the Board Certification requirements of this policy.

C. If, ~~upon Recredentialing~~at any time, CalOptima~~, a HN or PMG~~ finds that a contracted physician has failed to maintain his or her ~~Board Certification~~board certification as required by this ~~policy~~Policy, CalOptima~~, the HN or PMG~~ shall notify the contracted physician of his or her noncompliance with the requirements of this ~~policy~~Policy and shall require the contracted physician to ~~re-establish Board Certification~~demonstrate within ~~six (6) months~~thirty (30) calendar days after receipt of notice from CalOptima~~, the HN or PMG.~~ that he or she is actually board certified.

DRAFT

D. If the contracted physician fails to re-establish his or her Board Certificationdemonstrate within six (6) monthsthirty (30) calendar days after receipt of notice from CalOptima, HN or PMG, that he or she is board certified as required by this Policy, then CalOptima shall remove such contracted physician from participationwill terminate the contract within sixty (60) calendar days and upon appropriate notice to members, provide notice to the contracted physician that he or she is no longer eligible to participate in the CalOptima programprograms, and shall reassign any affected Members. members.

V.IV. ATTACHMENTS

Not Applicable

VI.V. REFERENCES

A. CalOptima Policy AA.1100: Glossary of Terms
B. CalOptima Policy CMC.1001: Glossary of Terms
C. CalOptima Policy GG.1609Δ: Credentialing and Recredentialing
D. CalOptima Policy GG.1643: Minimum Physician Standards
D. CalOptima Policy MA.1001: Glossary of Terms
E. CalOptima Policy CMC.1001: Glossary of Terms
F. CalOptimaTerms
F.G. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
H. NCQA Standards and Guidelines

VII.VI. REGULATORY AGENCY APPROVALS

None to Date

VIII.VII. BOARD ACTIONACTIONS

A. 06/01/17: Regular Meeting of the CalOptima Board of Directors
B. 8/708/07/-/07: Regular Meeting of the CalOptima Board of Directors
C. 6/506/05/07: Regular Meeting of the CalOptima Board of Directors

IX.VIII. REVIEW/REVISION HISTORY

Version	Version Date	Policy Number	Policy Title	Line(s) of Business
Original DateEffective	01/01/2008	GG.1633	Board Certification Requirements for Physicians	Medi-Cal
Revision Date 1Revised	03/01/2013	GG.1633	Board Certification Requirements for Physicians	Medi-Cal

DRAFT

Version	Version Date	Policy Number	Policy Title	Line(s) of Business
Revision Date 2Revised	08/01/2015	GG.1633Δ	Board Certification Requirements for Physicians	Medi-Cal OneCare OneCare Connect PACE
Revised	06/01/2017	GG.1633Δ	Board Certification Requirements for Physicians	Medi-Cal OneCare OneCare Connect PACE

1

1 **IX. GLOSSARY**
2

Term	Definition
Credentialing	The process of obtaining, verifying, assessing, and monitoring the qualifications of a Practitioner to provide quality and safe patient care services.
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.

3

Policy #:	GG.1633Δ
Title:	**Board Certification Requirements for Physicians**
Department:	Medical Affairs
Section:	Quality Improvement

CEO Approval: Michael Schrader ________

Effective Date:	01/01/08
Last Review Date:	06/01/17
Last Revised Date:	06/01/17

Applicable to: ☒ Medi-Cal
☒ OneCare
☒ OneCare Connect
☒ PACE

DRAFT

I. PURPOSE

This policy describes CalOptima's requirement for Board Certification of contracted physicians.

II. POLICY

A. A contracted physician shall be board certified within five (5) years following the date upon which that contracted physician completes his or her residency, with the exception of any contracted physician whose board certification time requirement is shorter or longer than the foregoing in which case such shorter or longer period shall apply. For example, a contracted podiatric physician shall be board certified within seven (7) years following the date upon which that contracted podiatric physician completes his or her residency.

B. A physician may be grandfathered and exempt from the requirements of this Policy if all of the following apply:

a. The physician was first licensed to practice medicine in a United States jurisdiction before January 1, 2008; and

b. The physician was a contracted physician with CalOptima or a Health Network prior to July 1, 2016; and

c. The physician's contract with CalOptima or the Health Network did not lapse or terminate for any reason.

C. If a physician's contract with CalOptima or a Health Network lapsed or terminated for any reason, as set forth in Section II.B. above, then the physician is considered a new physician and is not grandfathered for board certification purposes. In these cases, the physician must apply for a new contract and credentialed status and must meet all the requirements of CalOptima Policy GG.1643: Minimum Physician Standards, including without limitation, the board certification requirement.

D. Except as provided in Section II.B. of this Policy, a contracted physician who is required to be board certified shall, at all times, maintain that status in order to participate in CalOptima programs.

E. A contracted physician shall meet Credentialing and Recredentialing requirements, in accordance with CalOptima Policy GG.1650Δ: Credentialing and Recredentialing.

F. A Health Network shall establish policies and procedures for Board Certification of contracted physicians that, at minimum, meet and verify compliance with the requirements as outlined in this Policy.

III. PROCEDURE

A. A contracted physician shall indicate his or her Board Certification status as part of the Credentialing and Recredentialing process.

B. CalOptima shall independently verify that a contracted physician is either currently Board Certified, or exempt from the Board Certification requirements of this policy.

C. If, at any time, CalOptima finds that a contracted physician has failed to maintain his or her board certification as required by this Policy, CalOptima shall notify the contracted physician of his or her noncompliance with the requirements of this Policy and shall require the contracted physician to demonstrate within thirty (30) calendar days after receipt of notice from CalOptima that he or she is actually board certified.

D. If the contracted physician fails to demonstrate within thirty (30) calendar days after receipt of notice from CalOptima that he or she is board certified as required by this Policy, then CalOptima will terminate the contract within sixty (60) calendar days and upon appropriate notice to members, provide notice to the contracted physician that he or she is no longer eligible to participate in CalOptima programs, and reassign any affected members.

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. CalOptima Policy AA.1100: Glossary of Terms
B. CalOptima Policy CMC.1001: Glossary of Terms
C. CalOptima Policy GG.1609Δ: Credentialing and Recredentialing
D. CalOptima Policy GG.1643: Minimum Physician Standards
E. CalOptima Policy MA.1001: Glossary of Terms
F. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
G. NCQA Standards and Guidelines

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. 06/01/17: Regular Meeting of the CalOptima Board of Directors
B. 08/07/07: Regular Meeting of the CalOptima Board of Directors

DRAFT

1 C. 06/05/07: Regular Meeting of the CalOptima Board of Directors
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3 **VIII. REVIEW/REVISION HISTORY**
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Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	01/01/2008	GG.1633	Board Certification Requirements for Physicians	Medi-Cal
Revised	03/01/2013	GG.1633	Board Certification Requirements for Physicians	Medi-Cal
Revised	08/01/2015	GG.1633Δ	Board Certification Requirements for Physicians	Medi-Cal OneCare OneCare Connect PACE
Revised	06/01/2017	GG.1633Δ	Board Certification Requirements for Physicians	Medi-Cal OneCare OneCare Connect PACE

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IX. GLOSSARY

Term	Definition
Credentialing	The process of obtaining, verifying, assessing, and monitoring the qualifications of a Practitioner to provide quality and safe patient care services.
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.

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A Public Agency
Better. Together.

Policy #:	GG.1609Δ
Title:	**Credentialing and Recredentialing**
Department:	Medical Affairs
Section:	Quality Improvement
CEO Approval:	Michael Schrader ___________
Effective Date:	10/95
Last Review Date:	03/01/15
Last Revised Date:	03/01/15

This policy shall apply to the following CalOptima line of business (LOB):

- Medi-Cal
- OneCare
- OneCare Connect (Effective 7/1/15)
- PACE

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2
3 **I. PURPOSE**
4
5 To define the process by which CalOptima, a Health Network or Physician Medical Group
6 (PMG) shall evaluate and select a Practitioner or Healthcare Delivery Organization (HDO) for
7 participation in CalOptima.
8
9 **II. DEFINITIONS**
10

Term	Definition
Board Certification/Certified	Certification of a physician by one (1) of the boards recognized by the American Board of Medical Specialties (ABMS), or American Osteopathic Association (AOA), as meeting the requirements of that board for certification.
Credentialing	The process of obtaining, verifying, assessing, and monitoring the qualifications of a Practitioner to provide quality and safe patient care services.
Full Scope Site Review	An onsite inspection to evaluate the capacity or continuing capacity of a PCP Site to support the delivery of quality health care services using the Site Review Survey and Medical Record Review Survey.
Healthcare Delivery Organization (HDO)	Includes hospitals, home health agencies, skilled nursing facilities, extended care facilities, nursing homes, and free-standing surgical, laboratory, or other centers.
Skilled Nursing Facility (SNF)	Any institution, place, building, or agency that is licensed as such by the Department of Public Health (DPH), as defined in Title 22, CCR, Section 51121(a); or a distinct part or unit of a hospital that meets the standards specified in Title 22, CCR,

	Section 51215 (except that the distinct part of a hospital does not need to be licensed as an SNF), and that has been certified by the Department of Public Health (DPH) for participation as a SNF in the Medi-Cal program.

III. POLICY

A. CalOptima shall establish guidelines by which CalOptima and its Health Networks and PMGs shall evaluate and select Practitioners and HDOs to participate in CalOptima, in accordance with Title 42, Code of Federal Regulations, section 422.04(a).

B. The CalOptima Credentialing and Peer Review Committee (CPRC) shall be responsible for reviewing a Practitioner's or HDO's Credentialing information and determining such Practitioner's or HDO's participation in CalOptima.

C. CalOptima shall require Credentialing and Recredentialing of all of the following Practitioners and HDOs contracted with CalOptima:

1. Medical Practitioners, such as a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Dentist and Oral Surgeon

2. A Behavioral Health Provider which includes:

   a. Psychiatrist and other physicians;

   b. Addiction medicine specialist;

   c. Doctoral and master's-level psychologists who are State of California certified or licensed;

   d. Master's-level clinical social workers who are State of California certified or licensed;

   e. Master's-level clinical nurse specialists or psychiatric nurse practitioners who are nationally or State of California certified or licensed; and

   f. Other Behavioral Healthcare specialists that are licensed, certified or registered by the State of California to practice independently;

3. HDOs, which include, but are not limited to:

   a. An acute care hospital;

   b. Home health agency;

   c. Freestanding ambulatory surgi-center;

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d. Skilled Nursing Facility; and

e. Community Based Adult Services (CBAS) Centers.

4. Mid-Level Practitioners, which include, but are not limited to: a Certified Nurse Mid-Wife (CNM), Nurse Practitioner (NP), Physician Assistant (PA), Optometrist (OPT), and Registered Nurse Practitioner (RNP), who provides Covered Services to a Member, in accordance with CalOptima Policy GG.1606: Credentialing and Recredentialing of Mid-Level Practitioners.

D. CalOptima may not require Credentialing and Recredentialing for:

1. Practitioners that practice exclusively within the inpatient setting (e.g., Hospitalist) and provides care for a Member only as a result of the Member being directed to the hospital or inpatient setting;

2. Practitioners that practice exclusively within freestanding facilities, and provides care for a Member only as a result of the Member being directed to the facility;

3. Pharmacists who work for a Pharmacy Benefit Manager (PBM) to which CalOptima delegates utilization management (UM) functions;

4. Covering Practitioners (e.g., locum tenens) who do not have an independent relationship with CalOptima;

5. Practitioners that do not provide care for a Member in a treatment setting (e.g., Board-Certified consultant); and

6. A rental network Practitioner that is specifically for out-of-care services, and there are no incentives communicated to Members; Members have no obligation to seek care from rental network practitioners, and may see out-of-area practitioner.

E. CalOptima shall not add a Practitioner or HDO to the CalOptima network until such Practitioner or HDO has completed the Credentialing process, unless CalOptima determines it is in the best interest of the Member for the Practitioner to render care.

1. CalOptima may offer Provisional Credential Status to a Practitioner for a duration not to exceed sixty (60) calendar days in accordance with Section IV.B.1 of this policy.

F. CalOptima may delegate Credentialing and Recredentialing activities to a Health Network or PMG, in accordance with CalOptima Policy GG.1605Δ: Delegation and Oversight of Credentialing and Recredentialing Activities.

1. A Health Network or a PMG shall apply the participation guidelines set forth in this policy equally to its Contracted Practitioners and Providers.

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2. A Health Network or PMG shall submit a monthly report to CalOptima of its Credentialed and Recredentialed Practitioners. A Physician Hospital Consortium (PHC) will include all HDOs credentialed and recredentialed.

G. CalOptima, a Health Network or PMG shall Recredential a Practitioner or HDO every three (3) years.

H. CalOptima, Health Network or PMG shall ensure that all Practitioners maintain current California licensure, Drug Enforcement Agency (DEA) certification, and medical malpractice insurance in between Credentialing cycles and shall provide evidence of monthly review of the Medical Board of California Hot Sheet and Office of Inspector General (OIG) exclusion or suspension list.

I. On a monthly basis, CalOptima shall monitor the Medicare/Medi-Cal Sanction List. CalOptima shall immediately suspend any Practitioner or HDO identified on the Sanction List.

J. On a quarterly basis, CalOptima shall monitor the Northern and Southern California published list of Medicare Opt-Out Report from the Centers for Medicare & Medicaid Services (CMS). The report must be reviewed within thirty (30) calendar days of its release as part of the on-going monitoring process.

K. If CalOptima declines to include a Practitioner or an HDO in CalOptima, the plan shall notify such Practitioner or HDO in writing of the reason for its decision, in accordance with CalOptima Policy GG1616: Fair Hearing Plan for Practitioners and as described in California Participating Physician Application (CPPA) Addendum – Notice to Practitioners of Credentialing Rights and Responsibilities.

L. CalOptima shall not discriminate, in terms of participation, reimbursement, or indemnification, against any Practitioner who is acting within the scope of his or her license, certification, or registration under federal and state law, solely on the basis of the license or certification. This prohibition shall not preclude CalOptima from:

1. Refusing to grant participation to a Practitioner in excess of the number necessary to meet the needs of Members;

2. Using different reimbursement amounts for different specialties or for different Practitioners in the same specialty; and

3. Implementing measures designed to maintain quality and control costs consistent with CalOptima's responsibilities.

M. CalOptima, a Health Network or PMG shall not discriminate against a Practitioner that serves high-risk populations or specializes in the treatment of costly conditions.

N. CalOptima, a Health Network or PMG shall not make or decline Credentialing and Recredentialing decisions based solely on a Practitioner's race, ethnicity or national identity, gender, age, sexual orientation, or the type of procedure or patient in which the Practitioner specializes.

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O. CalOptima shall monitor and prevent discriminatory Credentialing decisions as follows:

1. Periodic audits of Credentialing files (in-process, denied, and approved files) to ensure Practitioners are not discriminated against;

2. Periodic audits of Practitioner Complaints to determine if there are complaints alleging Discrimination. (The CPRC reviews quarterly reports for all Complaints, including Discrimination);

3. Maintain a heterogeneous Credentialing committee membership; and

4. Uphold the requirement of those responsible for Credentialing decisions to sign a statement affirming that they do not discriminate when making decisions.

P. CalOptima shall maintain the Confidentiality of Credentialing files, in accordance with CalOptima Policy GG.1604Δ: Confidentiality of Credentialing Files.

IV. PROCEDURE

A. Peer Review Body

1. CalOptima, a Health Network or PMG shall designate a Peer Review Body (PRB) that uses a peer-review process to make recommendations and decisions regarding Credentialing and Recredentialing.

2. Such PRB shall include representation from a range of Practitioners, a majority of whom shall be peers of the Practitioner or Applicant, and shall be responsible for reviewing a Practitioner's Credentialing and Recredentialing files, and determining the Practitioner's participation in CalOptima.

3. The Chief Medical Officer (CMO) or his or her designee shall deem a Practitioner's Credentialing or Recredentialing file, clean and approved, upon meeting the clean file review process.

a. A clean file consists of a complete application with a signed attestation and consent form, supporting documents, and verification of no professional review actions or malpractice claims (pending or settled) within the last five (5) years from the date of the Credentialing or Recredentialing review.

b. A clean file shall be considered approved, and effective on the date that the CMO or his or her designee review and approve a Practitioner's Credentialing or Recredentialing file, and deem the file clean.

i. An approved list of clean files shall be presented at the CPRC to be reflected in the meeting minutes.

c. Files that do not meet the clean file review process include, but are not limited to:

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i. Malpractice claims; or

ii. OIG or National Practitioner Data Bank (NPDB) report, with information on the report or health status that may limit or enable a Practitioner to perform his or her specific duties.

d. Files that do not meet the credentialing criteria shall be presented to the CPRC for review and determination to accept, limit, restrict, or deny the application.

e. The CPRC meeting minutes shall reflect any discussion and determination or approval of file(s).

4. The PRB shall make recommendations, shall be based on the Practitioners' ability to deliver care based on the Credentialing information collected from the clean file review process, and shall be verified prior to making a Credentialing decision.

a. The QI Department shall send Practitioner or applicant a decision letter, along with Appeal right's information, to include, but not be limited to:

i. Acceptance;

ii. Acceptance with restrictions;

iii. Conditional acceptance; or

iv. Denial of the application, with a letter of explanation forwarded to the applicant.

5. CalOptima shall monitor and prevent discriminatory practices, to include, but not be limited to:

a. Monitoring:

i. CalOptima shall conduct periodic audits of Credentialing files (in-process, denied, and approved files) to ensure that Practitioners are not discriminated against; and

ii. Review Practitioner Complaints to determine if there are Complaints alleging discrimination.

iii. On a quarterly basis, the QI Department shall review Grievances, Appeals, and potential quality of care issues for complaints alleging discrimination, and will report outcomes to the CPRC for review and determination.

b. Preventing:

i. The QI Department shall maintain a heterogeneous Credentialing committee, and will require those responsible for Credentialing decisions to sign a statement affirming that they do not discriminate.

B. Practitioner Credentialing

1. CalOptima may assign provisional Credential Status for the duration of sixty (60) calendar days while CalOptima undertakes the full Credentialing process. CalOptima shall require primary source verification of the following for provisional Credential status, as applicable:

   a. Current license to practice;

   b. Current and valid DEA certificate;

   c. Current malpractice insurance that meets minimal requirements, and review of past five (5) years history;

   d. Query of NPDB, OIG, and Medi-Cal Sanctions and Investigations;

      i. Cumulative Medi-Cal suspension/ineligibility.

   e. Currently Credentialed by a participating Health Network or PMG with an open panel;

   f. Complete and current Full Scope Facility Site Review (FSR), with a passing score of 80% or better, for PCPs and high volume obstetrics and gynecologist;

   g. Profile Sheet on file from affiliated Health Network or PMG;

   h. Completion of the full scope Credentialing application and attestations; and

   i. A Practitioner may only be provisionally Credentialed once.

2. A Practitioner shall submit a completed, signed, and dated Credentialing application to CalOptima, a Health Network or PMG that includes a current and signed attestation regarding:

   a. Any work history gap that exceeds six (6) months, including written clarification;

   b. The essential functions of the position that the Practitioner cannot perform, with or without accommodation (i.e., health status);

   c. Lack of present illegal drug use that impairs current ability to practice;

   d. History of any loss of license or limitations on licensure or privileges;

   e. History of any loss or limitation of privileges or disciplinary activity;

   f. Current malpractice insurance coverage;

   g. The correctness and completeness of the application; and

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h. Current Full Scope FSR with a passing score within last three (3) years.

3. A Practitioner shall ensure that all information included in a Credentialing application is no more than six (6) months old.

4. Upon receipt of a complete Credentialing application, CalOptima or a Health Network or PMG shall verify the following:

   a. A current, valid California license to practice in effect at the time of the PRB's decision;

   b. Current attestation, including an HIV specialist attestation, if applicable;

   c. Current professional liability (malpractice) insurance or self-insurance (e.g., trust, escrow accounts coverage) in the minimum amounts of one million dollars ($1,000,000.00) per occurrence and three million dollars ($3,000,000.00) aggregate per year at the time of the PRB's decision;

   d. Written or verbal confirmation from the Practitioner's primary inpatient admitting facility that the Practitioner has privileges in good standing, or confirmation that the Practitioner refers patients to hospital-based Practitioners (Hospitalist);

   e. No exclusion, suspension, or ineligibility to participate in any state and federal health care program at the time of the PRB's decision;

   f. Active enrollment status with Medi-Cal;

      i. The CMO or his or her designee has the ability to make exceptions in regards to Medi-Cal enrollment status in order to satisfy access and continuity of care requirements;

      ii. The CMO or his or her designee may also make exceptions to Providers outside of Orange, Los Angeles, San Bernardino, Riverside and San Diego Counties, on a case-by-case basis

   g. The QI Department shall review all complaints filed against a Practitioner.

   h. No exclusion from participation at any time in federal or state health care programs based on conduct within the last ten (10) years that supports a mandatory exclusion under the Medicare program, as set forth in Title 42, United States Code, Sections 1320.7(a), as follows:

      i. A conviction of a criminal offense related to the delivery of an item or service under federal or state health care programs;

      ii. A felony conviction related to neglect or abuse of patients in connection with the delivery of a health care item or service;

      iii. A felony conviction related to health care fraud; or

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iv. A felony conviction related to the unlawful manufacture, distribution, prescription or dispensing of a controlled substance.

i. A valid DEA or Controlled Dangerous Substances (CDS) certificate, if applicable, in effect at the time of the Credentialing decision;

j. Education and training, including Board Certification if the Practitioner states on the application that he or she is Board Certified;

k. Work history including all activity since completion of training (on initial Credentialing) and any change since last Recredentialing. The Practitioner shall provide, in writing, an explanation of any gaps of six (6) months or more;

l. Status of clinical privileges at a CalOptima contracted hospital designated by the Practitioner, as applicable. Practitioner may be part of a Health Network or PMG that utilizes an admitting panel, or may have coverage arrangements with other Practitioners that have been credentialed by the Health Network or PMG. Any alternative admitting arrangements must be documented in the Credentialing file;

m. History of professional liability claims that resulted in settlements or judgments paid by or on behalf of the Practitioner; and

n. A valid National Practitioner Identifier (NPI) number.

5. CalOptima, a Health Network or PMG shall verify the information provided through primary or secondary source verification using industry-recognized verification sources or a credentials verification organization. This information includes, but is not limited to:

a. Current license to practice;

b. Education and training, including evidence of graduation from an appropriate professional school, and, if applicable, completion of residency, and specialty training;

c. Board Certification;

d. Clinical privilege in a hospital, as designated by the Practitioner, verified by contacting the facility and obtaining a copy of the Practitioner directory;

e. A copy of current malpractice insurance certificate;

f. Valid DEA or CDS certification, obtained through confirmation by National Technical Information Service (NTIS); and

g. History of professional liability claims, information about sanction or limitation of licensure, or information about eligibility for the Medicare program, obtained through the NPDB and the Health Integrity Protection Databank, and OIG.

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6. CalOptima, a Health Network or PMG shall provide the applicant with notification of the Credentialing decision within sixty (60) calendar days after the date of the PRB's decision.

7. CalOptima, a Health Network or PMG shall render a final decision within one hundred eighty (180) calendar days from the date of the signature attestation.

8. If CalOptima, a Health Network or PMG is unable to render a decision within one hundred eighty (180) calendar days after receipt of the application for any Practitioner, the Practitioner's Credentialing or Recredentialing application shall be considered expired.

9. CalOptima shall reassign any Members assigned to a Practitioner with Provisional Credential status whose application is expired, after sixty (60) calendar days, to another physician pursuant to CalOptima's contract with the Department of Health Care Services (DHCS).

C. Practitioner Recredentialing

1. CalOptima, a Health Network or PMG shall Recredential a Practitioner every three (3) years after initial Credentialing. At the time of Recredentialing, CalOptima, a Health Network, or PMG shall:

   a. Collect and verify, at a minimum, all of the information required for initial Credentialing, as set forth in Section III.C of this policy, including any change in work history, except historical data already verified at the time of the initial Credentialing of the Practitioner; and

   b. Incorporate the following data in the decision-making process:

      i. Member Complaints, grievances, and Appeals, including number and type during the past three (3) years;

      ii. Information from quality review activities;

      iii. Utilization management (UM) information;

      iv. Member satisfaction;

      v. Medical Record reviews;

      vi. FSR results; and

      vii. Compliance with the terms of the Practitioner's contract.

D. CalOptima shall conduct on-site reviews of a Practitioner in the Credentialing and Recredentialing process, in accordance with CalOptima Policy GG.1608Δ: Full Scope Site Reviews.

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E. CalOptima, a Health Network or PMG shall ensure that a Practitioner has current California licensure, DEA certificate (if applicable), and malpractice insurance at all times during such Practitioner's participation in CalOptima.

F. Practitioner Rights

1. New applicants for Credentialing will receive Practitioner Rights attached to the California Participating Practitioner Application (CPPA) as Addendum A, describing the following:

   a. Right to review information

      i. Practitioners will be notified of their right to review information CalOptima has obtained to evaluate their Credentialing application, attestation, or curriculum vitae.

   b. Right to correct erroneous information

      i. All Practitioners will be notified by certified mail when Credentialing information obtained from other sources varies substantially from that provided by the Practitioner;

      ii. All Practitioners have the right to correct erroneous information, as follows:

         a) The Practitioner has forty-eight (48) hours from date of notification to correct erroneous information;

         b) Requests for correction of erroneous information must be submitted by certified mail with a detailed explanation regarding erroneous information, as well as copy(ies) of corrected information; and

         c) All submissions will be mailed to CalOptima's Quality Improvement (QI) Department using the following address:

         Attention: Quality Improvement Department – Credentialing

         CalOptima
         505 City Parkway West
         Orange, CA 92868

      iii. CalOptima is not required to reveal the source of information, if the information is not obtained to meet CalOptima's Credentialing verification requirements or if law prohibits Disclosure.

3. Documentation of receipt of Corrections

   a. A Practitioner shall be notified via a letter to document CalOptima's receipt of the identified erroneous information.

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4. Right to be notified of application status

   a. Practitioners will be notified of their right to be informed of the status of their application.

   b. Practitioners can contact the Credentialing Department by phone, e-mail or facsimile requesting the status of their application. The QI Department will respond within one (1) business day of the status of the Practitioner's application.

G. Healthcare Delivery Organization (HDO) Credentialing and Recredentialing

1. Before contracting with an HDO, and every three (3) years after executing a contract, CalOptima shall ensure that the HDO is in good standing with state and federal licensing and regulatory bodies, and that the HDO has been reviewed and approved by an accrediting body. If the HDO has not been approved by an accrediting body, evidence of a DHCS site review must be presented, or performance of an FSR must be completed. If the HDO fails to meet the above mentioned criteria, CalOptima will not Credential the HDO.

2. CalOptima shall ensure that an HDO:

   a. Has active Medi-Cal enrollment status;

   b. Is licensed to operate in the state, and is in compliance with any other applicable state or federal requirement;

   c. Is reviewed and approved by an appropriate accrediting body, or meets the standards established by CalOptima. Accrediting bodies include, but are not limited to:

      i. Joint Commission;

      ii. Accreditation Association for Ambulatory Health Care (AAAHC);

      iii. Commission on Accreditation of Rehabilitation Facilities (CARF);

      iv. Community Health Accreditation Program (CHAP);

      v. Continuing Care Accreditation Commission (CCAC); and

      vi. Clinical Laboratory Improvement Amendments (CLIA);

   d. Maintains current liability (malpractice) insurance of at least the minimum amounts required by the Contract for Health Care Services, which are:

      i. General liability at one million ($1,000,000) per occurrences and three million ($3,000,000) aggregate;

      ii. Professional liability at one million ($1,000,000) per occurrences and three million ($3,000,000) aggregate;

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2 iii. Non- facilities liability at one million ($1,000,000) per occurrence and two
3 million ($2,000,000) aggregate; and
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5 iv. Professional liability at one million ($1,000,000) per occurrence and three
6 million ($3,000,000) aggregate.
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8 3. A hospital shall submit the following documentation:
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10 a. A copy of the certificate of accreditation by the Joint Commission or another CMS-
11 deemed accreditation organization;
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13 b. A copy of its current California Department of Public Health (DPH) license;
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15 c. A copy of its Medicare certificate and a copy of the Medicare exemptions, if any; and
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17 d. A current certificate of insurance.
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19 4. A home health care Provider, Skilled Nursing Facility (including an intermediate, sub-
20 acute, or extended care facility), free-standing surgical center, stand alone urgent care
21 center, portable x-ray supplier, radiology facility, laboratory facility, and dialysis facility
22 (a Provider of end-stage renal disease services), hospice, comprehensive outpatient
23 rehabilitation facility (CORF), outpatient physical therapy and speech therapy provider,
24 ambulatory surgery center (ASC), and Provider of outpatient diabetes self-management
25 shall submit the following documentation:
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27 a. A copy of its current California license;
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29 b. An applicable accreditation or on-site review or certification by CMS or DHCS;
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31 i. If the site is not accredited or certified by CMS or DHCS, an FSR shall be
32 performed. The facility shall not be Credentialed, if an FSR is not performed.
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34 c. A laboratory facility shall submit a CMS issued CLIA certificate, or a hospital based
35 exemption from CLIA;
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37 d. A copy of its Medicare certificate;
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39 e. A copy of DHP license or most recent DHP audit report; and
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41 f. A current certificate of insurance.
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43 5. A Durable Medical Equipment (DME) vendor shall submit the following documentation
44 to CalOptima, a Health Network or PMG (CalOptima and Health Networks are not
45 required to Credential or Recredential DME vendors):
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47 a. A copy of its California business license;
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49 b. A copy of its Medicare certificate; and

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c. A current certificate of insurance.

6. A CBAS Center shall submit the following documentation to CalOptima to ensure compliance with Title 22 of the California Code of Regulations: :

   a. Copy of State and City license;

   b. California Department of Aging (CDA) Survey results along with Corrective Action Plan and Approval letter from CDA;

   c. Copy of Biohazard Contract;

   d. Copy of Staff license and certification;

   e. Trained staff CPR certification;

   f. A copy of current certificates of insurances;

   g. A copy of equipment calibration logs; and

   h. Copy of attendance sign in sheet for CBAS training of all staff.

7. Miscellaneous service vendor

   a. A copy of its California business license;

   b. A current certificate of insurance;

   c. A copy of all staff certifications or licensure;

   d. A copy of equipment calibration logs; and

   e. A copy of accreditation or certification.

8. Except as provided in CalOptima Policy GG1608Δ: Full Scope Site Reviews, CalOptima does not delegate the FSR and Medical Record Review (MRR) processes to a Health Network or PMG. CalOptima assumes all authority, responsibility, and coordination of FSRs and MRRs, and reports its findings to Health Networks or PMGs to incorporate the documents to support review prior to Credentialing decisions.

H. CalOptima, a Health Network or PMG shall maintain Credentialing files that include documentation of required elements, as described in this policy.

I. A Health Network or PMG shall submit the following reports to CalOptima:

1. On a monthly basis, a report of Credentialed and Recredentialed Practitioners, and any adverse decisions taken by the peer review committee;

TO BE RETIRED BY GG.1650 & GG.1651

2. On an annual basis, a report documenting the Health Network's or PMG's evaluation process of any sub-delegated agency; and

3. Upon CalOptima's request, a report that lists all Practitioners with current licensure, DEA certification, Board Certification status, and malpractice information.

J. CalOptima shall conduct Credentialing oversight audits of a Health Network or PMG, in accordance with CalOptima Policy GG.1619: Health Network Delegation Oversight.

V. ATTACHMENTS

A. California Participating Physician Application (CPPA)
B. Verification Matrix

VI. REFERENCES

A. CalOptima Contract with the Department of Health Care Services (DHCS)
B. CalOptima Contract for Health Care Services
C. Title 42, Code of Federal Regulations, Section 422.04(a)
D. Title 42, Code of Federal Regulations, Section 422.205
E. Title 42, United States Code, Section 1320.7(a)
F. California Business and Professions Code, Section 805
G. California Evidence Code, Section 1157
H. Title XVIII and XIV of the Social Security Act
I. CalOptima Policy AA.1000: Glossary of Terms
J. CalOptima Policy GG.1605Δ: Delegation and Oversight of Credentialing and Recredentialing
K. CalOptima Policy GG.1606: Credentialing and Recredentialing of Mid-Level Practitioners
L. CalOptima Policy GG.1608Δ: Full Scope Site Reviews
M. CalOptima Policy GG.1619: Health Network Delegation Oversight
N. 2014 NCQA Standards and Guidelines
O. MMCD Policy Letter 02-03: Credentialing and Recredentialing: Timeline Change, New Primary Source Verification Requirements, and Verification of Credentials of Non-Physician Medical Practitioners
P. OneCare MA.1001: Glossary of Terms

VII. REGULATORY APPROVALS

04/28/15: Department of Health Care Services

VIII. BOARD ACTION

Not Applicable

IX. REVISION HISTORY

Version	Version Date	Policy Number	Policy Title
Original Date	10/1995	GG.1609	Health Network Practitioner Credentialing Program

TO BE RETIRED BY GG.1650 & GG.1651

Version	Version Date	Policy Number	Policy Title
			Standards
Revision Date 1	12/1995	GG.1609	Health Network Practitioner Credentialing Program Standards
Revision Date 2	12/1996	GG.1609	Health Network Practitioner Credentialing Program Standards
Revision Date 3	02/1998	GG.1609	Health Network Practitioner Credentialing Program Standards
Revision Date 4	01/1999	GG.1609	Credentialing and Recredentialing
Revision Date 5	08/2000	GG.1609	Credentialing and Recredentialing
Revision Date 6	02/2001	GG.1609	Credentialing and Recredentialing
Revision Date 7	01/01/2006	MA.7009	Credentialing and Recredentialing
Revision Date 8	07/01/2007	GG.1609	Credentialing and Recredentialing
Revision Date 9	07/01/2009	GG.1609	Credentialing and Recredentialing
Revision Date 10	09/01/2011	GG.1609	Credentialing and Recredentialing
Revision Date 11	03/01/2012	MA.7009	Credentialing and Recredentialing
Revision Date 12	02/01/2013	GG.1609	Credentialing and Recredentialing
Review Date 1	06/01/2014	GG.1609	Credentialing and Recredentialing
Revision Date 13	02/01/2015	MA.1609	Credentialing and Recredentialing
Revision Date 14	03/01/2015	GG.1609Δ	Credentialing and Recredentialing

1

TO BE RETIRED BY GG.1650 & GG.1651

Policy #:	GG.1606Δ
Title:	**Credentialing and Recredentialing of Mid-Level Practitioners**
Department:	Medical Affairs
Section:	Quality Improvement
CEO Approval:	Michael Schrader ________
Effective Date:	12/95
Last Review Date:	8/1/15
Last Revised Date:	8/1/15

This policy shall apply to the following CalOptima line of business (LOB):

- Medi-Cal
- OneCare
- OneCare Connect
- PACE

TO BE RETIRED BY GG.1650

1
2 **I. PURPOSE**
3
4 To establish a process for ensuring that Mid-Level Practitioners who participate in CalOptima have the
5 necessary credentials and supervision to perform their functions.
6
7 **II. DEFINITIONS**
8

Term	Definition
Credentialing	The process of obtaining, verifying, assessing, and monitoring the qualifications of a Practitioner to provide quality and safe patient care services.
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.
Mid-level Practitioner	A non-physician practitioner who has a professional license and certification. They include, but are not limited to, a Registered Nurse Practitioner (RNP), Nurse Practitioner (NP), Certified Nurse Midwife (CNM), Physician Assistant (PA), Certified Registered Nurse Anesthetist (CRNA), Optometrist, Acupuncturist, Licensed Clinical Social Worker (LCSW), or Chiropractor.
Physician Medical Group	A California professional medical corporation that employs or has entered into contracts with physicians who are licensed to practice medicine in the State of California that has entered into a contract with CalOptima to arrange for the provision of Covered Services to Members assigned to that Provider Group.

9
10 **III. POLICY**
11
12 A. CalOptima or a delegated Health Network and Physician Medical Group (PMG) shall Credential
13 and Recredential all Mid-Level Practitioners, in accordance with this policy.
14
15 B. A Mid-Level Practitioner shall be credentialed appropriately under the supervision of a practicing
16 Practitioner who has executed a signed Delegation Services Agreement with the Mid-Level
17 Practitioner.
18

IV. PROCEDURE

A. Credentialing

1. All Mid-Level Practitioners shall have a valid, current license or certificate issued by the State of California. Copies of current licenses and certificates of agreements with supervising physicians must be kept in the Credentialing files.

   a. Nurse Practitioners and Nurse Midwives shall be certified, in accordance with the requirements of the Board of Registered Nursing (BRN) and applicable regulations of the BRN.

   b. Physician Assistants shall be licensed, in accordance with the requirements of the Physician Assistant Examiners Committee and the Medical Board of California.

2. Mid-Level Practitioners shall maintain skills in their field of practice by participating in continuing medical education programs, following the guidelines of the Physician Assistant, Nurse Practitioner, and Certified Nurse Midwife certification process. The supervising physician shall monitor this process.

3. Mid-Level Practitioners shall maintain their Advanced Cardiopulmonary Life Support certification.

B. Supervision

1. All Mid-Level Practitioners shall practice under the supervision of a licensed physician, either directly or through the use of medical policies and procedures (e.g., protocols established by the Practitioner according to the category of Practitioner).

2. A Practitioner who supervises a Mid-Level Practitioner shall be Credentialed, in accordance with the CalOptima Policy GG.1609Δ: Credentialing and Recredentialing.

3. A supervising Practitioner shall submit, to each Health Network in which he or she participates, copies of the licenses for all Mid-Level Practitioners employed by him or her, and verification that his or her liability insurance covers the Mid-Level Practitioner, or verification that the Mid-Level Practitioner has his or her own coverage.

4. A supervising Practitioner shall review and co-sign all charts involving care provided by a Mid-Level Practitioner within thirty (30) days after the date the care was given.

5. A supervising Practitioner shall review and co-sign all charts involving care provided by a Physician Assistant within thirty (30) days after a medication has been ordered.

6. A supervising Practitioner shall review and co-sign all charts involving care provided by a Physician Assistant within thirty (30) days after a medication has been prescribed, administered, or dispensed, and/or the Physician Assistant transmits a Schedule II drug order.

7. The supervising Practitioner must be available for consultation with the Mid-Level Practitioner at all times when the Mid-Level Practitioner is providing services, either by physical presence, by telephone, or by electronic communication.

TO BE RETIRED BY GG.1650

8. A supervising Practitioner is responsible for a Mid-Level Practitioner at all times, and may authorize and approve a Mid-Level Practitioner to perform primary care services, pursuant to the CalOptima Policy GG.1602Δ: Mid-Level Practitioner Scope of Practice.

9. The number of non-physician medical Practitioners who may be supervised by a single Primary Care Practitioner (PCP) shall be limited to the full-time equivalent of one (1) of the following:

   a. Four (4) Nurse Practitioners;

   b. Three (3) Nurse Midwives;

   c. Two (2) Physician Assistants; or

   d. Four (4) of the above individuals in any combination that does not exceed the limit stated in either (b) or (c) above.

10. A Mid-Level Practitioner may participate in the after-hours call network, provided that the supervising Practitioner is also available for consultation at all times during which the Mid-Level Practitioner is on call.

C. Recredentialing/Site Review

1. The Recredentialing process for Mid-Level Practitioner shall be repeated every three (3) years.

2. At the time of the on-site facility audit, documents requested for review by CalOptima's Certified Site Reviewers shall include the signed agreement between the Practitioner and the Mid-Level Practitioner, and the Supervising Practitioner certificate, if a Physician Assistant is employed.

V. ATTACHMENTS

A. California Participating Practitioner Application

VI. REFERENCES

A. CalOptima Policy AA.1100: Glossary of Terms
B. CalOptima Policy GG.1602Δ: Mid-Level Practitioner Scope of Practice
C. CalOptima Policy GG.1609Δ: Credentialing and Recredentialing
D. CalOptima Policy GG.1615Δ: Corrective Action Plan for Practitioners
E. California Business and Professions Code, Section 805
F. California Evidence Code, Section 1157
G. Title 42, Code of Federal Regulations, Section 422.04(a)
H. Title 42, Code of Federal Regulations, Section 422.205
I. Title 42, United States Code, Section 1320-7(a)
J. CalOptima Policy MA.1001: Glossary of Terms
K. CalOptima Policy CMC.1001: Glossary of Terms
L. CalOptima Three-Way Contract with CMS and DHCS for Cal MediConnect

VII. REGULATORY APPROVALS

None to Date

VIII. BOARD ACTION

TO BE RETIRED BY GG.1650

1
2 None to Date
3
4 **IX. REVIEW/REVISION HISTORY**
5

Version	Version Date	Policy Number	Policy Title
Original Date	12/1995	GG.1606	Credentialing and Recredentialing of Mid-Level Practitioners
Revision Date 1	03/1999	GG.1606	Credentialing and Recredentialing of Mid-Level Practitioners
Revision Date 2	11/1999	GG.1606	Credentialing and Recredentialing of Mid-Level Practitioners
Revision Date 3	04/01/2007	GG.1606	Credentialing and Recredentialing of Mid-Level Practitioners
Revision Date 4	03/01/2013	GG.1606	Credentialing and Recredentialing of Mid-Level Practitioners
Revision Date 5	08/01/2015	GG.1606	Credentialing and Recredentialing of Mid-Level Practitioners

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TO BE RETIRED BY GG.1650

CalOptima Board Action Agenda Referral

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

Report Item

37. Consider Adopting a Support Position for the Reauthorization of the Federal Children's Health Insurance Program (CHIP)

Contact

Phil Tsunoda, Executive Director, Public Policy and Public Affairs, (714) 246-8418

Recommended Action

Adopt a support position for the reauthorization of CHIP.

Background

CHIP was created by the Balanced Budget Act of 1997 and enacted by Title XXI of the Social Security Act. CHIP is a state-federal partnership that provides health insurance to low-income children. In 1998, California launched its CHIP program, known as the Healthy Families Program (HFP). In February 2009, the Children Health Insurance Program Reauthorization Act of 2009 was signed into law, extending CHIP through 2013. The Affordable Care Act (ACA) then extended CHIP for an additional two years through 2015. In 2015, the funding program was extended for two years, through September 30, 2017, as part of the Medicare Access and CHIP Reauthorization Act of 2015.

Although the CHIP legislative authorization does not expire, without congressional action, states will not receive any new federal funds for CHIP beyond September 30, 2017. At this time, there is no legislative vehicle to reauthorize CHIP past that date. However, staff anticipates that there will be action in the near future with that intention, given the wide bipartisan support by both the U.S. House of Representatives and the U.S. Senate of previous reauthorization efforts. In January, the Medicaid and CHIP Payment and Access Commission (MACPAC), a nonpartisan congressional advisory body, recommended to Congress that it extend CHIP by five years to 2022.

According to the federal law that established CHIP, states may use CHIP funds to create a standalone program (like California's Healthy Families Program (HFP)) or to expand its Medicaid program to include children in families with higher income. The federal government currently contributes 88 percent of the costs for children enrolled in standalone programs as well as states that include CHIP within their Medicaid programs. By comparison, the federal government currently contributes 50 percent of the costs for California's Medi-Cal Classic members and 95 percent of the costs for Medi-Cal Expansion members.

After the passage of California Assembly Bill (AB) 1494 (Chapter 28, Statutes of 2012), HFP members were transitioned to Medi-Cal. However, as part of the transition, the Department of Health Care Services (DHCS) maintained eligibility thresholds for these individuals. Currently, Medi-Cal eligibility extends to individuals up to 138 percent of the Federal Poverty Level (FPL), while eligibility for children ages 0–19 extends up to 266 percent of the FPL.

CalOptima enrollment currently includes approximately 109,000 Medi-Cal members age 0–19 with an HFP aid code. This represents approximately 30 percent of all members in that age range, and 15 percent of CalOptima's total membership.

Discussion

As part of CalOptima's efforts to ensure collaboration and partnership with the community, staff engages with the Orange County legislative delegation to provide information and advocates on the behalf of the agency and our members. In recent discussions with members of our delegation, CalOptima's contracted federal lobbyist, Akin Gump Strauss Hauer & Feld, LLP, has discussed the reauthorization of the CHIP program as a key legislative priority, due to the number of members served by the program. If and when official legislation is introduced, staff recommends that the Board take a position lending CalOptima's support for this effort.

Fiscal Impact

There is no fiscal impact.

Rationale for Recommendation

Staff recommends a support position for future legislation that reauthorizes the CHIP program, in order to ensure continuity of care for the over 109,000 children who receive their health care services from CalOptima. Staff and our federal lobbyists would draft a support letter and share it with members of the Orange County congressional delegation, as well as with key Senate and House committee members and staff, as appropriate.

Concurrence

Gary Crockett, Chief Counsel

Attachments

None

/s/ Michael Schrader — *5/25/2017*

Authorized Signature — **Date**

CalOptima Board Action Agenda Referral

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

Report Item

38. Consider Authorizing Contracts with the Orange County Health Care Agency (OCHCA) and Other Participating Organizations for the Whole Person Care (WPC) Pilot

Contact

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

Recommended Actions

1. Authorize the Chief Executive Officer (CEO), with assistance of legal counsel, to contract with the Orange County Health Care Agency (OCHCA) for the Whole Person Care (WPC) pilot; and
2. Authorize the CEO, with assistance of legal counsel, to enter into information sharing agreements with other organizations participating in the Whole Person Care (WPC) pilot, subject to compliance with all applicable State and Federal privacy laws.

Background

On December 30, 2015 California's Department of Health Care Services (DHCS) received approval from the Centers for Medicaid & Medicare Services (CMS) for the renewal of the state's Medi-Cal Section 1115 waiver program. The renewal waiver, known as Medi-Cal 2020, includes up to $6.2 billion of federal funding and extends the waiver for five years, from December 30, 2015 to December 31, 2020. One of the provisions of Medi-Cal 2020 is the Whole Person Care Pilot, a county-run program that is intended to develop infrastructure and integrate systems of care to coordinate services for the most vulnerable Medi-Cal beneficiaries.

OCHCA collaborated with CalOptima, additional county agencies, hospitals, community clinics, community-based organizations and others to design and submit an application to DHCS for WPC in Orange County. Orange County's WPC pilot focuses on developing infrastructure and integrating systems of care during the first two years and enhanced services in subsequent years. The Pilot will target high utilizing Medi-Cal beneficiaries who are homeless members and those living with mental illness who are homeless or at risk of homelessness. OCHCA will used redirected funding and matching federal funds to implement Orange County's WPC pilot.

One of the DHCS requirements of the WPC Pilot application was for the county to include a letter of participation from the Medi-Cal managed care plan. On June 2, 2016, the CalOptima Board of Directors authorized CalOptima's participation with OCHCA in the WPC pilot program, including providing the OCHCA a letter of participation for the program.

OCHCA submitted its WPC pilot application to DHCS on July 1, 2016. CalOptima's commitment letter dated June 29, 2016 was included with OCHCA's application. DHCS approved OCHCA's initial application in October, 2016 for a total of $23.5 million over five

years. After allocating funds for the initial approved applications, DHCS solicited additional applications for the remaining funds available through the Waiver. On March 1, 2017, OCHCA submitted a supplemental application. DHCS is expected to announce awards for the supplemental applications on June 2, 2017. If approved, the total WPC pilot funding for Orange County would be $33,125,000. DHCS recently advised that contracts for WPC pilots must be executed by July 1, 2017.

Discussion

OCHCA's initial application was approved by DHCS in October 2016. Under the approved application and CalOptima's contract with OCHCA, CalOptima will receive $100,000 per year for 4 years to provide:

- Administrative support:
  - Physical space for meetings, as well as information systems and project management support for the workgroups;
  - Baseline data to facilitate goal setting and program development;
  - Data sharing about beneficiaries for better coordination of care, subject to applicable privacy laws, as well as HEDIS data to demonstrate improved outcomes for homeless, such as decreased ED visits and hospitalization, as well as increased utilization for prescription, professional and preventative services.
- Coordination support:
  - A WPC Personal Care Coordinator (PCC) to help homeless WPC beneficiaries and organizations supporting them, to navigate CalOptima, health networks and provider.

If OCHCA's supplemental application submitted on March 1, 2017 is approved on June 2, 2017, CalOptima will receive an additional $409,200 for CalOptima's case management system enhancements to support bi-directional communication and care plan sharing.

To participate in WPC, CalOptima is required to enter an agreement with OCHCA. Additionally, and in compliance with all applicable State and Federal privacy laws, CalOptima anticipates entering into agreements with various entities participating in the WPC to support information sharing (e.g., contracts including Business Associate Agreements). These participating entities include, for example, OCHCA's vendor providing the platform for bi-directional information sharing, recuperative care providers, and community-based organizations providing services to beneficiaries who are homeless, at risk of homelessness and/or having mental illness.

Fiscal Impact

The fiscal impact of the recommended action to authorize contracts with the OCHCA and other participating organizations for the WPC pilot is expected to be budget neutral. Management anticipates receiving up to $809,200 over the four year period of the proposed WPC pilot to support PCC salary and benefits and enhancements to CalOptima's case management system. Only currently budgeted positions will be used to support the requirements of the WPC pilot's implementation, with no additional fiscal impact anticipated.

Rationale for Recommendation
CalOptima has a long-standing relationship with the Orange County Health Care Agency. The two entities share common goals of improving access to care and health care outcomes for vulnerable residents of Orange County. The WPC Pilot provides an opportunity to integrate systems of care and reduce inappropriate emergency department and inpatient utilization for CalOptima's highest-risk members.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Board Action dated June 2, 2016, Authorize Participation with the Orange County Health Care Agency in the Department of Health Care Services Whole Person Care Pilot Program
2. June 29, 2016 CalOptima Letter of Participation to the Orange County Health Care Agency for Whole Person Care Pilot Program

/s/ Michael Schrader *5/25/2017*
Authorized Signature **Date**

Back to Agenda

CalOptima Board Action Agenda Referral

Action To Be Taken June 2, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item

18. Authorize Participation with the Orange County Health Care Agency in the Department of Health Care Services (DHCS) Whole Person Care (WPC) Pilot Program

Contact

Cheryl Meronk, Director, Strategic Development, (714) 246-8400
Arif Shaikh, Director, Public Policy and Government Affairs, (714) 246-8400

Recommended Action

Authorize participation with the Orange County Health Care Agency (HCA) in the DHCS WPC Pilot program, including providing the HCA with a letter of participation for the program.

Background

On December 30, 2015 California's Department of Health Care Services (DHCS) received approval from the Centers for Medicaid & Medicare Services (CMS) for the renewal of the state's Medi-Cal Section 1115 waiver program. The renewal waiver, known as Medi-Cal 2020, includes up to $6.2 billion of federal funding and extends the waiver for five years, from December 30, 2015 to December 31, 2020. One of the provisions of Medi-Cal 2020 is the Whole Person Care Pilot, a county-run program that is intended to develop infrastructure and integrate systems of care to coordinate services for the most vulnerable Medi-Cal beneficiaries. On April 7, 2016, the Orange County Health Care Agency submitted a Letter of Intent (LOI) to DHCS to participate in the WPC Pilot.

Discussion

As per the LOI, the county aims to focus its WPC Pilot on developing infrastructure and integrating systems of care for high utilizing Medi-Cal beneficiaries who access county mental health services, substance use disorder services, and homeless services programs, and also have high instances of emergency room and inpatient utilization. One of the requirements of the DHCS WPC Pilot application is for the county to include a letter of participation from the Medi-Cal managed care plan. The WPC Pilot application must be submitted by July 1, 2016.

CalOptima's participation in the county's WPC Pilot, subject to full compliance with all applicable privacy laws applicable to CalOptima, will focus on the following areas:

- Entering into agreements with the county to share data about beneficiaries for better coordination of care
- Coordination with CalOptima's contracted health networks and providers to identify members who can benefit from WPC Pilot initiatives
- Working with the county and other entities associated with the WPC Pilot to analyze the effectiveness of the program as it relates to emergency department and inpatient utilization trends

Back to Agenda

Fiscal Impact

CalOptima does not anticipate incurring material operating expenses related to the recommended action to provide Orange County Health Care Agency with a letter of participation for the DHCS WPC pilot program. As program parameters are finalized, staff will keep the Board updated on the level of staffing resources committed.

Rationale for Recommendation

CalOptima has a long-standing relationship with the Orange County Health Care Agency. The two entities share common goals of improving access to care and health care outcomes for vulnerable residents of Orange County. The WPC Pilot provides an opportunity to integrate systems of care and reduce inappropriate emergency department and inpatient utilization for CalOptima's highest-risk members.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. CalOptima Letter of Participation to the Orange County Health Care Agency for WPC
2. Orange County Health Care Agency LOI to DHCS for WPC
3. Whole Person Care (WPC) Pilot Program (DHCS PowerPoint)

/s/ Michael Schrader *5/26/2016*

Authorized Signature **Date**

Back to Agenda

June 2, 2016

Mark Refowitz
Director
Orange County Health Care Agency
405 W. 5th Street, 7th Floor
Santa Ana, CA, 92610

Dear Mr. Refowitz:

This letter is to confirm CalOptima's commitment and participation in the Whole Person Care (WPC) Pilot as the Medi-Cal managed care plan for Orange County, subject to full compliance with all applicable privacy laws applicable to CalOptima.

As specified in the WPC application being submitted by the County of Orange as the lead entity, CalOptima is committed to working in partnership with the County in implementing the WPC Pilot. The pilot will focus on developing infrastructure and integrating systems of care for our members who are homeless or at risk of homelessness, and will also specifically target those who are also seriously mentally ill. Additionally, we look forward to the impact of our collaboration with all the participating entities in improving health outcomes for these members.

We are particularly encouraged by the potential of the WPC Pilot to improve data sharing across the participating entities in order to better coordinate care. We believe that certain infrastructure components included in the WPC Application have broader relevance to helping serve all Medi-Cal beneficiaries served by CalOptima and we eagerly await the results of their implementation and evaluation in this pilot opportunity.

Thank you for your role as the lead entity and we look forward to working with you and the other collaborative partners on this program.

Sincerely,

Michael Schrader
Chief Executive Officer

DRAFT

MARK A. REFOWITZ
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OFFICE OF THE DIRECTOR

405 W. 5th STREET, 7th FLOOR
SANTA ANA, CA 92701
FAX: (714) 834-5506

April 7, 2016

TO: Sarah Brooks, Deputy Director
Health Care Delivery Systems, Department of Health Care Services

SUBJECT: Whole Person Care Pilot Letter of Intent

Pursuant to instructions dated March 18, 2016, this serves as the Letter of Intent, on behalf of Orange County, for our participation in the Whole Person Care (WPC) pilot. .

Lead Entity Contact Information:

1. Lead Entity Name and Mailing Address is:
   Orange County Health Care Agency, 405 W 5th St, Santa Ana, CA 92701.
2. Point of Contact Name, E-mail Address, and Telephone Number is:
   Melissa Tober, Special Projects Manager, mtober@ochca.com , (714) 834-5891

Preliminary WPC Pilot Design:

1. ***Include a statement about your organization's interest in participating in a WPC pilot.***

   The Orange County Health Care Agency (HCA) is keenly interested in WPC pilot participation based upon our successful collaboration with the DHCS on the Coverage Initiative Program and later the Low Income Health Program. In both of these instances, our collaboration enhanced our working relationship with DHCS, enhanced health care outcomes for vulnerable populations in Orange County, and led to a more efficient transition into Medi-Cal for those populations that are now covered pursuant to the Medi-Cal expansion (MCE) transition.

   HCA believes that through our collaboration on WPC we will, similarly, be able improve outcomes for hard to serve populations, improve care coordination, and increase access to needed social and supportive services through the policies that the DHCS has articulated for WPC.

2. ***Describe the geographic area in which the WPC pilot would operate and the target population(s) for the pilot.***

   - Geographic area: HCA is committed to a collaborative process with local stakeholders about all program parameters relating to WPC. Nonetheless, HCA assumes that the initial geographic focus will be on areas of high Medi-Cal enrollment and high utilization of county mental health, homeless services, and substance use disorder services, and also have high instances of emergency room and inpatient utilization. In Orange County, those areas include primarily Santa Ana, Garden Grove, and Anaheim (with a combined population of over one million people). It is expected, however, that this is an initial focus and during the five-year term of the WPC, other areas of Orange County will be included.

Back to Agenda

- Population: Subject to a collaborative process with Orange County partners, HCA believes that WPC will be focused on high utilizing Medi-Cal beneficiaries who access county mental health services, substance use disorder services, and homeless services programs, and also have high instances of emergency room and inpatient utilization.

3. ***List the potential participating entities that would work in partnership with your organization as part of the WPC pilot. Indicate if the entity is a managed care plan, a health services and specialty mental health agency/department, a public agency/department, or a community partner.***

- Orange County Health Care Agency – Lead Entity and also includes:
  - County Behavioral Health (Mental Health and Substance Abuse).
  - County Public Health.
- Orange County Community Resources, which includes:
  - Homeless Prevention Program.
  - Orange County Housing Authority.
  - Veterans Service Office.
- Orange County Social Services Agency.
- CalOptima – the County Organized Health System (COHS) serving Orange County.
- Orange County 211 – A nonprofit offering a comprehensive information and referral system.
- Share Our Selves – A nonprofit FQHC that is also the only community health center in Orange County with a federal designation as a Healthcare for Homeless provider.
- Illumination Foundation – A nonprofit Orange County homeless community provider.
- Others as may be identified during the collaboration process.

4. ***Describe possible interventions and infrastructure that the WPC pilot may implement:***

With respect to infrastructure and data sharing, Orange County is evaluating, with plans to be more definitive in its application:

- Expanding the Homeless Management Information System currently managed by Orange County 211 to include a public health/health module.
- Re-tooling an electronic referral system, previously used for the Low Income Health Program, to link homeless beneficiaries to a care coordination team following an emergency room visit or inpatient admission. This process would happen in real time, allowing the necessary resources to reach the beneficiary when they are at their most vulnerable and have the highest need.
- Establishing/strengthening existing care coordination efforts among the participating entities, through data sharing/coordination.
- Other options as may be raised during the collaborative process, including the local 911 system.

With respect to care not currently reimbursed by Medicaid, Orange County is evaluating, with plans to be more definitive in its application:

- Expansion of recuperative care, a program that provides short- term medical care and care management to homeless persons who are recovering from an acute illness or injury, and whose conditions would be exacerbated by living on the street or in a shelter.
- Establishing medical bridge housing.
- Peer support services, including but not limited to transportation to medical appointments and in-home support services.

Back to Agenda

- Additional wrap-around and supportive services that not only facilitate a beneficiary's ability to obtain permanent housing, but also allow them to maintain their housing.
- Other options as may be raised during the collaborative process.

5. ***Note whether or not the WPC pilot would provide housing and supportive services to the target population(s):***

Please see the response to question 4 with respect to supportive services which includes recuperative care and medical bridge housing, as well as wraparound and supportive services to the beneficiary. In addition to supporting the beneficiary to obtain and maintain housing, to the extent that the policies of the WPC Pilot allow, creative solutions to identifying housing options and opportunities will also be explored during the collaboration process. Orange County's rental vacancy rate is 1% to 2%, compared to 4% for California as a whole, placing available rental housing at a premium and causing rents to increase.

Thank you for this opportunity.

Mark A. Refowitz, Director

DG/RS/MAR:mh 16-034

cc: Frank Kim, County Executive Officer
Mark Denny, Chief Operating Officer

Back to Agenda

Attachment to June 1, 2017 Board of Directors Meeting Agenda Item 38

Whole Person Care (WPC) Pilot Program

Sarah Brooks, Deputy Director
Health Care Delivery Systems
Department of Health Care Services

May 16, 2016

Back to Agenda

Presentation Overview

1. WPC Program Overview
2. Key Elements of the WPC Pilots
   - Goals and Strategies
   - Lead and Participating Entities
   - Target Populations
   - Activities/Services
3. Letters of Intent
4. STC Attachments
   - Universal Metrics
   - Variant Metrics
5. Implementation Activities
6. Application Elements and Timeline
7. Questions/Open Discussion

Back to Agenda

DHCS

WPC Program Overview

Program Duration	Goal	Funding
• 5-year program authorized under the Medi-Cal 2020 waiver	• To test locally-based initiatives that will coordinate physical health, behavioral health, and social services for beneficiaries who are high users of multiple health care systems and have poor outcomes	• Up to $1.5 billion in federal funds available to match local public funds over 5 years • Up to $300 million annually is available • Based on semi-annual reporting of activities/interventions • Non-federal share provided via Intergovernmental Transfers (IGT)

Back to Agenda

Goals and Strategies

Increase:

- Integration among county agencies, health plans, providers, and other entities within the participating county or counties that serve high-risk, high-utilizing beneficiaries
- Coordination and appropriate access to care for the most vulnerable Medi-Cal beneficiaries
- Access to housing and supportive services

Reduce:

- Inappropriate emergency department and inpatient utilization

Back to Agenda

Goals and Strategies

Develop:

- An infrastructure that will ensure local collaboration among the entities participating in the WPC pilots over the long term

Improve:

- Health outcomes for the WPC population
- Data collection and sharing among local entities

Achieve:

- Targeted quality and administrative improvement benchmarks

Back to Agenda

Lead Entities

Lead Entities:	Lead Entity Responsibilities:
• County • A city and county • A health or hospital authority • A designated public hospital • A district/municipal public hospital • A federally recognized tribe • A tribal health program under a Public Law 93-638 contract with the federal Indian Health Services • A consortium of any of the above entities	• Submits Letter of Intent and application • Serves as the contact point for DHCS • Coordinates WPC pilot • Collaborates with participating entities

Participating Entities

Participating Entities must include at least:

- One (1) Medi-Cal managed care health plan
- One (1) health services agency/department
- One (1) specialty mental health agency/department
- One (1) public agency/department
- Two (2) community partners

Participating Entity Responsibilities:

- Collaborates with the lead entity to design and implement the WPC pilot
- Provides letters of participation
- Contributes to data sharing/reporting

Back to Agenda

Lead and Participating Entities

- Lead entities indicate in the application who the participating entities will be.
  – DHCS encourages a collaborative approach.
- Only one Medi-Cal managed care plan is required to participate, but DHCS encourages including multiple plans.
  – Medi-Cal managed care plan participation must include the plan’s entire network (i.e., where delegation of risk has occurred to an entity in the plan’s network).
  – Specific exclusions and exceptions may be considered on a case-by-case basis.
- Lead entities cannot also be one of the two required community partners.

Back to Agenda

Target Populations

WPC pilots identify high-risk, high-utilizing Medi-Cal beneficiaries in their geographic area.

- Work with participating entities to determine the best target population(s) and areas of need.

Target population(s) may include, but are not limited to, individuals:

- with repeated incidents of avoidable emergency use, hospital admissions, or nursing facility placement;
- with two or more chronic conditions;
- with mental health and/or substance use disorders;
- who are currently experiencing homelessness; and/or
- who are at risk of homelessness, including individuals who will experience homelessness upon release from institutions (e.g., hospital, skilled nursing facility, rehabilitation facility, jail/prison, etc.).

Back to Agenda

Letters of Intent

- DHCS released instructions for a Letter of Intent (LOI) in March 2016.
- The purpose of the LOI was to gauge the level of interest, obtain preliminary program design, and provide an opportunity for entities to submit questions
  - Submission of an LOI was voluntary and will not preclude lead entities from applying when the WPC application is released.
- 29 LOIs were received from 28 counties.

Back to Agenda

Letters of Intent

	Lead Entity	Geographic Area
1	Alameda County Health Care Services Agency	Alameda County, with concentration in the "880 corridor" stretching from Oakland to Hayward
2	Arrowhead Regional Medical Center	San Bernardino County
3	Calaveras County Health and Human Services Agency	Calaveras County
4	California Rural Indian Health Board (CRIHB)	Statewide
5	Contra Costa Health Services	Contra Costa County (Urban areas)
6	County of Imperial Public Health Department	Imperial County (geographic area TBD)
7	County of San Mateo Health System	San Mateo County
8	Humboldt County Department of Health and Human Services	Humboldt County
9	Kern Medical Center	Kern County (Individuals residing within a 15 mile radius of KMC and/or their assigned medical home)
10	Kings County Department of Public Health	Kings County
11	Los Angeles County	Los Angeles County in all 8 county service planning areas
12	Mathiesen Memorial Health Clinic	Calaveras,Tuolumne, and Mariposa Counties
13	Mendocino County Health & Human Services Agency	Mendocino County
14	Monterey County Health Department	Monterey County
15	Orange County Health Care Agency	Orange County with focus on areas of high Medi-Cal enrollment and high utilization of county resources (primarily Santa Ana, Garden Grove, and Anaheim)

Back to Agenda

Letters of Intent

	Lead Entity	Geographic Area
16	Placer County Health and Human Services	Placer County
17	Riverside University Health System Department of Population Health	Riverside County
18	San Benito County Health and Human Services Agency	San Benito County
19	San Diego County Health and Human Services Agency	San Diego County
20	San Francisco Department of Public Health	City of San Francisco
21	San Joaquin County Health Care Services Agency	San Joaquin County – (initial targets Stockton and Lathrop areas with entire county by demo end)
22	Santa Clara Valley Health and Hospital System	Santa Clara County
23	Shasta County Health and Human Services Agency	Shasta County
24	Solano County Health and Social Services	Solano County
25	Southern Indian Health Council	San Diego County (rural southeast)
26	Tulare County Health and Human Services Agency	Tulare County
27	Ventura County Health Care Agency	Ventura County
28	WellSpace Health	Sacramento
29	Yolo County Health and Human Services Agency	Yolo County

- The list of the lead entities that voluntarily submitted LOIs can also be found at the following link: http://www.dhcs.ca.gov/services/Documents/WPCLOISubmissions.pdf.

Back to Agenda

Activities/Services

Generally, WPC pilot payments may support activities that:

- **Build infrastructure** to integrate services among local entities that serve the target population.
- **Provide services not otherwise covered or directly reimbursed by Medi-Cal** to improve care for the target population, such as housing components.*
- **Implement strategies** to improve integration, reduce unnecessary utilization of health care services, and improve health outcomes.

*Federal WPC payments are not available for services provided to non-Medi-Cal beneficiaries.

Back to Agenda

Activities/Services Examples

- Care coordination
- Recuperative care/medical respite
- Sobering centers
- Transportation
- Field-based care, such as case managers, therapists, or nurses delivering services on the street or in the home
- New IT infrastructure

Back to Agenda

Activities/Services: Housing Supports & Services

WPC pilots for Housing Supports/Services:

- May target individuals who are experiencing, or are at risk of, homelessness who have a demonstrated medical need for housing or supportive services.
- Must have participating entities that include local housing authorities, local continuum of care program, and community-based organizations serving homeless individuals.

Back to Agenda

Activities/Services: Housing Supports & Services

Federal Medicaid funds may not be used to cover the cost of:

- Room and board
- Monthly rental or mortgage expense
- Food
- Regular utility charges
- Household appliances or items that are intended for purely diversional/recreational purposes

However, state or local government and community entity contributions that are not used to match WPC pilot federal financial participation (FFP) may be allocated to fund support for long-term housing, including rental housing subsidies.

Back to Agenda

Activities/Services: Housing Supports & Services

Eligible Housing Supports & Services include:

- Individual Housing Transition Services: housing transition services to assist beneficiaries with obtaining housing, such as individual outreach and assessments.
- Individual Housing & Tenancy Sustaining Services: services to support individuals in maintaining tenancy once housing is secured, such as tenant and landlord education and tenant coaching.
- Additional transition services, such as searching for housing, communicating with landlords, and coordinating moves.

Back to Agenda

Activities/Services: Housing Supports & Services

Additional transition services:

- Transportation
- Environmental accommodations for accessibility
- Housing transition services beyond case management services that do not constitute room and board, such as:
  - Security deposits
  - Utility set-up fees
  - First month coverage of utilities
  - One-time cleaning prior to occupancy, etc.

Back to Agenda

Activities/Services: Flexible Housing Pool

The flexible housing pool:

- May include funding created from savings generated by reductions in health, behavioral, and acute care costs, which result from WPC pilot housing-related strategies.
- Can be used to fund additional supports and services that are not available for (FFP), such as rental subsidies, home setup, deposits, and utilities.

Back to Agenda

STC Attachments

- There are three Special Terms and Conditions (STC) protocols related to Whole Person Care:
  - Attachment GG – Reporting and Evaluation
  - Attachment HH – WPC Pilot Requirements and Application Process
  - Attachment MM – WPC Pilot Requirements and Metrics
- Attachment MM describes the universal and variant metrics that WPC pilots are required to report on.

Back to Agenda

Universal Metrics

All WPC are required to report on the same set of universal metrics.

- These include four (4) health outcomes measures and three (3) administrative measures.
- **Health Outcomes Measures:**
  - 1. Ambulatory Care
  - 2. Inpatient Utilization
  - 3. Follow-up After Mental Health Illness Hospitalization
  - 4. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- **Administrative Measures:**
  - 1. Comprehensive Care Plan
  - 2. Care Coordination, Case Management, and Referral Infrastructure
  - 3. Data and Information Sharing Infrastructure

Back to Agenda

Variant Metrics

Variant metrics are specific to the WPC target population(s), strategies, and interventions.

- Each WPC Pilot must report on a minimum of four (4) variant metrics, including:
  - 1. One administrative metric in addition to the Universal care coordination and data sharing metrics
  - 2. One standard health outcomes metrics (e.g., HEDIS) applicable to the WPC Pilot population across all five program years for each target population
  - 3. WPC Pilots utilizing the PHQ-9 shall report the Depression Remission at Twelve Months (NQF 0710) metric; all other Pilots shall report one alternative health outcomes metric.
  - 4. WPC Pilots including a severely mentally ill (SMI) target population must report on the Adult Major Depression Disorder (MDD): Suicide Risk Assessment (NQF 0104) WPC Pilots; all other Pilots shall report one alternative health outcomes metric.
- WPC Pilots implementing a housing component must report a metric specific to the housing intervention.

Back to Agenda

Implementation Activities To Date

Completed

- Issued frequently asked questions (FAQs); continually updated as clarifications must be made
- Conducted FAQ webinar
- Released Letter of Intent to gauge level of interest; collected responses
- Released draft application and selection criteria
- Public comment on draft application and selection criteria
- Submitted selection criteria to CMS for approval

Next Steps

- Finalize Attachment MM (metrics protocol) with CMS
- Issue all three protocols (Attachment GG, Attachment HH, and Attachment MM) as final
- Submit valuation outline prior to releasing application
- Release final application and selection criteria
- Conduct application webinar
- Review applications which are due July 1
- Convene a Learning Collaborative

Back to Agenda

The WPC application must provide information on:

- The target population of the WPC pilot
- Services, interventions, and strategies that will be used for each target population
- How data sharing will occur between the participating entities
- The performance measures the WPC pilot will use to track progress
- The plan for collecting, reporting, and analyzing data
- How monitoring of the participating entities' performance will occur

Back to Agenda

WPC Application Elements (cont'd)

The WPC application must provide information on:

- The universal and variant metrics that the WPC pilots will report on
- The WPC pilot financing structure, including the funding flow to the lead entity and participating entities
- The total requested funding amount to operate the WPC pilot
- An attestation for the WPC pilot lead entity to participate in learning collaboratives to share best practices among pilot entities

Back to Agenda

Application Timeline

2016 Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec 2016

FAQs released
Mar 16

LOI released
Mar 18

FAQ webinar
Mar 22

LOI due
Apr 8

Application and selection criteria public comment period
Apr 11 – 18

CMS approves application
May 6

DHCS issues application
May 16

Application webinar
May 19

Applications due
Jul 1

Applications review completed
Sep 1

Applicants' written responses due
Sep 8

DHCS notifies CMS of decisions
Oct 7

DHCS notifies applicants of final decisions
Oct 24

Applicants' formal approval due
Nov 3

Back to Agenda

Resources

Visit our webpage:

- http://www.dhcs.ca.gov/services/Pages/WholePersonCarePilots.aspx

Submit questions/sign up for the listserv:

- 1115WholePersonCare@dhcs.ca.gov

Back to Agenda

Questions and Discussion

Back to Agenda

June 29, 2016

Sarah Brooks
Deputy Director
Health Care Delivery Systems
Department of Health Care Services
1501 Capitol Avenue, MS 4000
Sacramento, CA 95814

Dear Ms. Brooks:

This letter is to confirm CalOptima's commitment and participation in the Whole Person Care (WPC) Pilot as the Medi-Cal managed care plan for Orange County, subject to full compliance with all applicable privacy laws applicable to CalOptima.

As specified in the WPC application being submitted by the County of Orange as the lead entity, CalOptima is committed to working in partnership with the County in implementing the WPC Pilot. The pilot will focus on developing infrastructure and integrating systems of care for our members who are homeless or at risk of homelessness, and will also specifically target those who are also seriously mentally ill. Additionally, we look forward to the impact of our collaboration with all the participating entities in improving health outcomes for these members.

We are particularly encouraged by the potential of the WPC Pilot to improve data sharing across the participating entities in order to better coordinate care. We believe that certain infrastructure components included in the WPC Application have broader relevance to helping serve all Medi-Cal beneficiaries served by CalOptima and we eagerly await the results of their implementation and evaluation in this pilot opportunity.

We look forward to working with the other collaborative partners on this program.

Sincerely,

Michael Schrader
Chief Executive Officer

Agenda Item 39 to follow Closed Session

Consider Chief Executive Officer and Chief Counsel
Performance Reviews and Compensation

Back to Agenda

CalOptima Board Action Agenda Referral

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

Report Item
40. Election of Officers of the Board of Directors for Fiscal Year 2017-18

Contact
Michael Schrader, Chief Executive Officer, (714) 246-8400

Recommended Action
Elect Board Chair and Vice Chair for terms effective July 1, 2017 through June 30, 2018, or until the election of a successor(s), unless the Board Chair or Vice Chair shall sooner resign or be removed from office.

Background/Discussion
In accordance with Article VIII, Section 8.1 of CalOptima's Bylaws, the Board shall elect one of its Directors as Chair at an organizational meeting. The Chair shall be the principal officer of the Board and shall preside at all meetings of the Board, shall appoint all members of the Ad Hoc Committees, as well as the chair of the Ad Hoc Committees and all Committees other than the Member and Provider Advisory Committees. The Chair shall perform all duties incident to the office and such other duties as may be prescribed by the Board from time to time.

Section 8.2 of the CalOptima Bylaws states that the Board shall elect one of its Directors to serve as Vice Chair at an organizational meeting. The Vice Chair shall perform the duties of the Chair if the Chair is absent from the meeting or is otherwise unable to act.

The Chair and Vice Chair terms shall commence on the first day of the month after the organizational meeting at which they are elected to their respective positions.

Fiscal Impact
There is no fiscal impact.

Rationale for Recommendation
The recommended actions are in accordance with Article VIII of the CalOptima Bylaws.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *5/25/2017*
Authorized Signature — **Date**

Back to Agenda

Board of Directors Meeting
June 1, 2017

Provider Advisory Committee (PAC) Update

May 11, 2017 PAC Meeting

Thirteen (13) PAC members were in attendance at the May PAC meeting.

As we have been reporting to the Board, PAC has four seat appointments expiring on June 30, 2017 for the Community Health Clinics, Hospital, Physician and Traditional/Safety Net Representatives. The PAC Nomination process began on March 1, 2017 and ended on March 31, 2017. Members Batra, Bruhns and Pham who were not up for reappointment, volunteered to serve on the nomination ad hoc subcommittee. The ad hoc subcommittee met on April 24, 2017 and PAC approved the slate of recommended candidates at the May 11, 2017 PAC Regular meeting. PAC recommendations have been submitted separately of this report for the CalOptima Board's final approval. PAC recommended candidates for a three-year term from July 1, 2017 to June 30, 2020 include the following:

- New appointment for Craig G. Myers as the Community Health Clinics representative;
- Reappoint Suzanne Richards as the Hospital representative;
- Reappoint Jacob Sweidan, M.D. as the Physician representative;
- Reappoint Jena Jensen as the Traditional/Safety Net representative

PAC also made the following recommendations for the PAC Chairperson and Vice Chairperson positions for a one-year term:

- Reappoint Teri Miranti as the PAC Chairperson for FY 2017-2018;
- Reappoint Suzanne Richards as the PAC Vice-Chairperson for FY 2017-2018

Michael Schrader, Chief Executive Officer reported on the current budget process for FY 2017-2018 and noted that CalOptima had received the Medi-Cal rates from the State for both Classic and Expansion members. The rates received included a reduction of $55M for Classic members and $62M for Expansion members, totaling $117M rate reductions to CalOptima. There was a lot of discussion among the members and CalOptima staff on this topic. Michael Schrader reported that CalOptima's Finance Department is busy preparing the FY 17-18 Operating Budget based on the rate cuts from the State.

Ladan Khamseh, Chief Operating Officer reported on the complimentary direct deposit for providers through U.S. Bank that went into effect on April 10, 2017. She noted that the providers can now access their funds directly and look at their claim details electronically.

As part of the CMO report, Marsha Choo provided an update on the member/provider incentive for screening of Breast Cancer, Cervical Cancer and Postpartum checkups.

Back to Agenda

Nancy Huang, Interim Chief Financial Officer presented the March Financial Report. Ms. Huang also reported on the proposed reinsurance policy changes and presented on the OneCare Connect (OCC) comparison of financial and utilization performance of the CalOptima Community Network (CCN) and contracted health networks. There was discussion about the comparison study and PAC members made recommendations to make sure the study was valid. PAC members would also like to provide additional metrics that CalOptima staff could include in this comparison prior to going to the CalOptima Board of Directors.

PAC received the following updates from CalOptima executive staff at the May 11, 2017 PAC meeting: Network Operations, Federal and State legislative and updates on the Community Based Adult Services (CBAS) and Skilled Nursing Facility (SNF) 2016 Satisfaction Survey.

Once again, the PAC appreciates and thanks the CalOptima Board for the opportunity to present input and updates on the PAC's current activities.

Provider Advisory Committee
FY 2016 - 2017 Accomplishments

During FY 2016-2017 the Provider Advisory Committee (PAC) of the CalOptima Board of Directors provided input on provider issues to ensure that CalOptima members continue to receive high quality health care services. The following list highlights their accomplishments:

- PAC CAHPS Ad Hoc Committee made up from representatives from the Community Health Centers, Health Networks, Pharmacy, Physician and the Non-Physician Medical Practitioner held five meetings to provide feedback and advice to CalOptima staff towards training, education and upcoming focus groups for the next 2017 CAHPS survey, with mutual goals to increase scores.

- The PAC Community Clinic Representative participated in two safety net meetings with CalOptima Board members who represent clinics and CalOptima leadership. The discussion focused on ways CalOptima can partner with the safety net in Orange County. The representative also co-chaired the OC Health Improvement Partnership in 2016.

- PAC members shared the news with their constituencies and professional organizations regarding CalOptima's ranking as California's top-ranked Medi-Cal health plan, according to the National Committee for Quality Assurance's (NCQA's) Medicaid Health Insurance Plan Rankings for 2016–2017.

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

- One of the two PAC LTSS Representatives provided input and assisted CalOptima staff to create electronic remittance advice implementation.

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

- All PAC members completed the annual Compliance Training for 2016/17 by the deadline.

Back to Agenda

- 2017 PAC Nomination Ad Hoc subcommittee met on April 24, 2017, to select new PAC members for the four PAC vacancies: Community Health Centers; Hospital; Physician and Traditional/ plus the PAC Chair and Vice Chair for FY 2017-18. Three ad hoc members presented the slate of candidates to the full PAC on May 11, 2017 with their recommendations.

- PAC members supported the intergovernmental transfer (IGT) projects that are completed or in progress, as well as the proposed recommendations for the use of the remaining IGT funds.

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

- PAC members attendance equals on average over 81% of members attend each monthly meeting and there are 11 out of 15 members attending each meeting.

- In addition to meeting on a monthly basis over the course of the FY 2016-17, PAC members have participated in at least eight (8) ad hoc subcommittees and dedicated approximately 331 hours or the equivalent of 41 business days. This does not account for the time spent preparing for meetings, reviewing reports, participating in their professional associations and communicating with CalOptima staff and their respective constituencies.

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

CalOptima Board of Directors'
Provider Advisory Committee

GOALS AND OBJECTIVES FY 2017-2018			
CalOptima Strategic Priority	**CalOptima Goals**	**CalOptima Objectives**	**PAC Activities**
I. Innovation	**Pursue innovative programs and services to optimize member access to care**	**1. Delivery System Innovation - Utilize pay-for performance, creative partnerships, sponsored initiatives and technology to empower networks and providers to drive innovation and improve member access.**	Increase overall outcome of HEDIS metrics for cancer screenings, diabeties care and preventive care by: 1) Obtaining and reviewing quarterly reports from CalOptima Management for HEDIS and CAHPS indicators blinded by Networks and Community Health Centers 2) PAC membership addressing their contituencies to set a goal to improve HEDIS performance metrics. PAC Members to discuss ideas collected from their constituencies to develop a plan to reach the goal. 3) Coordinating data from the community and CalOptima using CalOptima's data warehouse.
		2. Program Integration - Implement programs and services that create an integrated service experience for members, including an integrated physical and behavioral health service model.	1) Monitor access and coordination of behavioral health and medical services through regular updates from CalOptima and Magellan. 2) Continue Whole Person Care Model updates.
		3. Program Incubation - Incubate new programs and pursue service approaches to address unmet member needs by sponsoring program pilots addressing areas such as substance abuse, behavioral health services, childhood obesity and complex conditions.	PAC will provide input into IGT funding recommendations prior to board approval.
II. Value	**Maximize the value of care for members by ensuring quality in a cost effective way**	**1. Data Analytics Infrastructure - Establish robust IT infrastructure and integrated data warehouse to enable predictive modeling, effective performance accountability and data-based decision making.**	PAC Members to identify three (3) burdensome administrative pain points to improve efficiencies and work with CalOptima Staff to address these.

Back to Agenda

CalOptima Board of Directors'
Provider Advisory Committee

GOALS AND OBJECTIVES FY 2017-2018			
CalOptima Strategic Priority	**CalOptima Goals**	**CalOptima Objectives**	**PAC Activities**
II. Value (Cont.)	**Maximize the value of care for members by ensuring quality in a cost effective way (Cont.)**	**2. Pay for Value - Launch pay-for performance and quality incentive initiatives that encourage provider participation, facilitate accurate encouter data submissions, improved clinical quality and member experience outcomes, and the spread of best practices.**	Increase overall outcome of HEDIS metrics for cancer screenings, diabeties care and preventive care by: 1) Obtaining and reviewing quarterly reports from CalOptima Management for HEDIS and CAHPS indicators blinded by Networks and Community Health Centers 2) PAC membership addressing their contituencies to set a goal to improve HEDIS performance metrics. PAC Members to discuss ideas collected from their constituencies to develop a plan to reach 3) Coordinating data from community and CalOptima using CalOptima's data warehouse.
		3. Cost Effectiveness - Implement efficient systems and processes to facilitate better understanding of internal cost drivers, eliminate administrative redundancies, and promote effective and standardized internal practices.	Explore ideas to broaden access for hard to find providers.
III. Partnership and Engagement	**Engage providers and community partners in improving the health status and experience of our members**	**1. Provider Collaboration - Enhance partnerships with networks, physicians and the Provider Advisory Committee to imprve service to providers and members, expand access, and advance shared health priorities.**	Provide timely input on key issues prior to Board decision.
		2. Member Engagement - Seek input from the Member Advisory Committee and plan's diverse membership to better understand member needs, and ensure the implementation of services and programs that strengthen member choice and experience and improve health outcomes.	Hold a joint MAC/PAC Meeting once a year to share information if MAC is agreeable.

Back to Agenda

CalOptima Board of Directors' Provider Advisory Committee

GOALS AND OBJECTIVES FY 2017-2018			
CalOptima Strategic Priority	**CalOptima Goals**	**CalOptima Objectives**	**PAC Activities**
III. Partnership and Engagement (Cont.)	**Engage providers and community partners in improving the health status and experience of our members (Cont.)**	**3. Community Partnerships - Establish new organizational partnerships and collaborations to understand, measure and address social determinants of health that lead to health disparities among the plan's vulnerable populations.**	Review quarterly reports from CalOptima Management for HEDIS and CAHPS indicators blinded by Networks and Community Health Centers
		4. Shared Advocacy - Utilize provider and community relationships to educate stakeholders about health policy issues impacting the safety-net delivery system and community members, and promote the value of CalOptima to members, providers, and the broader population health of the Orange County Community.	Support Board and CalOptima to proactively respond to ACA, OCC and Cal MediConnect changes.

Charge of the Advisory Committees pursuant to Resolution No. 2-14-95:

1. Provide advice and recommendations to the Board on issues concerning CalOptima as directed by the Board.
2. Engage in study, research and analysis on issues assigned by the Board or generated by the committees.
3. Serve as liaisons between interested parties and the Board.
4. Assist the Board in obtaining public opinion on issues related to CalOptima.
5. Initiate recommendations on issues of study to the Board for their approval and consideration.
6. Facilitate community outreach for CalOptima and the CalOptima Board.

Back to Agenda

Board of Directors Meeting
June 1, 2017

OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan)
Member Advisory Committee Update

The OneCare Connect Member Advisory Committee (OCC MAC) did not reach quorum at the April 27, 2017 meeting.

At the May 25, 2017 OCC MAC meeting, OCC MAC considered and approved the following Report items: FY 2016-17 Accomplishments, highlighting OCC MAC's activities for the past fiscal year; FY 2017-18 OCC MAC meeting schedule in which OCC MAC will continue to meet monthly; FY 2017-18 Goals and Objectives that outline OCC MAC's goals for the upcoming fiscal year; and the FY 2017-18 slate of candidates, Chair and Vice Chair.

The OCC MAC considered a slate of candidates for five seats expiring on June 30, 2017, including: a Representative Serving Members with Disabilities; Representative Serving Members from an Ethnic or Cultural Community; In Home Supportive Services (IHSS) or Union Provider representative; and OneCare Connect (OCC) member or family member of an OCC member (2 seats available). The proposed slate of candidates included four candidates for the five impending vacancies. One of the open OCC MAC member/family member seats did not receive eligible applicants and will remain vacant until filled. OCC MAC is reopening the recruitment for this seat. The recommended candidates will serve a two-year term from July 1, 2017 to June 30, 2019. After considering the recommended slate of candidates, Chair and Vice Chair, OCC MAC selected the following proposed candidates for the Board of Directors' consideration:

- Reappoint Sandy Finestone as the Representative Serving Persons with Disabilities;
- Reappoint Sara Lee as the Representative Serving Persons from an Ethnic or Cultural Community;
- Reappoint Josefina Diaz as the OneCare Connect Member/Family Member Representative;
- Appoint Richard Santana as the In-Home Supportive Services (IHSS)/Union Provider Representative; and
- Appoint Gio Corzo as Chair and Patty Mouton as Vice Chair for a one-year term ending June 30, 2018.

OCC MAC Members Jorge Solé, Social Services Agency representative, and Lena Berlove, In-Home Supportive Services - Public Authority representative, have notified CalOptima staff that

Back to Agenda

they are retiring from their respective agencies, effective immediately, leaving two non-voting agency representative seats vacant. Once the agencies have identified replacements for the positions, CalOptima staff will submit the candidates for the Board's consideration to fill the agency representative seats.

The OCC MAC appreciates the opportunity to provide the CalOptima Board with input and updates on OCC MAC activities.

Back to Agenda

OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan)

OneCare Connect Member Advisory Committee
FY 2016-2017 Accomplishments

During FY 2016-2017, the OneCare Connect Member Advisory Committee (OCC MAC) of the CalOptima Board of Directors provided input to ensure that OneCare Connect members receive quality health care services. The following list highlights the accomplishments:

- A member of the OCC MAC participated on the request for proposal (RFP) committee that reviewed and selected Magellan Health, Inc. as CalOptima's managed behavioral health organization.

- OCC MAC Member, who also serves as the Cal MediConnect Ombudsman, provided quarterly updates and feedback from the community regarding the OneCare Connect program.

- OCC MAC members recommended the addition of a Vice Chair position at its September 22, 2016 OCC MAC meeting to assist the Board-appointed OCC MAC Chair, ensuring smooth and streamlined committee administration. The Board approved the Vice Chair position at the October 6, 2016 meeting.

- OCC MAC members reviewed CalOptima's draft Strategic Plan for 2017-2019 and supported the Board of Directors' approval of the updated plan. The new strategic priorities include innovation, value, and partnerships and engagement.

- An OCC MAC Nomination Ad Hoc Subcommittee convened to select the proposed slate of candidates, Chair and Vice Chair for the positions expiring on June 30, 2017. The OCC MAC reviewed the proposed candidates at its May 25, 2017 meeting and forwarded their recommendations to the Board for consideration and approval at the June 1, 2017 meeting.

- An OCC MAC Goals and Objectives Ad Hoc Subcommittee convened to develop goals and objectives for FY 2017-18. Based on the Board-approved Strategic Plan, OCC MAC approved the FY 2017-18 OCC MAC Goals and Objectives on May 25, 2017 and submitted them to the Board as an informational item on June 1, 2017.

- OCC MAC members provided input on CalOptima's strategies to maximize enrollment, retention, and member outreach efforts to OneCare Connect members.

Back to Agenda

- An OCC MAC member volunteers to present an overview at each OCC MAC meeting on the agency or organization they represent.

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

- All OCC MAC members completed the annual Compliance Training.

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

- OCC MAC members contributed at least 260 "official" hours to CalOptima during FY 2016-17, including OCC MAC meetings, ad hoc meetings, and Board meetings. These hours do not account for the innumerable hours that OCC MAC members dedicate to members on a day-to-day basis.

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

Back to Agenda

CalOptima Board of Directors'
OneCare Connect Member Advisory Committee
Goals and Objectives
FY 2017-2018

GOALS AND OBJECTIVES FY 2017-2018			
CalOptima Strategic Priority	**CalOptima Goals**	**CalOptima Objectives**	**OCC MAC Activities**
I. Innovation	**Pursue innovative programs and services to optimize member access to care**	1. Delivery System Innovation - Utilize pay-for performance, creative partnerships, sponsored initiatives and technology to empower networks and providers to drive innovation and improve member access.	• Monitor CalOptima's pay-for-value program as well as member and provider incentive initiatives •Provide input to ensure member access to health care services. •Provide input to improve and streamline access between CalOptima and delegated networks.
		2. Program Integration - Implement programs and services that create an integrated service experience for members, including an integrated physical and behavioral health service model.	• Monitor and provide input on access and care coordination of behavioral health from Magellan. • Provide input on coordinating and integrating physical and behavioral health care for OCC members. •Outreach to community stakeholders to increase awareness of CalOptima behavioral health services.
		3. Program Incubation - Incubate new programs and pursue service approaches to address unmet member needs by sponsoring program pilots addressing areas such as substance abuse, behavioral health services, childhood obesity and complex conditions.	• Provide input on proposed pilot programs addressing areas of unmet needs (i.e. substance abuse, homelessness) •Provide input on IGT funding prior to Board approval. •Encourage OCC MAC participation as needed at CalOptima work groups, forums and meetings, etc. that address unmet needs.

Back to Agenda

CalOptima Board of Directors'
OneCare Connect Member Advisory Committee
Goals and Objectives
FY 2017-2018

GOALS AND OBJECTIVES FY 2017-2018			
CalOptima Strategic Priority	**CalOptima Goals**	**CalOptima Objectives**	**OCC MAC Activities**
II. Value	**Maximize the value of care for members by ensuring quality in a cost effective way**	1. Data Analytics Infrastructure - Establish robust IT infrastructure and integrated data warehouse to enable predictive modeling, effective performance accountability and data-based decision making.	• Provide input, as needed, to improve efficiencies and systems/processes that affect OCC members.
		2. Pay for Value - Launch pay-for performance and quality incentive initiatives that encourage provider participation, facilitate accurate encouter data submissions, improved clinical quality and member experience outcomes, and the spread of best practices.	• Provide input on pay-for-value and quality incentive initiatives. • Provide input on findings from Member Experience program, CAHPS and HEDIS. • Provide input to improve member experience outcomes.
		3. Cost Effectiveness - Implement efficient systems and processes to facilitate better understanding of internal cost drivers, eliminate administrative redundancies, and promote effective and standardized internal practices.	• Provide input, as needed, to ensure OneCare Connect maximizes health care dollars.

Back to Agenda

CalOptima Board of Directors'
OneCare Connect Member Advisory Committee
Goals and Objectives
FY 2017-2018

GOALS AND OBJECTIVES FY 2017-2018			
CalOptima Strategic Priority	**CalOptima Goals**	**CalOptima Objectives**	**OCC MAC Activities**
III. Partnership and Engagement	**Engage providers and community partners in improving the health status and experience of our members**	1. Provider Collaboration - Enhance partnerships with networks, physicians and the Provider Advisory Committee to improve service to providers and members, expand access, and advance shared health priorities.	• Work with CalOptima and the advisory committees to ensure members have access to providers.
		2. Member Engagement - Seek input from the Member Advisory Committee and plan's diverse membership to better understand member needs, and ensure the implementation of services and programs that strengthen member choice and experience and improve health outcomes.	•Ensure that the Board is informed of member issues and concerns prior to the Board's consideration or action upon major decisions or initiatives. • Ensure OCC MAC has strong representation when seats become vacant. • Provide input regarding OneCare Connect, especially to improve member experience and health outcomes.
		3. Community Partnerships - Establish new organizational partnerships and collaborations to understand, measure and address social determinants of health that lead to health disparities among the plan's vulnerable populations.	•OCC MAC members participate in community outreach to increase stakeholder awareness of OCC and its benefits. •Encourage OCC MAC members to attend CalOptima's educational events to increase awareness of issues among CalOptima's members (i.e. Awareness & Education Seminars, Informational Series and Community Alliance Forums).

Back to Agenda

CalOptima Board of Directors'
OneCare Connect Member Advisory Committee
Goals and Objectives
FY 2017-2018

GOALS AND OBJECTIVES FY 2017-2018			
CalOptima Strategic Priority	**CalOptima Goals**	**CalOptima Objectives**	**OCC MAC Activities**
		4. Shared Advocacy - Utilize provider and community relationships to educate stakeholders about health policy issues impacting the safety-net delivery system and community members, and promote the value of CalOptima to members, providers, and the broader population health of the Orange County Community.	•Work with CalOptima and community stakeholders to advocate for continuation of OCC and CMC. •Work with CalOptima to inform stakeholders about health policy issues that impact CalOptima. •Promote OCC and its benefits to community by outreaching to colleagues, attending forums/events, distributing information, etc.

Charge of the Advisory Committees pursuant to Resolution No. 2-14-95:

1. Provide advice and recommendations to the Board on issues concerning CalOptima as directed by the Board.
2. Engage in study, research and analysis on issues assigned by the Board or generated by the committees.
3. Serve as liaisons between interested parties and the Board.
4. Assist the Board in obtaining public opinion on issues related to CalOptima.
5. Initiate recommendations on issues of study to the Board for their approval and consideration.
6. Facilitate community outreach for CalOptima and the CalOptima Board.

Back to Agenda

Board of Directors Meeting
June 1, 2017

Member Advisory Committee Update

At the May 11, 2017 Member Advisory Committee (MAC) meeting, MAC considered and approved the following Report items: FY 2016-17 Accomplishments, highlighting MAC's activities for the past fiscal year; FY 2017-18 MAC meeting schedule in which MAC will continue to meet bimonthly; FY 2017-18 Goals and Objectives that outline MAC's goals for the upcoming fiscal year; FY 2017-18 slate of candidates, Chair and Vice Chair; and reclassification of the MAC Long-Term Care (LTC) seat to a Long-Term Services and Supports (LTSS) seat.

The MAC considered a slate of candidates for the following six seats expiring on June 30, 2017, including: Adult Beneficiaries, Family Support, Medi-Cal Beneficiaries, Persons with Disabilities, Recipients of CalWORKs and Seniors. After considering the recommended slate of candidates, Chair and Vice Chair, MAC selected the following proposed candidates for the Board of Directors' consideration:

- Reappoint Sandy Finestone as the Adult Beneficiaries Representative;
- Reappoint Patty Mouton as the Medi-Cal Beneficiaries Representative;
- Reappoint Suzanne Butler as the Persons with Disabilities Representative;
- Reappoint Carlos Robles as the Recipients of CalWORKs Representative;
- Reappoint Mallory Vega as the Seniors Representative;
- Appoint Ilia Rolon as the as the Family Support Representative; and
- Appoint Sally Molnar as Chair and Patty Mouton as Vice Chair.

MAC also considered reclassifying the LTC seat to a LTSS seat. Based on the Department of Health Care Services' (DHCS') new regulations to further integrate LTSS services into Medi-Cal managed care plans and correspondingly, Member Advisory Committees, effective July 1, 2017, the MAC approved this action. MAC is forwarding the recommendation to the Board of Directors for consideration.

In addition to the above actions, MAC received the following informational updates. Pshyra Jones, Director, Health Education and Disease Management, presented highlights from the Group Needs Assessment recently conducted to identify members' health needs and health risks, evaluate cultural and linguistic needs and identify gaps in services. Janine Kodama, Director, GARS, presented the Member Trend Report for 2016, which outlined the trend rate for complaints (appeals/grievances) for the Medi-Cal program. Laura Guest, Supervisor, Quality Improvement, presented the results from the 2016 Community-Based Adult Services (CBAS) and skilled nursing facilities (SNF) surveys. MAC members noted the favorable satisfaction survey results for the CBAS programs.

Also at the May meeting, MAC members received the following updates from CalOptima's executive staff, including the Chief Executive Officer, Chief Medical Officer, Chief Operating Officer, Network Operations and State and Federal Legislative updates.

The MAC appreciates the opportunity to provide the CalOptima Board with input and updates on the MAC's activities.

Back to Agenda

Member Advisory Committee
FY 2016-2017 Accomplishments

During FY 2016-2017, the Member Advisory Committee (MAC) of the CalOptima Board of Directors provided input on member issues to ensure that CalOptima members receive high quality health care services. The following list highlights the accomplishments:

- A member of the MAC participated as a reviewer for the member health needs assessment request for proposal (RFP) vendor proposals. The Board of Directors approved CalOptima to lead and conduct a county-wide Medi-Cal member health needs assessment.

- A member of the MAC participated on the RFP committee that reviewed and selected Magellan Health, Inc. as CalOptima's managed behavioral health organization.

- MAC members reviewed the intergovernmental transfer (IGT) expenditure update and supported the funding of the proposed programs. For IGTs 4 and 5, funding categories were developed by a special workgroup of the Member and Provider Advisory Committees, with additional recommendations from the CalOptima Board.

- MAC members reviewed CalOptima's draft Strategic Plan for 2017-2019 and supported the Board of Directors' approval of the updated plan, including new strategic priorities, innovation, value, and partnerships and engagement.

- MAC members supported CalOptima's recommendation to extend the health network minimum enrollment timeframe, contingent upon the health network's performance and meeting operational requirements.

- MAC members recommended the addition of a Vice Chair position at the November 10, 2016 meeting to assist the Board-appointed MAC Chair, ensuring smooth and streamlined committee administration. The Board approved the Vice Chair position at the December 1, 2016 meeting.

- A MAC Nomination Ad Hoc Subcommittee convened to select the proposed slate of candidates, Chair and Vice Chair for the positions due to expire on June 30, 2017. The MAC reviewed the proposed candidates at its May 11, 2017 meeting and forwarded their recommendations to the Board for consideration and approval at its June 1, 2017 meeting.

Back to Agenda

- A MAC Goals and Objectives Ad Hoc Subcommittee convened to develop goals and objectives for FY 2017-18. Based on the Board-approved Strategic Plan, MAC approved the FY 2017-18 MAC Goals and Objectives on May 11, 2017 and submitted them to the Board as an informational item on June 1, 2017.

- MAC members and individuals from the community gave informative presentations at MAC meetings to help MAC stay connected to those they represent. In addition, MAC increased its awareness of the autism community and their needs through provider and community presentations.

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

- All MAC members completed the annual Compliance Training.

- MAC Chair and Seniors' representative participates on the PACE Advisory Committee to provide input to the PACE Center. In addition, the MAC Chair reports to the Quality Assurance Committee of the Board regarding the PACE Center.

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

- MAC members contributed at least 245 "official" hours to CalOptima during FY 2016-17, including MAC meetings, ad hoc meetings, and Board meetings. These hours do not account for the innumerable hours that MAC members dedicate to members on a day-to-day basis.

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

CalOptima Board of Directors'
Member Advisory Committee
Goals and Objectives
FY 2017-2018

GOALS AND OBJECTIVES FY 2017-2018				
CalOptima Strategic Priority	**CalOptima Goals**	**CalOptima Objectives**	**MAC Activities**	**MAC Progress**
I. Innovation	**Pursue innovative programs and services to optimize member access to care**	1. Delivery System Innovation - Utilize pay-for performance, creative partnerships, sponsored initiatives and technology to empower networks and providers to drive innovation and improve member access.	• Monitor CalOptima's pay-for-value program as well as member and provider incentive initiatives • Review and provide input on member experience results, HEDIS and CAHPS indicators and other surveys	
		2. Program Integration - Implement programs and services that create an integrated service experience for members, including an integrated physical and behavioral health service model.	• Monitor and provide input on access and care coordination of behavioral health from Magellan. • Provide input on coordinating and integrating physical and behavioral health care	
		3. Program Incubation - Incubate new programs and pursue service approaches to address unmet member needs by sponsoring program pilots addressing areas such as substance abuse, behavioral health services, childhood obesity and complex conditions.	• Provide input on collaborating with community based organizations to identify community resources and address unmet needs • Provide input on proposed pilot programs addressing areas of unmet needs (such as substance abuse) • Provide input on CalOptima's role in the Whole Person Care proposal (homeless) •Provide input on IGT funding initiatives	
II. Value	**Maximize the value of care for members by ensuring quality in a cost effective way**	1. Data Analytics Infrastructure - Establish robust IT infrastructure and integrated data warehouse to enable predictive modeling, effective performance accountability and data-based decision making.	• Provide input to CalOptima to improve efficiencies and systems/processes that affect members.	

Back to Agenda

CalOptima Board of Directors'
Member Advisory Committee
Goals and Objectives
FY 2017-2018

GOALS AND OBJECTIVES FY 2017-2018				
CalOptima Strategic Priority	**CalOptima Goals**	**CalOptima Objectives**	**MAC Activities**	**MAC Progress**
		2. Pay for Value - Launch pay-for performance and quality incentive initiatives that encourage provider participation, facilitate accurate encouter data submissions, improved clinical quality and member experience outcomes, and the spread of best practices.	•Provide input on pay-for-value and quality incentive initiatives. • Provide input on findings from Member Experience program, CAHPS and HEDIS. • Provide input to improve member experience outcomes. •Provide input on IGT funding initiatives	
		3. Cost Effectiveness - Implement efficient systems and processes to facilitate better understanding of internal cost drivers, eliminate administrative redundancies, and promote effective and standardized internal practices.	• Provide input to ensure CalOptima maximizes health care dollars.	
III. Partnership and Engagement	**Engage providers and community partners in improving the health status and experience of our members**	1. Provider Collaboration - Enhance partnerships with networks, physicians and the Provider Advisory Committee to improve service to providers and members, expand access, and advance shared health priorities.	• Work with the Provider Advisory Committee to ensure members have access to providers.	

Back to Agenda

CalOptima Board of Directors'
Member Advisory Committee
Goals and Objectives
FY 2017-2018

GOALS AND OBJECTIVES FY 2017-2018				
CalOptima Strategic Priority	**CalOptima Goals**	**CalOptima Objectives**	**MAC Activities**	**MAC Progress**
		2. Member Engagement - Seek input from the Member Advisory Committee and plan's diverse membership to better understand member needs, and ensure the implementation of services and programs that strengthen member choice and experience and improve health outcomes.	•Ensure that the Board is informed of member issues and concerns prior to the Board's consideration or action upon major decisions or initiatives • Ensure MAC provides input into proposed services and programs, especially to improve both member experience and health outcomes. •areas to consider include hospital readmissions, palliative care, substance abuse, ABA/mental health, IHSS/LTSS	
		3. Community Partnerships - Establish new organizational partnerships and collaborations to understand, measure and address social determinants of health that lead to health disparities among the plan's vulnerable populations.	• Provide input to ensure collaboration with community stakeholders and members. •Provide input to CalOptima to address health disparities among vulnerable populations. • Provide input on CalOptima's role in the Whole Person Care proposal (homeless).	
		4. Shared Advocacy - Utilize provider and community relationships to educate stakeholders about health policy issues impacting the safety-net delivery system and community members, and promote the value of CalOptima to members, providers, and the broader population health of the Orange County Community.	•Work with CalOptima and community stakeholders to respond to changes in health policy, including OCC, ACA, CMC. •Ensure MAC has strong representation. •Encourage MAC members to attend CalOptima's community education events to enhance MAC's knowledge of issues impacting members.	

Charge of the Advisory Committees pursuant to Resolution No. 2-14-95:

1. Provide advice and recommendations to the Board on issues concerning CalOptima as directed by the Board.
2. Engage in study, research and analysis on issues assigned by the Board or generated by the committees.

Back to Agenda

CalOptima Board of Directors'
Member Advisory Committee
Goals and Objectives
FY 2017-2018

GOALS AND OBJECTIVES FY 2017-2018				
CalOptima Strategic Priority	**CalOptima Goals**	**CalOptima Objectives**	**MAC Activities**	**MAC Progress**

3. Serve as liaisons between interested parties and the Board.
4. Assist the Board in obtaining public opinion on issues related to CalOptima.
5. Initiate recommendations on issues of study to the Board for their approval and consideration.
6. Facilitate community outreach for CalOptima and the CalOptima Board.

Back to Agenda

Financial Summary

April 2017

Board of Directors Meeting

June 1, 2017

Nancy Huang

Interim Chief Financial Officer

Back to Agenda

FY 2016-17: Consolidated Enrollment

- April 2017 MTD:
  - Overall enrollment was 792,511 member months
    - Actual lower than budget by 15,940 or 2.0%
      - Medi-Cal: unfavorable variance 10,487 members
        - Medi-Cal Expansion (MCE) favorable to budget by 12,382 members
        - SPD enrollment is favorable to budget by 5,523
        - TANF unfavorable variance 28,985 members
      - OneCare Connect: unfavorable variance of 5,589 members
    - 0.1% or 931 decrease from prior month
      - Medi-Cal: decrease of 835 from March
      - OneCare Connect: decrease of 111 from March
      - OneCare: increase of 11 from March
      - PACE: increase of 4 from March

Back to Agenda

FY 2016-17: Consolidated Enrollment

- April 2017 YTD:
  - Overall enrollment was 7,964,637 member months
    - Actual lower than budget by 70,268 or 0.9%
      - Medi-Cal: unfavorable variance of 22,442 members
        - Medi-Cal Expansion (MCE) growth higher than budget by 100,532
        - SPD enrollment higher than budget by 45,204 due to less than anticipated dual eligible members transferring to OneCare Connect
        - Offset by lower than budget TANF enrollment of 173,804
      - OneCare Connect: unfavorable variance of 48,237 members or 22.0%
      - PACE: unfavorable variance of 18 members or 1.0%
      - OneCare: favorable variance of 429 members or 3.6%

Back to Agenda

FY 2016-17: Consolidated Revenues

- April 2017 MTD:
  - Actual higher than budget by $58.6 million or 20.7%
    - Medi-Cal: favorable to budget by $75.9 million or 32.1%
      - Price related favorable variance of $79.1 million due to:
        - $57.6 million of FY16 revenue for Coordinated Care Initiative
        - $8.3 million of LTC revenue for non-LTC members
        - $4.2 million April 2017 IHSS revenue
        - Remaining from member mix difference versus budget
      - Volume related unfavorable variance of $3.2 million
    - OneCare Connect: unfavorable variance of $17.5 million or 40.4%
      - Unfavorable volume variance of $11.2 million
      - Unfavorable price variance of $6.3 million
        - For cohort mix and rate change and prior year revenue adjustments
        - CMC Medicare Part A and B rate decrease due to base rate and RAF score change

Back to Agenda

FY 2016-17: Consolidated Revenues (con't.)

- April 2017 YTD:
  - Actual higher than budget by $49.5 million or 1.8%
    - Medi-Cal: favorable to budget by $206.4 million or 8.8%
      - IHSS favorable revenue of $175.7 million
      - LTC favorable revenue of $57.5 million
    - OneCare Connect: unfavorable variance of $158.3 million or 35.4%
      - Medicare revenue unfavorable $106.2 million
      - Medi-Cal revenue unfavorable $52.1 million
    - OneCare: favorable $0.5 million or 3.7%
    - PACE: favorable $0.9 million or 7.3%

Back to Agenda

FY 2016-17: Consolidated Medical Expenses

- April 2017 MTD:
  - Actual higher than budget by $40.2 million or 14.9%
    - Medi-Cal: unfavorable variance of $55.5 million
      - MLTSS unfavorable variance $56.0 million
        - LTC unfavorable variance $6.6 million
        - IHSS related unfavorable variance approximately $49.4 million for true-up to county IHSS expense data for FY16
      - Provider Capitation unfavorable variance of $13.3 million
        - $12.7 million due to one shared risk group move to HMO model in February
      - Facilities expenses favorable variance of $11.2 million
        - Shared risk group move to HMO model in February
    - OneCare Connect: favorable variance of $15.9 million
      - Favorable volume variance of $10.7 million
      - Favorable price variance of $5.2 million
        - Lower than budget prescription drugs and facility costs

Back to Agenda

FY 2016-17: Consolidated Medical Expenses (Cont.)

- April 2017 YTD:
  - Actual higher than budget by $63.3 million or 2.3%
    - Medi-Cal: unfavorable variance of $202.9 million
      - Unfavorable price variance of $209.3 million
        - IHSS estimated expense $100.8 million higher than budget
        - Long Term Care expense $56.6 million higher than budget
        - Provider capitation unfavorable variance of $39.6 million for unbudgeted conversion of ASO contract to capitation
      - Favorable volume variance of $6.5 million
    - OneCare Connect: favorable variance of $139.0 million
      - Favorable volume variance of $92.8 million
      - Favorable price variance of $46.2 million

- Medical Loss Ratio (MLR):
  - April 2017 MTD: Actual: 91.0% Budget: 95.6%
  - April 2017 YTD: Actual: 96.1% Budget: 95.6%

Back to Agenda

FY 2016-17: Consolidated Administrative Expenses

- April 2017 MTD:
  - ➢ Actual higher than budget by $3.4 million or 30.3%
    - Salaries and Benefits: unfavorable variance of $3.9 million due to GASB 68 annual requirement for CalPERS actuarial report of $5.5 million
    - Other categories: favorable variance of $0.4 million

- April 2017 YTD:
  - ➢ Actual lower than budget by $18.3 million or 15.8%
    - Salaries and Benefits: favorable variance of $10.7 million driven by lower than budgeted FTE
    - Other categories: favorable variance of $7.6 million

- Administrative Loss Ratio (ALR):
  - ➢ April 2017 MTD: Actual: 4.3% Budget: 4.0%
  - ➢ April 2017 YTD: Actual: 3.4% Budget: 4.1%

Back to Agenda

FY 2016-17: Change in Net Assets

- April 2017 MTD:
  - $18.6 million surplus
  - $17.5 million favorable to budget
    - Higher than budgeted revenue of $58.6 million
    - Higher than budgeted medical expenses of $40.2 million
    - Higher than budgeted administrative expenses of $3.4 million
    - Higher than budgeted investment and other income of $2.5 million

- April 2017 YTD:
  - $24.8 million surplus
  - $14.6 million favorable to budget
    - Higher than budgeted revenue of $49.5 million
    - Higher than budgeted medical expenses of $63.3 million
    - Lower than budgeted administrative expenses of $18.3 million
    - Higher than budgeted investment and other income of $10.0 million

Back to Agenda

Enrollment Summary: April 2017

Month-to-Date					Year-to-Date			
Actual	Budget	Variance	%	Enrollment (By Aid Category)	Actual	Budget	Variance	%
60,525	56,180	4,345	7.7%	Aged	588,704	554,720	33,984	6.1%
622	680	(58)	(8.5%)	BCCTP	6,214	6,774	(560)	(8.3%)
48,504	47,268	1,236	2.6%	Disabled	485,802	474,022	11,780	2.5%
326,989	344,780	(17,791)	(5.2%)	TANF Child	3,322,519	3,413,444	(90,925)	(2.7%)
97,358	108,552	(11,194)	(10.3%)	TANF Adult	1,009,811	1,092,690	(82,879)	(7.6%)
3,336	2,743	593	21.6%	LTC	32,686	27,059	5,627	20.8%
237,712	225,330	12,382	5.5%	MCE	2,333,910	2,233,378	100,532	4.5%
775,046	**785,533**	**(10,487)**	**(1.3%)**	**Medi-Cal**	**7,779,646**	**7,802,088**	**(22,442)**	**(0.3%)**
15,975	**21,564**	**(5,589)**	**(25.9%)**	**OneCare Connect**	**170,732**	**218,969**	**(48,237)**	**(22.0%)**
201	**210**	**(9)**	**(4.3%)**	**PACE**	**1,857**	**1,875**	**(18)**	**(1.0%)**
1,289	**1,144**	**145**	**12.7%**	**OneCare**	**12,402**	**11,973**	**429**	**3.6%**
792,511	**808,451**	**(15,940)**	**(2.0%)**	**CalOptima Total**	**7,964,637**	**8,034,905**	**(70,268)**	**(0.9%)**

Back to Agenda

Financial Highlights: April 2017

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
792,511	808,451	(15,940)	(2.0%)	Member Months	7,964,637	8,034,905	(70,268)	(0.9%)
341,053,457	282,479,926	58,573,531	20.7%	Revenues	2,868,459,698	2,818,947,607	49,512,091	1.8%
310,297,534	270,136,155	(40,161,378)	(14.9%)	Medical Expenses	2,757,344,926	2,694,081,413	(63,263,513)	(2.3%)
14,812,940	11,368,826	(3,444,114)	(30.3%)	Administrative Expenses	97,742,788	116,034,506	18,291,718	15.8%
15,942,983	**974,945**	**14,968,038**	**1535.3%**	**Operating Margin**	**13,371,985**	**8,831,689**	**4,540,296**	**51.4%**
2,618,978	134,754	2,484,223	1843.5%	Non Operating Income (Loss)	11,415,527	1,394,242	10,021,285	718.8%
18,561,961	**1,109,699**	**17,452,262**	**1572.7%**	**Change in Net Assets**	**24,787,512**	**10,225,931**	**14,561,581**	**142.4%**
91.0%	95.6%	4.6%		Medical Loss Ratio	96.1%	95.6%	(0.6%)	
4.3%	4.0%	(0.3%)		Administrative Loss Ratio	3.4%	4.1%	0.7%	
4.7%	0.3%	4.3%		Operating Margin Ratio	0.5%	0.3%	0.2%	
100.0%	100.0%			Total Operating	100.0%	100.0%		

Back to Agenda

Consolidated Performance Actual vs. Budget: April (in millions)

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
17.7	1.3	16.4	Medi-Cal	24.2	8.7	15.6
(0.3)	0.0	(0.3)	OneCare	0.2	0.2	(0.1)
(1.2)	(0.2)	(1.0)	OCC	(11.2)	2.1	(13.3)
(0.3)	(0.1)	(0.2)	PACE	0.1	(2.1)	2.2
15.9	**1.0**	**15.0**	**Operating**	**13.3**	**8.8**	**4.4**
2.6	0.1	2.5	Inv./Rental Inc, MCO tax	11.5	1.4	10.1
2.6	**0.1**	**2.5**	**Non-Operating**	**11.5**	**1.4**	**10.1**
18.6	**1.1**	**17.5**	**TOTAL**	**24.8**	**10.2**	**14.6**

Back to Agenda

Consolidated Revenue & Expense: April 2017 MTD

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare	OneCare Connect	PACE	Consolidated
Member Months	537,334	237,712	775,046	1,289	15,975	201	792,511
REVENUES							
Capitation Revenue	$ 194,173,102	$ 118,293,508	$ 312,466,610	$ 1,442,147	$ 25,811,365	$ 1,333,336	$ 341,053,457
Other Income	-	-	-	-	-	-	-
Total Operating Revenues	194,173,102	118,293,508	312,466,610	1,442,147	25,811,365	1,333,336	341,053,457
MEDICAL EXPENSES							
Provider Capitation	39,573,545	49,402,598	88,976,143	405,269	8,579,067	-	97,960,479
Facilities	24,015,581	21,649,188	45,664,769	719,839	2,515,576	574,710	49,474,895
Ancillary	-	-	-	24,483	997,618	-	1,022,101
Skilled Nursing	-	-	-	(15,391)	-	-	(15,391)
Professional Claims	8,732,685	8,403,227	17,135,912	-	-	293,775	17,429,687
Prescription Drugs	17,405,187	16,548,301	33,953,488	421,340	3,879,134	121,346	38,375,307
Long-term Care Facility Payments	80,657,545	12,246,754	92,904,299	-	8,342,926	1,133	101,248,358
Medical Management	2,688,600	-	2,688,600	26,386	876,175	386,177	3,977,337
Reinsurance & Other	(489,599)	988,556	498,957	4,331	163,020	158,452	824,760
Total Medical Expenses	172,583,543	109,238,626	281,822,168	1,586,257	25,353,515	1,535,593	310,297,534
Medical Loss Ratio	**88.9%**	**92.3%**	**90.2%**	**110.0%**	**98.2%**	**115.2%**	**91.0%**
GROSS MARGIN	**21,589,560**	**9,054,882**	**30,644,442**	**(144,110)**	**457,849**	**(202,257)**	**30,755,924**
ADMINISTRATIVE EXPENSES							
Salaries, Wages & Benefits			10,557,511	31,406	723,528	79,501	11,391,947
Professional fees			169,934	20,230	-	3,001	193,165
Purchased services			682,914	30,474	113,157	1,161	827,706
Printing and Postage			202,870	15,863	41,958	6,224	266,916
Depreciation and Amortization			350,328	-	-	2,069	352,398
Other expenses			1,351,239	280	40,334	8,919	1,400,771
Indirect cost allocation, Occupancy expense			(376,713)	25,447	728,917	2,388	380,038
Total Administrative Expenses			12,938,083	123,701	1,647,895	103,263	14,812,940
Admin Loss Ratio			**4.1%**	**8.6%**	**6.4%**	**7.7%**	**4.3%**
INCOME (LOSS) FROM OPERATIONS			17,706,359	(267,811)	(1,190,045)	(305,520)	15,942,983
INVESTMENT INCOME			-	-	-	-	2,608,722
NET RENTAL INCOME			-	-	-	-	3,386
NET GRANT INCOME			6,810	-	-	-	6,810
OTHER INCOME			60	-	-	-	60
CHANGE IN NET ASSETS			**$ 17,713,229**	**$ (267,811)**	**$ (1,190,045)**	**$ (305,520)**	**$ 18,561,961**
BUDGETED CHANGE IN ASSETS			1,317,895	27,611	(223,864)	(146,697)	1,109,699
VARIANCE TO BUDGET - FAV (UNFAV)			16,395,334	(295,422)	(966,181)	(158,823)	17,452,262

Back to Agenda

Consolidated Revenue & Expense: April 2017 YTD

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare	OneCare Connect	PACE	Consolidated
Member Months	5,445,736	2,333,910	7,779,646	12,402	170,732	1,857	7,964,637
REVENUES							
Capitation Revenue	$ 1,488,222,589	$ 1,064,713,090	$ 2,552,935,679	$ 14,324,813	$ 288,524,951	$ 12,674,255	$ 2,868,459,698
Other Income	-	-	-	-	0	-	-
Total Operating Revenues	1,488,222,589	1,064,713,090	2,552,935,679	14,324,813	288,524,951	12,674,255	2,868,459,698
MEDICAL EXPENSES							
Provider Capitation	352,387,600	436,930,152	789,317,752	4,006,437	75,683,513	-	869,007,702
Facilities	282,747,509	287,007,452	569,754,961	3,574,520	83,383,437	2,940,791	659,653,709
Ancillary	-	-	-	414,527	8,078,826	-	8,493,353
Skilled Nursing	-	-	-	497,355	-	-	497,355
Professional Claims	88,376,460	89,818,427	178,194,887	-	-	2,320,866	180,515,753
Prescription Drugs	181,425,307	167,252,771	348,678,078	4,447,710	49,763,345	948,816	403,837,949
Long-term Care Facility Payments	498,988,350	30,943,990	529,932,340	-	54,540,373	59,284	584,531,998
Medical Management	28,939,186	-	28,939,186	225,216	9,929,934	3,985,649	43,079,986
Reinsurance & Other	(4,771,999)	10,273,541	5,501,542	47,136	986,130	1,192,314	7,727,121
Total Medical Expenses	1,428,092,414	1,022,226,333	2,450,318,746	13,212,900	282,365,559	11,447,720	2,757,344,926
Medical Loss Ratio	**96.0%**	**96.0%**	**96.0%**	**92.2%**	**97.9%**	**90.3%**	**96.1%**
GROSS MARGIN	**60,130,176**	**42,486,757**	**102,616,933**	**1,111,913**	**6,159,392**	**1,226,536**	**111,114,773**
ADMINISTRATIVE EXPENSES							
Salaries, Wages & Benefits			58,021,188	210,942	7,877,959	926,285	67,036,375
Professional Fees			1,365,293	164,844	318,115	46,934	1,895,186
Purchased services			6,936,990	244,637	1,315,212	39,103	8,535,941
Printing and Postage			1,988,439	86,878	552,610	8,842	2,636,769
Depreciation and Amortization			3,309,031			20,534	3,329,565
Other expenses			10,301,826	2,351	379,719	87,994	10,771,890
Indirect cost allocation, Occupancy expense			(3,655,010)	241,818	6,926,765	23,489	3,537,062
Total Administrative Expenses			78,267,758	951,470	17,370,380	1,153,181	97,742,788
Admin Loss Ratio			**3.1%**	**6.6%**	**6.0%**	**9.1%**	**3.4%**
INCOME (LOSS) FROM OPERATIONS			24,349,175	160,443	(11,210,988)	73,355	13,371,985
INVESTMENT INCOME			-	-	-	-	11,469,653
NET RENTAL INCOME			-	-	-	-	50,456
NET GRANT INCOME			(105,854)	-	-	-	(105,854)
OTHER INCOME			1,273	-	-	-	1,273
CHANGE IN NET ASSETS			**$ 24,244,593**	**$ 160,443**	**$ (11,210,988)**	**$ 73,355**	**$ 24,787,512**
BUDGETED CHANGE IN ASSETS			8,657,564	230,470	2,067,698	(2,124,043)	10,225,931
VARIANCE TO BUDGET - FAV (UNFAV)			15,587,029	(70,027)	(13,278,686)	2,197,398	14,561,581

Back to Agenda

Balance Sheet:
As of April 2017

ASSETS

Current Assets		
	Operating Cash	$547,444,222
	Catastrophic Reserves	11,017,632
	Investments	1,314,931,506
	Capitation receivable	342,198,083
	Receivables - Other	19,379,894
	Prepaid Expenses	7,095,242
	Total Current Assets	**2,242,066,578**
Capital Assets	Furniture and equipment	35,790,228
	Leasehold improvements	6,666,887
	505 City Parkway West	49,271,389
		91,728,503
	Less: accumulated depreciation	(37,199,361)
	Capital assets, net	**54,529,142**
Other Assets	Restricted deposit & Other	300,000
	Board-designated assets	
	Cash and cash equivalents	17,955,981
	Long term investments	516,239,691
	Total Board-designated Assets	534,195,671
	Total Other Assets	**534,495,671**
	Deferred outflows of Resources - Pension Contributions	9,133,218
	Deferred outflows of Resources - Difference in Experience	1,215,473
TOTAL ASSETS & OUTFLOWS		**2,841,440,083**

LIABILITIES & FUND BALANCES

Current Liabilities		
	Accounts payable	$17,463,408
	Medical claims liability	686,407,295
	Accrued payroll liabilities	10,193,845
	Deferred revenue	860,105,383
	Deferred lease obligations	209,840
	Capitation and withholds	531,371,369
	Total Current Liabilities	**2,105,751,141**
Other employment benefits liability		30,021,563
Net Pension Liabilities		15,430,763
Long Term Liabilities		100,000
TOTAL LIABILITIES		**2,151,303,467**
Deferred inflows of Resources - Excess Earnings		4,130,286
Deferred inflows of Resources - changes in Assumptions		1,651,640
Tangible net equity (TNE)		96,640,187
Funds in excess of TNE		587,714,503
Net Assets		**684,354,690**
TOTAL LIABILITIES, INFLOWS & FUND BALANCES		**2,841,440,083**

Back to Agenda

Board Designated Reserve and TNE Analysis
As of April 2017

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	145,963,515				
	Tier 1 - Logan Circle	145,759,457				
	Tier 1 - Wells Capital	145,693,263				
Board-designated Reserve						
		437,416,235	311,979,635	487,102,416	125,436,600	(49,686,181)
TNE Requirement	Tier 2 - Logan Circle	96,779,437	96,640,187	96,640,187	139,250	139,250
	Consolidated:	**534,195,672**	**408,619,822**	**583,742,603**	**125,575,850**	**(49,546,931)**
	Current reserve level	*1.83*	*1.40*	*2.00*		

Back to Agenda

UNAUDITED FINANCIAL STATEMENTS

April 2017

Back to Agenda

Table of Contents

Financial Highlights ... 3
Financial Dashboard ... 4
Statement of Revenues and Expenses – Consolidated Month to Date ... 5
Statement of Revenues and Expenses – Consolidated Year to Date ... 6
Statement of Revenues and Expenses – Consolidated LOB Month to Date ... 7
Statement of Revenues and Expenses – Consolidated LOB Year to Date ... 8
Highlights – Overall ... 9
Enrollment Summary ... 10
Enrollment Trended by Network Type ... 11
Highlights – Enrollment ... 12
Statement of Revenues and Expenses – Medi-Cal ... 13
Highlights – Medi-Cal ... 14
Statement of Revenues and Expenses – OneCare Connect ... 15
Highlights – OneCare Connect ... 16
Statement of Revenues and Expenses – OneCare ... 17
Statement of Revenues and Expenses – PACE ... 18
Statement of Revenues and Expenses – Building: 505 City Parkway ... 19
Highlights – OneCare, PACE & 505 City Parkway ... 20
Balance Sheet ... 21
Investments ... 22
Statement of Cash Flows ... 23
Highlights – Balance Sheet & Statement of Cash Flow ... 24
Statement of Revenues and Expenses – CalOptima Foundation ... 25
Balance Sheet – CalOptima Foundation ... 26
Highlights – CalOptima Foundation ... 27
Budget Allocation Changes ... 28

Back to Agenda

CalOptima - Consolidated
Financial Highlights
For the Ten Months Ended April 30, 2017

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
792,511	808,451	(15,940)	(2.0%)	Member Months	7,964,637	8,034,905	(70,268)	(0.9%)
341,053,457	282,479,926	58,573,531	20.7%	Revenues	2,868,459,698	2,818,947,607	49,512,091	1.8%
310,297,534	270,136,155	(40,161,378)	(14.9%)	Medical Expenses	2,757,344,926	2,694,081,413	(63,263,513)	(2.3%)
14,812,940	11,368,826	(3,444,114)	(30.3%)	Administrative Expenses	97,742,788	116,034,506	18,291,718	15.8%
15,942,983	**974,945**	**14,968,038**	**1535.3%**	**Operating Margin**	**13,371,985**	**8,831,689**	**4,540,296**	**51.4%**
2,618,978	134,754	2,484,223	1843.5%	Non Operating Income (Loss)	11,415,527	1,394,242	10,021,285	718.8%
18,561,961	**1,109,699**	**17,452,262**	**1572.7%**	**Change in Net Assets**	**24,787,512**	**10,225,931**	**14,561,581**	**142.4%**
91.0%	95.6%	4.6%		Medical Loss Ratio	96.1%	95.6%	(0.6%)	
4.3%	4.0%	(0.3%)		Administrative Loss Ratio	3.4%	4.1%	0.7%	
4.7%	0.3%	4.3%		Operating Margin Ratio	0.5%	0.3%	0.2%	
100.0%	100.0%			Total Operating	100.0%	100.0%		

Back to Agenda

CalOptima
Financial Dashboard
For the Ten Months Ended April 30, 2017

MONTH - TO - DATE

Enrollment

	Actual	Budget		Fav / (Unfav)	
Medi-Cal	775,046	785,533	↓	(10,487)	(1.3%)
OneCare	1,289	1,144	↑	145	12.7%
OneCare Connect	15,975	21,564	↓	(5,589)	(25.9%)
PACE	201	210	↓	(9)	(4.3%)
Total	792,511	808,451	↓	(15,940)	(2.0%)

Change in Net Assets ($000)

	Actual	Budget		Fav / (Unfav)	
Medi-Cal	$ 17,713	$ 1,318	↑	$ 16,395	1244.1%
OneCare	(268)	28	↓	(295)	(1069.9%)
OneCare Connect	(1,190)	(224)	↓	(966)	(431.6%)
PACE	(306)	(147)	↓	(159)	(108.3%)
505 Bldg.	3	(74)	↑	77	104.6%
Investment Income & Other	2,609	208	↑	2,400	1152.2%
Total	$ 18,562	$ 1,110	↑	$ 17,452	1572.7%

MLR

	Actual	Budget		% Point Var
Medi-Cal	90.2%	95.7%	↑	5.5
OneCare	110.0%	90.3%	↓	(19.7)
OneCare Connect	98.2%	95.2%	↓	(3.0)

Administrative Cost ($000)

	Actual	Budget		Fav / (Unfav)	
Medi-Cal	$ 12,938	$ 8,863	↓	$ (4,075)	(46.0%)
OneCare	124	101	↓	(23)	(22.3%)
OneCare Connect	1,648	2,283	↑	635	27.8%
PACE	103	122	↑	19	15.7%
Total	$ 14,813	$ 11,369	↓	$ (3,444)	(30.3%)

Total FTE's Month

	Actual	Budget	Fav / (Unfav)
Medi-Cal	859	886	27
OneCare	4	3	(1)
OneCare Connect	231	239	7
PACE	46	59	12
Total	1,140	1,186	46

MM per FTE

	Actual	Budget	Fav / (Unfav)
Medi-Cal	902	887	16
OneCare	322	381	(59)
OneCare Connect	69	90	(21)
PACE	4	4	1
Total	1,298	1,362	(64)

YEAR - TO - DATE

Year To Date Enrollment

	Actual	Budget		Fav / (Unfav)	
Medi-Cal	7,779,646	7,802,088	↓	(22,442)	(0.3%)
OneCare	12,402	11,973	↑	429	3.6%
OneCare Connect	170,732	218,969	↓	(48,237)	(22.0%)
PACE	1,857	1,875	↓	(18)	(1.0%)
Total	7,964,637	8,034,905	↓	(70,268)	(0.9%)

Change in Net Assets ($000)

	Actual	Budget		Fav / (Unfav)	
Medi-Cal	$ 24,245	$ 8,658	↑	$ 15,587	180.0%
OneCare	160	230	↓	(70)	(30.4%)
OneCare Connect	(11,211)	2,068	↓	(13,279)	(642.2%)
PACE	73	(2,124)	↑	2,197	103.5%
505 Bldg.	50	(689)	↑	740	107.3%
Investment Income & Other	11,470	2,083	↑	9,386	450.5%
Total	$ 24,788	$ 10,226	↑	$ 14,562	142.4%

MLR

	Actual	Budget		% Point Var
Medi-Cal	96.0%	95.8%	↓	(0.2)
OneCare	92.2%	90.7%	↓	(1.5)
OneCare Connect	97.9%	94.3%	↓	(3.6)

Administrative Cost ($000)

	Actual	Budget		Fav / (Unfav)	
Medi-Cal	$ 78,268	$ 90,401	↑	$ 12,133	13.4%
OneCare	951	1,050	↑	98	9.4%
OneCare Connect	17,370	23,384	↑	6,014	25.7%
PACE	1,153	1,199	↑	46	3.9%
Total	$ 97,743	$ 116,035	↑	$ 18,292	15.8%

Total FTE's YTD

	Actual	Budget	Fav / (Unfav)
Medi-Cal	8,448	8,859	411
OneCare	37	30	(7)
OneCare Connect	2,269	2,386	117
PACE	424	573	149
Total	11,056	11,848	792

MM per FTE

	Actual	Budget	Fav / (Unfav)
Medi-Cal	921	881	40
OneCare	332	399	(67)
OneCare Connect	75	92	(17)
PACE	4	3	1
Total	1,332	1,375	(42)

Back to Agenda

CalOptima - Consolidated
Statement of Revenue and Expenses
For the One Month Ended April 30, 2017

	Actual $	Actual PMPM*	Month Budget $	Month Budget PMPM*	Variance $	Variance PMPM
Member Months**	792,511		808,451		(15,940)	
Revenues						
Medi-Cal	$ 312,466,610	$ 403.16	$ 236,517,116	$ 301.09	$ 75,949,494	$ 102.07
OneCare	1,442,147	1,118.81	1,331,452	1,163.86	110,695	(45.05)
OneCare Connect	25,811,365	1,615.73	43,315,304	2,008.69	(17,503,939)	(392.95)
PACE	1,333,336	6,633.51	1,316,054	6,266.92	17,282	366.59
Total Operating Revenue	341,053,457	430.35	282,479,926	349.41	58,573,531	80.94
Medical Expenses						
Medi-Cal	281,822,168	363.62	226,336,604	288.13	(55,485,564)	(75.49)
OneCare	1,586,257	1,230.61	1,202,661	1,051.28	(383,596)	(179.33)
OneCare Connect	25,353,515	1,587.07	41,256,568	1,913.21	15,903,052	326.14
PACE	1,535,593	7,639.77	1,340,322	6,382.49	(195,271)	(1,257.28)
Total Medical Expenses	310,297,534	391.54	270,136,155	334.14	(40,161,378)	(57.40)
Gross Margin	30,755,924	38.81	12,343,771	15.27	18,412,153	23.54
Administrative Expenses						
Salaries and Benefits	11,391,947	14.37	7,502,146	9.28	(3,889,801)	(5.09)
Professional fees	193,165	0.24	445,419	0.55	252,254	0.31
Purchased services	827,706	1.04	1,031,208	1.28	203,502	0.23
Printing and Postage	266,916	0.34	475,347	0.59	208,431	0.25
Depreciation and Amortization	352,398	0.44	385,117	0.48	32,720	0.03
Other	1,400,771	1.77	1,102,284	1.36	(298,487)	(0.40)
Indirect cost allocation, Occupancy expense	380,038	0.48	427,305	0.53	47,267	0.05
Total Administrative Expenses	14,812,940	18.69	11,368,826	14.06	(3,444,114)	(4.63)
Income (Loss) From Operations	15,942,983	20.12	974,945	1.21	14,968,038	18.91
Investment income						
Interest income	2,033,635	2.57	208,333	0.26	1,825,302	2.31
Realized gain/(loss) on investments	(162,339)	(0.20)	-	-	(162,339)	(0.20)
Unrealized gain/(loss) on investments	737,426	0.93	-	-	737,426	0.93
Total Investment Income	2,608,722	3.29	208,333	0.26	2,400,388	3.03
Net Rental Income	3,386	0.00	(73,579)	(0.09)	76,965	0.10
Total Net Grant Income	6,810	0.01	-	-	6,810	0.01
Other Income	60	0.00	-	-	60	0.00
Change In Net Assets	**18,561,961**	**23.42**	**1,109,699**	**1.37**	**17,452,262**	**22.05**
Medical Loss Ratio	**91.0%**		**95.6%**		**4.6%**	
Administrative Loss Ratio	**4.3%**		**4.0%**		**(0.3%)**	

* PMPMs for Revenues and Medical Expenses are calculated using line of business enrollment

** Includes MSSP

Back to Agenda

CalOptima - Consolidated - Year to Date
Statement of Revenue and Expenses
For the Ten Months Ended April 30, 2017

	Actual		Year to Date Budget		Variance	
	$	PMPM*	$	PMPM*	$	PMPM
Member Months**	7,964,637		8,034,905		(70,268)	
Revenues						
Medi-Cal	$ 2,552,935,679	$ 328.16	$ 2,346,493,401	$ 300.75	$ 206,442,279	$ 27.40
OneCare	14,324,813	1,155.04	13,814,179	1,153.78	510,634	1.26
OneCare Connect	288,524,951	1,689.93	446,823,461	2,040.58	(158,298,510)	(350.65)
PACE	12,674,255	6,825.12	11,816,567	6,302.17	857,689	522.96
Total Operating Revenue	2,868,459,698	360.15	2,818,947,607	350.84	49,512,091	9.31
Medical Expenses						
Medi-Cal	2,450,318,746	314.97	2,247,435,125	288.06	(202,883,621)	(26.91)
OneCare	13,212,900	1,065.38	12,533,814	1,046.84	(679,086)	(18.54)
OneCare Connect	282,365,559	1,653.85	421,371,292	1,924.34	139,005,733	270.49
PACE	11,447,720	6,164.63	12,741,182	6,795.30	1,293,462	630.67
Total Medical Expenses	2,757,344,926	346.20	2,694,081,413	335.30	(63,263,513)	(10.90)
Gross Margin	111,114,773	13.95	124,866,195	15.54	(13,751,422)	(1.59)
Administrative Expenses						
Salaries and Benefits	67,036,375	8.42	77,722,275	9.67	10,685,900	1.26
Professional fees	1,895,186	0.24	4,189,686	0.52	2,294,500	0.28
Purchased services	8,535,941	1.07	9,737,096	1.21	1,201,155	0.14
Printing and Postage	2,636,769	0.33	4,672,662	0.58	2,035,893	0.25
Depreciation and Amortization	3,329,565	0.42	3,851,172	0.48	521,608	0.06
Other	10,771,890	1.35	11,583,717	1.44	811,827	0.09
Indirect cost allocation, Occupancy expense	3,537,062	0.44	4,277,898	0.53	740,836	0.09
Total Administrative Expenses	97,742,788	12.27	116,034,506	14.44	18,291,718	2.17
Income (Loss) From Operations	13,371,985	1.68	8,831,689	1.10	4,540,296	0.58
Investment income						
Interest income	15,687,298	1.97	2,083,334	0.26	13,603,964	1.71
Realized gain/(loss) on investments	(188,262)	(0.02)	-	-	(188,262)	(0.02)
Unrealized gain/(loss) on investments	(4,029,382)	(0.51)	-	-	(4,029,382)	(0.51)
Total Investment Income	11,469,653	1.44	2,083,334	0.26	9,386,319	1.18
Net Rental Income	50,456	0.01	(689,092)	(0.09)	739,548	0.09
Total Net Grant Income	(105,854)	(0)	-	-	(105,854)	(0)
Other Income	1,273	0.00	-	-	1,273	0.00
Change In Net Assets	**24,787,512**	**3.11**	**10,225,931**	**1.27**	**14,561,581**	**1.84**
Medical Loss Ratio	**96.1%**		**95.6%**		**(0.6%)**	
Administrative Loss Ratio	**3.4%**		**4.1%**		**0.7%**	

* PMPMs for Revenues and Medical Expenses are calculated using line of business enrollment

** Includes MSSP

Back to Agenda

CalOptima - Consolidated - Month to Date
Statement of Revenues and Expenses by LOB
For the One Month Ended April 30, 2017

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare	OneCare Connect	PACE	Consolidated
Member Months	537,334	237,712	775,046	1,289	15,975	201	792,511
REVENUES							
Capitation Revenue	$ 194,173,102	$ 118,293,508	$ 312,466,610	$ 1,442,147	$ 25,811,365	$ 1,333,336	$ 341,053,457
Other Income	-	-	-	-	-	-	-
Total Operating Revenues	194,173,102	118,293,508	312,466,610	1,442,147	25,811,365	1,333,336	341,053,457
MEDICAL EXPENSES							
Provider Capitation	39,573,545	49,402,598	88,976,143	405,269	8,579,067	-	97,960,479
Facilities	24,015,581	21,649,188	45,664,769	719,839	2,515,576	574,710	49,474,895
Ancillary	-	-	-	24,483	997,618	-	1,022,101
Skilled Nursing	-	-	-	(15,391)	-	-	(15,391)
Professional Claims	8,732,685	8,403,227	17,135,912	-	-	293,775	17,429,687
Prescription Drugs	17,405,187	16,548,301	33,953,488	421,340	3,879,134	121,346	38,375,307
Long-term Care Facility Payments	80,657,545	12,246,754	92,904,299	-	8,342,926	1,133	101,248,358
Medical Management	2,688,600	-	2,688,600	26,386	876,175	386,177	3,977,337
Reinsurance & Other	(489,599)	988,556	498,957	4,331	163,020	158,452	824,760
Total Medical Expenses	172,583,543	109,238,626	281,822,168	1,586,257	25,353,515	1,535,593	310,297,534
Medical Loss Ratio	**88.9%**	**92.3%**	**90.2%**	**110.0%**	**98.2%**	**115.2%**	**91.0%**
GROSS MARGIN	**21,589,560**	**9,054,882**	**30,644,442**	**(144,110)**	**457,849**	**(202,257)**	**30,755,924**
ADMINISTRATIVE EXPENSES							
Salaries, Wages & Benefits			10,557,511	31,406	723,528	79,501	11,391,947
Professional fees			169,934	20,230	-	3,001	193,165
Purchased services			682,914	30,474	113,157	1,161	827,706
Printing and Postage			202,870	15,863	41,958	6,224	266,916
Depreciation and Amortization			350,328	-	-	2,069	352,398
Other expenses			1,351,239	280	40,334	8,919	1,400,771
Indirect cost allocation, Occupancy expense			(376,713)	25,447	728,917	2,388	380,038
Total Administrative Expenses			12,938,083	123,701	1,647,895	103,263	14,812,940
Admin Loss Ratio			**4.1%**	**8.6%**	**6.4%**	**7.7%**	**4.3%**
INCOME (LOSS) FROM OPERATIONS			17,706,359	(267,811)	(1,190,045)	(305,520)	15,942,983
INVESTMENT INCOME			-	-	-	-	2,608,722
NET RENTAL INCOME			-	-	-	-	3,386
NET GRANT INCOME			6,810	-	-	-	6,810
OTHER INCOME			60	-	-	-	60
CHANGE IN NET ASSETS			**$ 17,713,229**	**$ (267,811)**	**$ (1,190,045)**	**$ (305,520)**	**$ 18,561,961**
BUDGETED CHANGE IN ASSETS			1,317,895	27,611	(223,864)	(146,697)	1,109,699
VARIANCE TO BUDGET - FAV (UNFAV)			16,395,334	(295,422)	(966,181)	(158,823)	17,452,262

Back to Agenda

CalOptima - Consolidated - Year to Date
Statement of Revenues and Expenses by LOB
For the Ten Months Ended April 30, 2017

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare	OneCare Connect	PACE	Consolidated
Member Months	5,445,736	2,333,910	7,779,646	12,402	170,732	1,857	7,964,637
REVENUES							
Capitation Revenue	$ 1,488,222,589	$ 1,064,713,090	$ 2,552,935,679	$ 14,324,813	$ 288,524,951	$ 12,674,255	$ 2,868,459,698
Other Income	-	-	-	-	0	-	-
Total Operating Revenues	1,488,222,589	1,064,713,090	2,552,935,679	14,324,813	288,524,951	12,674,255	2,868,459,698
MEDICAL EXPENSES							
Provider Capitation	352,387,600	436,930,152	789,317,752	4,006,437	75,683,513	-	869,007,702
Facilities	282,747,509	287,007,452	569,754,961	3,574,520	83,383,437	2,940,791	659,653,709
Ancillary	-	-	-	414,527	8,078,826	-	8,493,353
Skilled Nursing	-	-	-	497,355	-	-	497,355
Professional Claims	88,376,460	89,818,427	178,194,887	-	-	2,320,866	180,515,753
Prescription Drugs	181,425,307	167,252,771	348,678,078	4,447,710	49,763,345	948,816	403,837,949
Long-term Care Facility Payments	498,988,350	30,943,990	529,932,340	-	54,540,373	59,284	584,531,998
Medical Management	28,939,186	-	28,939,186	225,216	9,929,934	3,985,649	43,079,986
Reinsurance & Other	(4,771,999)	10,273,541	5,501,542	47,136	986,130	1,192,314	7,727,121
Total Medical Expenses	1,428,092,414	1,022,226,333	2,450,318,746	13,212,900	282,365,559	11,447,720	2,757,344,926
Medical Loss Ratio	**96.0%**	**96.0%**	**96.0%**	**92.2%**	**97.9%**	**90.3%**	**96.1%**
GROSS MARGIN	**60,130,176**	**42,486,757**	**102,616,933**	**1,111,913**	**6,159,392**	**1,226,536**	**111,114,773**
ADMINISTRATIVE EXPENSES							
Salaries, Wages & Benefits			58,021,188	210,942	7,877,959	926,285	67,036,375
Professional Fees			1,365,293	164,844	318,115	46,934	1,895,186
Purchased services			6,936,990	244,637	1,315,212	39,103	8,535,941
Printing and Postage			1,988,439	86,878	552,610	8,842	2,636,769
Depreciation and Amortization			3,309,031			20,534	3,329,565
Other expenses			10,301,826	2,351	379,719	87,994	10,771,890
Indirect cost allocation, Occupancy expense			(3,655,010)	241,818	6,926,765	23,489	3,537,062
Total Administrative Expenses			78,267,758	951,470	17,370,380	1,153,181	97,742,788
Admin Loss Ratio			**3.1%**	**6.6%**	**6.0%**	**9.1%**	**3.4%**
INCOME (LOSS) FROM OPERATIONS			24,349,175	160,443	(11,210,988)	73,355	13,371,985
INVESTMENT INCOME			-	-	-	-	11,469,653
NET RENTAL INCOME			-	-	-	-	50,456
NET GRANT INCOME			(105,854)	-	-	-	(105,854)
OTHER INCOME			1,273	-	-	-	1,273
CHANGE IN NET ASSETS			**$ 24,244,593**	**$ 160,443**	**$ (11,210,988)**	**$ 73,355**	**$ 24,787,512**
BUDGETED CHANGE IN ASSETS			8,657,564	230,470	2,067,698	(2,124,043)	10,225,931
VARIANCE TO BUDGET - FAV (UNFAV)			15,587,029	(70,027)	(13,278,686)	2,197,398	14,561,581

Back to Agenda

April 30, 2017 Unaudited Financial Statements

SUMMARY

MONTHLY RESULTS:

- Change in Net Assets is $18.6 million, $17.5 million favorable to budget
- Operating surplus is $15.9 million with a surplus in non-operating of $2.6 million

YEARLY RESULTS:

- Change in Net Assets is $24.8 million, $14.6 million favorable to budget
- Operating surplus is $13.4 million with a surplus in non-operating of $11.4 million

Change in Net Assets by LOB ($millions)

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
17.7	1.3	16.4	Medi-Cal	24.2	8.7	15.6
(0.3)	0.0	(0.3)	OneCare	0.2	0.2	(0.1)
(1.2)	(0.2)	(1.0)	OCC	(11.2)	2.1	(13.3)
(0.3)	(0.1)	(0.2)	PACE	0.1	(2.1)	2.2
15.9	**1.0**	**15.0**	**Operating**	**13.4**	**8.8**	**4.4**
2.6	0.1	2.5	Inv./Rental Inc, MCO tax	11.4	1.4	10.1
2.6	**0.1**	**2.5**	**Non-Operating**	**11.4**	**1.4**	**10.1**
18.6	**1.1**	**17.5**	**TOTAL**	**24.8**	**10.2**	**14.6**

Back to Agenda

CalOptima

Enrollment Summary

For the Ten Months Ended April 30, 2017

Month-to-Date					Year-to-Date			
Actual	**Budget**	**Variance**	**%**	**Enrollment (By Aid Category)**	**Actual**	**Budget**	**Variance**	**%**
60,525	56,180	4,345	7.7%	Aged	588,704	554,720	33,984	6.1%
622	680	(58)	(8.5%)	BCCTP	6,214	6,774	(560)	(8.3%)
48,504	47,268	1,236	2.6%	Disabled	485,802	474,022	11,780	2.5%
326,989	344,780	(17,791)	(5.2%)	TANF Child	3,322,519	3,413,444	(90,925)	(2.7%)
97,358	108,552	(11,194)	(10.3%)	TANF Adult	1,009,811	1,092,690	(82,879)	(7.6%)
3,336	2,743	593	21.6%	LTC	32,686	27,059	5,627	20.8%
237,712	225,330	12,382	5.5%	MCE	2,333,910	2,233,378	100,532	4.5%
775,046	**785,533**	**(10,487)**	**(1.3%)**	**Medi-Cal**	**7,779,646**	**7,802,088**	**(22,442)**	**(0.3%)**
15,975	**21,564**	**(5,589)**	**(25.9%)**	**OneCare Connect**	**170,732**	**218,969**	**(48,237)**	**(22.0%)**
201	**210**	**(9)**	**(4.3%)**	**PACE**	**1,857**	**1,875**	**(18)**	**(1.0%)**
1,289	**1,144**	**145**	**12.7%**	**OneCare**	**12,402**	**11,973**	**429**	**3.6%**
792,511	**808,451**	**(15,940)**	**(2.0%)**	**CalOptima Total**	**7,964,637**	**8,034,905**	**(70,268)**	**(0.9%)**

Actual	Budget	Variance	%	Enrollment (By Network)	Actual	Budget	Variance	%
136,339	50,042	86,297	172.4%	HMO	751,131	483,449	267,682	55.4%
221,705	236,830	(15,125)	(6.4%)	PHC	2,279,472	2,351,857	(72,385)	(3.1%)
238,775	340,064	(101,289)	(29.8%)	Shared Risk Group	3,106,526	3,404,618	(298,092)	(8.8%)
178,227	158,597	19,630	12.4%	Fee for Service	1,642,517	1,562,172	80,345	5.1%
775,046	**785,533**	**(10,487)**	**(1.3%)**	**Medi-Cal**	**7,779,646**	**7,802,088**	**(22,442)**	**(0.3%)**
15,975	**21,564**	**(5,589)**	**(25.9%)**	**OneCare Connect**	**170,732**	**218,969**	**(48,237)**	**(22.0%)**
201	**210**	**(9)**	**(4.3%)**	**PACE**	**1,857**	**1,875**	**(18)**	**(1.0%)**
1,289	**1,144**	**145**	**12.7%**	**OneCare**	**12,402**	**11,973**	**429**	**3.6%**
792,511	**808,451**	**(15,940)**	**(2.0%)**	**CalOptima Total**	**7,964,637**	**8,034,905**	**(70,268)**	**(0.9%)**

Back to Agenda

CalOptima
Enrollment Trend by Network Type
Fiscal Year 2017

Network Type	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	MMs
HMO													
Aged	351	350	355	368	363	381	379	3,103	3,062	3,050	-	-	11,762
BCCTP	1	1	1	(8)	2	1	1	1	1	1	-	-	2
Disabled	1,799	1,797	1,813	1,866	1,853	1,858	1,875	5,780	5,752	5,697	-	-	30,090
TANF Child	24,211	24,455	24,733	24,928	24,987	25,083	24,928	53,811	53,432	52,933	-	-	333,501
TANF Adult	7,929	7,872	7,914	7,850	8,029	7,967	7,871	25,446	25,155	24,830	-	-	130,863
LTC	-	-	-	-	-	-	-	3	4	3	-	-	10
MCE	12,989	13,224	13,464	14,034	13,897	14,116	14,200	49,527	49,627	49,825	-	-	244,903
	47,280	47,699	48,280	49,038	49,131	49,406	49,254	137,671	137,033	136,339	-	-	751,131
PHC													
Aged	1,495	1,464	1,488	1,458	1,427	1,419	1,408	1,439	1,420	1,416	-	-	14,434
BCCTP	-	-	-	1	-	-	-	-	-	-	-	-	1
Disabled	7,903	7,872	7,862	7,865	7,804	7,779	7,783	7,751	7,741	7,647	-	-	78,007
TANF Child	169,358	168,529	169,733	169,714	168,615	168,294	165,979	164,330	163,343	162,600	-	-	1,670,495
TANF Adult	15,260	14,945	14,649	14,593	14,161	13,880	13,457	13,195	13,019	12,782	-	-	139,941
LTC	-	-	-	4	-	-	-	-	-	-	-	-	4
MCE	38,002	38,200	37,601	38,070	37,874	37,886	37,361	37,214	37,122	37,260	-	-	376,590
	232,018	231,010	231,333	231,705	229,881	229,258	225,988	223,929	222,645	221,705	-	-	2,279,472
Shared Risk Group													
Aged	7,658	7,627	7,635	7,726	7,528	7,546	7,501	4,834	4,813	4,800	-	-	67,668
BCCTP	-	-	-	8	1	-	-	-	-	-	-	-	9
Disabled	14,428	14,307	14,189	14,253	14,073	14,084	14,005	10,083	10,022	9,861	-	-	129,305
TANF Child	118,748	118,149	118,421	117,922	116,971	116,744	114,746	84,105	83,246	82,334	-	-	1,071,386
TANF Adult	63,849	62,814	62,579	62,266	61,355	60,893	59,355	40,848	40,247	39,602	-	-	553,808
LTC	-	-	-	3	3	3	5	3	5	5	-	-	27
MCE	140,640	140,811	137,172	139,776	139,565	140,094	138,165	103,233	102,694	102,173	-	-	1,284,323
	345,323	343,708	339,996	341,954	339,496	339,364	333,777	243,106	241,027	238,775	-	-	3,106,526
Fee for Service (Dual)													
Aged	43,684	45,173	45,173	45,522	46,007	46,233	46,592	46,682	46,856	47,201	-	-	459,123
BCCTP	27	26	24	23	23	23	25	27	27	28	-	-	253
Disabled	19,790	20,086	20,071	20,264	20,375	20,497	20,471	20,510	20,662	20,528	-	-	203,254
TANF Child	3	2	2	3	4	3	3	2	2	3	-	-	27
TANF Adult	1,179	1,162	1,184	1,197	1,181	1,216	1,220	1,200	1,211	1,217	-	-	11,967
LTC	2,868	2,910	2,941	2,906	2,940	2,914	2,914	2,913	2,887	2,963	-	-	29,156
MCE	2,960	2,975	2,721	2,750	2,822	2,893	2,818	2,842	2,852	2,789	-	-	28,422
	70,511	72,334	72,116	72,665	73,352	73,779	74,043	74,176	74,497	74,729	-	-	732,202
Fee for Service (Non-Dual)													
Aged	3,746	2,850	3,183	3,608	3,450	3,667	3,600	3,761	3,794	4,058	-	-	35,717
BCCTP	606	608	598	589	594	595	587	590	589	593	-	-	5,949
Disabled	4,533	4,269	4,390	4,368	4,488	4,548	4,567	4,569	4,643	4,771	-	-	45,146
TANF Child	22,710	23,011	22,504	23,069	23,658	23,949	25,193	25,695	28,202	29,119	-	-	247,110
TANF Adult	15,792	16,253	16,501	17,109	17,090	17,340	17,949	17,668	18,603	18,927	-	-	173,232
LTC	368	370	362	314	334	328	357	338	353	365	-	-	3,489
MCE	35,946	36,543	37,812	36,999	38,607	39,499	42,203	41,903	44,495	45,665	-	-	399,672
	83,701	83,904	85,350	86,056	88,221	89,926	94,456	94,524	100,679	103,498	-	-	910,315
MEDI-CAL TOTAL													
Aged	56,934	57,464	57,834	58,682	58,775	59,246	59,480	59,819	59,945	60,525	-	-	588,704
BCCTP	634	635	623	613	620	619	613	618	617	622	-	-	6,214
Disabled	48,453	48,331	48,325	48,616	48,593	48,766	48,701	48,693	48,820	48,504	-	-	485,802
TANF Child	335,030	334,146	335,393	335,636	334,235	334,073	330,849	327,943	328,225	326,989	-	-	3,322,519
TANF Adult	104,009	103,046	102,827	103,015	101,816	101,296	99,852	98,357	98,235	97,358	-	-	1,009,811
LTC	3,236	3,280	3,303	3,227	3,277	3,245	3,276	3,257	3,249	3,336	-	-	32,686
MCE	230,537	231,753	228,770	231,629	232,765	234,488	234,747	234,719	236,790	237,712	-	-	2,333,910
	778,833	778,655	777,075	781,418	780,081	781,733	777,518	773,406	775,881	775,046	-	-	7,779,646
PACE	177	179	179	180	183	183	184	194	197	201	-	-	1,857
OneCare	1,171	1,164	1,192	1,220	1,228	1,275	1,304	1,281	1,278	1,289	-	-	12,402
OneCare Connect	18,902	18,245	17,727	17,352	17,067	16,810	16,346	16,222	16,086	15,975	-	-	170,732
TOTAL	799,083	798,243	796,173	800,170	798,559	800,001	795,352	791,103	793,442	792,511	-	-	7,964,637

Back to Agenda

ENROLLMENT:

Overall MTD enrollment was 792,511

- Unfavorable to budget by 15,940
- Decreased 931 or 0.1% from prior month
- Increased 3,358 or 0.4% from prior year (April 2016)

Medi-Cal enrollment was 775,046

- Unfavorable to budget by 10,487
    - Expansion favorable by 12,382
    - SPD favorable by 5,523
    - LTC favorable by 593
    - TANF unfavorable by 28,985
- Decreased 835 from prior month

OneCare Connect enrollment was 15,975

- Unfavorable to budget by 5,589
- Decreased 111 from prior month

OneCare enrollment was 1,289

- Favorable to budget by 145
- Increased 11 from prior month

PACE enrollment at 201

- Unfavorable to budget by 9
- Increased 4 from prior month

Back to Agenda

CalOptima - Medi-Cal Total
Statement of Revenues and Expenses
For the Ten Months Ended April 30, 2017

Month Actual	Month Budget	Month $ Variance	Month % Variance		YTD Actual	YTD Budget	YTD $ Variance	YTD % Variance
775,046	785,533	(10,487)	(1.3%)	Member Months	7,779,646	7,802,088	(22,442)	(0.3%)
				Revenues				
312,466,610	236,517,116	75,949,494	32.1%	Capitation revenue	2,552,935,679	2,346,493,401	206,442,279	8.8%
312,466,610	236,517,116	75,949,494	32.1%	Total Operating Revenues	2,552,935,679	2,346,493,401	206,442,279	8.8%
				Medical Expenses				
88,976,143	75,677,350	(13,298,793)	(17.6%)	Provider capitation	789,317,752	751,841,497	(37,476,255)	(5.0%)
45,664,769	56,892,976	11,228,207	19.7%	Facilities	569,754,961	564,784,650	(4,970,311)	(0.9%)
17,135,912	18,000,004	864,091	4.8%	Professional Claims	178,194,887	173,362,302	(4,832,585)	(2.8%)
33,953,488	34,315,254	361,766	1.1%	Prescription drugs	348,678,078	342,396,464	(6,281,615)	(1.8%)
92,904,299	36,943,039	(55,961,260)	(151.5%)	MLTSS	529,932,340	370,118,453	(159,813,888)	(43.2%)
2,688,600	4,491,316	1,802,716	40.1%	Medical Management	28,939,186	44,765,094	15,825,907	35.4%
498,957	16,667	(482,290)	(2,893.7%)	Reinsurance & other	5,501,542	166,667	(5,334,875)	(3,200.9%)
281,822,168	226,336,604	(55,485,564)	(24.5%)	Total Medical Expenses	2,450,318,746	2,247,435,125	(202,883,621)	(9.0%)
30,644,442	10,180,512	20,463,930	201.0%	Gross Margin	102,616,933	99,058,275	3,558,657	3.6%
				Administrative Expenses				
10,557,511	6,464,988	(4,092,523)	(63.3%)	Salaries, wages & employee benefits	58,021,188	67,082,195	9,061,007	13.5%
169,934	329,612	159,678	48.4%	Professional fees	1,365,293	3,157,653	1,792,360	56.8%
682,914	829,632	146,718	17.7%	Purchased services	6,936,990	7,676,108	739,117	9.6%
202,870	311,516	108,646	34.9%	Printing and postage	1,988,439	3,123,010	1,134,571	36.3%
350,328	383,061	32,733	8.5%	Depreciation & amortization	3,309,031	3,830,611	521,580	13.6%
1,351,239	1,084,510	(266,728)	(24.6%)	Other operating expenses	10,301,826	10,933,306	631,480	5.8%
(376,713)	(540,702)	(163,989)	(30.3%)	Indirect cost allocation	(3,655,010)	(5,402,172)	(1,747,162)	(32.3%)
12,938,083	8,862,617	(4,075,466)	(46.0%)	Total Administrative Expenses	78,267,758	90,400,711	12,132,954	13.4%
				Operating Tax				
13,679,400	8,896,807	(4,782,593)	(53.8%)	Tax Revenue	117,860,327	88,432,728	(29,427,599)	(33.3%)
10,191,105	0	(10,191,105)	0.0%	Premium tax expense	102,290,273	0	(102,290,273)	0.0%
3,488,295	8,896,807	5,408,513	60.8%	Sales tax expense	15,570,054	88,432,728	72,862,674	82.4%
0	0	0	0.0%	Total Net Operating Tax	0	0	0	0.0%
				Grant Income				
96,463	287,500	(191,038)	(66.4%)	Grant Revenue	550,213	2,875,000	(2,324,788)	(80.9%)
63,750	250,000	186,250	74.5%	Grant expense - Service Partner	449,438	2,500,000	2,050,563	82.0%
25,903	37,500	11,597	30.9%	Grant expense - Administrative	206,629	375,000	168,371	44.9%
6,810	0	6,810	0.0%	Total Net Grant Income	(105,854)	0	(105,854)	0.0%
60	0	60	0.0%	Other income	1,273	0	1,273	0.0%
17,713,229	1,317,895	16,395,334	1,244.1%	Change in Net Assets	24,244,594	8,657,564	15,587,030	180.0%
90.2%	95.7%	5.5%	5.8%	Medical Loss Ratio	96.0%	95.8%	(0.2%)	(0.2%)
4.1%	3.7%	(0.4%)	(10.5%)	Admin Loss Ratio	3.1%	3.9%	0.8%	20.4%

Back to Agenda

MEDI-CAL INCOME STATEMENT – APRIL MONTH:

REVENUES of $312.5 million are favorable to budget by $75.9 million, driven by:

- Price related favorable variance of $79.1 million due to:
  - $23.1 million of fiscal year 2016 Coordinated Care Initiative (CCI) revenue for non-IHSS members
  - $34.5 million of fiscal year 2016 CCI revenue for IHSS members
  - $8.3 million of LTC revenue for non-LTC members
  - $4.2 million for April 2017 IHSS revenue
  - Remaining from member mix

- Volume related unfavorable variance of: $3.2 million

MEDICAL EXPENSES: Overall $281.8 million, unfavorable to budget by $55.5 million due to:

- **Long term care claim payments (MLTSS)** are unfavorable to budget $56.0 million due to:

  - LTC unfavorable variance of $6.6 million driven by higher LTC claim expense due to less than anticipated members enrolling in OneCare Connect

  - IHSS related unfavorable variance of approximately $49.4 million due to true-up to county IHSS expense data for fiscal year 2016 corresponding to the favorable revenue variance above

- **Provider Capitation** is unfavorable to budget $13.3 million due to approximately $12.7 million unfavorable variance due to shared risk group move to HMO model beginning February for overall monthly increase of capitation of $12.7 million

- **Facilities** expenses are favorable to budget $11.2 million due to:

  - Favorable variance due to shared risk group move to HMO model beginning February
  - Favorable variance of $2.7 million for current month claim estimate adjustment relating to prior periods for the HMO move

ADMINISTRATIVE EXPENSES are $12.9 million, unfavorable to budget $4.1 million, driven by:

- Salary & Benefits: $4.1 million unfavorable to budget due to annual GASB 68 requirement and adjustments for this year's CalPERS actuarial report ($5.5 million), offset by open positions

- Non-Salary: In line with budget

CHANGE IN NET ASSETS is $17.7 million for the month, favorable to budget by $16.4 million

Back to Agenda

CalOptima - OneCare Connect
Statement of Revenues and Expenses
For the Ten Months Ended April 30, 2017

Month Actual	Month Budget	Month $ Variance	Month % Variance		YTD Actual	YTD Budget	YTD $ Variance	YTD % Variance
15,975	21,564	(5,589)	(25.9%)	Member Months	170,732	218,969	(48,237)	(22.0%)
				Revenues				
7,097,633	11,431,588	(4,333,955)	(37.9%)	Medi-Cal Capitation revenue	66,205,853	118,302,214	(52,096,361)	(44.0%)
18,713,732	31,883,716	(13,169,984)	(41.3%)	Medicare Capitation revenue	222,319,098	328,521,247	(106,202,149)	(32.3%)
25,811,365	43,315,304	(17,503,939)	(40.4%)	Total Operating Revenue	288,524,951	446,823,461	(158,298,510)	(35.4%)
				Medical Expenses				
8,579,067	9,539,390	960,323	10.1%	Provider capitation	75,683,513	98,394,926	22,711,413	23.1%
2,515,576	11,096,154	8,580,578	77.3%	Facilities	83,383,437	113,609,664	30,226,227	26.6%
997,618	674,741	(322,877)	(47.9%)	Ancillary	8,078,826	6,851,488	(1,227,338)	(17.9%)
8,342,926	10,185,931	1,843,006	18.1%	Long Term Care	54,540,373	103,430,445	48,890,072	47.3%
3,879,134	7,907,925	4,028,791	50.9%	Prescription drugs	49,763,345	80,331,544	30,568,199	38.1%
876,175	1,231,400	355,224	28.8%	Medical management	9,929,934	12,447,164	2,517,230	20.2%
163,020	621,027	458,007	73.7%	Other medical expenses	986,130	6,306,060	5,319,930	84.4%
25,353,515	41,256,568	15,903,052	38.5%	Total Medical Expenses	282,365,559	421,371,292	139,005,733	33.0%
457,849	2,058,736	(1,600,887)	(77.8%)	Gross Margin	6,159,392	25,452,169	(19,292,778)	(75.8%)
				Administrative Expenses				
723,528	926,049	202,520	21.9%	Salaries, wages & employee benefits	7,877,959	9,496,716	1,618,757	17.0%
0	86,521	86,521	100.0%	Professional fees	318,115	785,604	467,489	59.5%
113,157	181,216	68,059	37.6%	Purchased services	1,315,212	1,797,130	481,918	26.8%
41,958	148,414	106,455	71.7%	Printing and postage	552,610	1,401,544	848,934	60.6%
40,334	2,910	(37,424)	(1,286.1%)	Other operating expenses	379,719	528,570	148,851	28.2%
728,917	937,491	208,574	22.2%	Indirect cost allocation, Occupancy Expense	6,926,765	9,374,907	2,448,142	26.1%
1,647,895	2,282,600	634,705	27.8%	Total Administrative Expenses	17,370,380	23,384,471	6,014,092	25.7%
				Operating Tax				
(101)	0	(101)	0.0%	Tax Revenue	(466,018)	0	(466,018)	0.0%
(101)	0	101	0.0%	Sales tax expense	(466,018)	0	466,018	0.0%
0	0	0	0.0%	Total Net Operating Tax	0	0	0	0.0%
(1,190,045)	(223,864)	(966,181)	(431.6%)	Change in Net Assets	(11,210,988)	2,067,698	(13,278,686)	(642.2%)
98.2%	95.2%	(3.0%)	(3.1%)	Medical Loss Ratio	97.9%	94.3%	(3.6%)	(3.8%)
6.4%	5.3%	(1.1%)	(21.2%)	Admin Loss Ratio	6.0%	5.2%	(0.8%)	(15.0%)

Back to Agenda

ONECARE CONNECT INCOME STATEMENT – APRIL MONTH:

REVENUES of $25.8 million are unfavorable to budget by $17.5 million driven by:

- Volume related unfavorable variance of $11.2 million due to lower enrollment
- Price related unfavorable variance of $6.3 million due:
    - Fiscal year 2016 unfavorable variance of $11.7 million for cohort mix and rate change
    - CMC Medicare Part A and B rate decreases due to base rate and RAF score changes

MEDICAL EXPENSES are favorable to budget $15.9 million due to:

- Volume related favorable variance of $10.7 million across all categories related to the provider group moving to HMO model in February as well as lower long term care expenses
- Price related favorable variance of $5.2 million

ADMINISTRATIVE EXPENSES are favorable to budget by $0.6 million

CHANGE IN NET ASSETS is ($1.2) million, $1.0 million unfavorable to budget

Back to Agenda

CalOptima - OneCare
Statement of Revenues and Expenses
For the Ten Months Ended April 30, 2017

Month Actual	Month Budget	Month $ Variance	Month % Variance		YTD Actual	YTD Budget	YTD $ Variance	YTD % Variance
1,289	1,144	145	12.7%	Member Months	12,402	11,973	429	3.6%
				Revenues				
1,442,147	1,331,452	110,695	8.3%	Capitation revenue	14,324,813	13,814,179	510,634	3.7%
1,442,147	1,331,452	110,695	8.3%	Total Operating Revenue	14,324,813	13,814,179	510,634	3.7%
				Medical Expenses				
405,269	363,672	(41,597)	(11.4%)	Provider capitation	4,006,437	3,759,530	(246,907)	(6.6%)
719,839	294,862	(424,977)	(144.1%)	Inpatient	3,574,520	3,070,822	(503,698)	(16.4%)
24,483	44,381	19,898	44.8%	Ancillary	414,527	470,235	55,708	11.8%
(15,391)	21,056	36,447	173.1%	Skilled nursing facilities	497,355	223,395	(273,960)	(122.6%)
421,340	437,091	15,751	3.6%	Prescription drugs	4,447,710	4,575,043	127,333	2.8%
26,386	50,848	24,463	48.1%	Medical management	225,216	362,549	137,332	37.9%
4,331	(9,249)	(13,580)	(146.8%)	Other medical expenses	47,136	72,240	25,104	34.8%
1,586,257	1,202,661	(383,596)	(31.9%)	Total Medical Expenses	13,212,900	12,533,814	(679,086)	(5.4%)
(144,110)	128,791	(272,901)	(211.9%)	Gross Margin	1,111,913	1,280,365	(168,452)	(13.2%)
				Administrative Expenses				
31,406	20,896	(10,510)	(50.3%)	Salaries, wages & employee benefits	210,942	214,687	3,745	1.7%
20,230	17,619	(2,611)	(14.8%)	Professional fees	164,844	154,762	(10,082)	(6.5%)
30,474	19,373	(11,102)	(57.3%)	Purchased services	244,637	253,834	9,198	3.6%
15,863	13,710	(2,152)	(15.7%)	Printing and postage	86,878	130,790	43,912	33.6%
280	89	(192)	(216.5%)	Other operating expenses	2,351	886	(1,465)	(165.4%)
25,447	29,494	4,047	13.7%	Indirect cost allocation, Occupancy Expense	241,818	294,936	53,118	18.0%
123,701	101,180	(22,520)	(22.3%)	Total Administrative Expenses	951,470	1,049,895	98,426	9.4%
(267,811)	27,611	(295,422)	(1,069.9%)	Change in Net Assets	160,443	230,470	(70,027)	(30.4%)
110.0%	90.3%	(19.7%)	(21.8%)	Medical Loss Ratio	92.2%	90.7%	(1.5%)	(1.7%)
8.6%	7.6%	(1.0%)	(12.9%)	Admin Loss Ratio	6.6%	7.6%	1.0%	12.6%

Back to Agenda

CalOptima - PACE
Statement of Revenues and Expenses
For the Ten Months Ended April 30, 2017

Month Actual	Month Budget	Month $ Variance	Month % Variance		YTD Actual	YTD Budget	YTD $ Variance	YTD % Variance
201	210	(9)	(4.3%)	Member Months	1,857	1,875	(18)	(1.0%)
				Revenues				
1,006,698	940,634	66,064	7.0%	Medi-Cal capitation revenue	9,625,490	8,392,448	1,233,043	14.7%
326,638	375,421	(48,783)	(13.0%)	Medicare capitation revenue	3,048,765	3,424,119	(375,354)	(11.0%)
1,333,336	1,316,054	17,282	1.3%	Total Operating Revenues	12,674,255	11,816,567	857,689	7.3%
				Medical Expenses				
295,964	395,354	99,390	25.1%	Clinical salaries & benefits	2,969,912	4,009,695	1,039,783	25.9%
0	0	0	0.0%	Pace Center Support salaries & benefits	0	0	0	0.0%
574,710	264,572	(310,138)	(117.2%)	Claims payments to hospitals	2,940,791	2,391,855	(548,936)	(23.0%)
293,775	284,570	(9,205)	(3.2%)	Professional Claims	2,320,866	2,543,719	222,853	8.8%
121,346	136,582	15,236	11.2%	Prescription drugs	948,816	1,310,460	361,644	27.6%
1,133	27,097	25,964	95.8%	Long-term care facility payments	59,284	244,968	185,684	75.8%
110,665	84,112	(26,552)	(31.6%)	Patient Transportation	830,463	760,417	(70,046)	(9.2%)
49,663	49,349	(314)	(0.6%)	Depreciation & amortization	492,816	493,490	674	0.1%
37,655	37,214	(441)	(1.2%)	Occupancy expenses	377,699	372,140	(5,559)	(1.5%)
2,820	13,833	11,013	79.6%	Utilities & Facilities Expense	143,958	138,330	(5,628)	(4.1%)
75	308	233	75.6%	Purchased Services	1,264	2,786	1,522	54.6%
19,650	24,547	4,897	19.9%	Indirect Allocation	186,070	245,470	59,400	24.2%
0	0	0	0.0%	Reinsurance	0	0	0	0.0%
28,137	22,785	(5,352)	(23.5%)	Other Expenses	175,781	227,851	52,070	22.9%
1,535,593	1,340,322	(195,271)	(14.6%)	Total Medical Expenses	11,447,720	12,741,182	1,293,462	10.2%
(202,257)	(24,268)	(177,989)	(733.4%)	Gross Margin	1,226,536	(924,615)	2,151,150	232.7%
				Administrative Expenses				
79,501	90,213	10,712	11.9%	Salaries, wages & employee benefits	926,285	928,676	2,391	0.3%
3,001	11,667	8,666	74.3%	Professional fees	46,934	91,667	44,733	48.8%
1,161	988	(173)	(17.5%)	Purchased services	39,103	10,024	(29,079)	(290.1%)
6,224	1,707	(4,518)	(264.7%)	Printing and postage	8,842	17,317	8,476	48.9%
2,069	2,056	(13)	(0.6%)	Depreciation & amortization	20,534	20,562	28	0.1%
8,919	14,775	5,857	39.6%	Other operating expenses	87,994	120,955	32,961	27.3%
2,388	1,023	(1,365)	(133.5%)	Indirect cost allocation, Occupancy Expense	23,489	10,227	(13,262)	(129.7%)
103,263	122,429	19,166	15.7%	Total Administrative Expenses	1,153,181	1,199,428	46,247	3.9%
				Operating Tax				
0	0	0	0.0%	Tax Revenue	14,215	0	14,215	0.0%
0	0	0	0.0%	Premium tax expense	14,215	0	(14,215)	0.0%
0	0	0	0.0%	Total Net Operating Tax	0	0	0	0.0%
(305,520)	(146,697)	(158,823)	(108.3%)	Change in Net Assets	73,355	(2,124,043)	2,197,398	103.5%
115.2%	101.8%	(13.3%)	(13.1%)	Medical Loss Ratio	90.3%	107.8%	17.5%	16.2%
7.7%	9.3%	1.6%	16.7%	Admin Loss Ratio	9.1%	10.2%	1.1%	10.4%

Back to Agenda

CalOptima - Building 505 City Parkway
Statement of Revenues and Expenses
For the Ten Months Ended April 30, 2017

Month					Year - To - Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
24,056	21,285	2,772	13.0%	Rental income	241,463	212,849	28,614	13.4%
24,056	21,285	2,772	13.0%	Total Operating Revenue	241,463	212,849	28,614	13.4%
				Administrative Expenses				
1,525	2,085	560	26.8%	Professional fees	14,673	20,850	6,177	29.6%
29,507	22,405	(7,103)	(31.7%)	Purchase services	298,567	224,048	(74,520)	(33.3%)
158,802	210,141	51,338	24.4%	Depreciation & amortization	1,573,474	2,101,408	527,934	25.1%
14,913	14,300	(613)	(4.3%)	Insurance expense	158,918	143,003	(15,915)	(11.1%)
138,322	198,033	59,711	30.2%	Repair and maintenance	1,023,613	1,933,632	910,019	47.1%
33,350	0	(33,350)	0.0%	Other Operating Expense	409,086	0	(409,086)	0.0%
(355,750)	(352,100)	3,650	1.0%	Indirect allocation, Occupancy Expense	(3,287,323)	(3,520,998)	(233,676)	(6.6%)
20,671	94,864	74,194	78.2%	Total Administrative Expenses	191,007	901,941	710,934	78.8%
3,386	(73,579)	76,965	104.6%	Change in Net Assets	50,456	(689,092)	739,548	107.3%

Back to Agenda

OTHER STATEMENTS – APRIL MONTH:

ONECARE INCOME STATEMENT

REVENUES of $1.4 million; $0.1 million are favorable to budget

MEDICAL EXPENSES are $1.6 million, $0.4 million unfavorable to budget

CHANGE IN NET ASSETS is ($0.3 million); $0.3 million unfavorable to budget

PACE INCOME STATEMENT

CHANGE IN NET ASSETS for the month is ($0.3) million; $0.2 million unfavorable to budget

505 CITY PARKWAY BUILDING INCOME STATEMENT

CHANGE IN NET ASSETS for the month is $3.4 thousand; $77.0 thousand favorable to budget

CalOptima
BALANCE SHEET
April 30, 2017

ASSETS			LIABILITIES & FUND BALANCES	
Current Assets			Current Liabilities	
	Operating Cash	$547,444,222	Accounts payable	$17,463,408
	Catastrophic Reserves	11,017,632	Medical claims liability	686,407,295
	Investments	1,314,931,506	Accrued payroll liabilities	10,193,845
	Capitation receivable	342,198,083	Deferred revenue	860,105,383
	Receivables - Other	19,379,894	Deferred lease obligations	209,840
	Prepaid Expenses	7,095,242	Capitation and withholds	531,371,369
			Total Current Liabilities	**2,105,751,141**
	Total Current Assets	**2,242,066,578**		
Capital Assets	Furniture and equipment	35,790,228		
	Leasehold improvements	6,666,887		
	505 City Parkway West	49,271,389	Other employment benefits liability	30,021,563
		91,728,503		
	Less: accumulated depreciation	(37,199,361)	Net Pension Liabilities	15,430,763
	Capital assets, net	**54,529,142**	Long Term Liabilities	100,000
			TOTAL LIABILITIES	**2,151,303,467**
Other Assets	Restricted deposit & Other	300,000		
			Deferred inflows of Resources - Excess Earnings	4,130,286
	Board-designated assets		Deferred inflows of Resources - changes in Assumptions	1,651,640
	Cash and cash equivalents	17,955,981		
	Long term investments	516,239,691	Tangible net equity (TNE)	96,640,187
	Total Board-designated Assets	534,195,671	Funds in excess of TNE	587,714,503
	Total Other Assets	**534,495,671**		
			Net Assets	**684,354,690**
	Deferred outflows of Resources - Pension Contributions	9,133,218		
	Deferred outflows of Resources - Difference in Experience	1,215,473		
TOTAL ASSETS & OUTFLOWS		**2,841,440,083**	**TOTAL LIABILITIES, INFLOWS & FUND BALANCES**	**2,841,440,083**

Back to Agenda

CalOptima
Board Designated Reserve and TNE Analysis
as of April 30, 2017

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	145,963,515				
	Tier 1 - Logan Circle	145,759,457				
	Tier 1 - Wells Capital	145,693,263				
Board-designated Reserve						
		437,416,235	311,979,635	487,102,416	125,436,600	(49,686,181)
TNE Requirement	Tier 2 - Logan Circle	96,779,437	96,640,187	96,640,187	139,250	139,250
	Consolidated:	**534,195,672**	**408,619,822**	**583,742,603**	**125,575,850**	**(49,546,931)**
	Current reserve level	*1.83*	*1.40*	*2.00*		

CalOptima
Statement of Cash Flows
April 30, 2017

	Month Ended	Year-To-Date
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets	18,561,961	24,787,512
Adjustments to reconcile change in net assets		
to net cash provided by operating activities		
Depreciation and amortization	511,200	4,903,038
Changes in assets and liabilities:		
Prepaid expenses and other	5,326,721	(310,995)
Catastrophic reserves		
Capitation receivable	(46,114,831)	125,173,031
Medical claims liability	5,495,093	87,712,438
Deferred revenue	(47,216,388)	269,402,742
Payable to providers	13,537,377	129,545,067
Accounts payable	(21,849,744)	10,410,183
Other accrued liabilities	3,069,420	11,069,530
Net cash provided by/(used in) operating activities	(68,679,192)	662,692,545
GASB 68 CalPERS Adjustments	(1,718,288)	(1,718,288)
CASH FLOWS FROM INVESTING ACTIVITIES		
Purchase of Investments	119,410,237	(295,666,874)
Purchase of property and equipment	(197,991)	(4,436,616)
Change in Board designated reserves	(1,146,650)	(58,360,306)
Net cash provided by/(used in) investing activities	118,065,597	(358,463,796)
NET INCREASE/(DECREASE) IN CASH & CASH EQUIVALENTS	47,668,117	302,510,460
CASH AND CASH EQUIVALENTS, beginning of period	$510,793,737	255,951,393
CASH AND CASH EQUIVALENTS, end of period	**$ 558,461,854**	**$ 558,461,854**

Back to Agenda

BALANCE SHEET:

ASSETS decreased $24.8 million from March

- **Cash and Cash Equivalents** increased by $47.7 million due to the timing of state checks received, month-end cut-off
- **Short-term Investments** decreased $119.4 million due to payment receipt timing and cash funding requirements
- **Net Capitation Receivables** increased $45.3 million based upon payment receipt timing and receivables

LIABILITIES decreased $47.0 million from March

- **Deferred Revenue** decreased $47.2 million driven by DHS payments as compared to rates
- **Capitaton Payable** increased $13.5 million driven by IBNR margins
- **Accrued Expenses** decreased **$**21.4 million based on the timing of sales tax payments
- **Medical Claims Liability** by line of business increased $5.5 million

NET ASSETS are $684.4 million

CalOptima Foundation
Statement of Revenues and Expenses
For the Ten Months Ended April 30, 2017
Consolidated

Month Actual	Month Budget	Month $ Variance	Month % Variance		YTD Actual	YTD Budget	YTD $ Variance	YTD % Variance
				Revenues				
0	2,264	(2,264)	(100.0%)	Income - Grant	27,164	22,644	4,520	20.0%
2,084	0	2,084	0.0%	In Kind Revenue - HITEC Grant	74,497	0	74,497	0.0%
2,084	2,264	(180)	(8.0%)	Total Operating Revenue	101,661	22,644	79,017	349.0%
				Operating Expenditures				
0	6,184	6,184	100.0%	Personnel	27,195	61,842	34,647	56.0%
0	2,985	2,985	100.0%	Taxes and Benefits	26,240	29,848	3,608	12.1%
0	0	0	0.0%	Travel	(3)	0	3	0.0%
0	0	0	0.0%	Supplies	7,009	10,000	2,991	29.9%
0	0	0	0.0%	Contractual	20,388	17,174	(3,214)	(18.7%)
2,084	232,065	229,981	99.1%	Other	22,538	2,320,652	2,298,114	99.0%
2,084	241,234	239,150	99.1%	Total Operating Expenditures	103,368	2,439,516	2,336,148	95.8%
0	0	0	0.0%	Investment Income	0	0	0	0.0%
0	(238,970)	(238,970)	(100.0%)	Program Income	(1,706)	(2,416,872)	(2,415,166)	(99.9%)

Back to Agenda

CalOptima Foundation
Balance Sheet
April 30, 2017

ASSETS		LIABILITIES & NET ASSETS	
Operating cash	2,893,139	Accounts payable-Current	0
Grants receivable	0	Deferred Revenue	0
Prepaid expenses	0	Payable to CalOptima	0
Total Current Assets	**2,893,139**	Grants-Foundation	0
		Total Current Liabilities	0
		Total Liabilities	0
		Net Assets	2,893,139
TOTAL ASSETS	**2,893,139**	**TOTAL LIABILITIES & NET ASSETS**	**2,893,139**

Back to Agenda

CALOPTIMA FOUNDATION – APRIL MONTH

INCOME STATEMENT:

Revenues

- Revenues from Health Information Technology for Economic and Clinical Health Act (HITECH) and in-kind contributions from CalOptima
- The Foundation recognized $101,661 FY17 YTD in total operating revenues
    - HITECH Grant revenue totaled $27,164 YTD which leaves $0 remaining in HITECH Grant funding as of April 2017
    - CalOptima in-kind contribution totaled $74,497 YTD
- Revenue budget variances attributed to:
    - YTD CalOptima grant budget is $0, as the ONC grant funding was to have ended in the previous fiscal year. The grant was extended through September 26, 2016
    - CalOptima in-kind revenue was not included in FY17 budget

Expenses

- Operating expenses were $103,368 for grant related activities incurred YTD FY17
- Expense categories include staff services, travel and miscellaneous supplies
    - $2.3 million favorable variance YTD
    - FY17 budget was based on remaining fund balance in Foundation total assets
    - Actual expenses were much lower than anticipated for CalOptima support activities

BALANCE SHEET:

Assets

- Cash of $2.9 million remains from the FY14 transfer of $3.0 million from CalOptima for grants and programs in support of providers and the community

Liabilities

- $0

Back to Agenda

Budget Allocation Changes
Reporting Changes for April 2017

Transfer Month	Line of Business	From	To	Amount	Expense Description	Fiscal Year
July	OneCare Connect	Office of Compliance - Professional Fees (Consultant for Annual CPE Audit & CMS Mock Audit)	Office of Compliance - Professional Fees - Consultant for DMHC Mock Audit	$69,000	Re-purpose $53,631 from Professional Fees (Consultant for Annual CPE Audit) and $15,369 from Professional Fees (Consultant for CMS Mock Audit) to pay for consultant for DMHC Mock Audit	2017
July	COREC	REC - Other	REC - Comp Supply/Minor Equip	$10,000	Re-allocate funds to cover costs for computer equipment upgrade which is approved ONC grant managers	2017
July	Medi-Cal	IS-Application Development - Software Maintenance - Corporate Software Maintenance	IS-Application Development - Software Maintenance - Human Resources Corporate Application Software Maintenance	$63,810	Re-purpose funds within Software Maintenance (from Corporate Software Maintenance to Human Resources Corporate Application Software Maintenance) to pay for FY17 Ceridian Software Maintenance	2017
July	Medi-Cal	IS-Application Development - Software Maintenance - Corporate Software Maintenance	IS-Application Development - Software Maintenance - Human Resources Corporate Application Software Maintenance	$15,010	Re-purpose funds within Software Maintenance (from Corporate Software Maintenance to Human Resources Corporate Application Software Maintenance) to pay for FY17 Talentova Learning Management System	2017
July	Medi-Cal	IS-Application Development - Software Maintenance - Corporate Software Maintenance	IS-Application Development - Software Maintenance - Human Resources Corporate Application Software Maintenance	$23,900	Re-purpose funds within Software Maintenance (from Corporate Software Maintenance to Human Resources Corporate Application Software Maintenance) to pay for Silk Road	2017
July	Medi-Cal	Claims Administration - Purchased Services - Integration of Claim Editing Software	Claims Administration - Purchased Services - LTC Rate Adjustments	$98,000	Re-purpose funds from within Purchased Services (Integration of Claim Editing Software) to pay for LTC Adjustments (TriZetto Robot Process)	2017
July	Medi-Cal	Human Resources - Advertising, Travel, Comp Supply/Minor Equip, Subscriptions, Courier/Delivery	Human Resources - Professional Fees (Salary & Compensation Research), Public Activities, Office Supplies, Food Service Supplies, Professional Dues, Training & Seminars, Cert./Cont. Education	$84,491	Re-allocate HR FY17 Budget based on HR dept's past spending trends to better meet department's need	2017
July	Medi-Cal	IS-Infrastructure - Telephone - General Telecommunication and Network Connectivity	IS-Infrastructure - Purchased Services - Disaster Recovery Services	$35,575	Re-allocate funds from Telephone (General Telecommunication and Network Connectivity) to Purchased Services to pay for Disaster Recovery Services	2017
August	Medi-Cal	Other Pay	Quality Analytics - Purchased Services	$67,000	Re-allocate funds to Quality Analytics Purchased Services for additional funds that is needed for CG-CAHPS survey	2017
August	Medi-Cal	Other Pay	Community Relations - Professional Fees & Printing	$43,640	Re-allocate funds to Community Relations Professional Fees and Printing budgets for contracts with Tony Lam and Communications Lab and printing costs of Community Option Fair	2017
August	Medi-Cal	IS-Application Management - Purchased Services - Healthcare Productivity Automation	IS-Application Management - Purchased Services - Direct Hire Fees	$10,957	Re-purpose funds from Purchased Services (Healthcare Productivity Automation) to pay for Direct Hire fees	2017
August	Medi-Cal	Other Pay	IS-Application Development - Comp Supplies/Minor Equipments	$20,400	Re-allocate funds to cover costs of DocuSign, Box, and Primal Script 2016	2017
August	Medi-Cal	Claims Administration - Purchased Services	Claims Administration - Office Supplies, Training & Seminars, Printing	$15,000	Re-allocate funds from Purchased Services (Integration of Claim Editing Software & Inventory Management Forecasting) to Office Supplies, Training & Seminars, and Printing to better meet department's needs	2017
September	Medi-Cal	Health Education & Disease Management - Professional Fees	Health Education & Disease Management - Other Operating Expenses	$30,000	Re-allocate funds from Professional Fees (Childhood Obesity Program Design & Evaluation) to Member & Provider Incentives to support incentives for the Group Needs Assessment (GNA) and other Health Education / Disease Management activities.	2017
October	Capital	Facilities - Relocate Trash Enclosure	Facilities - 505 Sound Recording System	$50,555	Re-allocate from Relocate Trash Enclosure project for additional funds that are needed for the 505 Sound Recording System project.	2017
October	Medi-Cal	IS-Infrastructure - Professional Fees - Enterprise Identity Access Management	IS-Infrastructure - HW/SW Maintenance - Information Security Data Loss Prevention Solution	$21,041	Re-allocate from Professional Services for an Enterprise Identity Access Management to HW/SW Maintenance for Information Security Data Loss Prevention Solution Annual Maintenance on additional funds that are needed.	2017
October	Medi-Cal	Facilities - Computer Supply/Minor Equipment - Office Furniture & Equipment	Facilities - Computer Supply/Minor Equipment - Other Articles of Minor Equipment	$27,000	Repurpose funds in Comp supply/minor equipment for re-upholstering chairs in the member service lobby and other minor equipment expenses to better meet the Department's need.	2017
December	Medi-Cal	Human Resources - Professional Fees - Executive Coaching	Human Resources - Professional Fees - Consultant Fees	$20,000	Repurpose from Executive Coaching for interim director of HR consultant fees	2017
December	Medi-Cal	Health Education & Disease Management - Medical Management Activities	Health Education & Disease Management - Medical Management Activities	$75,000	Repurpose funds for the department printing and postage needs	2017
January	Medi-Cal	IS-Application Development - Finance Reporting Tool to Great Plains	IS-Application Development - Great Plains Software Upgrade	$20,000	Re-allocate funds from Finance Reporting Software for Great Plains budget to Great Plains Software Upgrade budget for additional funds are needed to complete the project.	2017
February	Medi-Cal	IS-Application Management - Purchased Services	IS-Application Development - Purchased Services	$19,320	Re-allocate funds from IS Application Management Purchased Services budget for direct placement fee needed in the Department.	2017
February	Medi-Cal	IS-Application Management - Comp supply/Minor Equip	IS-Infrastructure - Subscriptions	$30,000	Re-allocate funds from Computer Supply/Minor Equipment for Gartner Subscription needed in the Department.	2017
February	Medi-Cal	IS-Infrastructure - Training & Seminars	IS-Infrastructure - Subscriptions	$30,000	Re-allocate funds from Training & Seminars for Gartner Subscription needed in the Department.	2017
February	Medi-Cal	IS-Application Management - Training & Seminars	IS-Infrastructure - Subscriptions	$10,741	Re-allocate funds from Training & Seminars for Gartner Subscription needed in the Department.	2017
February	Medi-Cal	Accounting - Professional Fees	Facilities - Professional Fees	$17,000	Re-allocate funds from Accounting Financial Audit budget to Facilities Professional Fees budget for consulting services related to restacking and other Facilities projects.	2017
February	Capital	IS-Application Development - Data Warehouse Enterprise Infrastructure Expansion	IS-Application Development - K2 Business Application Workflow Upgrade	$47,300	Re-allocate funds from Data Warehouse Enterprise Infrastructure Expansion to K2 Business Application Workflow Upgrade for additional funds needed to complete the project.	2017
March	Medi-Cal	IS - Infrastructure - Telephone	IS-Application Management - Maintenance HW/SW	$29,000	Re-allocate funds from Telephone Budget to HW/SW Maintenance budget for funds needed on Claim Editor Annual Renewal	2017
March	Medi-Cal	IS - Infrastructure - Professional Fees	IS - Infrastructure - Professional Fees	$14,000	Repurpose funds from miscellaneous consulting/professional services at the Cal Optima Data Center to support upcoming Microsoft 2016 upgrade.	2017
April	Medi-Cal	IS - Application Management - Purchased Services	Cultural & Linguistic Services - Purchased Services	$85,000	Re-allocate funds from Purchased Services in IS Application Management to Purchased Services in Cultural & Linguistic Services for funds needed in translation/interpreting services.	2017
April	Medi-Cal	Quality Improvement (Medical Management)- Public Activities, Telephone, Minor Equipment/Computer Supplies	Quality Improvement (Medical Management) - Subscriptions	$11,410	Re-allocate funds to Quality Improvement Subscriptions budget for additional funds needed for AMA subscriptions.	2017

This report summarizes budget transfers between general ledger classes that are greater than $10,000 and less than $100,000.
This is the result of Board Resolution No. 12-0301-01 which permits the CEO to make budget allocation changes within certain parameters.

Board of Directors' Meeting
June 1, 2017

Monthly Compliance Report

The purpose of this report is to provide compliance updates to CalOptima's Board of Directors, including but may not be limited to, updates on internal and health network audits conducted by CalOptima's Audit & Oversight department, regulatory audits, privacy updates, fraud, waste, and abuse (FWA) updates, and any notices of non-compliance or enforcement action issued by regulators.

A. Updates on Regulatory Audits

1. OneCare Connect

- Medicare-Medicaid Plan (MMP) Denial Letter Monitoring: On 4/19/17, CMS' contractor, IMPAQ International (IMPAQ), notified all Medicare-Medicaid Plans (MMPs) of a new monitoring effort for MMP denial letters. This monitoring effort attempts to understand the frequency and types of errors, identify potential areas of risk to beneficiaries, capture best practices, and assess whether MMPs are implementing their plan decision letters in a manner compliant with CMS rules and regulations and three-way contracts. On 4/26/17, IMPAQ held a webinar presentation to provide an overview of the study and data collection materials. CalOptima must submit all required data for its OneCare Connect program by May 26, 2017.

- Mock Audit of Medication Therapy Management (MTM) Program: In preparation for a CMS MTM program audit, CalOptima has engaged a consultant to conduct a mock audit on its MTM program using the 2017 CMS audit protocols for MTM. The scope of the audit includes all OneCare Connect members who were enrolled in the MTM program during the look-back period of January 1, 2016 through December 31, 2016. The mock audit is taking place from April through July 2017.

- Medicare Data Validation Audit (DVA): On an annual basis, CMS requires all plan sponsors to conduct a validation audit of all Parts C and D data reported via an independent consultant. CalOptima has contracted with a consultant, Advent Advisory Group, to conduct the validation audit for its OneCare Connect program. The validation audit started in March and is expected to end in June 2017. On April 20, 2017, Advent conducted the virtual onsite portion of the audit, which assessed and validated CalOptima's reporting procedures through staff interviews and source documentation review for the following measures:

    - Parts C and D Grievances
    - Organization Determinations and Reconsiderations
    - Coverage Determinations and Redeterminations
    - Medicare Therapy Management (MTM) Program
    - Special Needs Plan (SNP) Care Management

Back to Agenda

2. OneCare

- Medicare Data Validation Audit (DVA): On an annual basis, CMS requires all plan sponsors to conduct a validation audit of all Parts C and D data reported via an independent consultant. CalOptima has contracted with a consultant, Advent Advisory Group, to conduct the validation audit for its OneCare program. The validation audit started in March and is expected to end in June 2017. On April 20, 2017, Advent conducted the virtual onsite portion of the audit, which assessed and validated CalOptima's reporting procedures through staff interviews and source documentation review for the following measures:

  - Parts C and D Grievances
  - Organization Determinations and Reconsiderations
  - Coverage Determinations and Redeterminations
  - Medicare Therapy Management (MTM) Program
  - Sponsor Oversight of Agents
  - Special Needs Plan (SNP) Care Management

3. Other

- 2016 DMHC Routine Examination: The Department of Managed Health Care (DMHC) conducted a routine examination of CalOptima's financial and administrative affairs during an onsite audit taking place from August 15, 2016 to September 16, 2016. The audit primarily focused on CalOptima's Healthy Families Program in place during the review period, and on CalOptima's organization-wide finances and administration. On April 28, 2017, CalOptima received a final report which noted one (1) finding that required remediation by CalOptima. The finding has been remediated and the DMHC concluded that no further action is required.

B. Regulatory Compliance Notices

1. CalOptima did not receive any compliance notices from its regulators for the months of April and May 2017.

Back to Agenda

C. Updates on Internal and Health Network Audits

1. Internal Audits: Medi-Cal

- Medi-Cal Utilization Management (UM): Prior Authorization (PA) Requests

Month	imelines for Urgents	Clinical Decision Making (CDM) for Urgents	Letter Score for Jrgent	imelines for Routine	Timelines for Denials	CDM for enial	Letter Score for Denials	imelines for Modifiec	CDM for Modifie	Letter Score for Modifie	imelines for Deferrals	CDM for Deferrals	Letter Score for Deferrals
December 2016	100%	93%	91%	20%	50%	83%	96%	71%	100%	98%	Nothing to Report	Nothing to Report	Nothing to Report
January 2017	80%	93%	91%	20%	90%	94%	83%	70%	77%	98%	0%	0%	0%
February 2017	100%	89%	85%	67%	60%	90%	97%	100%	73%	96%	0%	44%	85%

➢ The lower scores for timeliness were due to the following reasons:
  - Failure to meet timeframe for decision (Routine – 5 business days)
  - Failure to meet timeframe for initial notification to the requesting provider (24 hours)
  - Failure to meet timeframe for provider written notification (2 business days)

➢ The lower scores for clinical decision making were due to the following reasons:
  - Failure to have appropriate professional make decision
  - Failure to use criteria for decision

➢ The lower letter scores were due to the following reasons:
  - Failure to provide information on how to file a grievance
  - Failure to provide language assistance program (LAP) insert with approved threshold languages
  - Failure to describe why the request did not meet criteria in lay language
  - Failure to provide description of services in lay language

- Medi-Cal Claims: Professional and Hospital Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
December 2016	100%	100%	100%	100%
January 2017	100%	100%	100%	100%
February 2017	80%	100%	100%	100%

➢ The compliance rate for paid claims timeliness has decreased from 100% in January 2017 to 80% in February 2017 due to failure to pay claims within 45 business days from original date of receipt.

- Medi-Cal Claims: Provider Dispute Resolutions (PDRs)

Month	Letter Accuracy	Determination Timeliness	Acknowledgement Timeliness
December 2016	100%	95%	100%
January 2017	100%	85%	100%
February 2017	100%	85%	95%

➢ The compliance rate for acknowledgement timeliness has decreased from 100% in January 2017 to 95% in February 2017 due to failure to process paper submission of acknowledgement within 15 business days.

- Medi-Cal Customer Service: Call center activity is reviewed for appropriate classification, routing, and privacy handling.

Month	Medi-Cal Call Center	Member Liaison Call Center
December 2016	99%	99%
January 2017	99%	99%
February 2017	100%	100%

➢ The compliance rate for both the Medi-Cal and Member Liaison Call Centers has remained stable at or above 99% from December 2016 through February 2017.

2. Internal Audits: OneCare

- OneCare Pharmacy: Formulary Rejected Claims Review

Month	% Claims Rejected in Error (Member Impact)
December 2016	0%
January 2017	0%
February 2017	0%

➢ No claims were rejected in error due to formulary restrictions from December 2016 through February 2017.

- OneCare Pharmacy: Coverage determination timeliness is reviewed on a daily basis to ensure that they are processed in the appropriate timeframe.

Month	% Compliant with Timeliness
December 2016	100%
January 2017	100%
February 2017	100%

➢ The compliance rate for coverage determination timeliness remained stable at 100% from December 2016 through February 2017.

- OneCare Pharmacy: Coverage determinations for protected classes of drugs are reviewed weekly to ensure that they are processed in accordance with regulatory requirements.

Month	Protected Drug Cases Reviewed	Protected Drug Cases Failed	Overall Compliance
December 2016	4	0	100%
January 2017	11	0	100%
February 2017	15	0	100%

➢ The compliance rate for protected classes of drugs has remained stable at 100% from December 2016 through February 2017.

Back to Agenda

- OneCare Pharmacy: Coverage determinations for unprotected classes of drugs are reviewed weekly to ensure that they are processed in accordance with regulatory requirements.

Month	Unprotected Drug Cases Reviewed	Unprotected Drug Cases Failed	Overall Compliance
December 2016	23	0	100%
January 2017	33	0	100%
February 2017	27	0	100%

  - ➢ The compliance rate for unprotected classes of drugs has remained stable at 100% from December 2016 through February 2017.

- OneCare Utilization Management

Month	Timeliness for Expedited Initial Organization Determination (EIOD)	Clinical Decision Making for EIOD	Letter Score for EIOD	Timeliness for Standard Organization Determination (SOD)	Letter Score for SOD	Timelines s for Denials	Clinical Decision Making for Denials	Letter Score for Denials
December 2016	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report
January 2017	Nothing to Report	Nothing to Report	Nothing to Report	75%	0%	Nothing to Report	Nothing to Report	Nothing to Report
February 2017	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report

  - ➢ There were no files to review for February 2017.

- OneCare Claims: Professional and Hospital Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
December 2016	90%	90%	100%	90%
January 2017	100%	100%	100%	70%
February 2017	100%	100%	100%	60%

  - ➢ The compliance rate for denied claims accuracy decreased from 70% in January 2017 to 60% in February 2017 due to claim being denied in error for no authorization.

- OneCare Claims: Provider Dispute Resolutions (PDRs)

Month	Determination Timeliness	Payment Accuracy	Letter Accuracy	Check Lag
December 2016	100%	50%	100%	100%
January 2017	100%	50%	100%	100%
February 2017	71%	100%	100%	100%

  - ➢ The compliance rate for determination timeliness has decreased from 100% in January 2017 to 71% in February 2017 due to failure to process claims within 30 calendar days.

  - ➢ The compliance rate for payment accuracy has increased from 50% in January 2017 to 100% in February 2017.

- OneCare Customer Service: Call center activity is reviewed for appropriate classification, routing, and privacy handling.

Month	OneCare Customer Service
December 2016	100%
January 2017	100%
February 2017	98%

  - ➢ The compliance rate for the OneCare Customer Service Call Center has decreased from 100% in January 2017 to 98% in February 2017 due to the following areas:
    - – Failure to verify member eligibility
    - – Failure to provide appropriate guidance to the member

3. Internal Audits: OneCare Connect

- OneCare Connect Pharmacy: Formulary Rejected Claims Review

Month	% Claims Rejected in Error (Member Impact)
December 2016	0%
January 2017	0%
February 2017	0%

  - ➢ No claims were rejected in error due to formulary restrictions from December 2016 through February 2017.

- OneCare Connect Pharmacy: Coverage determination timeliness is reviewed on a daily basis to ensure that they are processed in the appropriate timeframe.

Month	% Compliant with Timeliness
December 2016	100%
January 2017	99%
February 2017	99%

➢ The compliance rate for coverage determination timeliness remains at or above 99% from December 2016 through February 2017.

- OneCare Connect Pharmacy: Coverage determinations for protected classes of drugs are reviewed weekly to ensure that they are processed in accordance with regulatory requirements.

Month	Protected Drug Cases Reviewed	Protected Drug Cases Failed	Overall Compliance
December 2016	30	1	97%
January 2017	38	0	100%
February 2017	48	0	100%

➢ The compliance rate for coverage determinations for protected drug cases has remained stable at 100% from January 2017 through February 2017.

- OneCare Connect Pharmacy: Coverage determinations for unprotected classes of drugs are reviewed weekly to ensure that they are processed in accordance with regulatory requirements.

Month	Unprotected Drug Cases Reviewed	Unprotected Drug Cases Failed	Overall Compliance
December 2016	120	0	100%
January 2017	82	0	100%
February 2017	72	0	100%

➢ The compliance rate for coverage determinations for unprotected classes of drugs remained at 100% from December 2016 through to February 2017.

Back to Agenda

- <u>OneCare Connect Utilization Management</u>: Prior Authorization (PA) Requests

Month	imelines for Urgents	Clinical Decision Making for Urgents	Letter Score for Urgents	'imelines For Routine	Letter Score for ꞯoutin	'imelines for Denials	Clinical Decision Making for Denials	Letter Score for Denials	imeli ess for lodif d	Clinical Decision Making for Modifiec	Letter Score for lodifie	'imelines for Deferrals	Clinical Decision Making for Deferrals	Letter Score for Deferrals
December 2016	70%	lothing t Report	95%	40%	30%	83%	78%	83%	N/A	N/A	N/A	N/A	N/A	N/A
January 2017	90%	N/A	30%	40%	35%	100%	100%	50%	N/A	N/A	N/A	N/A	N/A	N/A
February 2017	lothing t Report	lothing t Report	Nothing tc Report	78%	28%	Nothing tc Report	Nothing t Report	lothing t Report	N/A	N/A	N/A	N/A	N/A	N/A

- The lower scores for timeliness were due to the following:
  - Failure to meet timeframe for decision (Routine – 5 business days)
  - Failure to meet timeframe for provider initial notification to the requesting provider (24 hours)
  - Failure to meet timeframe for provider written notification (2 business days)

- The lower scores for letter review were due to the following:
  - Failure to provide letter in most current CMS template
  - Failure to provide letter with description of services in lay language

- <u>OneCare Connect Claims</u>: Professional and Hospital Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
December 2016	100%	100%	100%	100%
January 2017	50%	80%	100%	80%
February 2017	50%	90%	100%	100%

- The compliance rate for paid claims timeliness has remained at 50% from January 2017 to February 2017 due to failure to meet the required timeline for paid claims within 30 calendar days.

- OneCare Connect Claims: Provider Dispute Resolutions (PDRs)

Month	Determination Timeliness	Payment Accuracy	Letter Accuracy	Check Lag
December 2016	100%	94%	100%	100%
January 2017	100%	100%	100%	N/A
February 2017	100%	95%	100%	67%

  - ➢ The compliance rate for payment accuracy has decreased from 100% in January 2017 to 95% in February 2017 due to underpaid claims.
  - ➢ The compliance rate for check lag had a low score of 67% in February 2017 due to checks not clearing within 14 calendar days.

- OneCare Connect Customer Service: Call center activity is reviewed for appropriate classification, routing, and privacy handling.

Month	OneCare Connect Customer Service
December 2016	100%
January 2017	100%
February 2017	100%

  - ➢ The compliance rate for the OneCare Connect Customer Service Call Center has remained stable at 100% from December 2016 through February 2017.

4. Internal Audits: PACE

- PACE Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
December 2016	100%	100%	100%	100%
January 2017	67%	100%	100%	100%
February 2017	70%	70%	100%	100%

  - ➢ The compliance rate for paid claims timeliness has increased from 67% in January 2017 to 70% in February 2017. However, the low compliance score is due to failure to process claims within 30 calendar days.

- ➢ The compliance rate for paid claims accuracy has decreased from 100% in January 2017 to 70% in February 2017 due to an error in claims development.

- PACE Claims: Provider Dispute Resolutions (PDRs)

Month	Determination Accuracy	Letter Accuracy	Acknowledgement Timeliness	Check LAG
December 2016	100%	100%	100%	100%
January 2017	100%	100%	100%	100%
February 2017	100%	100%	100%	100%

- ➢ The compliance rate for determination accuracy, letter accuracy, acknowledgement timeliness, and check lag remained stable at 100% from December 2016 through February 2017.

5. Health Network Audits: Medi-Cal, OneCare, and OneCare Connect

As previously reported, monthly file reviews for health networks were suspended in January 2017 due to preparation for the Joint Medical Audit performed by the Department of Health Care Services (DHCS) and the Department of Managed Health Care (DMHC). Alternatively, CalOptima's Audit & Oversight Department conducted webinar reviews to assess the processing of utilization management files and claims from each health network's systems.

The monthly file reviews for the respective audit areas resumed in February 2017.

- Medi-Cal Utilization Management (UM): Prior Authorization (PA) Requests

Month	imelines for Urgent	Clinical ecisior Making (CDM) for Urgent	Letter Score for Urgent	imelines for Routine	imelines for Denials	CDM for enials	Letter Score for enials	imelines for Modified	CDM for lodifie	Letter Score for Modifiec	imelines for Deferrals	CDM for Deferrals	Letter Score for Deferrals
February 2017	80%	100%	88%	84%	50%	89%	94%	49%	95%	100%	Nothing to Report	Nothing to Report	Nothing to Report

- ➢ The lower scores for timeliness were due to the following reasons:
  - – Failure to meet timeframe for decision (Urgent – 72 hours; Routine – 5 business days)
  - – Failure to meet timeframe for member notification (Routine – 2 business days)
  - – Failure to meet timeframe for provider initial notification (24 hours)
  - – Failure to provide proof of written notification to requesting provider (2 business days)

- ➢ The lower scores for clinical decision making (CDM) were due to the following reasons:

Back to Agenda

  - Failure to cite the criteria utilized to make the decision
  - No indication of adequate clinical information obtained to make the decision to deny
  - No indication that the medical reviewer was involved in the denial determination

- ➢ The lower letter scores were due to the following reasons:
  - Language assistance program (LAP) insert was not provided to member and typographical errors were identified throughout the document
  - Failure to provide letter with description of services in lay language
  - Failure to provide letter in member's primary language
  - Failure to include name and contact information for health care professional responsible for decision to deny
  - Failure to provide information on how to file a grievance
  - Failure to outline reason for not meeting the criteria in lay language
  - Failure to provide referral back to primary care provider (PCP) on denial letter
  - Failure to provide peer-to-peer discussion of the decision with medical reviewer

- Medi-Cal Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
February 2017	99%	86%	99%	92%

- ➢ The lower compliance scores were due to the following reasons:
  - Claims paid untimely
  - Claims paid at incorrect rate

- Medi-Cal Claims: Misclassified Hospital Claims

Month	Misclassified Paid Claims	Misclassified Denied Claims
February 2017	100%	100%

- ➢ No findings for February 2017.

- Medi-Cal Claims: Hospital Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
February 2017	100%	100%	100%	100%

➢

➢ No findings for February 2017.

6. Health Network Audits: OneCare

- OneCare Utilization Management (UM): Prior Authorization (PA) Requests

Month	Timeliness for Expedited Initial Organization Determination (EIOD)	Clinical Decision Making for EIOD	Letter Score for EIOD	Timeliness for Standard Organization Determination (SOD)	Letter Score for SOD	Timelines for Denials	Clinical Decision Making for Denials	Letter Score for Denials
February 2017	67%	Nothing to Report	49%	91%	64%	100%	73%	91%

➢ The lower letter scores were due to the following reasons:
  - Failure to use approved CMS letter template
  - Failure to provide letter with description of services in lay language
  - Failure to use CalOptima logo

➢ The lower scores for clinical decision making (CDM) were due to the following reasons:
  - Failure to cite the criteria utilized to make the decision
  - No indication of adequate clinical information obtained to make the decision to deny
  - No indication that the medical reviewer was involved in the denial determination

➢ The lower scores for timeliness were due to the following reasons:
  - Failure to meet time frame for member oral notification (Expedited – 72 hours)
  - Failure to meet time frame for provider initial notification (Expedited – 24 hours)
  - Failure to meet time frame for decision making (Expedited – 24 hours)

- OneCare Claims: Misclassified Claims

Month	Misclassified Paid Claims	Misclassified Denied Claims
February 2017	100%	93%

➢ The lower compliance score for misclassified denied claims was due to duplicate claims reported on the universe.

- OneCare Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
February 2017	94%	90%	94%	94%

➢ The lower compliance scores were due to the following reasons:
  – Paid and denied claims were processed untimely
  – Inaccurate payment of paid claims due to withdrawal of two percent (2%) sequestration
  – Incorrect denied reason applied

7. Health Network Audits: OneCare Connect

- OneCare Connect Utilization Management (UM): Prior Authorization (PA) Requests

Month	imelines for Urgents	Clinical Decision Making (CDM) for Urgents	Letter Score for Irgent	imelines For Routine	Letter Score for Routin	imelines for Denials	CDM for Denials	Letter Score for Denials	imelines for Modifieds	CDM for Modifieds	Letter Score for lodified	imelines for Deferrals	CDM for Deferrals	Letter Score for Deferrals
February 2017	76%	100%	58%	91%	66%	31%	79%	72%	32%	100%	95%	Nothing to Report	Nothing to Report	Nothing to Report

➢ The lower scores for timeliness were due to the following reasons:
  – Failure to meet timeframe for decision (Urgent – 72 hours; Routine – 5 business days)
  – Failure to meet timeframe for member notification (2 business days)
  – Failure to meet timeframe for provider initial notification (24 hours)
  – Failure to provide proof of successful initial written notification to requesting provider (2 business days)

➢ The lower scores for clinical decision making were due to the following reasons:
  – Failure to cite the criteria utilized to make the decision
  – No indication of adequate clinical information obtained to make the decision to deny

- Failure to have appropriate professional making decision

➢ The lower letter scores were due to the following reasons:
- Failure to provide letter in member's primary language
- Failure to outline reason for not meeting the criteria in lay language in denial letter
- Failure to provide letter with description of services in lay language
- Failure to provide peer-to-peer discussion of the decision with medical reviewer
- Failure to provide information on how to file a grievance
- Failure to provide referral back to primary care provider (PCP) on denial letter
- Language assistance program (LAP) insert was not provided to member and typographical errors were identified throughout the document
- Failure to include name and contact information for health care professional responsible for decision to deny

- OneCare Connect Claims: Misclassified Claims

Month	Misclassified Paid Claims	Misclassified Denied Claims
February 2017	99%	91%

➢ The lower score for misclassified denied claims is due to line item denials reported on the universe.

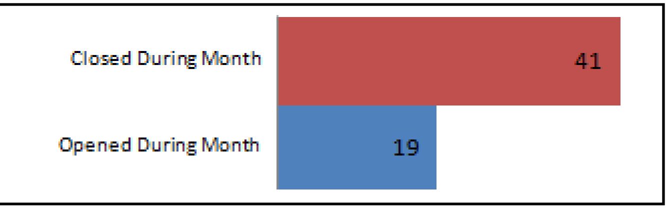
- OneCare Connect Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
February 2017	92%	80%	90%	92%

➢ The lower scores were due to the following reasons:
- Paid and denied claims were processed untimely
- Incorrect denial reason applied
- Inaccurate payment of claims due to withdrawal of two percent (2%) sequestration

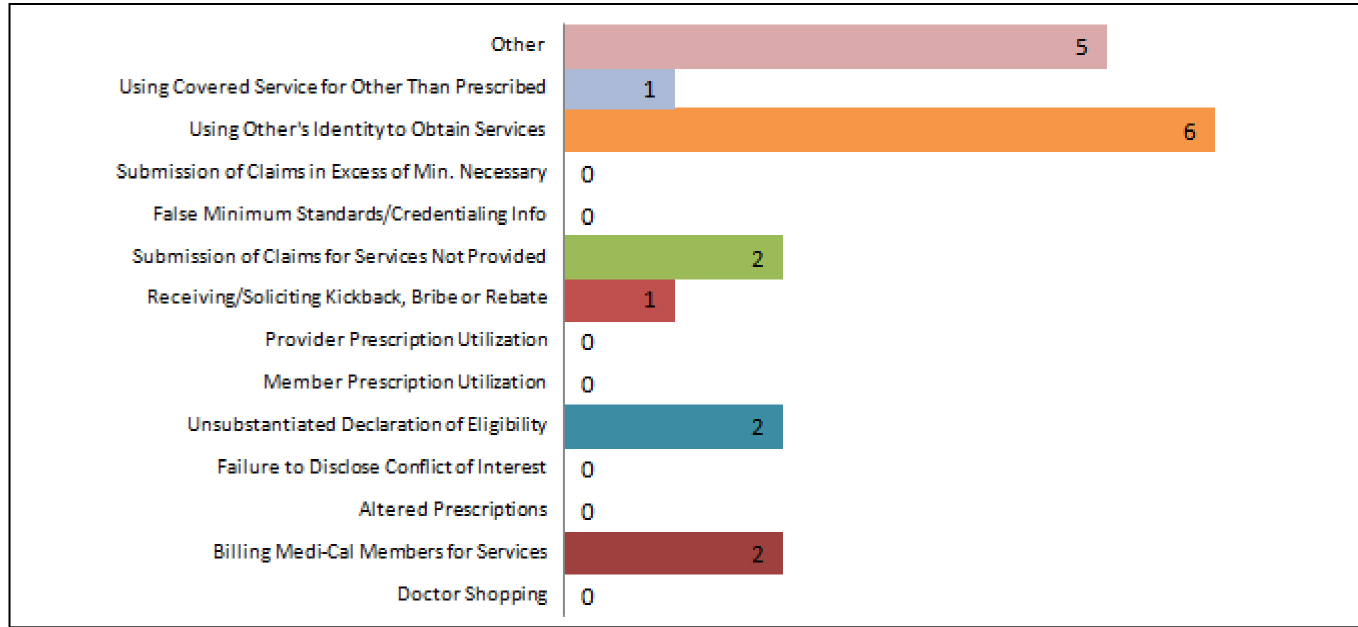
D. Special Investigations Unit (SIU) / Fraud, Waste & Abuse (FWA) Investigations (April 2017)

Case Status
Case status at the end of April 2017



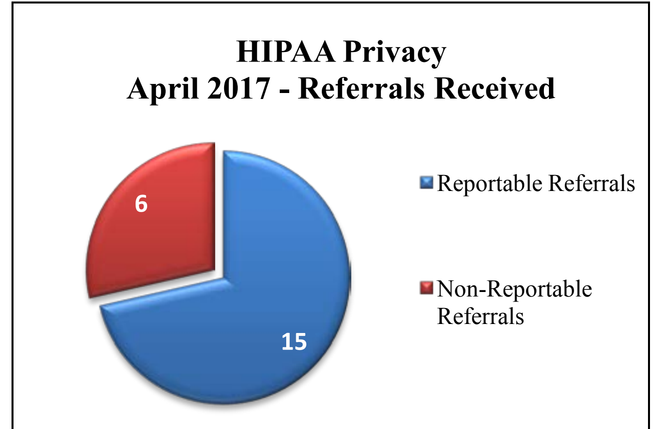
Note: Cases that are referred to DHCS or the MEDIC are not "closed" until CalOptima receives notification of case closure from the applicable government agency.

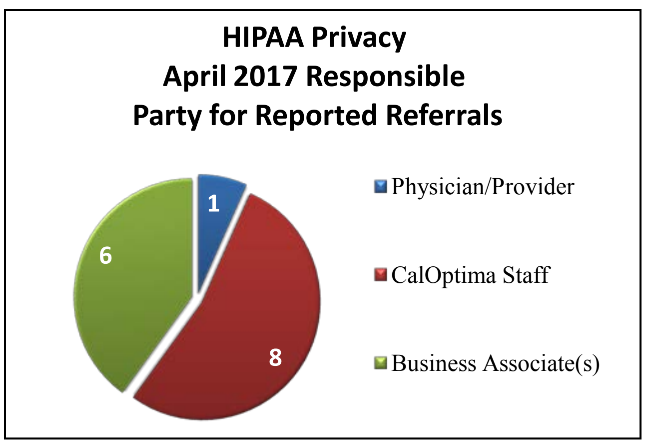
Types of FWA Cases: (Received in April 2017)

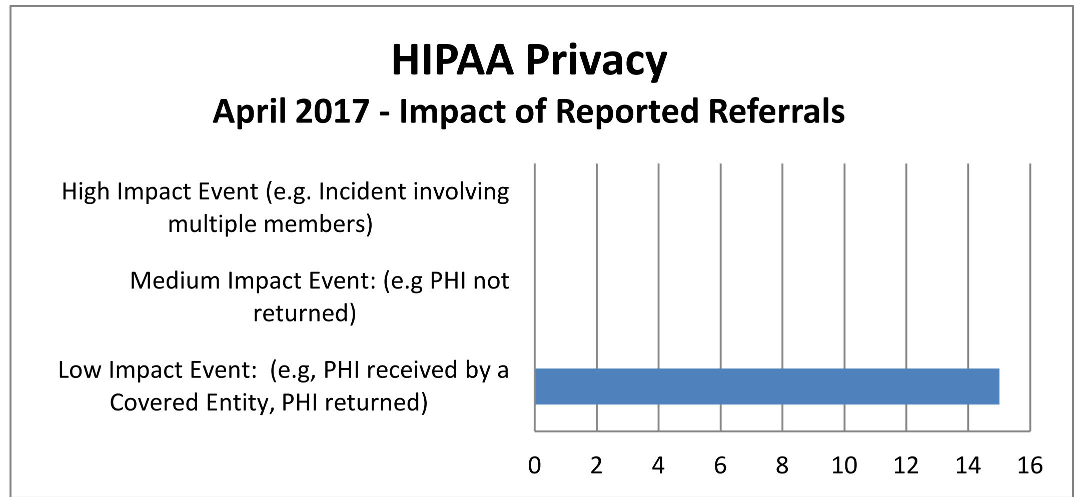


Back to Agenda

E. Privacy Update (April 2017)







PRIVACY STATISTICS

Total Number of Referrals Reported to DHCS (State)	15
Total Number of Referrals Reported to DHCS and Office for Civil Rights (OCR)	0
Total Number of Referrals Reported	**15**

Federal & State Legislative Advocate Reports

Board of Directors Meeting
June 1, 2017

Akin Gump Strauss Hauer & Feld / Edelstein Gilbert Robson & Smith

Back to Agenda

M E M O R A N D U M

May 22, 2017

To: CalOptima

From: Akin Gump Strauss Hauer & Feld, LLP

Re: May Report

With the passage of the American Health Care Act (AHCA) by the House on May 4, this month saw both the fallout from that dramatic act earlier in the month as well as a return to some bipartisan health care legislating on non-Affordable Care Act (ACA) related bills later in the month. The following summary of health care activity on Capitol Hill covers the month of May through May 22.

The American Health Care Act
On May 4, the House narrowly passed the AHCA, which would rapidly phase out funding for the Medicaid expansion beginning in 2020 and convert federal funding for Medicaid from an open-ended commitment to a per capita cap. Specifically, States that have already expanded could keep the enhanced match for expansion enrollees until December 31, 2019, but, after that, they would receive an enhanced FMAP for only individuals enrolled as of December 31, 2019, who do not become disenrolled for more than a month ("grandfathered expansion enrollees"). Beginning in FY 2020, the AHCA would convert federal financing of Medicaid to a per capita cap model for most enrollees, with an option for states to receive block grant funding for certain children and non-expansion adults. The final vote tally was 217 to 213.

The House was able to overcome its previous failure by adopting an amendment negotiated by Rep. Tom MacArthur (R-NJ-3), a leader of the moderate Tuesday Group, and leaders of the conservative Freedom Caucus, which would give states the option of waiving a number of consumer protections and insurance mandates for plans offered in the individual marketplace exchanges. A majority was further cemented by increasing funding in the bill for high risk pools to cover individuals with pre-existing conditions. Democratic representatives from the Orange County area – Representatives Correa (D-CA-46), Lowenthal (D-CA-47), and Sanchez (D-CA-38) – all voted against the AHCA while Republican representatives from the Orange County area – Representatives Issa (R-CA-49), Rohrabacher (R-CA-48), Royce (R-CA-39), and Walters (R-CA-45) – all voted for it.

In a rare departure from House procedure, the chamber voted on the AHCA without a score from the Congressional Budget Office estimating the bill's impact on spending, revenue, the deficit or insurance coverage. A CBO score, required of all bills voted on by Congress, is particularly important for consideration of the AHCA because the AHCA must comply with strict budget rules under reconciliation, which will allow the Senate to pass the bill with a simple majority

Back to Agenda

rather than the typical 60 vote threshold now required of most legislation. If the CBO score finds that the AHCA is not in compliance with the reconciliation instructions, then it is possible that a second vote in the House is required to bring it into compliance. The AHCA may not be in compliance, for example, if it does not achieve the deficit reduction amounts for each Senate Committee that it will be referred to when it arrives in the Senate or if it increases the deficit outside the 10 year budget window. Following the House vote, CBO has taken longer to complete its score than expected because it has little experience or data on which to model the option that the MacArthur amendment gives states. CBO plans to release its score of the House-passed AHCA on Wednesday, May 24.

This procedural delay in the House has not slowed the Senate from moving forward. Throughout the House debate on the AHCA, a number of Republican Senators made clear that the AHCA did not have sufficient support in the Senate, whose Republican majority of 52 seats means that only 2 Republican Senators can defect and still pass a bill with the help of a tie-breaking vote from Vice President Pence. Senate Republicans have, therefore, embarked on writing their own bill.

Eschewing the typical bill writing process in the Senate Finance or HELP Committees, Senate Republicans established a 13 member working group shortly after House passage to develop their own bill. The 13 members of the working group are Senators McConnell (R-KY), Cornyn (R-TX), Thune (R-SD), Barrasso (R-WY), Alexander (R-TN), Hatch (R-UT), Enzi (R-WY), Cruz (R-TX), Lee (R-UT), Cotton (R-AR), Gardner (R-CO), Portman (R-OH), and Toomey (R-PA). This group comprises the Senate Republican leadership, chairs of the relevant committees (Budget, Finance, and HELP), and leading conservatives and moderates.

When it was announced, Senate Republicans were criticized for failing to include any Republican female Senators like Senator Collins (R-ME) or Senator Murkowski (R-AK), both of whom are more moderate than their conference colleagues. Consequently, the working group has broadened informally to include all Republican Senators, who discuss specific health care topics at their regular Tuesday, Wednesday, and Thursday lunches in the Capitol.

There are a number of Senators within the Republican conference concerned about the impact of ACA repeal on Medicaid expansion and are seeking policies that more closely align with the interests of CalOptima. For example, Senator Portman, whose home state of Ohio expanded its Medicaid program and currently has a Republican governor, is reportedly proposing to allow the Medicaid expansion to be phased out over five years starting in 2020 – a slower approach than what is currently included in the AHCA.

According to informal conversations with Senate leadership aides of both parties, Senate Republicans will attempt to complete their consideration of a bill to repeal and replace the ACA before the August recess. Although the exact milestone is up for debate, at some point, the reconciliation instructions that allow Republicans to pass this bill with a simple majority will expire because it is tied to the FY17 budget. For example, it may no longer be in order to consider an FY17 reconciliation bill (i.e., in this case, the AHCA) at the end of FY17 (September 30, 2017) or following the consideration of the FY18 budget resolution. The final determination will be made by the Senate parliamentarian. In addition to the budget calendar putting pressure on Congressional Republicans to complete their work on repealing and replacing the ACA, they also hope to use the FY18 budget reconciliation process for tax reform. As a result, Capitol Hill observers are looking to the end of September as the goal for Republicans to finish AHCA consideration completely. Despite this tight timeline and due to the working group process described above, the AHCA discussion in the Senate has largely moved behind closed doors and received less media attention than the negotiations among House members.

Children's Health Insurance Program

Fallout at the beginning of the month from House passage of the AHCA did spill over to other health care issues. The Senate Finance Committee delayed a previously scheduled hearing for May 9 on reauthorizing the Children's Health Insurance Program, which is set to expire at the end of this fiscal year. Chairman Orrin Hatch (R-UT) and Ranking Member Ron Wyden (D-OR) agreed to postpone the hearing, which as of this writing has not been rescheduled, out of a fear that it would devolve into a partisan argument about the AHCA and polarize CHIP reauthorization, which both parties want to pass on time. Currently, there is no legislative text introduced or public that would reauthorize CHIP.

The Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act (S. 870)

The Senate Finance Committee did move quickly, however, the following week on bipartisan legislation to improve the way that Medicare serves patients with chronic conditions. On May 16, the Committee held a hearing on the CHRONIC Care Act and approved the bill unanimously two days later in an executive session. Among other provisions, the bill would permanently authorize Special Needs Plans for beneficiaries dually eligible for Medicare and Medicaid benefits (D-SNPs) if certain requirements are met.

By 2021, a D-SNP contract would be required to have a unified grievances and appeals procedure in place, and by 2021, a D-SNP would be required to integrate Medicare and Medicaid long-term services and supports and/or behavioral health services by meeting one of three requirements:

1. Enter into a contract with a state Medicaid agency and coordinate long-term services and supports (LTSS), behavioral health services, or both by meeting an additional minimum set of requirements determined by the Secretary through the MMCO and based on input from stakeholders;

2. Satisfy the requirements of a FIDE-SNP, except the requirement that the D-SNP have similar average levels of frailty as the Program for All-inclusive Care for the Elderly (PACE) or enter into a capitated contract with the state Medicaid agency to provide LTSS, behavioral health, or both LTSS and behavioral health; or

3. The parent organization must assume clinical and financial responsibility for the Medicare and Medicaid benefits provided to individuals who are enrolled in a D-SNP and a Medicaid managed care organization that provides LTSS or behavioral health services, with the same parent organization.

In addition, the bill would establish the Federal Office of Medicare and Medicaid Coordinated Health Care (MMCO) within CMS to facilitate Medicare and Medicaid coordination, dual eligible beneficiary care, and other activities. Under the bill, the MMCO would be designated as the dedicated CMS contact point to assist states in addressing D-SNP Medicare-Medicaid misalignments. In this role, MMCO would be required to establish a uniform process for disseminating Medicare contract information to state Medicaid agencies as well as to D-SNPs and to establish basic resources for states interested in exploring D-SNPs as a platform for integrating Medicare and Medicaid services for dual eligible beneficiaries.

Under current law, authorization for SNPs is set to expire on December 31, 2018. There is no companion legislation in the House.

Back to Agenda

EDELSTEIN GILBERT ROBSON & SMITH LLC

Donald B. Gilbert   Michael R. Robson   Trent E. Smith   Alan L. Edelstein OF COUNSEL

CALOPTIMA LEGISLATIVE REPORT
By Don Gilbert and Trent Smith
May 22, 2017

The Governor released his May Revise on May 11, officially kicking off the "Budget Season" in Sacramento. Budget Subcommittees in both the Assembly and Senate are meeting to debate the details of the Governor's revised budget proposal. The Legislature must adopt a State Budget by June 15 and the Governor has until June 30 to sign it into law.

The Governor again advocated that the Legislature act with caution and fiscal constraint when crafting a state budget. The Governor voiced concern that the economy is slowing and state revenues will decline in the near future. In fact, the Department of Finance (DOF) estimates that tax revenue for the current fiscal year will be $1.9 billion lower than previously estimated.

Of interest to CalOptima, the Governor's May Revision upholds the January proposal of $169 million in the current year for county Medi-Cal administration costs.

The May Revision also includes an additional $45.4 million, bringing the total to $188.2 million in the General Fund, to provide full-scope Medi-Cal benefits to 185,000 undocumented children.

The Managed Care Organization (MCO) tax passed by the Legislature last year provides $1.1 billion in the current year and an estimated $1.7 in the budget year for the Medi-Cal program. MCO funding is also dedicated to developmental services ($287 million), retiree health prefunding ($240 million), medical education programs ($2 million), increased rates for intermediate care facilities ($135 million), and forgiveness of retroactive recoupments from small Distinct Part Nursing Facilities.

Further, the May Revision proposes to use $265.8 million in MCO proceeds to restore the seven percent across-the-board reduction in hours for IHSS beneficiaries. The Governor proposes to use MCO funding for this purpose until the expiration of the new MCO fix on June 30, 2019.

Like in his January Budget proposal, The Governor's May Revise continues the Coordinated Care Initiative (CCI), but excludes In Home Support Services (IHSS). Specifically, the proposal removes the IHSS benefit from Medi-Cal managed care capitation rates, returns bargaining for IHSS workers' wages and benefits to the seven CCI counties, and reestablishes the county share-of-cost in IHSS. The net fiscal result to counties was an estimated cost of $623 million. However, the Governor recognized the need to mitigate these county costs. His May Revise provides General Fund allocations totaling to more than $592 million. It is our understanding that the California State Association of Counties (CSAC) approved this compromise.

Back to Agenda

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The May Revise also proposes some major changes in the 340B drug program, which allows Federally Qualified Health Clinics (FQHC) and public hospitals to purchase prescription drugs at significantly discounted prices. The clinics and hospitals can sell the drugs at an increases price and keep the profits to use in the care of their patients. The Department of Health Care Services (DHCS) is proposing trailer bill language to correct problems regarding the use of contract pharmacies in the 340B Drug Billing program. There are instances where a 340B covered clinic or hospital does not directly dispense medications to a beneficiary, instead they contract with a different pharmacy, typically a non-340B entity, who dispenses the drug at a non-340B price that is then billed to the department or health plan. The trailer bill language proposes to no longer permit the use of contract pharmacies in the 340B program in Medi-Cal. The goal is to avoid inappropriate duplicate discounts and prevents unnecessary overpayment in Medi-Cal.

DHCS is also proposing trailer bill language to codify the new drug ingredient reimbursement methodology and dispensing fee for pharmacies. This proposal is expected to create new unspecified savings for the Medi-Cal program.

Another issue that may be of interest to CalOptima is a proposal by DHCS to recoup some revenue that may have been wrongly allocated to health plans based on how an enrollee was deemed eligible for Medi-Cal. Effective January 1, 2014, the Affordable Care Act (ACA) expanded Medicaid coverage to previously ineligible persons, primarily adults at or below 138 percent of the federal poverty level. This new “expansion” group was designated a certain rate. However, DHCS claims that some people placed in the expansion group were otherwise eligible for Medi-Cal under a different designation, where health plans would have received a lower rate. DHCS wants to review and recalculate certain enrollee’s Medi-Cal designations, which could require some health plans to pay back revenue that they otherwise would not have received.

Meanwhile, health plans and public hospitals continue to negotiate details of a new financing mechanism required under federal regulations. At issue is who will carry more financial risk – the health plans or the public hospitals. Under the current law, there is more ability to base rates on past encounter data. However, the new federal regulations prohibit any “lookback” and instead require the health plans and public hospitals to assume more risk. Stay tuned, as this issue could be debated up until the last days of session.

Finally, we met with representatives from the Western Center on Law and Poverty (WCLP) who reached out to our firm to discuss County Organized Health Systems (COHS) pursuing Knox-Keene Licensure (KKL). As you may recall, WCLP was the sponsor of legislation in 2015 that would have required COHS to secure a KKL. That legislation was soundly defeated on the Assembly Floor. Despite the very clear and convincing defeat, WCLP appears interested in revisiting the issue. We do not expect a bill this year, but we will be on the lookout. We believe it is possible that WCLP could introduce a bill next year that requires COHS to get a KKL. Based on feedback we received from them, the proposal would likely provide COHS an extended timeframe – several years - to get the KKL. We shared the various reasons why most COHS would oppose such a bill, but we still are suspicious that they will take another run at legislation.

Back to Agenda

2017–18 Legislative Tracking Matrix

STATE BILLS

Bill Number (Author)	Bill Summary	Bill Status	CalOptima Position
AB 15 (Maienschein)	This bill would require DHCS to increase the Denti-Cal provider reimbursement rates to the regional commercial rates for the 15 most common dental services. While the bill does not specify a dollar amount for the increase, it does note Denti-Cal's low utilization and funding levels, citing the need for increased reimbursement rates to attract additional providers. CalOptima members who receive Denti-Cal benefits outside of CalOptima may be affected by this proposed increase in funding. This bill would take effect on January 1, 2018.	**03/22/2017** Passed out of Assembly Committee on Health, referred to Assembly Committee on Appropriations	Watch
AB 340 (Arambula)	This bill would require the Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT) to include screenings for incidents of trauma that affect a child's mental or physical health. The EPSDT program is a comprehensive, preventive Medi-Cal benefit for children under the age of 21. CalOptima provides most EPSDT services, while the Orange County Health Care Agency (HCA) covers services not covered by CalOptima. Further clarification is needed in the bill to define whether trauma screening is considered a specialty mental health service offered by county mental health plans, or if Medi-Cal managed care plans would be responsible for providing these services.	**03/22/2017** Passed out of Assembly Committee on Health, referred to Assembly Committee on Appropriations	Watch
AB 675 (Ridley-Thomas)	This bill would appropriate $650 million of state General Fund dollars to DHCS in order to allow In-Home Supportive Services (IHSS) to continue as a Medi-Cal managed care benefit. The Coordinated Care Initiative (CCI) contained a "poison pill" that went into effect in January, meaning IHSS will no longer be a Medi-Cal managed care benefit beginning January 1, 2018. This bill aims to retain the IHSS provision of CCI by shifting dollars from the state General Fund to DHCS.	**04/26/2017** Passed Assembly Committee on Appropriations	Watch
SB 152 (Hernandez)	Based on the most recent guidance from DHCS, CalOptima will implement the Whole Child Model (WCM) no sooner than January 1, 2019. However, under current law, DHCS is required to submit a report to the Legislature no later than January 1, 2021 (two years after plan implementation). Since the WCM implementation date has been delayed, this bill has been introduced to allow plans the full three years to implement the WCM before DHCS submits its report to the Legislature.	**05/01/2017** Passed Senate, referred to Assembly	Watch
SB 171/ AB 205 (Hernandez/ Wood)	This bill would implement certain provisions of the CMS Medicaid managed care rules, making changes at the state level regarding Medi-Cal managed care plans and state fair hearings, time and distance requirements for providers, medical loss ratios, and public hospital financing.	**05/03/2017** Re-referred to Appropriations Committees	Watch
SB 223 (Atkins)	This bill would require Medi-Cal managed care plans to notify members of their nondiscriminatory protections, and translate its member materials into the top 15 languages as identified by the U.S. Census. Plans are currently required to translate materials into threshold languages based on regional population. It would also require interpreters to be deemed qualified by the state and receive additional ethics, conduct, and proficiency training.	**05/04/2017** Hearing set for May 25 in Senate Appropriations Committee	Watch

Bill Number (Author)	Bill Summary	Bill Status	CalOptima Position
SB 508 (Roth)	This bill would allow DHCS to create a dental health collaboration pilot program for Medi-Cal members in Riverside and San Bernardino counties. The program would coordinate efforts between health plans and DHCS to deliver more coordinated Denti-Cal services for Medi-Cal members and incentive based payment structures for Denti-Cal providers. According to the bill, this pilot program would be implemented for up to five years.	**04/24/2017** Hearing cancelled at the request of the bill author	Watch
State Budget Trailer Bill – Cal MediConnect	This trailer bill language (TBL) would establish statutory authority for the continuation of Cal MediConnect (CMC), which includes CalOptima's OneCare Connect. CMC is currently part of the Coordinated Care Initiative (CCI), which operates in seven counties and consists of both CMC, and the integration of Medi-Cal long-term services and supports, including In-Home Supportive Services (IHSS), into managed care. Gov. Brown's FY 2017–18 state budget proposed the continuation of CMC until December 31, 2019, even as the broader CCI is discontinued as of January 1, 2018. CCI's discontinuation means that IHSS administration will be transferred back to counties from managed care plans and that new state legislation will be required to authorize the CMC program past January 1, 2018.	**02/01/2017** Preliminary trailer bill language published by the Department of Finance	Watch

FEDERAL BILLS

Bill Number (Author)	Bill Summary	Bill Status	CalOptima Position
HR 1628 (Black)	The American Health Care Act (AHCA) would make sweeping changes to the national health care system. For CalOptima, the most significant changes would be 1) Changes to the Medicaid financing structure from the federal medical assistance percentage (FMAP) to a per capita cap system, 2) Decreased federal dollars for Medicaid expansion members who leave and return to the program, 3) Additional state authority to set "essential health benefit" requirements for Medicaid plans, and 4) Potentially decreased funding and additional restrictions for state waiver programs.	**05/04/2017** Passed the House	Watch
S 191 (Cassidy)	The Patient Freedom Act would repeal several mandates in the Affordable Care Act (ACA), such as the individual and employer mandates, as well as the essential health benefit requirements. The bill retains most of the ACA consumer protections, such as prohibiting discrimination, pre-existing conditions exclusions, and annual/lifetime limits. Once the ACA provisions are repealed, the bill would provide greater state flexibility for their Medicaid and exchange programs. Specifically, states would be given three options after the ACA provisions are repealed: 1) A state-specific health system (excluding the repealed ACA provisions) with 95 percent of current federal funding available to states prior to implementation of this bill, 2) A state-based health care system with no federal financial assistance, or 3) Continue under current system at funding no more than option 1 (state legislatures would be required to reinstate the ACA requirements and mandates repealed by S. 191).	**01/23/2017** Referred to Senate Committee on Finance	Watch

Bill Number (Author)	Bill Summary	Bill Status	CalOptima Position
S 870 (Hatch)	This bill would make a number of reforms to the Medicare program, and most importantly for CalOptima, it would permanently re-authorize dual eligible special needs plans (D-SNPs), including CalOptima's OneCare program. Historically, D-SNPs have been temporarily re-authorized by Congress, and are currently set to expire on December 31, 2018. According to the bill author, this bill aims to improve care for individuals with multiple chronic conditions and who are enrolled in Medicare and/or Medicaid.	**05/18/2017** Passed Senate Finance Committee	Support

The CalOptima Legislative Tracking Matrix includes information regarding legislation that directly impacts CalOptima and our members. These bills are closely tracked and analyzed by CalOptima's Government Affairs Department throughout the legislative session. All official "Support" and "Oppose" positions are approved by the CalOptima Board of Directors. Bills with a "Watch" position are monitored by staff to determine the level of impact.

2017 State Legislative Deadlines

January 4	Legislature reconvenes
February 17	Last day for legislation to be introduced
April 28	Last day for policy committees to hear and report bills to fiscal committees
May 12	Last day for policy committees to hear and report non-fiscal bills to the floor
May 26	Last day for fiscal committees to report fiscal bills to the floor
May 30–June2	Floor session only
June 2	Last day to pass bills out of their house of origin
June 15	Budget bill must be passed by midnight
July 21–August 21	Summer recess
September 1	Last day for fiscal committees to report bills to the floor
September 5–15	Floor session only
September 15	Last day for bills to be passed. Interim recess begins
October 15	Last day for Governor to sign or veto bills passed by the Legislature

Sources: 2017 State Legislative Deadlines, California State Assembly: http://assembly.ca.gov/legislativedeadlines

Board of Directors Meeting
June 1, 2017
CalOptima Community Outreach Summary — May 2017

Background
CalOptima is committed to serving our community by sharing information with current and potential members and strengthening relationships with our community partners. One of the ways CalOptima accomplishes this is through our participation in public events. CalOptima participates in public activities that meet at least one of the following criteria:

- Member interaction/enrollment: The event/activity attracts a significant number of CalOptima members and/or potential members who could enroll in any of CalOptima's programs.
- Branding: The event/activity promotes awareness of CalOptima in the community.
- Partnerships: The event/activity has the potential to create positive visibility for CalOptima and create a long-term collaborative partnership between CalOptima and the requesting entity.

We consider requests for sponsorship based on several factors including: the number of people the activity/event will reach; the marketing benefits for CalOptima; the strength of the partnership or level of involvement with the requesting entity; past participation; staff availability; and budget availability.

In addition to participating in community events, CalOptima staff actively participates in a number of community meetings including coalitions/collaboratives, committees and advisory groups focused on community health issues. CalOptima strives to address issues related to improving access to health care, reducing health disparities, strengthening the safety net system and promoting a healthier Orange County.

CalOptima Overview Presentation
In collaboration with the Community Alliances Forum Planning Committee, our Community Relations department will host a forum with the topic "Enhancing the Aging Experience Together: the Orange County Strategic Plan for Aging" on Wednesday, June 14, 2017, from 9 to 11 a.m. at Delhi Community Center.

The presentation will feature the Orange County Strategic Plan for Aging Initiative, a collaboration among Orange County's community leaders to develop a short-term and long-term strategic plan to prepare Orange County for the growing number of older adults and the issues they will face. Presenters will discuss the short-term strategic plan involving the 10 key initiatives that were created to benefit the lives of older adults living in Orange County, which will be implemented in July 2017 for 18 months. Most importantly, participants will learn of opportunities to collaborate across the various sectors to enhance the aging experience of older adults in the county.

For additional information or questions, please contact Tiffany Kaaiakamanu, manager of Community Relations at **657-235-6872**, or email tkaaiakamanu@caloptima.org.

Back to Agenda

Summary of Public Activities

During April, CalOptima participated in 38 community events, coalition and committee meetings:

Date	Events/Meetings	Audience Reached
5/01/17	• Orange County Health Care Agency Mental Health Services Act Steering Committee	Health and Human Service Providers
	• Orange County Communication Workgroup	Health and Human Service Providers
5/01/17	• Collaborative to Assist Motel Families Meeting	Health and Human Service Providers
5/03/17	• OneCare Connect Town Hall hosted by Orange County Global Medical Center and Orange County Communications Workgroup	Health and Human Service Providers
5/04/17	• Asian American Pacific Islander Heritage Month Celebration 2017 hosted by Southern California Edison	Health and Human Service Providers
5/05/17	• Covered Orange County General Meeting	Health and Human Service Providers
5/06/17	• Healthy Living Fair hosted by City of Anaheim	Members/Potential Members
5/08/17	• Orange County Veterans and Military Families Collaborative Meeting	Health and Human Service Providers
	• Fullerton Collaborative Meeting	Health and Human Service Providers
5/09/17	• Buena Clinton Neighborhood Coalition Meeting	Health and Human Service Providers
	• Susan G. Komen Orange County – Unidos Contra el Cancer del Seno	Health and Human Service Providers
	• San Clemente Youth Wellness and Prevention Coalition Meeting	Health and Human Service Providers
5/10/17	• Buena Park Collaborative Meeting	Health and Human Service Providers
	• Anaheim Homeless Collaborative Meeting	Health and Human Service Providers
5/11/17	• Orange County Strategic Plan on Aging	Health and Human Service Providers
5/12/17	• 2017 South County Senior Summit hosted by Office of Supervisor Lisa Bartlett, Orange County Office on Aging, Laguna Woods Village and Age Well Senior Services, Inc. (Sponsorship Fee: $10,000 includes logo prominently featured on event advertising as a "Diamond Sponsor," verbal recognition and special award presented by Supervisor Bartlett at the summit, half-page advertisement in event program, one large banner prominently displayed at summit, premium booth location, and agency information in event bag)	Members/Potential Members
	• Senior Citizens Advisory Council Meeting	Health and Human Service Providers

Back to Agenda

Date	Event	Audience
5/13/17	• Mental Health Awareness Resource Fair hosted by the Consulate of Mexico	Members/Potential Members
	• Spark in the Park Resource Fair hosted by SparkPoint Orange County	Members/Potential Members
5/16/17	• North Orange County Senior Collaborative Meeting	Health and Human Service Providers
	• Placentia Community Collaborative Meeting	Health and Human Service Providers
	• Vision Y Compromiso Orange County Ad Hoc Committee Meeting	Health and Human Service Providers
	• Orange County Cancer Coalition Meeting	Health and Human Service Providers
	• Vision Y Compromiso Orange County Committee	Health and Human Service Providers
5/17/17	• Covered Orange County Steering Committee	Health and Human Service Providers
	• Minnie Street Family Resource Center Professional Roundtable	Health and Human Service Providers
	• Orange County Pormotoras	Health and Human Service Providers
	• La Habra Move More Eat Healthy Plan Meeting	Health and Human Service Providers
5/18/17	• 2017 FaCT Conference Resource Fair hosted by Families and Communities Together (FaCT)	Health and Human Service Providers
	• Orange County Children's Partnership Committee (OCCP)	Health and Human Service Providers
5/20/17	• Air Power Games Day hosted by CHOC Children's Breathmobile	Members/Potential Members
5/21/17	• Community Options Fair hosted by South Coast Regional Project and Fairview Developmental Center	Members/Potential Members
5/22/17	• Stanton Collaborative	Health and Human Service Providers
5/23/17	• Orange County Senior Roundtable	Health and Human Service Providers
	• Santa Ana Building Healthy Communities	Health and Human Service Providers
5/24/17	• Senior Mini Resource Expo hosted by the City of Stanton	Members/Potential Members
5/25/17	• 23rd Annual Mental Health Conference Meeting of the Minds hosted by Mental Health Association of Orange County (Sponsorship fee: $1,000 includes one table for outreach, featured as supporting sponsor and quarter page ad in event program and six admissions to attend the conference)	Health and Human Service Providers
	• Disability Coalition of Orange County	Health and Human Service Providers

Back to Agenda

CalOptima organized or convened the following 21 community stakeholder events, meetings and presentations:

Date	Event/Meeting	Audience Reached
05/01/17	• Community-based organization presentation for Ruby Drive Elementary — Topic: CalOptima Overview	Member/Potential Member
05/02/17	• CalOptima Health Education Workshop — Topic: Healthy Weight Healthy You (Spanish)	Member/Potential Member
	• Community-based organization presentation for Melrose Elementary — Topic: CalOptima Overview	Health and Human Service Providers
05/04/17	• CalOptima New Member Orientation for Medicare-Medi-Cal Members (Vietnamese)	Member/Potential Member
	• Community-based organization presentation for Living Opportunities Management Company Triangle Terrace Affordable Senior Housing — Topic: CalOptima Overview	Member/Potential Member
05/05/17	• Community-based organization presentation for Minnie Street Family Resource Center — Topic: CalOptima Overview	Health and Human Service Providers
5/09/17	• CalOptima Health Education Workshop — Topic: Healthy Weight Healthy You (Spanish)	Member/Potential Member
5/10/17	• CalOptima Health Education Workshop — Topic: Healthy Weight Healthy You (English)	Member/Potential Member
	• OneCare Connect Forum hosted for Living Opportunities Management Company Huntington Garden Affordable Senior Housing — Topic: OneCare Connect	Member/Potential Member
5/11/17	• Community-based organization presentation for Placentia Yorba Linda Unified School District — Topic: CalOptima Overview	Health and Human Service Providers
5/12/17	• County Community Service Center education seminar — Topic: Mental Health Wellness: Understanding and Accessing Behavioral Health Benefits and Services (English)	Member/Potential Member
5/16/17	• CalOptima Health Education Workshop — Topic: Healthy Weight Healthy You (Spanish)	Member/Potential Member
	• Community-based organization presentation for Living Opportunities Management Company Huntington Garden Affordable Senior Housing —	Member/Potential Member

Back to Agenda

	Topic: CalOptima Overview	
5/17/17	• CalOptima Health Education Workshop — Topic: Healthy Weight Healthy You (English)	Member/Potential Member
5/19/17	• County Community Service Center education seminar — Topic: Mental Health Wellness: Understanding and Accessing Behavioral Health Benefits and Services (Spanish)	Member/Potential Member
5/23/17	• CalOptima Health Education Workshop — Topic: Healthy Weight Healthy You (Spanish)	Member/Potential Member
5/24/17	• CalOptima Health Education Workshops — Topic: Healthy Weight Healthy You (English)	Member/Potential Member
5/25/17	• CalOptima New Member Orientation for Medi-Cal Members (Vietnamese)	Member/Potential Member
5/26/17	• County Community Service Center education seminar — Topic: Mental Health Wellness: Understanding and Accessing Behavioral Health Benefits and Services (Vietnamese)	Member/Potential Member
5/30/17	• CalOptima Health Education Workshop — Topic: Healthy Weight Healthy You (Spanish)	Member/Potential Member
5/31/17	• CalOptima Health Education Workshops — Topic: Healthy Weight Healthy You (English)	Member/Potential Member

CalOptima endorsed the following four events during this reporting period (e.g., letters of support, program/public activity event with support or use of name/logo):

1. Letter of Support for Orange County Health Care Agency Tobacco Use Prevention Program

2. Use of CalOptima's OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) logo on the "OneCare Connect Town Hall for Physicians and Hospital Staff" flier.

3. 2017 South County Senior Summit hosted by Office of Supervisor Lisa Bartlett, Orange County Office on Aging, Laguna Woods Village and Age Well Senior Services, Inc. (Listed in Public Activities).
4. 23rd Annual Mental Health Conference Meeting of the Minds hosted by Mental Health Association of Orange County (Listed in Public Activities).

Back to Agenda

CalOptima Board of Directors
Community Activities

For more information on the listed items, contact Tiffany Kaaiakamanu, Manager of Community Relations, at 657-235-6872 or by email at tkaaiakamanu@caloptima.org.

June			
Thursday, 6/1 8:30am-12pm	+Wraparound OC and Family Support Network OC Wraparound Resource Fair	**Health/Resource Fair Open to the Public**	Mariners Church 5001 Newport Coast Irvine
Thursday, 6/1 9-11am	++Homeless Provider Forum	**Steering Committee Meeting: Open to Collaborative Members**	Covenant Presbyterian Church 1855 N. Orange Olive Rd. Orange
Friday, 6/2 9-10:30am	++Covered Orange County General Meeting	**Steering Committee Meeting: Open to Collaborative Members**	The Village 1505 E. 17th St. Santa Ana
Friday, 6/2 10-11am	++Help Me Grow Advisory Meeting	**Steering Committee Meeting: Open to Collaborative Members**	Help Me Grow 2500 Redhill Ave. Santa Ana
Saturday, 6/3 9am-2pm	+Pretend City Children's Museum Family Fun & Wellness Fair	**Health/Resource Fair Open to the Public**	Pretend City Children's Museum 29 Hubble Irvine
Monday, 6/5 1-4pm	++OCHCA Mental Health Services Act Steering Committee	**Steering Committee Meeting: Open to Collaborative Members**	Delhi Center 505 E. Central Ave. Santa Ana
Monday, 6/5 3:30-4:30pm	++OC Communication Workgroup	**Steering Committee Meeting: Open to Collaborative Members**	Location Varies
Tuesday, 6/6 9:30-11am	++Collaborative to Assist Motel Families	**Steering Committee Meeting: Open to Collaborative Members**	Anaheim Downtown Community Center 250 E. Center St. Anaheim

** CalOptima Hosted*

+ Exhibitor/Attendee
++ Meeting Attendee

Back to Agenda

Tuesday, 6/6 4:30-6pm	*Health Education Weight Control Class Presentation in Spanish	**Community Presentation Open to the Public** ***Registration required.***	CalOptima Room 150
Wednesday, 6/7 9-10:30am	++OC Aging Services Collaborative	**Steering Committee Meeting: Open to Collaborative Members**	Alzheimer's OC 2515 McCabe Way Irvine
Wednesday, 6/7 10am-12pm	++Anaheim Human Services Network	**Steering Committee Meeting: Open to Collaborative Members**	Orange County Family Justice Center 150 W. Vermont Anaheim
Wednesday, 6/7 10:30am-12pm	++OC Healthy Aging Initiative	**Steering Committee Meeting: Open to Collaborative Members**	Alzheimer's OC 2515 McCabe Way Irvine
Wednesday, 6/7 4:30-6pm	*Health Education Weight Control Class	**Community Presentation Open to the Public** ***Registration required.***	CalOptima Room 150
Wednesday, 6/7 2-3:30pm	+Westminster Family Resource Center Safe and Healthy Summer Family Resource Fair	**Health/Resource Fair Open to the Public**	Westminster Family Resource Center 7200 Plaza St. Westminster
Thursday, 6/8 10am-12pm	*Health Education Weight Control Class Presentation in Spanish	**Community Presentation Open to the Public** ***Registration required.***	Anaheim Ponderosa Community Center 2100 S. Haster St. Anaheim
Thursday, 6/8 11:30am-12:30pm	++FOCUS Collaborative Meeting	**Steering Committee Meeting: Open to Collaborative Members**	Magnolia Park Family Resource Center 11402 Magnolia St. Garden Grove
Friday, 6/9 9am-12pm	+City of Cypress Senior Center Community Resource Fair	**Health/Resource Fair Open to the Public**	Cypress Senior Center 9031 Grindlay St. Cypress
Friday, 6/9 9am-12pm	++Senior Citizen Advisory Council Meeting	**Steering Committee Meeting: Open to Collaborative Members**	Location varies
Monday, 6/12 1-2:30pm	++OC Veterans and Military Families Collaborative	**Steering Committee Meeting: Open to Collaborative Members**	Child Guidance Center 525 N. Cabrillo Park Dr. Santa Ana

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+ Exhibitor/Attendee
++ Meeting Attendee

Back to Agenda

Monday, 6/12 2:30-3:30pm	++Fullerton Collaborative	**Steering Committee Meeting: Open to Collaborative Members**	Fullerton Library 353 W. Commonwealth Ave. Fullerton
Tuesday, 6/13 11:30am-12:30pm	++Buena Clinton Neighborhood Coalition	**Steering Committee Meeting: Open to Collaborative Members**	Buena Clinton Youth and Family Center 12661 Sunswept Ave. Garden Grove
Tuesday, 6/13 2-4pm	++Susan G. Komen Orange County Unidos Contra el Cancer del Seno Coalition	**Steering Committee Meeting: Open to Collaborative Members**	Susan G. Komen OC 2817 McGaw Irvine
Tuesday, 6/13 4-5:30pm	++San Clemente Youth Wellness & Prevention Coalition	**Steering Committee Meeting: Open to Collaborative Members**	San Clemente High School 700 Avenida Pico San Clemente
Tuesday, 6/13 4:30-6pm	*Health Education Weight Control Class Presentation in Spanish	**Community Presentation Open to the Public** ***Registration required.***	CalOptima Room 150
Wednesday, 6/14 9-11am	*CalOptima Community Alliances Forum	**Community Presentation Open to the Public** ***Registration recommended.***	Delhi Community Center 505 E. Central Ave. Santa Ana
Wednesday, 6/14 10-11:30am	++Buena Park Collaborative	**Steering Committee Meeting: Open to Collaborative Members**	Buena Park Library 7150 La Palma Ave. Buena Park
Wednesday, 6/14 12-1:30pm	++Anaheim Homeless Collaborative	**Steering Committee Meeting: Open to Collaborative Members**	Anaheim Central Library 500 W. Broadway Anaheim
Wednesday, 6/14 4:30-6pm	*Health Education Weight Control Class	**Community Presentation Open to the Public** ***Registration required.***	CalOptima Room 150
Thursday, 6/15 8:30-10am	++Orange County Children's Partnership Committee	**Steering Committee Meeting: Open to Collaborative Members**	OC Hall of Administration 10 Civic Center Plaza Santa Ana
Thursday, 6/15 10am-12pm	*Health Education Weight Control Class Presentation in Spanish	**Community Presentation Open to the Public** ***Registration required.***	Anaheim Ponderosa Community Center 2100 S. Haster St. Anaheim

+ *Exhibitor/Attendee*
++ *Meeting Attendee*

Back to Agenda

Thursday, 6/15 1-2:30pm	++Surf City Senior Providers Network and Lunch	**Steering Committee Meeting: Open to Collaborative Members**	Central Park Senior Center 18041 Goldenwest St. Huntington Beach
Friday, 6/16 9-10am	++Commission to End Homelessness	**Steering Committee Meeting: Open to Collaborative Members**	Covenant Presbyterian Church 1855 N. Orange Olive Rd. Orange
Friday, 6/16 10am-12pm	++OC Care Coordination Collaborative for Kids	**Steering Committee Meeting: Open to Collaborative Members**	Help Me Grow 2500 Redhill Ave. Santa Ana
Saturday, 6/17 11am-3pm	+Rancho Santiago Community College Community Resource Fair	**Health/Resource Fair Open to the Public**	Santa Ana College 1530 W. 17th St. Santa Ana
Saturday, 6/17 9am-1pm	+North OC Senior Collaborative World Elder Abuse Awareness Day	**Health/Resource Fair Open to the Public**	Buena Park Senior Activity Center 8150 Knott Ave. Buena Park
Tuesday, 6/20 8:30-10am	++North OC Senior Collaborative	**Steering Committee Meeting: Open to Collaborative Members**	St. Jude Community Services 130 W. Bastanchury Rd. Fullerton
Tuesday, 6/20 9-10am and 2-3pm	++Vision Y Compromiso OC Committee Meeting	**Steering Committee Meeting: Open to Collaborative Members**	Council on Aging 2 Executive Circle Irvine
Tuesday, 6/20 10-11:30am	++Placentia Community Collaborative	**Steering Committee Meeting: Open to Collaborative Members**	Placentia Presbyterian Church 849 Bradford Ave. Placentia
Tuesday, 6/20 4:30-6pm	*Health Education Weight Control Class Presentation in Spanish	**Community Presentation Open to the Public** ***Registration required.***	CalOptima Room 150
Wednesday, 6/21 9:15-11am	++Covered OC Steering Committee	**Steering Committee Meeting: Open to Collaborative Members**	The Village 1505 E. 17th St. Santa Ana
Wednesday, 6/21 11am-1pm	++Minnie Street Family Resource Center Professional Roundtable	**Steering Committee Meeting: Open to Collaborative Members**	Minnie Street Family Resource Center 1300 McFadden Ave. Santa Ana

** CalOptima Hosted*

+ Exhibitor/Attendee
++ Meeting Attendee

Back to Agenda

Wednesday, 6/21 1-4pm	++Orange County Promotoras	**Steering Committee Meeting: Open to Collaborative Members**	Location Varies
Wednesday, 6/21 1:30-3pm	++La Habra Move More Eat Health Plan	**Steering Committee Meeting: Open to Collaborative Members**	Friends of Family Community Clinic 501 S. Idaho St. La Habra
Wednesday, 6/21 4:30-6pm	*Health Education Weight Control Class	**Community Presentation Open to the Public** ***Registration required.***	CalOptima Room 150
Thursday, 6/22 8:30-10am	++Disability Coalition of Orange County	**Steering Committee Meeting: Open to Collaborative Members**	Dayle McIntosh of OC 501N. Brookhurst St. Anaheim
Thursday, 6/22 10am-12pm	*Health Education Weight Control Class Presentation in Spanish	**Community Presentation Open to the Public** ***Registration required.***	Anaheim Ponderosa Community Center 2100 S. Haster St. Anaheim
Monday, 6/26 9-11am	++Community Health Research and Exchange	**Steering Committee Meeting: Open to Collaborative Members**	Healthy Smiles 2101 E. Fourth St. Santa Ana
Monday, 6/26 12:30-1:30pm	++Stanton Collaborative	**Steering Committee Meeting: Open to Collaborative Members**	Stanton Civic Center 7800 Katella Ave. Stanton
Tuesday, 6/27 7:30-9am	++OC Senior Roundtable	**Steering Committee Meeting: Open to Collaborative Members**	Orange Senior Center 170 S. Olive Orange
Tuesday, 6/27 3:30-4:30pm	++Santa Ana Building Healthy Communities	**Steering Committee Meeting: Open to Collaborative Members**	KidWorks 1902 W. Chestnut Ave. Santa Ana
Tuesday, 6/27 4:30-6pm	*Health Education Weight Control Class Presentation in Spanish	**Community Presentation Open to the Public** ***Registration required.***	CalOptima Room 150
Tuesday, 6/27 9:30am-12pm	City of Fountain Valley 12th Annual Senior Expo 2017	**Health/Resource Fair Open to the Public**	The Center at Founders Village Senior and Community Center 17967 Bushard St. Fountain Valley

** CalOptima Hosted*

+ Exhibitor/Attendee
++ Meeting Attendee

Back to Agenda

Wednesday, 6/28 4:30-6pm	*Health Education Weight Control Class	**Community Presentation Open to the Public** ***Registration required.***	CalOptima Room 150
Thursday, 6/29 10am-12pm	*Health Education Weight Control Class Presentation in Spanish	**Community Presentation Open to the Public** ***Registration required.***	Anaheim Ponderosa Community Center 2100 S. Haster St. Anaheim

+ *Exhibitor/Attendee*
++ *Meeting Attendee*

Back to Agenda