



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

**THURSDAY, MARCH 1, 2018
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
Ria Berger	Ron DiLuigi
Supervisor Andrew Do	Dr. Nikan Khatibi
Alexander Nguyen, M.D.	Richard Sanchez
J. Scott Schoeffel	Supervisor Michelle Steel
Supervisor Lisa Bartlett, 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. Assistance for Homeless Medi-Cal Members
 - b. Federal Budget
 - c. Federal Advocacy Visit
 - d. PACE Service Area Expansion
 - e. Development Agreement for 505 City Parkway West
 - f. Speaking Engagements
 - g. 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 February 1, 2018 Regular Meeting and the December 7, 2017 Special Meeting of the CalOptima Board of Directors
 - b. Receive and File Minutes of the November 15, 2017 Regular Meeting of the CalOptima Board of Directors' Quality Assurance Committee, the November 16, 2017 Regular Meeting of the CalOptima Board of Directors' Finance and Audit Committee, and the December 14, 2017 Meeting of the CalOptima Board of Directors' Provider Advisory Committee
3. [Consider Approval of the CalOptima 2018 Quality Improvement \(QI\) Program and 2018 QI Work Plan](#)
4. [Consider Approval of the CalOptima 2018 Utilization Management Program](#)
5. [Consider Approval of the 2018 CalOptima Program of All-Inclusive Care for the Elderly \(PACE\) Quality Assessment and Performance Improvement Plan](#)
6. [Consider Ratification of Increased Payment to Primary Care Physicians for the Depression Screening Incentive Program Funded by Intergovernmental Transfer \(IGT\) 1](#)
7. [Consider Approval of CalOptima Policy GG.1656, Quality Improvement and Utilization Management Conflicts of Interest](#)
8. [Consider Ratification of CalOptima's Pharmacy Management Residency Program and Approval of Related Policy](#)
9. [Consider Receiving and Filing the 2017 Compliance Program Effectiveness Audit Report](#)
10. [Consider Authorizing Proposed Budget Allocation Changes in the CalOptima Fiscal Year 2017-2018 Operating Budget](#)

REPORTS

11. [Consider Authorizing Extension of Existing Custom Durable Medical Equipment Contracts, and Contracts with Other Qualified Rehabilitation Wheelchair Suppliers](#)
12. [Consider Ratification of Amendment to CalOptima's Contract with MedImpact for Pharmacy Benefit Manager Services](#)
13. [Consider Authorizing Memoranda of Understanding with the County of Orange Social Services Agency Related to In-Home Support Services](#)

ADVISORY COMMITTEE UPDATES

14. [Provider Advisory Committee Update](#)
15. [OneCare Connect Cal MediConnect \(Medicare-Medicaid Plan\) Member Advisory Committee Update](#)
16. [Member Advisory Committee Update](#)

INFORMATION ITEMS

17. [January 2018 Financial Summary](#)
18. [Compliance Report](#)
19. [Federal and State Legislative Advocates Reports](#)
20. [CalOptima Community Outreach and Program Summary](#)

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

ADJOURNMENT

NEXT REGULAR MEETING: Thursday, April 5, 2018 at 2:00 p.m.

MEMORANDUM

DATE: March 1, 2018
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

Assistance for Homeless Medi-Cal Members

February marked a period of significant action regarding the homeless population living in the Santa Ana Riverbed, and CalOptima will be playing a supportive role. A federal judge brokered an agreement between attorneys representing the homeless and the County of Orange. Under the agreement, the county began clearing the riverbed on February 20, providing vouchers for 30-day motel stays and weekly \$75 food vouchers for six weeks. After the homeless get settled in the motels, CalOptima personal care coordinators, in conjunction with Orange County Health Care Agency staff, will be visiting to identify mental and physical health needs for people who are known to be CalOptima members. The coordinators will be supporting members in obtaining services by arranging appointments and transportation as necessary. The homeless situation is fluid, and discussions regarding long-term resolution are just beginning. I will keep your Board apprised of CalOptima's involvement.

Federal Budget

The protracted effort to pass a federal budget ended February 9, and considering how it handles health care issues affecting CalOptima, this budget was worth waiting for. Within the two-year budget agreement, the Medicaid program scored two major victories, including the permanent reauthorization of Dual Eligible Special Needs Plans (D-SNPs) and extended reauthorization for the Children's Health Insurance Program (CHIP) until 2027. This legislation provides a boost of confidence for CalOptima on two fronts: CalOptima can continue operating OneCare without concern about a possible sunset of D-SNPs and CalOptima's 112,000 children eligible through CHIP can be assured of coverage for nearly a decade. The budget also provides a favorable two-year extension of the Community Health Center Fund (CHCF) for our local network of Federally Qualified Health Centers. The CHCF provides 70 percent of federal grant funding for these centers. Finally, the budget includes \$6 billion to address the opioid crisis. These successes are due to effective advocacy by many, including CalOptima for engaging our delegation and the Association for Community Affiliated Plans for leading the charge overall.

Federal Advocacy Visit

Coming on the heels of the passage of a federal budget, Board members and staff visited with legislators in Washington, D.C., to reinforce the value of CalOptima as an innovative health plan committed to high-quality, cost-effective care. CalOptima met with staff from the offices of Sens. Dianne Feinstein and Kamala Harris, and Reps. Ed Royce, Alan Lowenthal, Mimi Walters

and Linda Sanchez. During the six meetings, each of the Board members in attendance focused on a particular area, with Dr. Nikan Khatibi covering our actions to address opioid use disorders, Ria Berger discussing the transition for California Children's Services to the Whole-Child Model, and Ron DiLuigi reviewing our services for seniors with the Program of All-Inclusive Care for the Elderly (PACE) and OneCare Connect.

PACE Service Area Expansion

On February 9, CalOptima received notice from the Centers for Medicare & Medicaid Services that our PACE Service Area Expansion application was approved. The expansion is effective March 8, 2018, and it enables CalOptima PACE to serve all of Orange County.

Development Agreement for 505 City Parkway West

Per your Board's direction at the December meeting, CalOptima staff informally met with City of Orange staff regarding the development agreement. The city received information regarding the Board's interest in extending the agreement's expiration date, perhaps to October 2026, and expanding the scope of the agreement from office usage to urban mixed use, which entails a combination of office, retail and residential uses. The city expressed preliminary support for exploring an extension of the expiration date as well as expanding the scope to urban mixed use, along with a desire to discuss the residential component in greater detail. A meeting regarding the development agreement between CalOptima and the city will be scheduled in March.

Speaking Engagements

CalOptima maintains an active presence at community, industry and legislative events. In February, I spoke on three occasions. On February 17 at the Tet Festival in Fountain Valley, I provided welcoming remarks and highlighted CalOptima's dedication to community engagement. On February 22, I was part of a panel at the UCI Annual Health Care Forecast Conference focused on updates regarding state programs. I discussed PACE, OneCare Connect, California Children's Services and the Health Homes Program, as well as our experience in strengthening delegation oversight to ensure quality in these programs and others. In Sacramento on February 27, at a gathering of regulators and legislative representatives convened by Local Health Plans of California, I shared CalOptima's current activities to serve members who are homeless. Topics included the recent actions in the Santa Ana Riverbed, recuperative care, Whole-Person Care and community grants.

Media Coverage

CalOptima's plan to expand PACE through partnerships with Community-Based Adult Services centers garnered media coverage in a variety of outlets, including the National PACE Association, Orange County Breeze, Orange County Business Journal and Orange County Register. The Register also mentioned CalOptima's participation at the recent Lunar New Year celebrations.

MINUTES
REGULAR MEETING
OF THE
CALOPTIMA BOARD OF DIRECTORS

February 1, 2018

A Regular Meeting of the CalOptima Board of Directors was held on February 1, 2018, at CalOptima, 505 City Parkway West, Orange, California. Chair Paul Yost, M.D., called the meeting to order at 2:00 p.m. Supervisor Steel led the Pledge of Allegiance.

ROLL CALL

Members Present: Paul Yost, M.D., Chair; Lee Penrose, Vice Chair; Ria Berger, Ron DiLuigi, Supervisor Andrew Do, Dr. Nikan Khatibi (at 2:15 p.m.), Alexander Nguyen, M.D., Richard Sanchez (non-voting), Scott Schoeffel, Supervisor Michelle Steel

Members Absent: All members present

Others Present: Michael Schrader, Chief Executive Officer; Gary Crockett, Chief Counsel; Greg Hamblin, 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 made the following announcement: Agenda Item 13, Consider Vendor Selection and Contracting for State Legislative Advocacy Services, was removed from the agenda due to potential conflicts of interest. Staff will re-issue the Request for Proposal for State Legislative Advocacy Services, and the Chair will form an ad hoc at the appropriate time. Staff will return to the Board with recommendations at a future meeting.

PRESENTATIONS/INTRODUCTIONS

Chair Yost welcomed Supervisor Michelle Steel to the Board. Supervisor Steel fills the seat previously held by Supervisor Lisa Bartlett. Chair Yost extended his appreciation on behalf of the Board to Supervisor Bartlett for her service.

On behalf of the Board of Directors, Chair Yost and Director Sanchez presented recognition to Mrs. Alan Edwards in memory of Dr. Alan Edwards, a long-serving member of the Provider Advisory Committee (PAC) as the Orange County Health Care Agency's representative, for his service to CalOptima and its members. PAC Chair Teri Miranti expressed appreciation on behalf of the PAC for Dr. Edwards' eleven years of service, and the expertise he provided to the Committee. On behalf of the Orange County Board of Supervisors, Supervisor Do recognized the contributions Dr. Edwards made to Orange County and extended condolences to his family.

MANAGEMENT REPORTS

1. Chief Executive Officer (CEO) Report

Michael Schrader, CEO, reported that, effective January 1, 2018, CalOptima assumed the responsibility for administering Medi-Cal behavioral health benefits for members, including Applied

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Behavioral Analysis services for children with autism. Mr. Schrader also provided an update on the Continuing Resolution to fund the federal government through February 8, 2018, and reauthorization of the Children's Health Insurance Program for six years. A review of the proposed FY 2018-19 state budget and Medi-Cal rate setting process was also reviewed with the Board.

PUBLIC COMMENTS

- Ana Sanchez, M.D., and Dr. Lilly Boyd – Oral re: Agenda Item 4, Consider Authorizing Contracting with or Amending Contracts with Community Health Centers Associated with St. Joseph Health to Serve as the Primary Care Provider for Participants Enrolled in the CalOptima Program of All-Inclusive Care for the Elderly.
- Ana Sanchez, M.D. – Oral re: Agenda Item 5, Consider Authorizing Contracting with or Amending Contracts with Community Based Physicians Associated with St. Joseph Health, Excluding St. Joseph Health-Affiliated Community Health Centers, for Primary Care Physicians Services for Participants Enrolled in the CalOptima Program of All-Inclusive Care for the Elderly
- Derek Tran, Mile Square Surgery Center, Inc. – Oral re: Agenda Item 6, Consider Authorizing Rate Methodology for Contracted Ambulatory Surgery Centers (ASCs) for Medi-Cal Services; Consider Ratifying Existing ASC Contracts and Authorizing Contracts with Additional ASCs Based on Proposed Methodology
- Berenice Nunez Constant, AltaMed; Reuben Franco, Orange County Hispanic Chamber of Commerce; and Jessica Prechtel, Coalition of Orange County Community Health Centers – Oral re: Agenda Item 8, Consider Authorizing Contracts with Alternative Care Settings to Support Expansion and Growth of CalOptima Program of All-Inclusive Care for the Elderly

CONSENT CALENDAR

2. Minutes

- a. Approve Minutes of the December 7, 2017 Regular Meeting of the CalOptima Board of Directors
- b. Receive and File Minutes of the November 9, 2017 Meeting of the CalOptima Board of Directors' Provider Advisory Committee, the November 9, 2017 Meeting of the CalOptima Board of Directors' Member Advisory Committee, and the November 16, 2017 Meeting of the CalOptima Board of Directors' OneCare Connect Cal MediConnect (Medicare-Medicaid Plan) Member Advisory Committee

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

3. Consider Adoption of Resolution Approving Updated Human Resources Policies

Action: On motion of Director Schoeffel, seconded and carried, the Board of Directors adopted Resolution No. 18-0201, Approving CalOptima's Updated Human Resources Policies GA.8044, Telework Program, and GA.8058, Salary Schedule. (Motion carried 9-0-0)

4. Consider Authorizing Contracting with or Amending Contracts with Community Health Centers Associated with St. Joseph Health to Serve as the Primary Care Provider for Participants Enrolled in the CalOptima Program of All-Inclusive Care for the Elderly (PACE)

Due to their provider affiliations, Director DiLuigi and Vice Chair Penrose did not participate in this item, and Vice Chair Penrose left the room during the discussion and vote. Director Schoeffel did not participate in this item and left the room during the discussion and vote due to potential conflicts of interest.

Action: *On motion of Supervisor Do, seconded and carried, the Board of Directors, subject to approval by the Department of Health Care Services and the Centers for Medicare & Medicaid Services of the Board-authorized waiver request, authorized the Chief Executive Officer, with the assistance of legal counsel, to enter into contracts, or amend contracts with Community Health Centers associated with St. Joseph Health to serve as primary care providers for participants enrolled in the CalOptima Program of All-Inclusive Care for the Elderly (PACE), as part of implementation of said waiver. (Motion carried 6-0-0; Director DiLuigi recused; Vice Chair Penrose and Director Schoeffel absent)*

5. Consider Authorizing Contracting with or Amending Contracts with Community Based Physicians Associated with St. Joseph Health, Excluding St. Joseph Health-Affiliated Community Health Centers, for Primary Care Physicians Services for Participants Enrolled in the CalOptima Program of All-Inclusive Care for the Elderly (PACE)

Due to his affiliation with St. Joseph Health, Vice Chair Penrose did not participate in this item and left the room during the discussion and vote. Director Schoeffel did not participate in this item and left the room during the discussion and vote due to potential conflicts of interest.

Action: *On motion of Director Nguyen, seconded and carried, the Board of Directors, subject to approval by the Department of Health Care Services and the Centers for Medicare & Medicaid Services of the Board-authorized waiver request, authorized the Chief Executive Officer, with the assistance of legal counsel, to enter into contracts, or amend contracts with Community Based Physicians associated with St. Joseph Health, excluding St. Joseph Health affiliated clinics, to serve as primary care physicians for participants enrolled in the CalOptima Program of All-Inclusive Care for the Elderly (PACE), as part of implementation of said waiver. (Motion carried 7-0-0; Vice Chair Penrose and Director Schoeffel absent)*

6. Consider Authorizing Rate Methodology for Contracted Ambulatory Surgery Centers (ASCs) for Medi-Cal Services; Consider Ratifying Existing ASC Contracts and Authorizing Contracts with Additional ASCs Based on Proposed Methodology

Due to his affiliation with St. Joseph Health, Vice Chair Penrose did not participate in this item and left the room during the discussion and vote. Director Schoeffel did not participate in this item and left the room during the discussion and vote due to potential conflicts of interest.

Action: *On motion of Director Berger, seconded and carried, the Board of Directors: 1) Authorized the Chief Executive Officer (CEO) to implement a rate methodology for Ambulatory Surgery Centers (ASCs) for outpatient Medi-Cal services based on Medicare ASC rates; 2) ratified contracts with ASCs based on Medicare rates for*

Medi-Cal services; and 3) Authorized the CEO, with the assistance of legal counsel, to enter into contracts and/or amendments with ASCs meeting Medi-Cal enrollment requirements for surgery services based on the proposed methodology. (Motion carried 7-0-0; Vice Chair Penrose and Director Schoeffel absent)

7. Consider Authorizing Amendment to Contract with Liberty Dental Plan of California, Inc. for Dental Services Provided to OneCare and OneCare Connect Members

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

Action: On motion of Director DiLuigi, seconded and carried, the Board of Directors authorized the Chief Executive Officer, or his designee, with the assistance of legal counsel, to enter into an amendment to the Liberty Dental Plan of California, Inc., contract to increase rates for supplemental dental benefits available to OneCare and OneCare Connect members for the 2018 benefit year as presented. (Motion carried 8-0-0; Director Schoeffel absent)

8. Consider Authorizing Contracts with Alternative Care Settings (ACS) to Support Expansion and Growth of CalOptima Program of All-Inclusive Care for the Elderly (PACE)

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

Richard Helmer, M.D., Chief Medical Officer, presented the recommended actions to authorize the Chief Executive Officer, with the assistance of legal counsel, to enter into contracts with Community Based Adult Services (CBAS) centers to serve as ACS sites for CalOptima PACE members, and contract with additional ACS sites on established operational and quality standards and potential PACE participant needs, subject to Board approval.

After discussion of the matter, Supervisor Do suggested amending the recommended actions to include staff reports to the Board on performance metrics.

Action: On motion of Director DiLuigi, seconded and carried, the Board of Directors authorized the Chief Executive Officer, with the assistance of legal counsel, to: 1) Enter into contracts with Community Based Adult Services (CBAS) centers to serve as Alternative Care Setting (ACS) sites for CalOptima PACE members; 2) Contract with additional ACS sites on established operational and quality standards and potential PACE participant needs; and 3) Staff to report performance metrics back to the Board. (Motion carried 8-0-0; Director Schoeffel absent)

9. Consider Authorizing Amendment of Existing Contract with Verscend Technologies

Sesha Mudunuri, Executive Director, Operations, presented the recommended action to authorize the Chief Executive Officer, with the assistance of legal counsel, to amend the existing contract with Verscend Technologies to extend the term for the period of March 1, 2018 through June 30, 2019, and authorize unbudgeted expenditures in an amount not to exceed \$285,822 from existing reserves for the Verscend Technologies contract amendment through June 30, 2018.

After considerable discussion of the matter, Supervisor Do recommended revising the contract extension period to March 1, 2018 through January 31, 2019.

Action: *On motion of Director Berger, seconded and carried, the Board of Directors authorized the Chief Executive Officer, with the assistance of legal counsel, to amend the existing contract with Verscend Technologies to extend the term for the period of March 1, 2018 through January 31, 2019; and authorized unbudgeted expenditures of an amount not to exceed \$285,822 from existing reserves for the Verscend Technologies contract amendment through June 30, 2018. (Motion carried 9-0-0)*

10. Consider Making an Exception to CalOptima's Supplemental Compensation Policy by Ratifying Employee Overpayments Related to Bilingual Pay

Action: *On motion of Supervisor Do, seconded and carried, the Board of Directors: 1) Approved an exception to CalOptima Policy GA.8052: Supplemental Compensation Policy for payments of bilingual pay to employees (and former employees) who continued to receive bilingual pay, but were not eligible for bilingual pay, after policy changes were approved by the Board on December 3, 2015, in an amount not to exceed \$60,000; and 2) Made a finding that such expenditures are for a public purpose and in furtherance of CalOptima's mission and statutory purpose. (Motion carried 8-1-0; Supervisor Steel voting no)*

11. Receive and File the Member Health Needs Assessment Executive Summary, Consider Authorization of the Allocation of Intergovernmental Transfer (IGT) 5 Funds, and Release Requests for Proposals for Community Grants

Action: *On motion of Supervisor Do, seconded and carried, the Board of Directors received and filed the CalOptima Member Health Needs Assessment Executive Summary, approved allocation of IGT 5 funds for each CalOptima Board-approved priority area, and authorized the release of Request for Proposals for community grants, with staff returning to the Board with evaluation of proposals and recommendations prior to any awards being granted. (Motion carried 9-0-0)*

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

Action: *On motion of Supervisor Do, seconded and carried, the Board of Directors: 1) Authorized expenditures for CalOptima's participation in the following community events: Up to \$5,000 and staff participation at the CEAVA Foundation and OC Parks Tet Festival 2018 Year of the Dog in Fountain Valley on February 16-18, 2018, up to \$5,000 and staff participation at the Union of Vietnamese Student Associations Southern California (UVSA) 37th Annual Tet Festival Year of the Dog in Costa Mesa on February 16-18, 2018, and up to \$10,000 and staff participation at the Age Well Senior Services' 2018 South County Senior Summit in Laguna Woods Village Performing Art Center on April 20, 2018; 2) Made a finding that such expenditures are for a public purpose and in furtherance of CalOptima's*

mission and statutory purpose; and 3) Authorized the Chief Executive Officer to execute agreements as necessary for the events and expenditures. (Motion carried 9-0-0)

13. Consider Vendor Selection and Contracting for State Legislative Advocacy Services

This item was removed from the agenda.

ADVISORY COMMITTEE REPORTS

14. Member Advisory Committee (MAC) Report

Sally Molnar, MAC Chair, thanked the Board for its actions on items on today 's meeting agenda that will make a difference in the lives of CalOptima members.

15. Provider Advisory Committee (PAC) Report

PAC Chair Teri Miranti provided an overview of the December 14, 2017 meeting activities. Topics for discussion at the February 8, 2018 PAC meeting include management reports, a presentation on telehealth for pediatric cardiology services, and a discussion on member access to certain providers. A joint meeting of the MAC, PAC, and OneCare Connect MAC will be held on March 8, 2018.

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

Gio Corzo, OCC MAC Chair, presented a review of the updates received at the December 14, 2017 meeting, including palliative care, OneCare Connect enrollment process and marketing and outreach campaign, and an update on outreach to providers on the appropriate prescribing patterns for opioids. It was noted that the OCC MAC is on target to meet its goals and objectives for FY 2017-18.

INFORMATION ITEMS

The following Information Items were accepted as presented:

17. December 2017 and November 2017 Financial Summaries
18. Compliance Report
19. Federal and State Legislative Advocates Reports
20. CalOptima Community Outreach and Program Summary

BOARD MEMBER COMMENTS

Board members congratulated staff on the successful transition of the administration of Medi-Cal behavioral health services to CalOptima and the completion of the Member Health Needs Assessment, and requested that staff provide updates on the Department of Health Care Services' medical loss ratio audit, as well as CalOptima's health network medical loss ratio audit.

ADJOURNMENT

Hearing no further business, Chair Yost adjourned the meeting at 5:24 p.m.

/s/ Suzanne Turf

Suzanne Turf
Clerk of the Board

Approved: March 1, 2018

MINUTES
SPECIAL MEETING
OF THE
CALOPTIMA BOARD OF DIRECTORS

December 7, 2017

A Special Meeting of the CalOptima Board of Directors was held on December 7, 2017, at CalOptima, 505 City Parkway West, Orange, California. Chair Paul Yost, M.D., called the meeting to order at 4:08 p.m.

ROLL CALL

Members Present: Paul Yost, M.D., Chair; Lee Penrose, Vice Chair; Supervisor Lisa Bartlett, Ria Berger, Ron DiLuigi, Supervisor Andrew Do, Richard Sanchez (non-voting)

Members Absent: Alexander Nguyen, M.D., Scott Schoeffel, Dr. Nikan Khatibi

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

PUBLIC COMMENTS

There were no requests for public comment.

ADJOURN TO CLOSED SESSION

The Board of Directors adjourned to closed session at 4:09 p.m. pursuant to Government Code section 54956.9, subdivision (d)(2), CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION: One case.

The Board reconvened to open session at 5:05 p.m. with no reportable actions taken.

ADJOURNMENT

Hearing no further business, the meeting adjourned at 5:05 p.m.

/s/ Suzanne Turf

Suzanne Turf
Clerk of the Board

Approved: March 1, 2018

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

CALOPTIMA
505 CITY PARKWAY WEST
ORANGE, CALIFORNIA

November 15, 2017

CALL TO ORDER

Chair Paul Yost called the meeting to order at 3:01 p.m. Director Nguyen led the pledge of Allegiance.

Members Present: Paul Yost, M.D., Chair; Ria Berger, Alexander Nguyen M.D.

Members Absent: Dr. Nikan Khatibi

Others Present: Michael Schrader, Chief Executive Officer; Richard Bock, M.D., Deputy Chief Medical Officer; Gary Crockett, Chief Counsel; Tracy Hitzeman, Executive Director, Clinical Operations; Diana Hoffman, Deputy Chief Counsel, Ladan Khamseh, Chief Operating Officer; Suzanne Turf, Clerk of the Board

PUBLIC COMMENTS

There were no requests for public comment.

CONSENT CALENDAR

1. Approve the Minutes of the September 20, 2017 Regular Meeting of the CalOptima Board of Directors Quality Assurance Committee

Action: ***On motion of Director Berger, seconded and carried, the Committee approved the Minutes of the September 20, 2017 Regular Meeting of the CalOptima Board of Directors' Quality Assurance Committee as presented. (Motion carried 3-0-0; Director Khatibi absent)***

REPORTS

2. Consider Recommending Board of Directors' Ratification and Amendment of Contract with Housecall Doctors Medical Group

Richard Bock, M.D., Deputy Chief Medical Officer, presented the action to recommend that the Board of Directors ratify contract with Housecall Doctors Medical Group, and authorize the Chief

Executive Officer, with the assistance of legal counsel, to amend the existing OneCare contract with Housecall Doctors Medical Group to include OneCare Connect line of business for members in the CalOptima Community Network.

Action: On motion of Director Berger, seconded and carried, the Committee recommended the Board of Directors ratify the contract with Housecall Doctors Medical Group, and authorize the Chief Executive Officer, with the assistance of legal counsel, to amend existing OneCare contract with Housecall Doctors Medical Group to include OneCare Connect line of business for members in the CalOptima Community Network. (Motion carried 3-0-0; Director Khatibi absent)

INFORMATION ITEMS

3. PACE Member Advisory Committee Update

This item was accepted as presented.

4. Behavioral Health Integration Update

Donald Sharps, M.D., Medical Director, presented a brief update on the transition of Medi-Cal behavioral health services including the status of the behavioral health provider network, staff recruitment, the development of internal workflow procedures, and member communication. Dr. Sharps also provided an update on the implementation of the Drug Medi-Cal Organized Delivery System, which is anticipated to begin on March 1, 2018.

5. Palliative Care Update

Tracy Hitzeman RN CCM, Executive Director, Clinical Operations, provided an overview of Senate Bill 1004, which requires the Department of Health Care Services (DHCS) to establish standards and provide technical assistance for Medi-Cal managed care plans to ensure the delivery of palliative care services effective January 1, 2018. It was noted health networks will be responsible for all palliative care services for their assigned members, and CalOptima plans to contract with providers for service delivery and care coordination for eligible CalOptima Direct and CalOptima Community Network members; reporting will be based on DHCS and plan requirements. CalOptima anticipates receiving guidance from DHCS regarding reporting requirements and approval for CalOptima policies and procedures.

6. Over/Under Utilization Report

Ms. Hitzeman presented a brief update on over/under utilization reporting and monitoring, and reviewed physician specific metrics related to unused authorizations, pharmacy utilization, and the frequency of selected procedures utilization.

7. Quarterly Reports to the Quality Assurance Committee

The following Quarterly Reports were accepted as presented:

- a. Quality Improvement Report
- b. Member Trend Report

ADJOURNMENT

Hearing no further business, Chair Yost adjourned the meeting at 3:41 p.m.

/s/ Suzanne Turf

Suzanne Turf
Clerk of the Board

Approved: February 20, 2018

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

CALOPTIMA
505 CITY PARKWAY WEST
ORANGE, CALIFORNIA

NOVEMBER 16, 2017

CALL TO ORDER

Chair Lee Penrose called the meeting to order at 2:04 p.m. Director DiLuigi led the Pledge of Allegiance.

Members Present: Lee Penrose, Chair; Scott Schoeffel, Ron DiLuigi

Members Absent: All members present

Others Present: Michael Schrader, Chief Executive Officer; Gary Crockett, Chief Counsel; Greg Hamblin, Chief Financial Officer; Ladan Khamseh, Chief Operating Officer; Len Rosignoli, Chief Information Officer; Suzanne Turf, Clerk of the Board

PUBLIC COMMENT

There were no requests for public comment.

INVESTMENT ADVISORY COMMITTEE UPDATE

1. Treasurer's Report

Chief Financial Officer Greg Hamblin presented an overview of the Treasurer's Report for the period July 1, 2017 through September 30, 2017. 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 September 21, 2017 Regular Meeting of the CalOptima Board of Directors' Finance and Audit Committee; Receive and File Minutes of the July 24, 2017 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 3-0-0)

REPORTS

3. Consider Recommending Board of Directors' Approval of the Annual Investment Policy for Calendar Year 2018

Mr. Hamblin presented the action to recommend that the CalOptima Board of Directors approve the Annual Investment Policy (AIP) for Calendar Year 2018. CalOptima's investment managers, Payden & Rygel, Logan Circle Partners, and Wells Capital Management, and CalOptima's investment advisor, Meketa Investment Group, Inc., submitted proposed revisions to the AIP for 2018. The proposed revisions were reviewed by the Board of Directors' Investment Advisory Committee. Mr. Hamblin provided a brief overview of the recommended changes for the Committee's consideration.

Action: On motion of Director Schoeffel, seconded and carried, the Committee recommended Board of Directors' approval of the Annual Investment Policy for Calendar Year 2018. (Motion carried 3-0-0)

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

Mr. Hamblin presented the action to recommend that the Board of Directors appoint Susan Munson for a two-year term to fill the current vacancy on the CalOptima Board of Directors' Investment Advisory Committee effective December 7, 2017.

Action: On motion of Director DiLuigi, seconded and carried, the Committee recommended that the Board of Directors appoint Susan Munson for a two-year term on the Board of Directors' Investment Advisory Committee effective December 7, 2017. (Motion carried 3-0-0)

5. Consider Recommending Board of Directors' Approval of Updates to Policy for Acceptable Use of Company-Issued Mobile Phones

Len Rosignoli, Chief Information Officer, presented the action to recommend Board of Directors' approval of proposed updates to CalOptima Policy GA.5005d: Acceptable Use of a Company-Issued Mobile Phone for Business Purposes. The proposed updates to the policy were reviewed with the Committee.

Action: On motion of Director Schoeffel, seconded and carried, the Committee recommended Board of Directors' approval of the updates to Policy GA.5005d: Acceptable Use of a Company-Issued Mobile Phone for Business Purposes as presented. (Motion carried 3-0-0)

INFORMATION ITEMS

6. September 2017 and August 2017 Financial Summaries

Mr. Hamblin provided an overview of the balance sheet, Board-Designated Reserves and tangible net equity (TNE) requirement as of September 30, 2017.

7. CalOptima Computer Systems Security Update

Mr. Rosignoli presented a review of the Information Security Update for the quarter ending September 30, 2017, as well as employee activities related to National Cyber Security Awareness during the month of October 2017.

The following Information Items were accepted as presented:

8. Cost Containment Improvements/Initiatives
9. Quarterly Reports to the Finance and Audit Committee
 - a. Shared Risk Pool Performance
 - b. Reinsurance Report
 - c. Health Network Financial Report
 - d. Purchasing Report

COMMITTEE MEMBER COMMENTS

Committee members extended their appreciation to Nancy Huang for her service as Interim Chief Financial Officer.

ADJOURNMENT

Hearing no further business, Chair Penrose adjourned the meeting at 2:40 p.m.

/s/ Suzanne Turf
Suzanne Turf
Clerk of the Board

Approved: February 15, 2018

MINUTES

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

December 14, 2017

A Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee (PAC) was held on Thursday, December 14, 2017, at the CalOptima offices located at 505 City Parkway West, Orange, California.

CALL TO ORDER

Teri Miranti, PAC Chair, called the meeting to order at 8:10 a.m., and Member Dr. Orras led the Pledge of Allegiance.

ESTABLISH QUORUM

Members Present: Teri Miranti, Chair; Suzanne Richards, MBA, FACHE, Vice Chair; Anjan Batra, M.D.; Donald Bruhns; Steve Flood; Jena Jensen; Craig G. Myers; John Nishimoto, O.D; George Orras, Ph.D., FAAP; Mary Pham, Pharm.D, CHC; Pamela Pimentel, R.N.; Jacob Sweidan, M.D.

Members Absent: Theodore Caliendo, M.D.; Mary Hale; Pamela Kahn, R.N.;

Others Present: Michael Schrader, Chief Executive Officer; Ladan Khamseh, Chief Operating Officer; Richard Bock, M.D., Deputy Chief Medical Officer; Greg Hamblin, Chief Financial Officer; Michelle Laughlin, Executive Director, Network Operations; Phil Tsunoda, Executive Director, Public Policy and Public Affairs; Tracy Hitzeman, Executive Director, Clinical Operations; Cheryl Simmons, Staff to the Provider Advisory Committee

The PAC observed a moment of silence in memory of Member Alan Edwards, M.D., who passed away in November. Dr. Edwards represented the Orange County Health Care Agency on the PAC for 11 years.

MINUTES

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

Action: On motion of Member Dr. Sweidan, seconded and carried, the Committee approved the minutes of the November 9, 2017 meeting. (Motion carried 12-0-0; Members Caliendo, Hale and Kahn absent)

PUBLIC COMMENTS

No requests for public comment were received.

CEO AND MANAGEMENT REPORTS

Chief Executive Officer Update

Michael Schrader, Chief Executive Officer, explained how the California Children's Services (CCS) Whole Child Model (WCM) is a high priority for CalOptima during the upcoming year and that a stakeholder meeting would be held on January 25, 2018 to discuss CalOptima's implementation plan for the WCM. Mr. Schrader noted that CalOptima has been scheduled for phase two of the State-wide implementation by the Department of Healthcare Services (DHCS) for the County Organized Health Systems. He also noted that more stakeholder meetings will be held throughout the year to prepare for the January 1, 2019 implementation.

Chief Operating Officer Update

Ladan Khamseh, Chief Operations Officer, discussed the outreach to members who were eligible for Medicare Part A through Social Services. Ms. Khamseh also provided an update on the behavioral health transition as it relates to provider contracting. She noted that some providers had not return their signed contract before the deadline and members had been notified that they would have to switch providers. She also noted that once the signed contracts were received, the Customer Service team had been pro-active in reaching out to the approximately 1300 members to let them know that they could continue to see their current providers. Mr. Schrader also noted that an orientation for newly-contracted behavioral health providers is scheduled for December 20, 2017.

Chief Medical Officer Update

Richard Helmer, M.D., Chief Medical Officer, reported on Senate Bill 1004, which requires the Department of Health Care Services (DHCS) to establish standards and provide technical assistance to ensure the delivery of palliative care services by Managed Care Plans. Dr. Helmer noted that CalOptima and its contracted health networks will be responsible for providing palliative care services to Medi-Cal members effective January 1, 2018. CalOptima anticipates receiving additional final guidance from DHCS before the implementation date

Chair Miranti reordered the agenda to hear Information Item B, Opioid Epidemic Update.

Opioid Epidemic Update

Richard Bock, M.D., Deputy Chief Medical Officer, presented an update on the current state of the opioid epidemic and its impact on Orange County, and CalOptima's role in helping reduce the number of CalOptima members addicted to opioids including formulary restrictions, Pharmacy Home Program, outreach to the highest Morphine Equivalent Dose (MED) prescribers and quality measures.

Chief Financial Officer Update

Greg Hamblin, Chief Financial Officer, presented the October 2017 financial report, and summarized CalOptima's financial performance and current reserve levels. Mr. Hamblin also reviewed the Health Network enrollment figures for the same period.

Network Operation Update

Michelle Laughlin, Executive Director Network Operations, provided an update on the behavioral health transition, and noted that DHCS has certified CalOptima's behavioral health provider network. Ms. Laughlin reported on staff's recent site visit at the Inland Empire Health Plan (IEHP). IEHP shared their best practices including a center of excellence for autism screening

Federal and State Budget Update

Phil Tsunoda, Executive Director, Public Policy and Public Affairs, provided an update on the State and Federal budgets, including the re-authorization of Children's Health Insurance Program (CHIP) funding, cost-sharing for the Exchanges, and the current state of the tax reform bill.

INFORMATION ITEMS

Optometry's Role in Patient Care

PAC Member John Nishimoto, OD, presented an overview of Optometry's role in patient care including early detection and intervention, and diabetic retinal exams. Dr. Nishimoto noted that approximately 64% of CalOptima members received retinal/eye exams in 2015.

PAC Member Updates

Chair Miranti solicited volunteers for a joint ad hoc of the Member Advisory Committee (MAC) and the OneCare Connect MAC to develop the agenda for the joint MAC, OCC MAC and PAC meeting scheduled on March 8, 2018. Members Pimentel, Orras and Myers agreed to participate with Chair Miranti on the ad hoc. The joint ad hoc meeting is scheduled on January 11, 2018.

ADJOURNMENT

There being no further business before the Committee, Chair Miranti adjourned the meeting at 10:01 a.m.

/s/ Cheryl Simmons

Cheryl Simmons
Staff to the PAC

Approved: February 8, 2018

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 1, 2018 **Regular Meeting of the CalOptima Board of Directors**

Consent Calendar

3. Consider Approval of the CalOptima 2018 Quality Improvement (QI) Program and 2018 QI Work Plan

Contact

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

Recommended Action

Recommend approval of the recommended revisions to the 2018 Quality Improvement Program and 2018 Quality Improvement Work Plan.

Background

As part of existing regulatory and accreditation mandated oversight processes, CalOptima's Quality Improvement ("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 operation 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 monitoring throughout the year and reported to QIC quarterly.

CalOptima staff has updated the 2018 QI Program Description and 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 all lines of business.

Discussion

The 2018 Quality Improvement Program is based on the 2017 Board-approved 2017 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 strategic initiatives.

The revisions are summarized as follows:

1. Updates the introductory pages to align with CalOptima's Vision, Mission & Strategic Plan for 2017-19;
2. Updates signature page (replaces Mark Refowitz with Paul Yost)
3. Updates the plans we offer, scope of services and who we work with – including an updated list of our Health Networks;
4. Updates the Behavioral Health Services CalOptima directly manages for Medi-Cal members, and contracts to Magellan Health, Inc. for the BH services portion of OneCare and OneCare Connect functions;
5. Updates the list of CalOptima Officers and staff and included a broader representation of the key areas supporting the QI Program;
6. Incorporates the description of CalOptima's approach to population health management in the design and delivery of care;
7. Updates to include Conflict of Interest policy statement applicable to Committee and Sub-Committee members;
8. Adds Cultural Competency Training during staff orientation, training and education
9. Updates the Advisory Committees and Quality Committees/Subcommittees structure that support the QI Program;
10. Updates BHQIC to monitor member experience with behavioral health services including call center, grievance and appeals, and potential for quality improvement;
11. Updates the 2018 QI Work Plan to reflect new goals and objectives in line with CalOptima's strategic objectives;
12. Updates 2018 Delegation Grid, removing Magellan as a delegated function for the Medi-Cal line of business;
13. Adds Farsi, Chinese and Arabic languages to the OCC member materials.

The recommended changes are designed to better review, analyze, implement and evaluate 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

The recommended action to approve the 2018 QI Program and 2018 QI Work Plan has no fiscal impact.

Concurrence

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

Attachments

1. Proposed 2018 Quality Improvement Program – Executive Summary of Revisions
2. Proposed 2018 Quality Improvement Program and 2018 Quality Improvement Work Plan

/s/ Michael Schrader
Authorized Signature

2/21/2018
Date

[Back to Agenda](#)

Quality Improvement (QI) Program 2018

Executive Summary of Revisions

1. Updates the introductory pages to align with CalOptima's Vision, Mission and Strategic Plan for 2017-19.
2. Updates signature page (replaces Mark Refowitz with Paul Yost).
3. Updates the plans we offer, scope of services and who we work with, including an updated list of our Health Networks.
4. Updates new initiatives on the horizon, including Whole-Person Care and Whole-Child Model.
5. Updates Behavioral Health Services that CalOptima directly manages for Medi-Cal members. For the BH services portion of OneCare and OneCare Connect, CalOptima contracts with Magellan Health, Inc.
6. Updates the list of CalOptima officers and staff, and includes a broader representation of the key areas supporting the QI Program.
7. Incorporates the description of CalOptima's approach to population health management in the design and delivery of care.
8. Updates to include Conflict of Interest policy statement applicable to committee and subcommittee members.
9. Adds Cultural Competency Training during staff orientation, training and education
10. Updates the advisory committees and Quality committees and subcommittees structure that support the QI Program.

11. Updates Behavioral Health Quality Improvement Committee (BHQIC) to monitor member experience with behavioral health services, including call center, grievance and appeals, and the potential for quality improvement.
12. Updates the 2018 QI Work Plan to reflect new goals and objectives aligned with CalOptima's strategic objectives.
13. Updates 2018 Delegation Grid, removing Magellan as a delegated function for the Medi-Cal line of business.
14. Adds Farsi, Chinese and Arabic languages to the OCC member materials.



A Public Agency

CalOptima

Better. Together.

2018~~2017~~

QUALITY IMPROVEMENT PROGRAM





CalOptima
Better. Together.

**~~2017~~2018 QUALITY IMPROVEMENT
PROGRAM
SIGNATURE PAGE**

Quality Improvement Committee Chair:

Richard 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**~~ — **Paul Yost, M.D.** _____ **Date**

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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, Quality Assurance Committee and Finance and Audit 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.

Steewardship: 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~~long-standing 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 be the best of it is~~ both a public agency ~~upholding public trust,~~ and a community health plan ~~seeking quality health care, efficiency and member satisfaction.~~

As both, CalOptima must:

- MakeProvide quality health care to ensure optional health outcomes for our members
- Support member and provider engagement and satisfaction
- Be good stewards of public funds by making the best use of our resources, ~~funding~~ and expertise
- ~~Solicit stakeholder input~~
- Ensure transparency in our governance procedures, including providing opportunities for stakeholder input
- Be accountable for the decisions we make

|

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

CalOptima as a public agency and a COHS has:

- Single plan responsible for providing Medi-Cal coverage in the county
- Mandatory enrollment of all full-scope Medi-Cal beneficiaries, including dual eligibles
- Responsible 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) operates exclusively as a “Zero-Cost Share, Medicaid-Subset Dual Special Needs Plan.” OC only enrolls beneficiaries who qualify as a zero-cost sharing Medicaid subset. To identify dual-eligible members, 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). 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 the program’s goal is to help members stay in their homes for as long as possible and shift services out of institutional settings and into the home and community. A key feature of CalOptima is identifying high-risk enrollees who need comprehensive care coordination, and assembling an appropriate care team to develop and track an individual care plan. Members eligible for OCC cannot enroll in OC.

WHAT 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 grew by an unprecedented 49 percent between 2014 and 2016!

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 reside in Orange County 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) <u>and non-medical transportation (NMT)</u>	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- and Case Management (CM) 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 OC HCA, CCS and the Regional Center of Orange County (RCOC).

Medi-Cal Managed Long-Term Services and Supports

~~Beginning~~Since July 1, 2015, DHCS integrated Long-Term Services and Supports (LTSS) ~~became a benefit~~benefits for ~~all~~CalOptima 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~~These integrated LTSS benefits include three 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)~~

OneCare (HMO SNP)

Our OneCare ~~(HMO SNP) means total care. Our~~ members withhave Medicare and Medi-Cal benefits ~~are~~ covered in one single plan, making it easier for our members to get the health care they need. Since 2005, CalOptima has been offering OC to low-income seniors and people with disabilities who qualify for both Medicare and Medi-Cal. OC has extensive experience serving the complex needs of the frail, disabled, dual eligible members in Orange County. With the start of OneCare Connect (OCC) in 2015, only individuals not eligible for OCC can enroll in OneCare.

To be a member of 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 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 <u>Transportation</u> 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 is a 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 both 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 in a better, more efficient and higher quality health care experience for the member.

To join 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 <u>Transportation</u> 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 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~~ seniors to help them continue living independently in the community.

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.

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, dietitians, physical therapists, occupational therapists, home-care staff, activity staff and transportation staff who are committed to planning, coordinating and delivering the most fitting and personalized health care to ~~our~~ participants.

PACE provides all the acute and long-term care services covered by Medicare and Medi-Cal. The services are arranged for participants, based on their needs as indicated by the 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 ON OUR HORIZON:

Palliative Care

~~CalOptima expects to implement palliative care standards for its Medi-Cal members no sooner than July 1.~~

Whole-Person Care

Whole-Person Care is a five-year pilot established by DHCS as part of California's Medi-Cal 2020 strategic plan. In Orange County, the pilot is being and led by the Orange County Health Care Agency ~~to~~. It will 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-Child Model

California Children's Services (CCS) is a statewide program for children with certain medical conditions. CCS provides medical care, case management, physical/occupational therapy and financial assistance. Currently, CCS services are carved out (separated) from most Medi-Cal managed care plans, including CalOptima. The Orange County Health Care Agency (OC HCA) manages the local CCS program. OC HCA provides case management, eligibility determination, service authorization and direct therapy under the Medical Therapy Program.

By July 1, 2018, CCS services will be a Medi-Cal managed care plan benefit. The goal is to improve health care coordination for the whole child, rather than handle CCS conditions separately. This approach is known as the Whole-Child Model.

By January 1, 2019, most other CCS functions will be part of CalOptima's Medi-Cal plan. Under this model, OC HCA will still determine eligibility, and handle the Medical Therapy Program.

CalOptima regularly meets with OC HCA about the CCS transition in Orange County. There are ongoing discussions about implementation, and decisions pending further guidance from the state. The priority for CalOptima and OC HCA is to make sure there is a seamless transition for the children and families involved. CalOptima will keep our stakeholders informed, and provide opportunities for feedback. 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 WE WORK WITH:

Contracted Health Networks/Contracted Network Providers

Providers have several options for participating in CalOptima's programs to provide health care to Orange County's Medi-Cal members. Providers can contract with a CalOptima health network, and/or participate through CalOptima Direct, and/or the CalOptima Community Network. CalOptima members can choose one of 1415 health networks (HNs), representing more than 7,500 practitioners.

Health Networks

CalOptima contracts with a variety of health network models to provide care to members. Since 2008, CalOptima's HNs consist of Health Maintenance Organizations (HMOs), Physician/Hospital Consortia (PHCs), and Shared Risk Medical Groups (SRGs). Through these HNs, CalOptima members have access to nearly 1,600 Primary Care Providers (PCPs), nearly 6,100 specialists, 30 hospitals, and 36 clinics.

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 private¹⁴ HNs for Medi-Cal. CCN is administered internally by CalOptima and is the 14th 15th 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 dual-eligibles (those with both Medicare and Medi-Cal who elect not to participate in CalOptima's MA SNP), share of cost members, and members residing outside of Orange County. Members enrolled in CalOptima Direct are not health network eligible.

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 14 HNs for Medi-Cal. CCN is administered internally by CalOptima and is the 15th network available for members to select, supplementing the existing health network delivery model and creating additional capacity for growth.

Health Networks

~~CalOptima contracts with a variety of health network models to provide care to members. Since 2008, CalOptima's HNs consist of 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 more than 1,500⁵⁹³ Primary Care Providers (PCPs), nearly 6,000⁰⁹² specialists and 30 hospitals, and 36 clinics. New health 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 networks:

Health Network/Delegate	Medi-Cal	OneCare	OneCare Connect
AltaMed Health Services	SRG	PMG SRG	SRG
AMVI/Prospect		SRG	
AMVI Care Health Network	PHC	PMG	PHC
Arta Western Health Network	SRG	PMG SRG	SRG

CCN

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

Upon successful completion of readiness reviews and audits, the 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, psychology, psychiatric consultation, medication management, and psychological testing when clinically indicated to evaluate a mental health condition. CalOptima directly manages all administrative functions of the Medi-Cal behavioral health benefits including utilization management, claims, credentialing the provider network, and customer service.

Member can receive behavioral health services within the scope of practice for primary care physicians (PCPs) including screening, brief intervention, and referral to treatment (SBIRT) services to members 18 and older who may 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. In addition, PCPs frequently manage the treatment of mental health conditions in their patients.

If a member needs behavioral health services not provided by their PCP, CalOptima members can access behavioral health services directly, without a physician referral by contacting the CalOptima representative for behavioral health assistance. If office based services are appropriate, the member will be provided with several behavioral health practitioners, based upon geographic proximity and clinical needs. If the member meets criteria for Specialty Mental Health Services, the member is referred to the Orange County Mental Health Plan. Specialty Mental Health Services are not the responsibility of CalOptima. Additionally, CalOptima covers behavioral health treatment (BHT) for members 20 years of age and younger with a diagnosis of Autism Spectrum Disorder (ASD).

OneCare and OneCare Connect Behavioral Health Services

CalOptima has contracted with Magellan Health Inc. for the behavioral health services portion of OneCare and OneCare Connect. Functions delegated to Magellan include utilization management, credentialing, and customer service.

CalOptima OneCare and OneCare Connect members can access behavioral health services by calling the CalOptima Behavioral Health Line. Members will be connected to a Magellan representative for behavioral health assistance. If office-based services are appropriate, the member is registered and given referrals to an appropriate provider. If ambulatory Specialty Mental Health needs are identified, services may be rendered through the Orange County Mental Health Plan.

CalOptima offers 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.

Medi-Cal Ambulatory Behavioral Health Services

CalOptima covers behavioral health treatment (BHT) services for members 20 years of age and younger with a diagnosis of Autism Spectrum Disorder (ASD). 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 Magellan Health, Inc. [a managed behavioral healthcare organization (MBHO)] for UM of the provider network, network adequacy and credentialing the provider network, 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).

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 screening for alcohol misuse, and provide people engaged in risky or hazardous drinking behavior 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 Magellan Health, Inc. for the behavioral health services portion of OC and OCC. The delegated functions are identical to those listed above.~~

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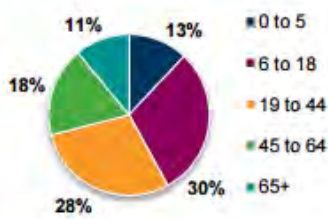
Fast Facts: February 2017

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

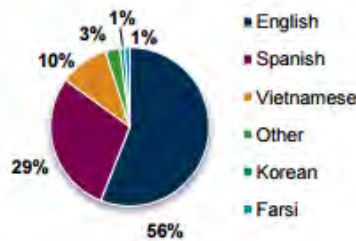
Membership Data as of December 31, 2016

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

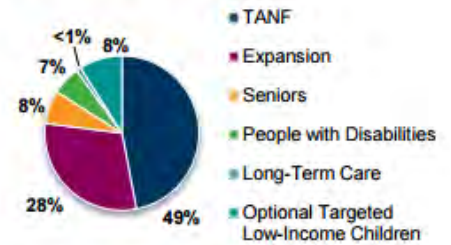
Member Age (All Programs)



Languages Spoken (All Programs)



Medi-Cal Aid Categories



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, 2017

Total CalOptima Membership 791,476	Program	Members
	Medi-Cal	774,646
	OneCare Connect	15,223
	OneCare (HMO SNP)	1,372
	Program of All-Inclusive Care for the Elderly (PACE)	235

Member Age (All Programs)

- 12% 0 to 5
- 30% 6 to 18
- 29% 19 to 44
- 18% 45 to 64
- 11% 65+

Languages Spoken (All Programs)

- 56% English
- 29% Spanish
- 10% Vietnamese
- 2% Other
- 1% Korean
- 1% Farsi
- <1% Chinese
- <1% Arabic

Medi-Cal Aid Categories

- 45% Temporary Assistance for Needy Families
- 31% Expansion
- 10% Optional Targeted Low-Income Children
- 8% Seniors
- 6% People with Disabilities
- <1% Long-Term Care

QUALITY IMPROVEMENT PROGRAM

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

CalOptima has developed programs using evidence-based guidelines that 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 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, BOARD OF DIRECTORS' COMMITTEES, AND RESPONSIBILITIES, 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 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.

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 comprised of 15 voting members, each seat represents a constituency served by CalOptima. 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, and preventative services. 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 Services and Support
- 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) reports directly to the CalOptima board of Directors, and 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. The meetings are open to the public.

Provider Advisory Committee

The Provider Advisory Committee (PAC) was established in 1995 by the CalOptima Board of Directors to advise the Board on issues impacting the CalOptima provider community. The PAC is comprised of providers who represent a broad provider community that serves CalOptima members. The PAC is comprised of 15 members, 14 of whom serve three-year terms with two consecutive term limits, along with a representative of the Orange County Health Care Agency, which maintains a standing seat. The meetings are open to the public. The 15 seats include:

- Health Network (1 seat)
- Hospitals (1 seat)

- Physicians (3 seats)
- Nurse (1 seat)
- Allied Health Services (1 seat)
- Community Health Centers (1 seat)
- Orange County Health Care Agency (HCA) (1 standing seat)
- Long Term Services and Support including (LTC facilities and CBAS) (2 seats)
- Non-Physician Medical Practitioner (1 seat)
- Traditional/Safety Net (1 seat)
- Behavioral/Mental Health (1 seat)
- Pharmacy (1 seat)

Whole-Child Model Family Advisory Committee

In 2018, CalOptima’s Board of Directors will establish the Whole-Child Model Family Advisory Committee (WCM FAC), as required by the state when California Children’s Services (CCS) becomes a Medi-Cal managed care plan benefit. The WCM FAC will provide advice and recommendations to the Board and staff on issues concerning WCM, serve as liaison between interested parties and the Board, and assist the Board and staff in obtaining public opinion on issues relating to CalOptima WCM. The committee can initiate recommendations on issues for study, and facilitate community outreach.

The WCM FAC will be composed of the following 11 voting seats:

- Family representatives: 7 to 9 seats
 - Authorized representatives, which includes parents, foster parents and caregivers of a CalOptima member who is a current recipient of CCS services; or
 - CalOptima members age 18-21 who are a current recipient of CCS services; or
 - Current CalOptima members over the age of 21 who transitioned from CCS services
- Interests of children representatives: 2 to 4 seats
 - Community-based organizations; or
 - Consumer advocates

Of the above seats, five members serve a one-year term, and six will serve a two-year term. WCM FAC meetings will be open to the public.

Quality Improvement Program, Role of CalOptima Officers for Quality Improvement Program

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 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 oversees strategies, programs, policies and procedures as they relate to CalOptima's medical care delivery system. The DCMO and CMO oversee Quality Analytics ([QA](#)), Quality ~~Management~~[Improvement \(QI\)](#), [Utilization Management \(UM\)](#), Case ~~Coordination, Case-~~Management ([CM](#)), ~~HE&DM,~~[Health Education & Disease Management \(HE&DM\)](#), Pharmacy Management ([PM](#)), Behavioral Health Integration ([BHI](#)), ~~and~~ Long-Term Services and Supports ([LTSS](#)), and [Enterprise Analytics](#).

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, ~~-~~Electronic Business and Human Resources.

Executive Director, Quality & Analytics (ED of [Q&A](#)) is responsible for facilitating the company-wide QI Program, driving improvements with Healthcare Effectiveness Data and Information Set (HEDIS), DHCS, CMS Star measures and ratings, and facilitating compliance with National Committee for Quality Assurance (NCQA) standards. The ED of [Q&A](#) serves as a member of the executive team and with the CMO/DCMO [and ED of Clinical Operations](#), supports efforts to promote adherence to established quality improvement strategies and programs throughout the company- [and makes certain that quality initiatives are aligned with Clinical Operations within Medical Affairs](#). Reporting to the ED of [Q&A](#) is the Director of Quality Analytics, the Director of Health Education & Disease Management, [and](#) the Director of 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: UM, Care Coordination, 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 [and ED of Q&A](#), 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; and [is responsible for](#) 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, ~~Managed Behavioral Health Organizations (MBHOs)~~ and ~~FDRs 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 HNs, ~~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) 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~~agency-wide practices that support accreditation by ~~the~~ NCQA, and meets Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS) quality requirements and measures.

The Quality and Clinical Operations departments, and Medical Directors, in conjunction with multiple CalOptima departments, 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 QI department is responsible for the execution and coordination of ~~the~~ quality assurance and improvement activities. 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.

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 agencywideagency-wide
- Evaluate and monitor provider credentials
- Support the maintenance of quality standards across the continuum of care andfor all lines of business
- Monitor and maintain agencywideagency-wide practices that support accreditation and meeting regulatory requirements.

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, programs 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 QA department activities include design, implementation and evaluation of initiatives to:

- Report, monitor 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 agency-wide
- 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
- Provide agency-wide 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 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 data
- Group Needs Assessments
- Results of Risk Stratification
- HEDIS Performance
- Member and Provider satisfaction surveys
- QI Projects: [Quality Improvement Project \(QIP\)s](#), [Performance Improvement Project \(PIP\)](#), [Plan-Do-Study-Act \(PDSA\)s](#) and [Chronic Care Improvement CCIPs](#))
- Health Risk Assessment (HRA) data

HEALTH EDUCATION & DISEASE MANAGEMENT DEPARTMENT

The Health Education & Disease Management (HE & DM) department, also known as Population Health Management (PHM) is the third area in Quality that provides program development and implementation for ~~agencywide~~agency-wide population health programs. ~~HE & DM~~PHM 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, Shape Your Life/Weight Management and Tobacco Cessation.

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 grades~~sixth-grade reading level and are culturally and linguistically appropriate for our members.

~~HE & DM~~PHM 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~~Execution and ~~coordinate~~coordination of programs with Case Management, QA and our Health Network Providers.

QI PROGRAM RESOURCES ~~AND COMMITTEE STRUCTURE~~

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:

Deputy Chief Medical Officer (DCMO) Director, Quality

~~The DCMO 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.

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 Director:
 - Manager, Quality Improvement
 - Supervisor, Quality Improvement (PQI)
 - Supervisor, Quality Improvement (Credentialing)
 - Supervisor, Quality Improvement (FSR)
 - QI Program Specialists
 - QI Nurse Specialists
 - Data ~~Analyst~~Analysts
 - Credentialing Coordinators
 - Program Specialists
 - 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~~agency-wide 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 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~~agency-wide population health initiatives. Ensures linkages supporting a whole-person perspective to health and health care with Case Management, Care 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 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 Dietitians
 - 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.

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 UM program, policies, and procedures. This director ensures the appropriate use of evidenced-based clinical review criteria/guidelines for medical necessity determinations. The director of UM also provides supervisory oversight and administration of the UM program, oversees all clinical decisions rendered for concurrent, prospective and retrospective reviews that support UM medical management decisions, serves on the Utilization and QI Committees, and participates in the UM Committee and the Benefit Management Subcommittee.

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

Director of Case Management is responsible for Case Management, Transitions of Care, Complex Case Management and the clinical operations of Medi-Cal, OCC and OC. 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 and quality measures.

Director of Long Term Services and Supports is responsible for LTSS programs, which include CBAS, ~~In-Home Supportive Services (IHSS)~~, LTC, and MSSP. The position supports a “Member-Centric” approach and helps keep members in the least restrictive living environment, ~~collaborate~~collaborates with ~~stakeholders including~~ community partners; and ~~ensure other stakeholders, and ensures~~ LTSS ~~services~~ are available to ~~the~~ appropriate ~~population~~populations. The 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 operational oversight for~~ behavioral health ~~care~~benefits and services for CalOptima ~~provided to~~ members. The ~~director leads and assists the organization in developing and successfully implementing short and long term strategic goals and objectives toward integrated care. The director plays a key leadership role in coordinating with all levels of CalOptima staff.~~Director 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 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~~is 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 STRATEGIC GOALS

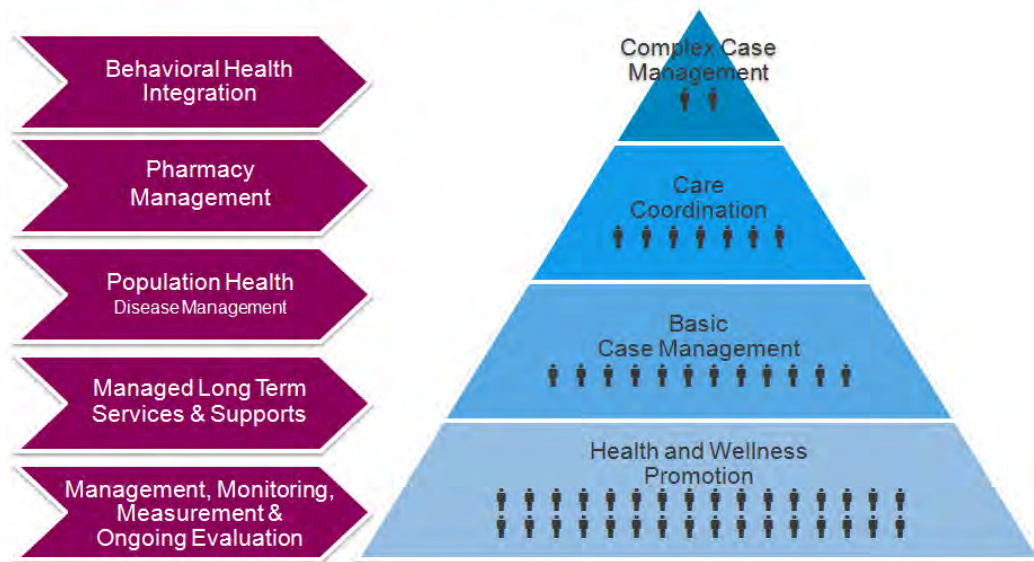
The purpose of the QI Program is to establish objective methods for systematically evaluating and improving the quality of care provided to CalOptima members. Through the QI Program, CalOptima strives to continuously improve the structure, processes and outcomes of its health care delivery system.

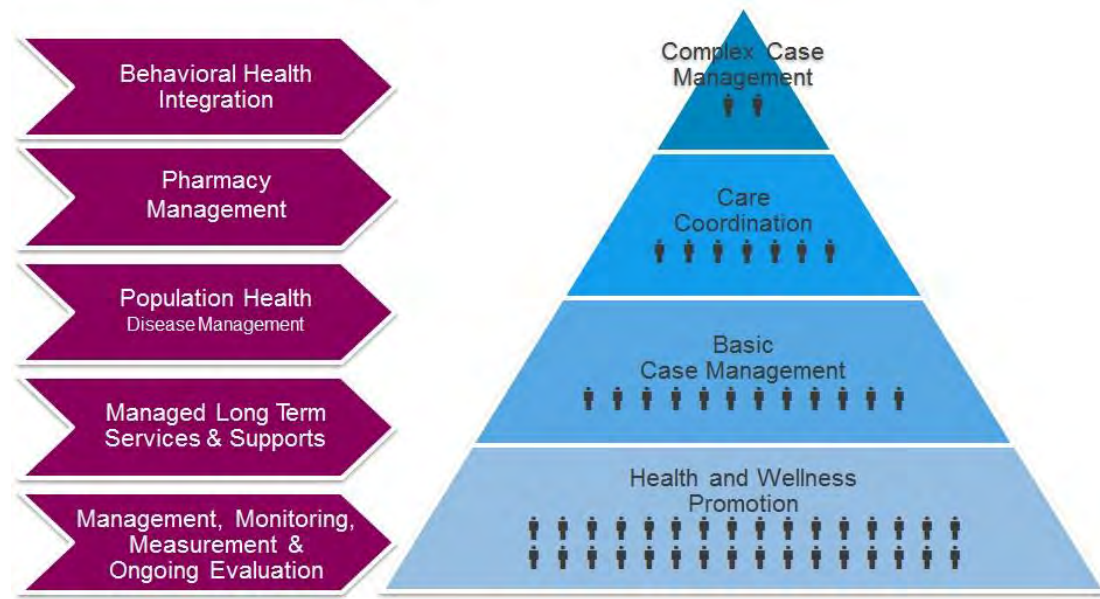
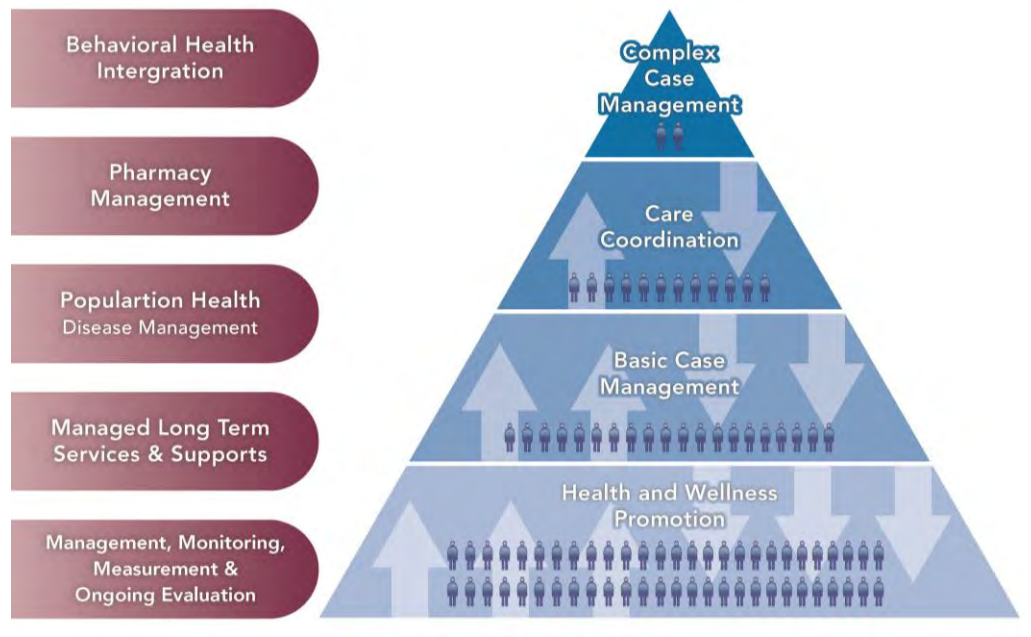
The QI Program incorporates continuous QI methodology that focuses on the specific needs of multiple stakeholders (members, health care providers and community and government agencies):

- 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:

Care Management Model

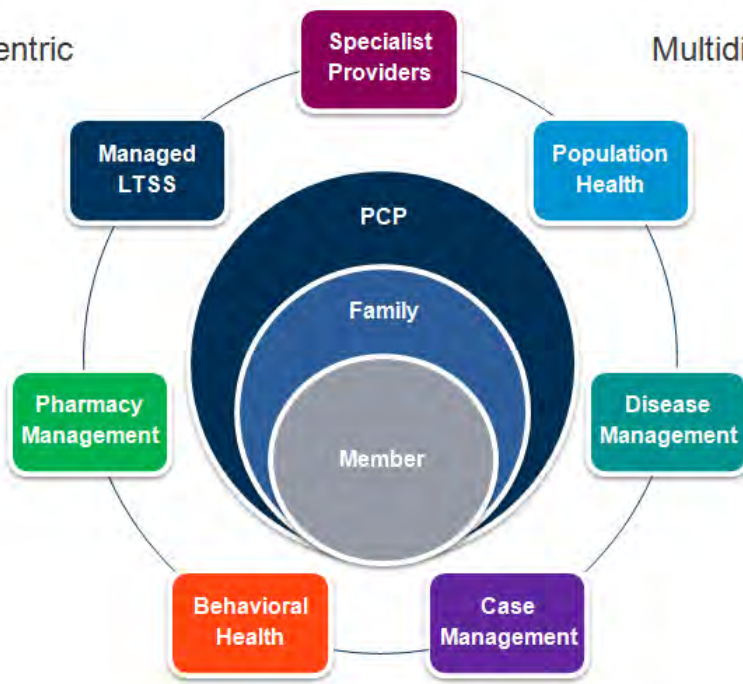


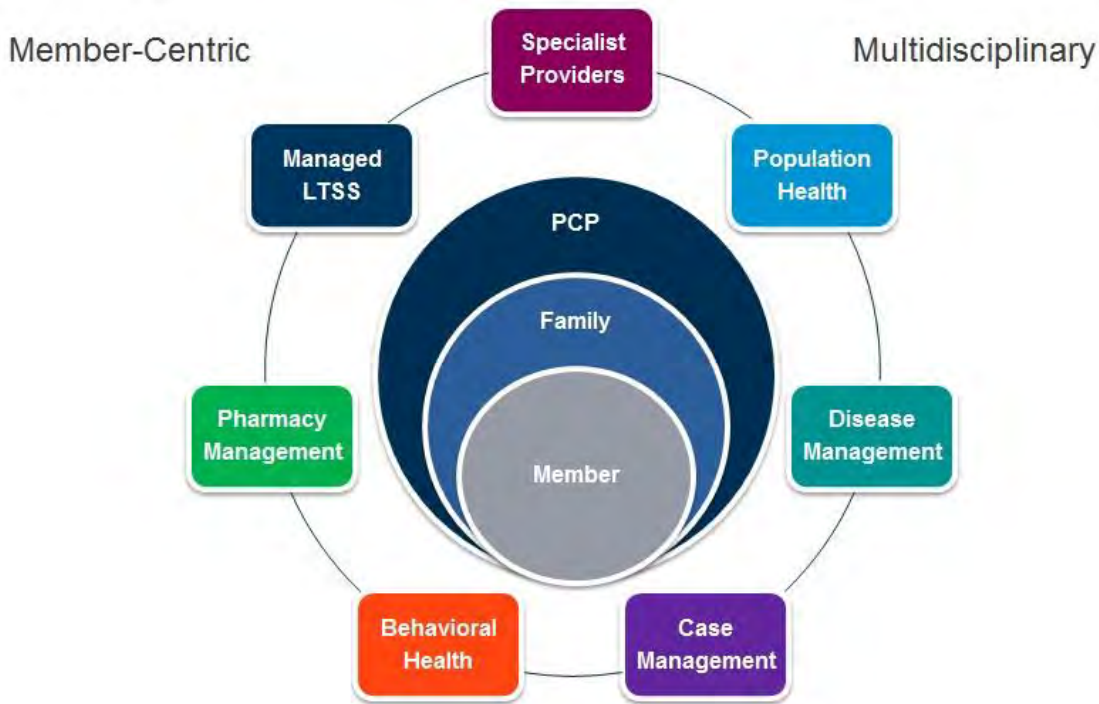
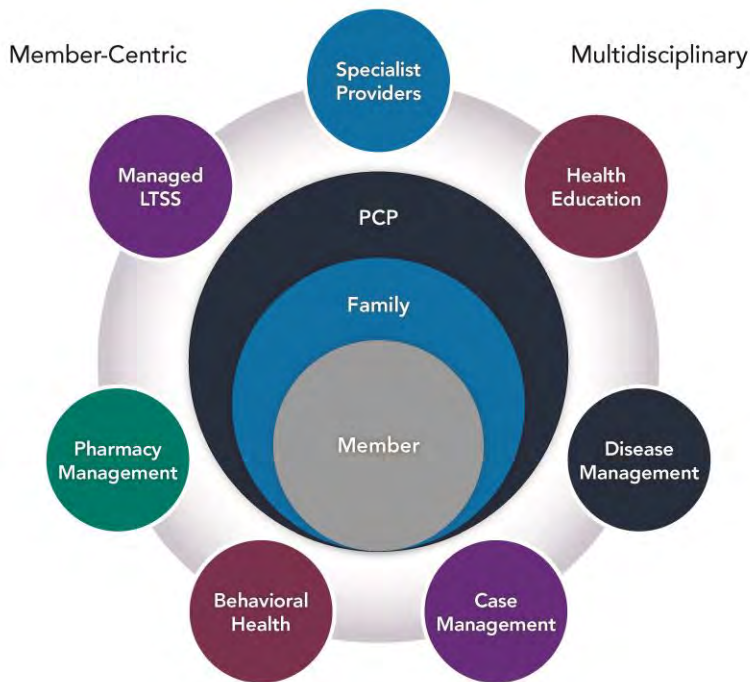


In addition, our model recognizes the importance of multiple resources to support our members' health needs. The coordination between our various medical and behavioral health providers, pharmacists, and care settings, — plus our internal experts, supports a member-centric approach to care/care coordination.

Member-Centric

Multidisciplinary





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, OC and 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 evaluating and 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~~ Health Networks
- 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~~Sets expectations to develop plans to design, measure, assess, and improve the quality of the organization's governance, management and support processes
- ~~Support~~Supports the provision of a consistent level of high quality of care and service for members throughout the contracted network, as well as monitors utilization practice patterns of practitioners, contracted hospitals, contracted services, ancillary services and specialty providers
- ~~Provide~~Provides 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, methicillin resistant *Staphylococcus aureus* (MRSA), scabies, tuberculosis, etc., as reported by the HNs.
- ~~Promote~~Promotes patient safety and minimizes risk through the implementation of patient safety programs and early identification of issues that require intervention and/or education and works 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~~Measurable Goals ~~from~~for 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- for the OneCare and OneCare Connect lines of business. The MOC meets the needs of ~~the~~ special member populations through strategic activities ~~and goals~~. Measureable. Measurable 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, behavioral health 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~~2018 QI Work Plan. Results are communicated quarterly to the QI Committee and evaluated annually.

QUALITY IMPROVEMENT WORK PLAN

The QI Work Plan outlines key activities for the upcoming year. It is reviewed and approved by the QIC and CalOptima's Board of Directors' Quality Assurance Committee. 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~~ addenda 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 or results are received.

The QI Program guides the development and implementation of an annual QI Work Plan and a separate UM Work Plan that includes:

- Care Coordination/Complex Case Management
- LTSS
- ~~Population~~ Health Education & Disease Management
- Organizational Quality Improvement Projects (~~t, Health Assessments and related CCIP, QIPs, PIPs, CCIPs, PDSAs~~)
- Access and Availability to Care
- Member Experience and Service (CAHPS)
- Patient Safety and Pharmacy Initiatives
- HEDIS, STARS and 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 CalOptima'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 CalOptima'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 APPENDIX A — [20172018](#) 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~~ diagnoses 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 [20172018](#) UM Program, all review staff are trained and audited in these principles. ~~Clinical Licensed clinical staff makes all medical necessity decisions reviews and any denial approves requested services based on medical necessity is made only utilizing evidence-based, review criteria. Requests not meeting medical necessity criteria are reviewed by a physician reviewer, including or furthered other other qualified reviewer. to make adverse determinations. This also includes those decisions made by delegated 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 measurements can be found in the [20172018](#) UM Program Description and related Work Plan.

BEHAVIORAL HEALTH

CalOptima monitors and works to improve the quality of behavioral health care and services provided to our members. The Behavioral Health Integration Department reviews the quality and

outcomes of behavioral health 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, providing behavioral health QI statistical data and follow-up on identified issues.

ENTERPRISE ANALYTICS

Enterprise Analytics provides leadership across CalOptima in the development and distribution of analytical capabilities. In conjunction with the executive team and key leaders across the organization, Enterprise Analytics drives the development of the strategy and roadmap for analytical capability. Operationally, there is a centralized enterprise analytics team to interface with all departments within CalOptima and key external constituents to execute on the roadmap. Working with departments that supply data, notably, Information Services, Claims, Customer Service, Provider Services and Medical Affairs, the Enterprise Analytics team develops or extends the data architecture and data definitions. Through work with key users of data, Enterprise Analytics develops the platform(s) and capabilities to meet CalOptima's critical information. This capability for QI includes provider preventable conditions, trimester-specific member mailing lists, high-impact specialists, and PDSA on LTC inpatient admissions.
~~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, providing 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 and 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 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. 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. The policy includes an attestation that is completed annually by all appointed, volunteer or employee employed positions serving on the the QI/UM Committees and subcommittees. Additionally, All employees who make or participate in the making of 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.
~~decisions that may which foreseeably may have a material effect on substantial economic interests impact and are in positions designated in the CalOptima Conflict of Interest Code, file a Statement of Economic Interests form and the supplement to Form 700 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.

STAFF ORIENTATION, TRAINING AND 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 and job specific training~~ with a staff ~~preceptor~~member. The following topics are covered during the introductory period, with specific training, as applicable to individual job descriptions:

- CalOptima New Employee Orientation and Boot Camp (CalOptima programs)
- HIPAA and Privacy
- 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 department program training, policies & procedures, etc.
- ~~Appeals process~~
- Seniors and Persons with Disabilities Awareness Training
- Cultural Competency 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 reimbursement for ~~each licensed employee~~employees.

MOC-related employees, ~~and~~ contracted providers and practitioners networks are trained at least annually on the 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 (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 safety program 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 Utilization monitoring
- Medication Management
- Case Management/Health Education & Disease Management
- Operational Aspects of Care and Service

To ensure member 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 HNs and practitioners in performing the following activities:

- Improving medical record documentation and legibility, establishing timely follow-up for lab results; addressing and distributing data on adverse outcomes or polypharmacy issues by the Pharmacy & 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 Americans with Disabilities Act (ADA) and Seniors and Persons with Disabilities (SPD) site review audits into the general facility site review process
- Tracking and trending of adverse event reporting to identify system issues that contribute to poor safety

Elements of the safety program address the environment of care and the safety of members, staff and others in a variety of settings. The focus of the program is to identify and remediate potential and actual safety issues, and to monitor ongoing staff education and training, including:

- Ambulatory setting
 - Adherence to ADA standards, including provisions for access and assistance in procuring appropriate equipment, such as electric exam tables
 - Annual blood-borne pathogen and hazardous material training
 - Preventative maintenance contracts to -promote that equipment is kept in good working order
 - Fire, disaster, and evacuation plan, testing and annual training
- Institutional settings including 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, appropriate investigation and remedial action
 - Administration of flu and pneumonia vaccine
- Administrative offices
 - Fire, disaster, and evacuation plan, testing and annual training
 -

QUALITY IMPROVEMENT COMMITTEES AND SUBCOMMITTEES

COMMITTEES AND KEY GROUP STRUCTURES

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 comprised of 15 voting members, each seat represents a constituency served by CalOptima. 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, and 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 Services and Support~~
- ~~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.

Provider Advisory Committee

The Provider Advisory Committee (PAC) was established in 1995 by the CalOptima Board of Directors to advise the Board on issues impacting the CalOptima provider community. The PAC is comprised of providers who represent a broad provider community that serves CalOptima

members. The PAC is comprised of 15 members, 14 of whom serve three year terms with two consecutive term limits, along with a representative of the Orange County Health Care Agency, which maintains a standing seat voting members, each who serve three year terms with the exception of the Orange County Health Care Agency which maintains a standing seat representing a constituency that works with CalOptima and our members. These is not subject to term limits. The 15 seats include:

- HNs
 - Health Network (1 seat)
- Hospitals (1 seat)
- Physicians (3 seats)
- Nurses
 - Nurse (1 seat)
- Allied Health Services (1 seat)
- Community Clinics/Health Centers (1 seat)
- Orange County Health Care Agency (HCA) (1 standing seat)
- LTSS/Long Term Services and Support including (LTC facilities and CBAS) (2 seats)
- Mid level practitioners
 - Non Physician Medical Practitioner (1 seat)
 - Traditional/Safety Net (1 seat)
- Behavioral/mental health/Mental Health (1 seat)
 - Pharmacy (1 seat)

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, and 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, and SRGs, and MBHO, and PMGs and contracted provider and practitioner partners. The composition of the QIC includes a participating Behavioral Health practitioner to specifically address integration of behavioral and physical health, appropriate utilization of recognized criteria, development of policies and procedures, and case review as needed, and identification of opportunities to improve care.

The QIC provides overall direction for the continuous improvement process and 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 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 for effective operation and evaluates policy decisions/achievement of objectives
- Oversees the analysis and evaluation of QI activities

- Makes certain that there is practitioner participation ~~in the QI Program~~ through attendance and discussion in the planning, design, implementation and review ~~of the QI program activities~~
- Identifies and prioritizes needed actions and interventions to improve quality
- Makes certain that there is follow-up as necessary to determine their effectiveness

Practice patterns of providers, practitioners, HMOs, PHCs, SRGs, ~~and 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, ~~and MBHO, and PMGs~~.

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

- **Plan** Detailed description and goals
- **Do** Implementation of the plan
- **Study** Data and collection
- **Act** Analyze data and develop conclusions

The goal of the QI Program is to improve the health outcomes of members through systematic and ongoing monitoring of specific focus areas and development and implementation of ~~QI Projects~~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 (Chair)
- ~~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 (BHQIC)
- Executive Director, Clinical Operations
- Executive Director, -Network Management
- Executive Director, Operations

● ~~Director, Business Integration~~

The QIC is supported by:

Executive Director, Quality ~~Improvement~~ & Analytics
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~~6) of which at least four (4) are physicians or practitioners. Once a quorum is attained, the meeting may proceed and any vote will be considered official, even if the quorum is not maintained. Participation is defined as attendance in person or participation by ~~phone~~telephone.

The QIC ~~meets no less than~~shall meet at least eight (8) times per calendar year, and reports to the Board QAC ~~no less than~~ quarterly.

QIC and all 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:

- Goals and objectives outlined in the QI Charter
- 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.

~~QUALITY IMPROVEMENT COMMITTEES AND SUBCOMMITTEES~~

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 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 and reported through the QIC are reported to the QIC at least quarterly.~~

The goals of the CPRC include:

1. Maintain a peer review and credentialing program that aligns with regulatory (DHCS, ~~and 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 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, QI (PQI issues), and GARS (complaints) and ~~take~~ evaluate to determine if further action ~~is required for~~ 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~~ recommendations 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, GARS, UM, Case Management, Pharmacy and LTSS) and/or the CMO or his/her physician designee related to CalOptima Direct/CalOptima Care Network or its delegated 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, ~~and 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 quality of care cases are ~~reviewed by the~~presented at 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, and 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 Community Network~~Direct network (CCN)~~ and/or the Health Networks (HNs). Physician participants shall represent a range of practitioners and specialties from CalOptima's network~~various specialties, including, but not limited to, general surgery, OB/GYN and primary care~~. In addition, the CPRC chairperson, ~~and CalOptima's CMO or DCMO/DCMO and CalOptima Medical Directors~~ 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 C Subcommittee (GARS)

The GARS subcommittee serves to protect the rights of our members, ~~and to~~ promote the provision of quality health care services and enforces~~ensures~~ 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 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 reported through the QIC~~and reports to the QIC~~.

Pharmacy & Therapeutics SubCommittee (P&T)

The P&T subcommittee is a forum for an evidence-based formulary review process. The P&T promotes clinically sound and cost effective pharmaceutical care for all CalOptima members, and reviews anticipated and actual drug utilization trends, parameters, and results on the basis of specific categories of drugs and formulary initiatives, as well as the overall program. In addition, the P&T 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 P&T provides written decisions regarding all formulary development and revisions. The P&T meets at least quarterly, and reports to the UMC~~subcommittee~~.

Utilization Management C Subcommittee (UMC)

The UMC 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 UMC subcommittee is multidisciplinary, and provides a comprehensive

approach to support the 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 UMC ~~subcommittee~~ monitors the utilization of health care services by CalOptima Direct and through the delegated HMOs, PHCs, SRGs, ~~and MBHO, and PMGs~~ to identify areas of under or over utilization that may adversely impact member care. The UMC ~~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 ~~reportsed through the QIC reports to the QIC.~~

The UMC ~~subcommittee~~ includes a minimum of four practicing physician representatives, reflecting CalOptima's HMO, PHC, SRG, ~~and 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:

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 ~~the~~ voting members, ~~with at least three non CalOptima employee members present 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 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 ~~reports to the Utilization Management Committee, and~~ 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/~~Legislative Affairs~~ department provides 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 QI Subcommittee (LTSS-QISC)

The LTSS subcommittee is composed of representatives from the LTC, CBAS, ~~HSS~~ and MSSP communities, which may include administrators, directors of nursing, facility Medical Directors, and pharmacy consultants, along with appropriate CalOptima staff. 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 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 subcommittee and reported through the QIC to the QIC.

Behavioral Health Quality Improvement Committee (BHQIC)

The BHQIC ensures members receive timely and satisfactory behavioral health care services, through enhancing 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
- Monitor member experience with behavioral health services including call center, grievance and appeals, and potential for quality improvement
- Oversee the functions of delegated activities
- Monitor ~~that~~ care rendered is based on established clinical criteria, clinical practice guidelines, and complies with regulatory and accrediting agency standards
- Ensure ~~that~~ member benefits and services are not underutilized and ~~that~~ assessment and appropriate interventions are taken to identify inappropriate over utilization
- Utilize member and network provider satisfaction study results when implementing quality activities
- Maintain compliance with evolving 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 ~~subcommittee~~ is the Medical Director, Behavioral Health, who is responsible for chairing the ~~subcommittee~~ and reporting through the QIC as well as reporting findings and recommendations to QIC.

The composition of the BHQIC 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-Executive~~ Director, Quality and Analytics
- Executive Director, Clinical Operations
- Medical Director, Utilization Management
- Director, Behavioral Health ~~Integration~~ Services
- Clinical Pharmacist
- Medical Director, Orange County Health Care Agency
- Medical Director, MBHO

- Chief Clinical Officer, 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 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 health](#) management, care management, complex case management, UM, LTC, 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. COPHS reviews these programs at least quarterly, [- reported through the QIC](#) and includes the following key individuals:

- Chief Medical Officer/Deputy Chief Medical Officer
- Executive Director, Clinical Operations
- Executive Director, Quality & Analytics
- Director, Case Management
- Director, Utilization Management
- Director, Health Education & Disease Management
- 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 (MESMEMX)

The final subcommittee in the quality committees structure is [MESMEMX](#) and focuses on the issues and factors that influence the member’s experience with the health care system for Medi-Cal, OC, OCC and LTSS. NCQA Medicaid Plan Ratings measure three dimensions – Prevention, Treatment and Customer Satisfaction. CalOptima’s QI program focuses on the performance in each of these areas. The [MESMEMX](#) is designed to assess the annual results of CalOptima’s CAHPS surveys, monitor the provider network, including access [&and](#) availability (CCN [&and](#) the HNs), review customer service metrics, and evaluate complaints, grievances, appeals, authorizations and referrals for the “pain points” in health care that impact our members.

This subcommittee meets at least bi-monthly [and is reported through the QIC](#) 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, Health Education & Disease Management
- Director, Utilization Management
- Manager, Quality Analytics

The MEMXS focuses on improving the following key areas of satisfaction:

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

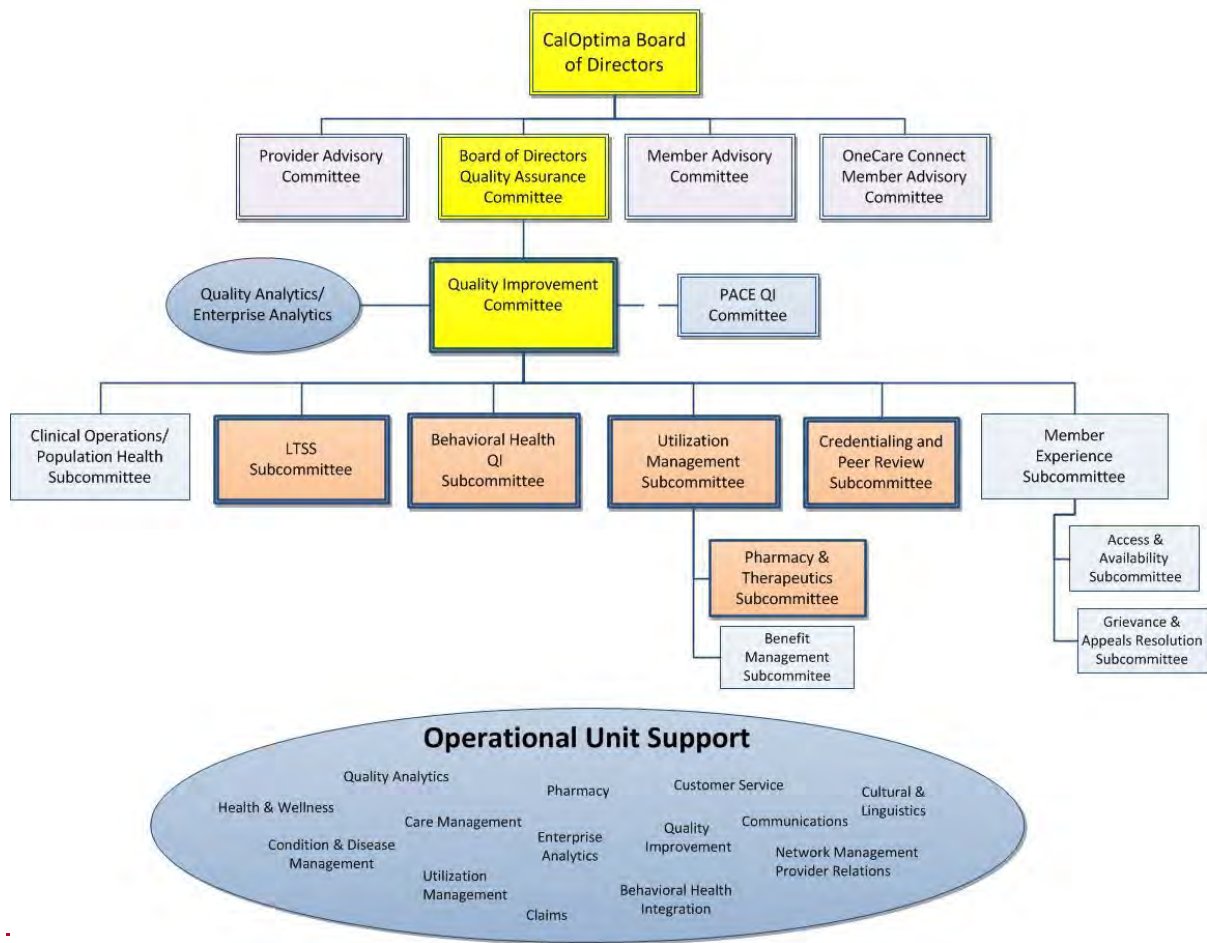
Whole-Child Model Clinical Advisory Committee (WCM CAC)

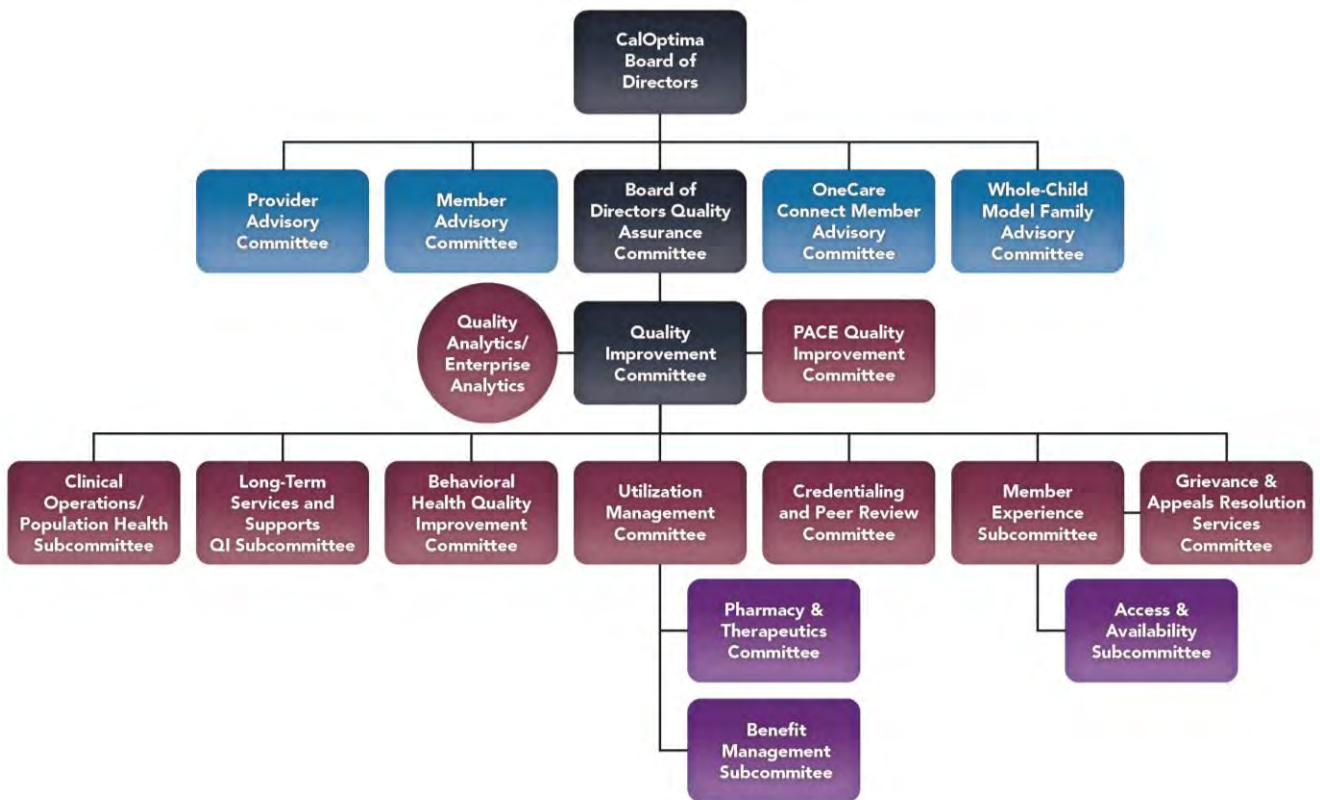
The WCM CAC is required by the state. The WCM CAC will report to the QI Committee, and is anticipated to be established in Fall 2018. The WCM CAC will advise on clinical issues relating to CCS conditions, including treatment authorization guidelines, etc.

The committee must include the following key individuals:

- Chief Medical Officer or equivalent
- County of Orange CCS Medical Director
- CCS Paneled Providers — at least 4

20172018 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 services and supports, and ancillary care services

- Access to and availability of services, including appointment availability, as described in the UM Program and in policy and procedure
- Coordination and continuity of care for 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 improvement, and 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, and ~~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 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), in order to 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.

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 management of transitions of care across the continuum of health care from outpatient or ambulatory to inpatient or institutionalized care, and back to ambulatory
- Ability of member to opt-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. SPD, OCC and OC members are stratified using a plan-developed tool that utilizes information from data sources such as acute hospital/emergency department utilization, severe and chronic conditions, and pharmacy. This stratification results in the categorizing members as “high” or “low” 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), or the Health Network/~~Group and system (primary), or system/transition (level (care coordination or complex) level,~~) dependent upon the results of the member’s HRA and/or evaluation or changes in the member’s health status.. 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 — 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~~ Health Network or ~~the~~ Health Plan for Community Network

- ICT Composition (appropriate to identified needs): member, caregiver, or authorized representative, health network (HN) Medical Director, PCP and/or specialist, ambulatory case manager (CM), hospitalist, hospital CM and/or discharge planners, HN 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 (as appropriate for identified needs): member, caregiver, or authorized representative, HN Medical Director, CalOptima clinical/HN case manager, PCP and/or specialist, social worker, and behavioral health specialist**~~

~~**Roles and responsibilities of this team:**~~

~~**Consultative for the PCP and HN teams**~~

~~**Encourages member engagement and participation in the ICT process**~~

~~**Coordinating the management of members with complex transition needs and development of ICP**~~

~~**Providing support for implementation of the ICP by the HN**~~

~~**Tracks and trends the activities of the ICTs**~~

~~**Analyze data from different data sources in the plan to evaluate the management of transitions and the activities of the 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)/OC and 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 rehospitalization
- High-risk and high-utilization program aimed at patients who frequently use emergency department (ED) services or have frequent hospitalizations, and at high-risk individuals (e.g., patients dually eligible for Medicare and Medicaid or patients who are institutionalized)
- Hospital case management program designed to coordinate care for patients during an inpatient admission and discharge planning
- Care management program focused on patient-specific activities and the coordination of services identified in members' care plans. Care management performs these activities and coordinates services for members to optimize their health status and quality of life

CalOptima's goals for ~~2017~~2018 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 ~~2017~~2018 Case Management Program Description for further details and program plans.

DISEASE-HEALTH MANAGEMENT PROGRAM

The Disease-Health Management (HDM) 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 HDM program stratifies the population and identifies appropriate interventions based on member needs. These interventions include coordinating care for members across locales and providing services, resources, and support to members as they learn to care for themselves and their condition. The HDM program also identifies those members in need of closer management, coordination and intervention. CalOptima assumes responsibility for the

HDM program for all of its lines of business, therefore the management for HDM is not delegated to the PHCs, SRGs, [and HMOs and PMGs](#). The contracted PHCs, SRGs, [and HMOs and PMGs](#) must participate collaboratively with interventions necessary to produce identified quality outcomes. The HDM Program is evaluated on an annual basis [and reported through the QIC](#).

Further details of the HDM programs, activities and measurements can be found in the [20172018 HDM Programs Description](#).

QUALITY ANALYTICS

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. - CalOptima's Clinical Data Warehouse is a dynamic environment which aggregates data from various core business processes, such as member eligibility, provider, encounters, claims, 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 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 database 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 data warehouse identifies members with a-specific 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 data warehouse can identify if a member or provider is over or under utilizing medical services. In analyzing claims and pharmacy data, the data warehouse can identify if a member did not refill their prescription for maintenance medication, such as high blood pressure medicines. The database can also identify over utilization or poor management by providers. For example, the system can list all members who have exceeded the specified timeframe for using a certain medication, such as persistent use of antibiotics greater than 61 days.

Identify Missing Preventive Care Services

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

Identify Members for Targeted Interventions

The rules for identifying members and initiating the intervention are customizable to CalOptima to fit our unique needs. By using the standard clinical rules and customizing CalOptima specific rules, the database is the primary conduit for targeting and prioritizing health education, disease management and HEDIS 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 and HOS measures. This information will guide CalOptima in not only targeting the members, but also the HMOs, PHCs, SRGs, [and](#) 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 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:~~

- 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~~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, [and 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.

Non-Delegated Activities

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

- QI, as delineated in the Contract for Health Care Services
- QI program for all lines of business, HMOs, PHCs, SRGs, [and MBHO](#), ~~and PMGs~~ must comply with all quality related operational, regulatory and accreditation standards
- [Medi-Cal Behavioral Health](#)
- DM 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 health care delivery organizations (HDOs)
- Credentialing and re-credentialing of HDOs
- Development of 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 [20172018](#) Delegation Grid.

SEE APPENDIX B — [20172018](#) DELEGATION GRID

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

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

Objectives for serving a culturally and linguistically diverse membership include:

- Analyze significant health care disparities in clinical areas
- Use practitioner and provider medical record reviews to understand the differences in care provided and outcomes achieved
- Consider outcomes of member grievances and complaints
- Conduct patient-focused interventions with culturally competent outreach materials that focus on race/ethnicity/language or gender specific risks
- Identify and reduce a specific health care disparity affecting a particular cultural, 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, optometrists, physician assistants, ~~optometrists~~, registered physician therapists, occupational therapists, speech therapists and audiologists, both in the delegated and CalOptima direct environments. Credentialing and ~~recredialing~~re-credentialing activities are delegated to the HNs 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, and SRGs, ~~and MBHO, and PMGs~~. CalOptima does, however, delegate this function to designated health plans in accordance with standards set forth by MMCD Policy Letter 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 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 SPD members, which includes access evaluation criteria to determine compliance with ADA requirements.

- Parking
- ~~Exterior ramps~~
- ~~Exterior stairways~~
- ~~Entrances~~
- ~~Building Interior circulation~~
- ~~Interior doors~~
- ~~Interior ramps~~
- ~~Interior stairways~~
- ~~Elevators~~
- ~~Controls~~
- ~~Sanitary facilities~~
- ~~Reception and waiting areas~~ Exterior
- ~~Diagnostic and treatment areas~~
- Participant Areas including the Exam Room
- Restroom
- Exam Room
- Exam Table/Scale

Medical Record Documentation Standards

CalOptima requires that its contracted HMOs, PHCs, ~~and SRGs, and 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-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, ~~and DHCS, and MRMIB~~.

The medical record should be protected ~~in~~ to ensure 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 ~~QI~~Quality Improvement department or Audit & Oversight department identifies an opportunity for improvement, the delegated or functional areas will determine the appropriate action(s) to be taken to correct the problem. Those activities specific to delegated entities will be conducted at the direction of the ~~QI~~Quality Improvement department or Audit ~~and~~& Oversight department as overseen by the Audit & Oversight Committee, reporting to the Compliance Committee. Those activities specific to CalOptima's functional areas will be overseen by the ~~QI~~Quality department as overseen by and reported to QIC. Actions for either delegates or functional areas may include the following:

- Development of cross-departmental teams utilizing continuous improvement tools (i.e. quality improvement plans or Plan-Do-Study-Act) to identify root causes, develop and implement solutions, and develop quality control mechanisms to maintain improvements.
- Discussion of the data/problem with the involved practitioner, either in the respective committee or by a Medical Director.
- Further observation of performance via the appropriate clinical monitor. (This process shall determine if follow-up action has resolved the original problem.)
- Discussion of the results of clinical monitoring. (The committee/functional area may refer an unresolved matter to the appropriate committee/functional area for evaluation and, if necessary, action.)
- Intensified evaluation when a trigger for evaluation is attained, or when further study needs to be designed to gather more specific data, i.e., when the current data is insufficient to fully define the problem.
- Changes in policies and procedures: 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~~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 [QI](#) work plan or calendar. The QI subcommittees 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 synopsised 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 QI 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~~2018 QI WORK PLAN

APPENDIX B — ~~2017~~2018 DELEGATION GRID

2018 Quality Improvement Work Plan

I. PROGRAM OVERSIGHT

- A. 2018 QI Annual Oversight of Program and Work Plan
- B. 2017 QI Program Evaluation
- C. 2018 UM Program and UM Workplan
- D. 2017 UM Program Evaluation
- E. 2018 Case Management Program
- F. 2018 Health Management Program
- G. Credentialing Peer Review Committee Oversight
- H. BHQIC Oversight
- I. UMC Oversight
- J. Member Experience SubCommittee Oversight
- K. LTSS QISC Oversight
- L. Clinical Operations/Population Health Oversight
- M. GARS Committee
- N. PACE QIC
- O. Quality Program Oversight - NCOA
- P. Quality Program Oversight - Health Plan Rating
- Q. Quality Program Oversight - Quality Withhold
- R. Pay for Value
- S. MOC Dashboard 2016-2019

INITIAL WORK PLAN AND APPROVAL:

Submitted and approved by QIC: Date:
 Submitted and approved by QAC: Date:
 Submitted and approved by Board of Director's Date:

Quality Improvement Committee Chairperson:

Richard Bock, MD Date:

Board of Directors' Quality Assurance Committee Chairperson:

Paul Yost, MD Date:

II. QUALITY OF CLINICAL CARE - CARE MANAGEMENT

- A. Review of Health Risk Assessments for OCC New Beneficiary's
- B. Review of Health Risk Assessments for OC New Beneficiary's
- C. Review of Health Risk Assessments for SPD New Beneficiary's
- D. Annual Collection and Review of Health Risk Assessments for OCC/ OC/ SPD existing members
- E. High ER Utilization
- F. Review Of Member Satisfaction With CM Programs
- G. Coordination of CCS Medical Home and CalOptima PCP
- H. HN MOC Oversight

III. QUALITY OF CLINICAL CARE - BEHAVIORAL HEALTH

- A. Follow-up Care for Children with Prescribed ADHD Medication (ADD): Initiation Phase
- B. Follow-up Care for Children with Prescribed ADHD Medication (ADD): Continuation Phase
- C. Antidepressant Medication Management (AMM): Acute Phase Treatment

- D. Antidepressant Medication Management (AMM): Continuation Phase Treatment
- E. Follow-up After Hospitalization within 30 days of discharge (FUH)
- F. Follow-up After Hospitalization within 7 days of discharge (FUH)
- G. Interdisciplinary Care Treatment Team Participation
- H. Adopt Behavioral Health Clinical Practice Guidelines

IV. QUALITY OF CLINICAL CARE - LONG TERM SERVICES AND SUPPORTS

- A. Review And Assess LTSS Hospital Admissions For Members Participating with Each Program
- B. Review And Assess LTSS Emergency Department Visits For Members Participating with Each Program
- C. Review And Assess LTSS Hospital Readmissions For Members Participating with Each Program
- D. Review And Assess LTSS utilization of Long Term Care, Home and Community Based Services For Member Participating in Each Program
- E. CBAS Member Satisfaction
- F. SNF Member Satisfaction

V. QUALITY OF CLINICAL CARE - IMPROVE HEDIS MEASURES

- A. Comprehensive Diabetes Care (CDC): HbA1c Testing
- B. Comprehensive Diabetes Care (CDC): HbA1c Poor Control (>9.0%)
- C. Comprehensive Diabetes Care (CDC): HbA1c Control (<8.0%)
- D. Comprehensive Diabetes Care (CDC): Eye Exam
- E. Comprehensive Diabetes Care (CDC): Medical Attention for Nephrology
- F. Comprehensive Diabetes Care (CDC): Blood Pressure Control (<140/90 mm Hg)
- G. All-Cause Hospital Readmissions (PRC)
- H. Prenatal and Postpartum Care Services (PPC): Timeliness of Prenatal Care
- I. Prenatal and Postpartum Care Services (PPC): Postpartum Care
- J. Childhood Immunization Status (CIS): Combo 3
- K. Childhood Immunization Status (CIS): Combo 10
- L. Lower Back Pain (LBP)
- M. Adult's Access to Preventive/Ambulatory Health Services (AAP) (Total)
- N. Children's Access to Primary Care Practitioners (CAP): 12-24 months
- O. Children's Access to Primary Care Practitioners (CAP): 25 months - 6 years
- P. Children's Access to Primary Care Practitioners (CAP): 7-11 years
- Q. Children's Access to Primary Care Practitioners (CAP): 12-19 years
- R. Cervical Cancer Screening (CCS)
- S. Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life (W34)

- T. Well-Care Visits in first 15 months of life (W15)
- U. Appropriate Testing for Children with Pharyngitis (CWP)
- V. Colorectal Cancer Screening (COL)
- W. Care of Older Adult (COA): Medication Review
- X. Care of Older Adult (COA): Functional Status Assessment
- Y. Care of Older Adult (COA): Pain Assessment
- Z. Breast Cancer Screening (BCS)
- AA. Statin Therapy for Patients with Cardiovascular Disease - Therapy (SPC)
- BB. Statin Therapy for Patients with Cardiovascular Disease - Adherence (SPC)
- CC. Persistence of Beta Blocker Treatment after a Heart Attack (PBH)
- DD. Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)

VI. QUALITY OF CLINICAL CARE - HEALTH EDUCATION & DISEASE MANAGEMENT

- A. Initial Health Assessment Completion Rate
- B. Review of Disease Management Programs
- C. Implementation of Population Health & Wellness Programs
- D. Adopt Medical Clinical Practice Guidelines

VII. QUALITY OF CLINICAL CARE - QUALITY IMPROVEMENT PROJECTS (QIP, PIP, PDSA, CCIP)

- A. **OneCare CCIP:** Diabetes to improve HBA1C Testing, Targeted mailings to members; Outreach to health networks; provide monthly Prospective Rates and member detail information to health networks
- B. **OneCare CCIP:** Connect Heart Health
- C. **OneCare Connect QIP:** To Improve 30-day Readmission Rate <16.8% ; Transition of Care program; health coach outreach
- D. **OneCare QIP (NEW):** Focus on Chronic Conditions (TBD)
- E. **Medi-Cal PIP:** Improving Diabetes Care for Medi-Cal Members with Poor Control (HbA1c >9%) residing in Santa Ana, CA. (Focus on health disparities); Targeted provider outreach in the CCN network; Increase referrals and participation in CalOptima' Disease Management program; Educational classes
- F. **Medi-Cal PIP:** Improving Adult's Access to Preventive/Ambulatory Health Services: Ages 45-64 years
- G. **OneCare Connect PIP:** Improving rate of completed Individualized Care Plan Completed for members and improve rate of Members with Documented Discussions of Care Goals
- H. **OneCare Connect PDSA -** Reducing Avoidable Hospitalizations and Other Adverse Events for Nursing Facility Residents (LTC - OCC); Treatment in Place training to targeted facility sites and Follow up with targeted facility sites by CalOptima nurses

VIII. SAFETY OF CLINICAL CARE

- A. Utilization of Opioid Analgesics
- B. Pharmacy Benefit Manager (PBM) Oversight
- C. Providers Shall Have Timely And Complete Facility Site Reviews
- D. Follow-up on Potential Quality Of Care Complaints
- E. CBAS Quality Monitoring
- F. SNF/LTC Quality Monitoring

IX. QUALITY OF SERVICE

- A. Increase CAHPS score on Rating of Health Plan
- B. Increase CAHPS score on Getting Needed Care
- C. Increase CAHPS score on Getting Care Quickly
- D. Increase CAHPS score on Customer Service
- E. Increase CAHPS score on Care Coordination
- F. Customer Service First Call Resolution
- G. Customer Service Access
- H. Review and Report GARS for all Lines of Business
- I. Member Accessing Pharmacy Benefit Information

X. NETWORK ADEQUACY

- A. Credentialing Of Provider Network Is Monitored
- B. Recredentialing Of Provider Network Is Monitored
- C. Termination of Practitioners
- D. Review of access to care for urgent appointments
- E. Review of access to care non-urgent primary care appointments
- F. Review of access to care specialty appointments
- G. Review of availability of primary care practitioners (min. provider ratios)
- H. Review of availability of primary care practitioners (geographic distribution)
 - I. Review of availability of specialty practitioners (min. provider ratios)
 - J. Review of availability of specialty practitioners (geographic distribution)
- K. Review of availability of behavioral health practitioners (min. provider ratios)
- L. Review of availability of behavioral health practitioners (geographic distribution)
- M. Network Pharmacy Access

XI. COMPLIANCE

- Delegation Oversight of HN Compliance (UM, CR, Claims)
- HN Compliance with CCM NCQA Standards

Reports to	Evaluation Category	Department	Person(s) Responsible	2018 QI Work Plan Element	Objective	Planned Activities	2018 Goal/Timeline	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues	Next Steps	Target Completion	Red - At Risk Yellow - Concern Green - On Target
I. PROGRAM OVERSIGHT											
QIC	Program Oversight	Quality Improvement	Esther Okajima/Kelly Rex-Kimmet	2018 QI Annual Oversight of Program and Work Plan	Approve QI Program and Workplan for 2018	QI Program and QI Work Plan will be adopted on an annual basis; QI Program Description-QIC-BOD; QI Work Plan-QIC-QAC	Annual Adoption				
QIC	Program Oversight	Quality Improvement	Esther Okajima/Kelly Rex-Kimmet	2017 QI Program Evaluation	Evaluate QI Program for 2017	QI Program and QI Work Plan will be evaluated for effectiveness on an annual basis	Annual Evaluation				
QIC	Program Oversight	Utilization Management	Tracy Hitzeman	2018 UM Program and UM Workplan	Approve UM Program and Workplan for 2018	UM Program and UM Work Plan will be adopted on an annual basis; Delegate UM annual oversight reports-from DOC	Annual Adoption				
QIC	Program Oversight	Utilization Management	Tracy Hitzeman	2017 UM Program Evaluation	Evaluate UM Program for 2017	UM Program and UM Work Plan will be evaluated for effectiveness on an annual basis; Delegate oversight from DOC	Annual Evaluation				
QIC	Program Oversight	Care Management	Sloane Petrillo	2018 Case Management Program	Approve CM Program for 2018	CM Program will be adopted on an annual basis; Delegation oversight reported by DOC	Annual Adoption				
QIC	Program Oversight	HE & DM	Pshyra Jones	2018 Health Management Program	Approve HM program for 2018	HM Program will be adopted on an annual basis	Annual Adoption				
QIC	Program Oversight	Quality Improvement	Esther Okajima	Credentialing Peer Review Committee Oversight	Peer Review of Provider Network	Review of initial and recredentialing applications, related quality of care issues, approvals, denials, and reported to QIC ; Delegation oversight reported by A&O quarterly to CPRC.	Quarterly Adoption of Report				
QIC	Program Oversight	Behavioral Health	Donald Sharps MD	BHQIC Oversight	Internal and External oversight of BHI Activities	BHQI meets quarterly to: monitor and identify improvement areas of member and provider services, ensure access to quality BH care, and enhance continuity and coordination between behavioral health and physical health care providers.	Quarterly Adoption of Report				
QIC	Program Oversight	Utilization Management	Tracy Hitzeman	UMC Oversight	Internal and External oversight of UM Activities	UMC meets quarterly; it monitored medical necessity, cost-effectiveness of care and services, reviewed utilization patterns, monitored over/under-utilization, and reviewed inter-rater reliability results	Quarterly Adoption of Report				
QIC	Program Oversight	Quality Analytics	Kelly Rex-Kimmet	Member Experience Subcommittee Oversight	Oversight of Member Experience activities to improve member experience	The MEMX Subcommittee assesses the annual results of CalOptima s CAHPS surveys, monitor the provider network including access & availability (CCN & the HNS), review customer service metrics and evaluate complaints, grievances, appeals, authorizations and referrals for the "pain points" in health care that impact our members.	Quarterly Adoption of Report				
QIC	Program Oversight	LTSS	Steven Chang	LTSS QISC Oversight	LTSS QI Oversight	The LTSS Quality Improvement Sub Committee meets on a quarterly basis and addresses key components of regulatory, safety, quality and clinical initiatives.	Quarterly Adoption of Report				
QIC	Program Oversight	Medical Affairs	Tracy Hitzeman/ Kelly Rex-Kimmet	Clinical Operations/Population Health Oversight	Clinical Operations Oversight	This COPHS monitors the progress of the established program goals and metrics defined for CalOptima s disease management, complex case management programs and Model of Care.	Quarterly Adoption of Report				
QIC	Program Oversight	GARS	Ana Aranda	GARS Committee	GARS Committee Oversight	The GARS Committee oversees the Grievance Appeals and Resolution of complaints by members for CalOptima's network. Results are presented to committee quarterly	Quarterly Adoption of Report				
QIC	Program Oversight	PACE	Dr. Miles Masatsugu	PACE QIC	PACE QIC Oversight	The PACE QIC oversees the activities and processes of the PACE center. Results are presented to PACE-QIC	Quarterly Adoption of Report				
QIC	Program Oversight	Quality & Analytics	Esther Okajima	Quality Program Oversight - NCQA	Maintain "Commendable" NCQA accreditation rating	Monitor specific HEDIS measures listed below. Conduct NCQA Renewal Survey submission May 2018	Maintain Commendable Status. Accreditation evaluated every three years. HEDIS measures scored annually.				
QIC	Program Oversight	Quality & Analytics	Kelly Rex-Kimmet	Quality Program Oversight - Health Plan Rating	Maintain or exceed NCQA 4.0 health plan rating	Monitor specific HEDIS measures listed below and Maintain Commendable Status.	Achieve 4.0 Health Plan Rating - Annual Assessment				
QIC	Program Oversight	Quality & Analytics	Kelly Rex-Kimmet/ Tracy Hitzeman	Quality Program Oversight - Quality Withhold	Earn Quality Withhold Dollars back for OneCare Connect in OCC QW program.	Quarterly monitoring and reporting to OCC Steering Committee and QIC	Annual Assessment				
QIC	Program Oversight	Quality Analytics	Kelly Rex-Kimmet/ Sandeep Mital	Pay for Value	<ul style="list-style-type: none"> Implement and monitor health network performance on P4V measures during the year; Calculate and distribute the P4V incentive payments to participating health networks for MY 2017; and Calculate and distribute the P4V incentive payments to participating providers in CCN for MY 2017 	<ul style="list-style-type: none"> Generate and share Prospective Rate reports monthly for all health networks on their performance on adult and child clinical measures Complete review of 2017 measures at the end of the year Hold provider education with Provider relations team to educate CCN providers and provider relations team on the new CCN P4V program. Implement CCN P4V Prospective Rate reporting 	National and State benchmarks				
QIC	Program Oversight	Medical Affairs	Tracy Hitzeman	MOC Dashboard 2016-2019	Present OC/OCC & SPD MOC Quality Matrix to QAC and Board of Directors by 2nd Quarter, 2017 ; Re-evaluate measurements through data analysis	Define analytics and resources to support the Model of Care for OC/OCC & SPD members; Implement activities to meet or exceed measures	Meet or exceed defined MOC Metrics				

II. QUALITY OF CLINICAL CARE - CARE MANAGEMENT

Reports to	Evaluation Category	Department	Person(s) Responsible	2018 QI Work Plan Element	Objective	Planned Activities	2018 Goal/Timeline	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues	Next Steps	Target Completion	Red - At Risk Yellow - Concern Green - On Target
COPHS	Quality of Clinical Care	Care Management	Sloane Petrillo	Review of Health Risk Assessments for OCC New Beneficiary's	OCC- Health Risk Assessment Outreach for members in the OneCare Connect Program monitored for completion and collection for Initial HRA	OCC- Administer the initial HRA to the high risk beneficiary within: 90 days of a beneficiary s enrollment OCC- Administer the initial HRA to the low risk beneficiary within: 45 days of a beneficiary s enrollment	For OCC Initial High Risk HRA, - Achieve Collection Rate of 56%, report quarterly				
COPHS	Quality of Clinical Care	Care Management	Sloane Petrillo	Review of Health Risk Assessments for OC New Beneficiary's	OC- Health Risk Assessment Outreach for members in the OneCare Program monitored for completion for Initial HRA	OC - Administer the Initial HRA within 90 days of beneficiary eligibility.	For OC Initial HRA - Achieve Collection Rate of 78%, report quarterly				
COPHS	Quality of Clinical Care	Care Management	Sloane Petrillo	Review of Health Risk Assessments for SPD New Beneficiary's	SPD- Health Risk Assessment Outreach for Seniors and Persons with Disabilities monitored for completion for Initial HRA	SPD- Administer the initial HRA to the high risk beneficiary within: 45 days of a beneficiary s eligibility; SPD- Administer the initial HRA to the low risk beneficiary within: 90 days of a beneficiary s eligibility	For SPD Initial High Risk HRA - Achieve Collection Rate of 63% report quarterly				
COPHS	Quality of Clinical Care	Care Management	Sloane Petrillo	Annual Collection and Review of Health Risk Assessments for OCC/ OC/ SPD existing members	OCC/OC/SPD: Administer the annual HRA to the beneficiary to all participants	OCC/OC/SPD: Administer the annual HRA to the beneficiary to all participants	Achieve 50% Collection rate for OCC Annual, and 34% for OC Annual. No goal set for SPD.				
COPHS	Quality of Clinical Care	Care Management	Sloane Petrillo	High ER Utilization	Evaluation and intervention for ongoing review of high ER utilizers	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	5% reduction in ER visits among intervention cohort				
COPHS	Quality of Clinical Care	Care Management	Sloane Petrillo	Review Of Member Satisfaction With CM Programs	Annual review of member feedback on the case management programs to assure high satisfaction and improved health status	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	Satisfaction with Case Management - 88%				
COPHS	Quality of Clinical Care	Care Management	Sloane Petrillo	Coordination of CCS Medical Home and CalOptima PCP	Monitor coordination efforts between CCS Medical Home and CalOptima PCP's	TBD	TBD				
COPHS	Quality of Clinical Care	Care Management	Sloane Petrillo	HN MOC Oversight	Regular review of the Health Network s performance of MOC functions	Review of 100% of MOC files with monthly feedback provided to Health Networks	HN to achieve 90% score				
III. QUALITY OF CLINICAL CARE - BEHAVIORAL HEALTH											
BHQIC	Quality of Clinical Care - HEDIS	Behavioral Health	Edwin Poon	Follow-up Care for Children with Prescribed ADHD Medication (ADD): Initiation Phase	Increase chances to meet or exceed HEDIS goals through effective interventions that are aligned with current practice and technological options.	<ul style="list-style-type: none"> Continue to hold monthly BH QI work group with representation from the various departments associated with the measures Continue to work on current intervention focus for AMM and ADD HEDIS measures BHI has several measures that are being monitored which may also serve as opportunity for improvements 	Medicaid: 48.18%				
BHQIC	Quality of Clinical Care - HEDIS	Behavioral Health	Edwin Poon	Follow-up Care for Children with Prescribed ADHD Medication (ADD): Continuation Phase	Increase chances to meet or exceed HEDIS goals through effective interventions that are aligned with current practice and technological options.	<ul style="list-style-type: none"> Continue to hold monthly BH QI work group with representation from the various departments associated with the measures Continue to work on current intervention focus for AMM and ADD HEDIS measures BHI has several measures that are being monitored which may also serve as opportunity for improvements 	Medicaid: 44.80%				
BHQIC	Quality of Clinical Care - HEDIS	Behavioral Health	Edwin Poon	Antidepressant Medication Management (AMM): Acute Phase Treatment	Increase chances to meet or exceed HEDIS goals through effective interventions that are aligned with current practice and technological options.	<ul style="list-style-type: none"> Continue to hold monthly BH QI work group with representation from the various departments associated with the measures Continue to work on current intervention focus for AMM and ADD HEDIS measures BHI has several measures that are being monitored which may also serve as opportunity for improvements 	Medicaid: 56.94% OneCare: 75.00% OneCare Connect: 63.45%				
BHQIC	Quality of Clinical Care - HEDIS	Behavioral Health	Edwin Poon	Antidepressant Medication Management (AMM): Continuation Phase Treatment	Increase chances to meet or exceed HEDIS goals through effective interventions that are aligned with current practice and technological options.	<ul style="list-style-type: none"> Continue to hold monthly BH QI work group with representation from the various departments associated with the measures Continue to work on current intervention focus for AMM and ADD HEDIS measures BHI has several measures that are being monitored which may also serve as opportunity for improvements 	Medicaid: 41.12% OneCare: 53.90% OneCare Connect: 47.09%				
BHQIC	Quality of Clinical Care - HEDIS	Behavioral Health	Edwin Poon	Follow-up After Hospitalization within 30 days of discharge (FUH)	FUH measures the percentage of discharges for patients 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow up visit with a mental health practitioner.	Will monitor and measure: The percentage of discharges for which the patient received follow up Back to Agenda	OCC Quality Withold Goal: 60.89%				

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BHQIC	Quality of Clinical Care - HEDIS	Behavioral Health	Edwin Poon	Follow-up After Hospitalization within 7 days of discharge (FUH)	FUH measures the percentage of discharges for patients 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow up visit with a mental health practitioner.	Will monitor and measure: - The percentage of discharges for which the patient received follow up within 7 days of discharge	OCC Quality Withold Goal: 56%				
BHQIC	Quality of Clinical Care	Behavioral Health	Edwin Poon	Interdisciplinary Care Treatment Team Participation	Behavioral health services, integration and coordination of care will be monitored and measured	Monitor and identify opportunities to improve integration and coordination	Maintain or improve the participation rate of 95% or higher for Medi-Cal, One Care and One Care Connect ICTs or ICPs completed				
BHQIC	Quality of Clinical Care	Behavioral Health	Edwin Poon	Adopt Behavioral Health Clinical Practice Guidelines	BH Clinical Practice Guidelines will be reviewed and adopted	Adoption of at least two behavioral health Clinical practice guidelines will be reviewed and adopted	Annual Adoption of BH Clinical Practice Guidelines				
IV. QUALITY OF CLINICAL CARE - LONG TERM SERVICES AND SUPPORTS											
LTSS-QISC	Quality of Clinical Care	LTSS	Steven Chang/ Cathy Osborn	Review And Assess LTSS Hospital Admissions For Members Participating with Each Program	Member review of Hospital Admissions (for each organization/program)	Measure those members participating in each program for hospital admissions 1. CBAS, 2. LTC, 3. MSSP	Working on Goals for 2018. Will publish by the end of Q1				
LTSS-QISC	Quality of Clinical Care	LTSS	Steven Chang/ Cathy Osborn	Review And Assess LTSS Emergency Department Visits For Members Participating with Each Program	Member review of Emergency Department Visits (for each organization/program)	Measure those members participating in each program for ED Visits 1. CBAS, 2. LTC, 3. MSSP	Working on Goals for 2018. Will publish by the end of Q1				
LTSS-QISC	Quality of Clinical Care	LTSS	Steven Chang/ Cathy Osborn	Review And Assess LTSS Hospital Readmissions For Members Parctipating with Each Program	Members reviewed for Hospital Readmissions (for each organization/program)	Measure and assess hospital readmissions within 30 days for members in each program to drive interventions to minimize hospital readmissions 1. CBAS, 2. LTC, 3. MSSP	Working on Goals for 2018. Will publish by the end of Q1				
LTSS-QISC	Quality of Clinical Care	LTSS	Steven Chang/ Cathy Osborn	Review And Assess LTSS utilization of Long Term Care, Home and Community Based Services For Member Participating in Each Program	Members reviewed for utilization of Long Term Care, Home and Community Based Services (for each organization/program)	Measure and assess utilization of LTC, Home and Community Based Services for members in each program 1. CBAS, 2. IHSS, 3. MSSP	Working on Goals for 2018. Will publish by the end of Q1				
LTSS-QISC	Quality of Clinical Care	Quality Improvement	Esther Okajima/ Laura Guest	CBAS Member Satisfaction	Monitor and/or improve member satisfaction in CBAS	a) Measure, assess and identify areas for improvement through the distribution of a member satisfaction survey. b) Implement interventions to assure high member satisfaction	90% of the Centers will achieve an overall satisfaction rating 3 or greater				
LTSS-QISC	Quality of Clinical Care	Quality Improvement	Esther Okajima/ Laura Guest	SNF Member Satisfaction	Monitor and/or improve member satisfaction in SNF/LTC facilities	a) Measure, assess and identify areas for improvement through the distribution of a member satisfaction survey. b) Implement interventions to assure high member satisfaction	90% of the facilities will achieve an overall satisfaction rating 3 or greater				
V. QUALITY OF CLINICAL CARE - HEDIS											
QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Comprehensive Diabetes Care (CDC): HbA1c Testing	Outreach to members who are due for HbA1c testing. Interventions may include; targeted mailings, educational outreach by health coaches/educators and incentives.	Medicaid: 87.1% OneCare: 93.82% OneCare Connect: 91.73%				
QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Comprehensive Diabetes Care (CDC): HbA1c Poor Control (>9.0%)	Outreach to members who have poor or uncontrolled HbA1c levels. For the CCN population, targeted outreach to high volume providers via medical director outreach. Interventions may include; targeted mailings, educational outreach by health coaches/educators and incentives and members are identified and enrolled in the disease management program with opt-out option.	Medicaid: 29.07% OneCare: 20% OneCare Connect: 27%				
QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Comprehensive Diabetes Care (CDC): HbA1c Control (<8.0%)	Interventions may include; targeted mailings with educational materials. Members are identified and enrolled in the disease management program with opt-out option.	Medicaid: 59.12% OneCare: 69.71% OneCare Connect: 64.72%				
QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Comprehensive Diabetes Care (CDC): Eye Exam	Targeted outreach to members who are due for a diabetic eye exam. Interventions may include; targeted mailings, educational outreach by health coaches/educators and incentives and members are identified and enrolled in the disease management program with opt-out option.	Medicaid: 65.83% OneCare: 81% OneCare Connect: 81%				
QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Comprehensive Diabetes Care (CDC): Medical Attention for Nephrology	Targeted outreach to members who are due for a screening. Interventions may include; targeted mailings, educational outreach by health coaches/educators and incentives and members are identified and enrolled in the disease management program with opt-out option.	Medicaid: 91.24% OneCare: 94% OneCare Connect: 96%				

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QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Comprehensive Diabetes Care (CDC): Blood Pressure Control (<140/90 mm Hg)	Outreach to diabetic members with high blood pressure. Interventions may include; targeted mailings, educational outreach by health coaches/educators and incentives and members are identified and enrolled in the disease management program with opt-out option.	Medicaid: 72.24% OneCare: 80.12 OneCare Connect: 70.83%				
QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	All-Cause Hospital Readmissions (PRC)	Continue to implement the Transition of Care program; focus on the health coaching intervention.	OneCare: 6% OneCare Connect: 9%				
QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Prenatal and Postpartum Care Services (PPC): Timeliness of Prenatal Care	Targeted outreach to members who are due for prenatal/postpartum visits. Interventions may include; targeted mailings and incentives. The Bright Steps maternal health program is set to launch July, 2018.	Medicaid: 86.79%				
QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Prenatal and Postpartum Care Services (PPC): Postpartum Care	Targeted outreach to members who are due for prenatal/postpartum visits. Interventions may include; targeted mailings and incentives. The Bright Steps maternal health program is set to launch July, 2018.	Medicaid: 69.44%				
QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Childhood Immunization Status (CIS): Combo 3	Targeted outreach to members who are due for an immunization. Interventions may include; preventive screening events, target mailings, incentives, and facets pop-ups.	Medicaid: 74.39%				
QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Childhood Immunization Status (CIS): Combo 10	Targeted outreach to members who are due for an immunization. Interventions may include; preventive screening events, target mailings, incentives, and facets pop-ups.	Medicaid: 37.23%				
QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Lower Back Pain (LBP)	Provider education and outreach	Medicaid: 74.40%				
QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Adult's Access to Preventive/Ambulatory Health Services (AAP) (Total)	Targeted outreach to members who are due for a preventive visit. Interventions may include; preventive screening events, target mailings, incentives, and facets pop-ups.	Medicaid: 76.17%				
QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Children's Access to Primary Care Practitioners (CAP): 12-24 months	Targeted outreach to members who are due for a preventive visit. Interventions may include; preventive screening events, target mailings, incentives, and facets pop-ups.	Medicaid: 95.7%				
QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Children's Access to Primary Care Practitioners (CAP): 25 months - 6 years	Targeted outreach to members who are due for a preventive visit. Interventions may include; preventive screening events, target mailings, incentives, and facets pop-ups.	Medicaid: 87.87%				
QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Children's Access to Primary Care Practitioners (CAP): 7-11 years	Targeted outreach to members who are due for a preventive visit. Interventions may include; preventive screening events, target mailings, incentives, and facets pop-ups.	Medicaid: 90.77%				
QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Children's Access to Primary Care Practitioners (CAP): 12-19 years	Targeted outreach to members who are due for a preventive visit. Interventions may include; preventive screening events, target mailings, incentives, and facets pop-ups.	Medicaid: 89.52%				
QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Cervical Cancer Screening (CCS)	Targeted outreach to members who are due for a screening. Interventions may include; preventive screening events, target mailings, incentives, and facets pop-ups.	Medicaid: 58.48%				
QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life (W34)	Targeted outreach to members who are due for a screening. Interventions may include; wellness events at high volume provider sites, target mailings, incentives, and facets pop-ups.	Medicaid: 80.64%				
QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Well-Care Visits in first 15 months of life (W15)	Targeted outreach to members who are due for a screening. Interventions may include; wellness events at high volume provider sites, target mailings, incentives, and facets pop-ups.	Medicaid: 56.11%				
QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Appropriate Testing for Children with Pharyngitis (CWP)	Provider outreach at PCP sites, Target urgent care centers	Medicaid: 67.15%				
QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Colorectal Cancer Screening (COL)	Targeted outreach to members who are due for a screening. Interventions may include; preventive screenings event, target mailings, incentives, and facets pop-ups.	OneCare: 63% OneCare Connect: 63%				
QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Care of Older Adult (COA): Medication Review	Targeted outreach to providers; obtain ICP for each members	OneCare: 88% OneCare Connect: 79%				
QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Care of Older Adult (COA): Functional Status Assessment	Targeted outreach to providers; obtain ICP for each member	OneCare: 67% OneCare Connect: 67%				
QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Care of Older Adult (COA): Pain Assessment	Targeted outreach to providers; obtain ICP for each member	OneCare: 94% OneCare Connect: 80%				
QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Breast Cancer Screening (BCS)	Targeted outreach to members who are due for a screening. Interventions may include; mobile mammography event, target mailings, incentives, and facets pop-ups.	Medicaid: 65.52% OneCare: 78% OneCare Connect: 78%				
QIC	Quality of Clinical Care - HEDIS	Pharmacy	Nicki Ghazanfarpour	Improve identified HEDIS Measures	Statin Therapy for Patients with Cardiovascular Disease - Therapy (SPC)	Physician notification faxes	Medicaid: 75.85%				
QIC	Quality of Clinical Care - HEDIS	Pharmacy	Nicki Ghazanfarpour	Improve identified HEDIS Measures	Statin Therapy for Patients with Cardiovascular Disease - Adherence (SPC)	Physician notification faxes	Medicaid: 73.43%				
QIC	Quality of Clinical Care - HEDIS	Pharmacy	Nicki Ghazanfarpour	Improve identified HEDIS Measures	Persistence of Beta Blocker Treatment after a Heart Attack (PBH)	Physician notification faxes	Medicaid: 80.95%				

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QIC	Quality of Clinical Care - HEDIS	Quality Analytics	Paul Jiang/ Marsha Choo	Improve identified HEDIS Measures	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)	Provider education via the AWARE Toolkit.	Medicaid: 24.91%				
VI. QUALITY OF CLINICAL CARE - HEALTH EDUCATION & DISEASE MANAGEMENT											
COPHS	Quality of Clinical Care	HE & DM	Pshyra Jones	Initial Health Assessment Completion Rate	To assure all new members are connected with a PCP and their health risks are assessed	IHA/IHEBA [Staying Healthy Assessment(SHA)] will be completed 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)	Improve plan performance over 2017 by 5%				
COPHS	Quality of Clinical Care	HE & DM	Pshyra Jones	Review of Disease Management Programs	Disease Management activity reviewed to assess clinical care delivered to members with Asthma, Diabetes and Heart Failure	Develop DM Program interventions to help improve HEDIS measures such as AMR, MMA, MPM, CBP; Assure DM programs are implemented across all populations; Conduct annual member satisfaction of DM programs; Evaluate the overall effectiveness of the Program-Participation Member Rates, ED, IP and RX related utilization	Improve program participation rates over 2017 by 3% Reduce ED and IP rates for program participants by 3% Increase member satisfaction with DM Programs to 90%				
COPHS	Quality of Clinical Care	HE & DM	Pshyra Jones	Implementation of Population Health & Wellness Programs	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	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	Implement revised program design-2018; Evaluate progress semi-annually				
COPHS	Quality of Clinical Care	HE & DM	Pshyra Jones	Adopt Medical Clinical Practice Guidelines	Clinical Practice Guidelines will be reviewed and adopted	Adoption of Clinical Practice Guidelines, as least three (3) will be reviewed and adopted (linked to DM: Diabetes, Asthma, CHF)	CPG's reviewed and adopted every two years				
VII. QUALITY OF CLINICAL CARE - QUALITY IMPROVEMENT PROJECTS											
QIC	Quality of Clinical Care	HE & DM	Pshyra Jones	Quality And Performance Improvement Projects (QIP, PIPS, CCIPs, PDSAs)	Implement DHCS and CMS Quality and Performance Improvement Projects (QIPs and PIPs), PDSAs, CCIPs	OneCare CCIP: Diabetes to improve HbA1C Testing, Targeted mailings to members; Outreach to health networks; provide monthly Prospective Rates and member detail information to health networks	Goal TBD/ Starting January 2018				
QIC	Quality of Clinical Care	HE & DM	Pshyra Jones	Quality And Performance Improvement Projects (QIP, PIPS, CCIPs, PDSAs)	Implement DHCS and CMS Quality and Performance Improvement Projects (QIPs and PIPs), PDSAs, CCIPs	OneCare CCIP: Connect Heart Health	Goal TBD/ Starting January 2018				
QIC	Quality of Clinical Care	Quality Analytics	Mimi Cheung	Quality And Performance Improvement Projects (QIP, PIPS, CCIPs, PDSAs)	Implement DHCS and CMS Quality and Performance Improvement Projects (QIPs and PIPs), PDSAs, CCIPs	OneCare Connect QIP: To Improve 30-day Readmission Rate <16.8% ; Transition of Care program; health coach outreach	TBD				
QIC	Quality of Clinical Care	Quality Analytics	Mimi Cheung	Quality And Performance Improvement Projects (QIP, PIPS, CCIPs, PDSAs)	Implement DHCS and CMS Quality and Performance Improvement Projects (QIPs and PIPs), PDSAs, CCIPs	OneCare QIP (NEW): Focus on Chronic Conditions (TBD)	TBD				
QIC	Quality of Clinical Care	Quality Analytics	Mimi Cheung	Quality And Performance Improvement Projects (QIP, PIPS, CCIPs, PDSAs)	Implement DHCS and CMS Quality and Performance Improvement Projects (QIPs and PIPs), PDSAs, CCIPs	Medi-Cal PIP: Improving Diabetes Care for Medi-Cal Members with Poor Control (HbA1c >9%) residing in Santa Ana, CA. (Focus on health disparities); Targeted provider outreach in the CCN network; Increase referrals and participation in CalOptima Disease Management program; Educational classes	TBD				
QIC	Quality of Clinical Care	Quality Analytics	Mimi Cheung	Quality And Performance Improvement Projects (QIP, PIPS, CCIPs, PDSAs)	Implement DHCS and CMS Quality and Performance Improvement Projects (QIPs and PIPs), PDSAs, CCIPs	Medi-Cal PIP: Improving Adult's Access to Preventive/Ambulatory Health Services: Ages 45-64 years	TBD				
QIC	Quality of Clinical Care	Quality Analytics	Mimi Cheung	Quality And Performance Improvement Projects (QIP, PIPS, CCIPs, PDSAs)	Implement DHCS and CMS Quality and Performance Improvement Projects (QIPs and PIPs), PDSAs, CCIPs	OneCare Connect PIP: Improving rate of completed Individualized Care Plan Completed for members and improve rate of Members with Documented Discussions of Care Goals	TBD				
QIC	Quality of Clinical Care	Quality Analytics	Mimi Cheung	Quality And Performance Improvement Projects (QIP, PIPS, CCIPs, PDSAs)	Implement DHCS and CMS Quality and Performance Improvement Projects (QIPs and PIPs), PDSAs, CCIPs	OneCare Connect PDSA - Reducing Avoidable Hospitalizations and Other Adverse Events for Nursing Facility Residents (LTC - OCC); Treatment in Place training to targeted facility sites and Follow up with targeted facility sites by CalOptima nurses	TBD				
VIII. SAFETY OF CLINICAL CARE											
UMC	Safety of Clinical Care	Pharmacy	Kris Gericke		Promote optimal utilization of opioid analgesics	Quarterly opioid analgesic monitoring. Formulary limits and prior authorization requirements for opioid analgesics. Prescriber monitoring and education	Reduction in opioid analgesic overutilization as measured by number of prescriptions and quantity per prescription for short-acting opioid analgesics				
UMC	Safety of Clinical Care	Pharmacy	Kris Gericke	Pharmacy Benefit Manager (PBM) Oversight	Provide ongoing monitoring of the PBM contract performance guarantees	Review and report on clinical and service metrics for MedImpact as it relates to performance guarantees	PBM Performance Guarantees met per the PBM Services Agreement				

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Reports to	Evaluation Category	Department	Person(s) Responsible	2018 QI Work Plan Element	Objective	Planned Activities	2018 Goal/Timeline	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues	Next Steps	Target Completion	Red - At Risk Yellow - Concern Green - On Target
CPRC	Safety of Clinical Care	Quality Improvement	Esther Okajima/ Katy Noyes	Providers Shall Have Timely And Complete Facility Site Reviews	To assure all new and re-credentialed providers are compliant with FSR/MRR/PAR requirements	Facility Site Reviews (FSR), Medical Record Reviews (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	100% of FSR/MRR/PARS Initial or Full Scope Surveys are completed within initial and re-credentialing timeframes				
CPRC	Safety of Clinical Care	Quality Improvement	Esther Okajima/ Laura Guest	Follow-up on Potential Quality Of Care Complaints	To assure patient safety and enhance patient experience by timeliness of clinical care reviews	QI Nurse Specialists and Medical Directors review cases and provide determination; Report all case results to CPRC for discussion; Present cases that have a severity rating 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	Achieve a turnaround time of 90 days on 90% of cases received; Review data for trends and patterns for potential further actions				
LTSS-QISC	Safety of Clinical Care	Quality Improvement	Esther Okajima/ Laura Guest	CBAS Quality Monitoring	Review CBAS quality monitoring of services provided	a) Continue to assess compliance of contracted CBAS Centers. Report to LTSS QIS Subcommittee. b) Continue to review Incident and Critical Incident Reports for Potential Quality of Care issues	a) All (100%) contracted CBAS centers will be audited at least annually against the audit performed by CDA. b) All (100%) CAPs generated as a result of the audit will be returned by the due date. c) The number of CBAS centers receiving a CAP will be reduced to 75% in 2018, down from 93% in 2017. d) All (100%) Incident and Critical Incident reports will be reviewed for Potential Quality of Care issues				
LTSS-QISC	Safety of Clinical Care	Quality Improvement	Esther Okajima/ Laura Guest	SNF/LTC Quality Monitoring	Review SNF/LTC quality monitoring of services provided	a) Continue to assess compliance of contracted SNF/LTC Facilities. Report to LTSS QIS Subcommittee. b) Continue to review Critical Incident Reports for Potential Quality of Care issues	a) All (100%) contracted SNF/LTC Facilities will be audited at least annually against the audit performed by DHCS. b) All (100%) CAPs generated, as a result of the audit, will be returned by the due date. c) The number of SNF/LTC Facilities receiving a CAP will be below 10%. d) All (100%) Critical Incident reports will be reviewed for Potential Quality of Care issues.				
IX. QUALITY OF SERVICE											
MEMX	Quality of Service	Quality Analytics	Kelly Rex-Kimmet/ Marsha Choo	Review of Member Experience (CAHPS)	Increase CAHPS score on Rating of Health Plan	Implement CG-CAHPS to obtain provider level specific member experience data. Utilize results from CalOptima's CG-CAHPS survey and explorations of other methods to "hear" our member will assist in developing strategies to improve Rating of Health Plan. Contract with vendor to implement Provider Coaching to improve provider satisfaction and overall member experience.	Adult Medicaid: 2.43 (50th Percentile) Child Medicaid: 2.57 (50th Percentile) OneCare Medicare: 86% (CMS 4 star goal) OneCare Connect: Medicare: 86% (CMS 4 star goal)				
MEMX	Quality of Service	Quality Analytics	Kelly Rex-Kimmet/ Marsha Choo	Review of Member Experience (CAHPS)	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.	Adult Medicaid: 2.28 (25th Percentile) Child Medicaid: 2.37 (25th Percentile) OneCare Medicare: 82% (CMS 3 star goal) OneCare Connect: Medicare: 82% (CMS 3 star goal)				
MEMX	Quality of Service	Quality Analytics	Kelly Rex-Kimmet/ Marsha Choo	Review of Member Experience (CAHPS)	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 timely access and appointment availability standards will improve rating of Getting Care Quickly.	Adult Medicaid: 2.33 (25th Percentile) Child Medicaid: 2.54 (25th Percentile) OneCare Medicare: 79% (CMS 4 star goal) OneCare Connect: Medicare: 76% (CMS 3 star goal)				

Reports to	Evaluation Category	Department	Person(s) Responsible	2018 Q1 Work Plan Element	Objective	Planned Activities	2018 Goal/Timeline	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues	Next Steps	Target Completion	Red - At Risk Yellow - Concern Green - On Target
MEMX	Quality of Service	Quality Analytics	Kelly Rex-Kimmet/ Marsha Choo	Review of Member Experience (CAHPS)	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. Contract with vendor to implement Provider Coaching for Customer Service staff.	Adult Medicaid: 2.54 (50th Percentile) Child Medicaid: 2.50 (25th Percentile) OneCare Medicare: 89% (CMS 3 star goal) OneCare Connect: Medicare: 89% (CMS 3 star goal)				
MEMX	Quality of Service	Quality Analytics	Kelly Rex-Kimmet/ Marsha Choo	Review of Member Experience (CAHPS)	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.	Adult Medicaid: 2.34 (25th Percentile) Child Medicaid: 2.36 (25th Percentile) OneCare Medicare: 85% (CMS 3 star goal) OneCare Connect: Medicare: 85% (CMS 3 star goal)				
MEMX	Quality of Service	Customer Service	Belinda Abeyta/ Albert Cardenas	Customer Service First Call Resolution	Gather data and information from members after interface with Customer Service to assure expectations/reason for call was resolved	Monitor port call information and determine key strategies to assure first call resolution/member satisfaction with customer service	85% of calls resolved at first call				
MEMX	Quality of Service	Customer Service	Belinda Abeyta/ Albert Cardenas	Customer Service Access	Customer Service call lines evaluated for average speed to answer; Customer Service call line evaluated for call abandonment rate	Customer Service lines monitored for average speed to answer; Customer service lines monitored for abandonment rate	ASA 30 Seconds <5% First Call Resolution 85%				
MEMX	Quality of Service	GARS	Ana Aranda	Review and Report GARS for all Lines of Business	Global review of member "pain points"; assure appropriate actions are taken to assist the member experience, and present data to the Member Experience Committee and QIC	a) Quarterly review of all GARS data to identify issues and trends; including Health Network b) Implement any necessary corrections d) Review health network quarterly totals of grievances e) Conduct a GARS trend analysis at least two times per year f) Compare GARS trend analysis with similar PQI analysis g) Determine plan of action for follow-up on specific providers if needed	Meet Regulatory Turnaround Times 100%				
MEMX	Quality of Service	Pharmacy	Kris Gericke	Member Accessing Pharmacy Benefit Information	Maintain member access to their pharmacy benefit and the operations of network pharmacies through the CalOptima website, or through telephone communication with CalOptima Customer Service staff	Monitor and annually report requirements for NCQA Member Connection 4: Pharmacy Benefit Information Standards	Via the CalOptima website Members are able to: -Submit Prior Authorization requests; -Conduct network pharmacy proximity searches based on zip code; -Find information on potential drug-drug interactions, common side effects and significant risks, and availability of generic substitutes; and -Receive responses to pharmacy inquiries within twenty-four (24) hours (or next business day).				
X. NETWORK ADEQUACY											
CPRC	Network Adequacy	Quality Improvement	Esther Okajima/ Melinda Enos	Credentialing Of Provider Network Is Monitored	Credentialing program activities monitored for volume and timeliness	New applicants processed within 180 calendar days of receipt of application; Report of initial credentialing file activity to CPRC	90% of initial credentialing applications are processed within 120 days of receipt of application				
CPRC	Network Adequacy	Quality Improvement	Esther Okajima/ Melinda Enos	Recredentialing Of Provider Network Is Monitored	Recredentialing of practitioners is completed timely	Recredentialing is processed every 36 months; Report of Admin term due to missed recredentialing cycle; Report of re-credentialing activity to CPRC	100% of all recredentialing files are processed within 36 months of last credentialing date				
MEMX	Network Adequacy	TBD	TBD	Termination of Practitioners	Termination of Practitioners is monitored, and Continuity and Coordination of Care reviewed and assessed	Termination of Practitioners is monitored through monthly ACT forms that are submitted to PDMS. 1) Members are notified of terminated practitioners with 30 days from when CalOptima is notified 2) Network is monitored to determine if adjustments to network are necessary.	Notification to members are within 30 days of notification to CalOptima 85% of the time.				
MEMX	Network Adequacy	Quality Analytics	Marsha Choo	Review of access to care for urgent appointments	1. Urgent care appointments without prior authorization within 48 hours of request 2. Urgent appointments with prior authorization with 96 hours of request	Data against goals will be measured and analyzed through the implementation of our annual Timely Access study. Results will be reported to committee and shared with contracted health networks. Quality Improvement Plans may be issued to health networks, including the CalOptima Community Network, for areas of non-compliance.	Appointment: 90% minimum performance level				

Reports to	Evaluation Category	Department	Person(s) Responsible	2018 Q1 Work Plan Element	Objective	Planned Activities	2018 Goal/Timeline	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues	Next Steps	Target Completion	Red - At Risk Yellow - Concern Green - On Target
MEMX	Network Adequacy	Quality Analytics	Marsha Choo	Review of access to care non-urgent primary care appointments	1. Non-urgent primary care appointments within 10 business days of request	Data against goals will be measured and analyzed through the implementation of our annual Timely Access study. Results will be reported to committee and shared with contracted health networks. Quality Improvement Plans may be issued to health networks, including the CalOptima Community Network, for areas of non-compliance.	Appointment: 90% minimum performance level				
MEMX	Network Adequacy	Quality Analytics	Marsha Choo	Review of access to care specialty appointments	1. Appointment with specialist within 15 business days of request 2. Non-urgent, non-physician mental health appointment within 10 business days of request 3. First pre-natal visit within 10 days	Data against goals will be measured and analyzed through the implementation of our annual Timely Access study. Results will be reported to committee and shared with contracted health networks. Quality Improvement Plans may be issued to health networks, including the CalOptima Community Network, for areas of non-compliance.	Appointment: 90% minimum performance level				
MEMX	Network Adequacy	Quality Analytics	Marsha Choo	Review of availability of primary care practitioners (min. provider ratios)	Primary care practitioner availability (min. provider ratio) is measured, assessed and adjusted to meet standard	Data against goals will be measured and analyzed for the following through the implementation of our provider data pull from FACETS. Results will be reported to committee and shared with contracted health networks. Quality Improvement Plans may be issued to health networks, including the CalOptima Community Network, for areas of non-compliance.	Minimum performance levels in CalOptima s Access and Availability Policies: GG.1600 and MA.7007				
MEMX	Network Adequacy	Quality Analytics	Marsha Choo	Review of availability of primary care practitioners (geographic distribution)	Primary care practitioner availability (geographic distribution) is measured, assessed and adjusted to meet standard	Data against goals will be measured and analyzed for the following through the implementation of our provider data pull from FACETS and GeoAccess Software. Results will be reported to committee and shared with contracted health networks. Quality Improvement Plans may be issued to health networks, including the CalOptima Community Network, for areas of non-compliance.	Minimum performance levels in CalOptima s Access and Availability Policies: GG.1600 and MA.7007				
MEMX	Network Adequacy	Quality Analytics	Marsha Choo	Review of availability of specialty practitioners (min. provider ratios)	High volume and high impact specialty availability (practitioner to member ratio) is measured, assessed and adjusted to meet standard	Data against goals will be measured and analyzed for the following through the implementation of our provider data pull from FACETS. Results will be reported to committee and shared with contracted health networks. Quality Improvement Plans may be issued to health networks, including the CalOptima Community Network, for areas of non-compliance.	Minimum performance levels in CalOptima s Access and Availability Policies: GG.1600 and MA.7007				
MEMX	Network Adequacy	Quality Analytics	Marsha Choo	Review of availability of specialty practitioners (geographic distribution)	High volume and high impact specialty availability (geographic distribution) is measured, assessed and adjusted to meet standard	Data against goals will be measured and analyzed for the following through the implementation of our provider data pull from FACETS and GeoAccess Software. Results will be reported to committee and shared with contracted health networks. Quality Improvement Plans may be issued to health networks, including the CalOptima Community Network, for areas of non-compliance.	Minimum performance levels in CalOptima s Access and Availability Policies: GG.1600 and MA.7007				
MEMX	Network Adequacy	Quality Analytics	Marsha Choo/ Edwin Poon	Review of availability of behavioral health practitioners (min. provider ratios)	Behavioral Health practitioner availability (practitioner to member ratio) is measured, assessed and adjusted to meet standard	Data against goals will be measured and analyzed for the following through the implementation of our provider data pull from FACETS. Results will be reported to committee and shared with contracted health networks. Quality Improvement Plans may be issued to health networks, including the CalOptima Community Network, for areas of non-compliance.	Minimum performance levels in CalOptima s Access and Availability Policies: GG.1600 and MA.7007				
MEMX	Network Adequacy	Quality Analytics	Marsha Choo/ Edwin Poon	Review of availability of behavioral health practitioners (geographic distribution)	Behavioral Health practitioner availability (geographic distribution) is measured, assessed and adjusted to meet standard	Data against goals will be measured and analyzed for the following through the implementation of our provider data pull from FACETS and GeoAccess Software. Results will be reported to committee and shared with contracted health networks. Quality Improvement Plans may be issued to health networks, including the CalOptima Community Network, for areas of non-compliance.	Minimum performance levels in CalOptima s Access and Availability Policies: GG.1600 and MA.7007				
MEMX	Network Adequacy	Pharmacy	Kris Gericke	Network Pharmacy Access	Network pharmacy availability (geographic distribution) is measured and assessed to meet the standard	Quarterly GeoAccess report	Pharmacy Network Access Requirements: -At least ninety percent (90%) of Members, on average, in urban areas live within two (2) miles of a Participating Pharmacy; -At least ninety percent (90%) of Members, on average, in suburban areas live within five (5) miles of a Participating Pharmacy; and -At least seventy percent (70%) of Members, on average, in rural areas live within fifteen (15) miles of a Participating Pharmacy				

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Reports to	Evaluation Category	Department	Person(s) Responsible	2018 QI Work Plan Element	Objective	Planned Activities	2018 Goal/Timeline	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues	Next Steps	Target Completion	Red - At Risk Yellow - Concern Green - On Target
AOC	Compliance	A&O	Solange Marvin	Delegation Oversight of HN Compliance (UM, CR, Claims)	Delegation Oversight of Health Networks to assess compliance of UM, CR, Claims	Delegated entity oversight supports how delegated activities are performed to expectations and compliance with standards, such as Prior Authorizations; Credentialing, Claims etc. **Report from AOC	98%				
AOC	Compliance	Care Management	Sloane Petrillo	HN Compliance with CCM NCQA Standards	Delegation Oversight of Health Networks to assess compliance of CCM	Delegated entity oversight supports how delegated activities are performed to expectations and compliance with standards, such as CCM; **Report from AOC	98%				

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2018 Delegation Grid

“Appendix B”

Domain/ Element Name	CalOptima	HN	Kaiser	MedImpact	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	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		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		Kaiser:Factor1 & Factor2
QI4F: BH Opportunities for Improvement-Member Experience	X				

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Domain/ Element Name	CalOptima	HN	Kaiser	MedImpact	Comments CO=CalOptima; P&P = Policies & Procedures
QI4G: Assessing Experience With the UM Process	X				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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Domain/ Element Name	CalOptima	HN	Kaiser	MedImpact	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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Domain/ Element Name	CalOptima	HN	Kaiser	MedImpact	Comments CO=CalOptima; P&P = Policies & Procedures
QI8C: Measuring Effectiveness-C&C	X		X		
QI8D: Transition to Other Care-C&C	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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Domain/ Element Name	CalOptima	HN	Kaiser	MedImpact	Comments CO=CalOptima; P&P = Policies & Procedures
NET1D: Practitioners Providing Behavioral Health (BH)	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		CO responsibility P&P, even if delegated
NET2C: Access to Specialty Care	X		X		
NET3A: Assessment of Member Experience Accessing the Network	X		X		For BH See QI4E: Kaiser Factor 1&2
NET3B: Opportunities to Improve Access to Non-behavioral Healthcare Services	X		X		
NET3C: Opportunities to Improve Access to BH Services	X		X		For BH See QI4E: Kaiser Factor1&2
NET5A: Notification of Termination	X	X	X		
NET5B: Continued Access to Practitioners	X	X	X		
NET6A: Physician Directory Data	X		X		
NET6B: Physician Directory Updates	X		X		

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Domain/ Element Name	CalOptima	HN	Kaiser	MedImpact	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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Domain/ Element Name	CalOptima	HN	Kaiser	MedImpact	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		CO responsibility P&P, even if delegated
UM2B: Availability of Criteria	X	X	X		CO responsibility P&P, even if delegated
UM2C: Consistency in Applying Criteria	X	X	X	X	CO responsibility P&P, even if delegated
UM3A: Access to Staff	X	X	X		CO responsibility P&P, even if delegated
UM4A: Licensed Health Professionals	X	X	X	X	CO responsibility P&P, even if delegated

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Domain/ Element Name	CalOptima	HN	Kaiser	MedImpact	Comments CO=CalOptima; P&P = Policies & Procedures
UM4B: Use of Practitioners for UM Decisions	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-	X		X		
UM4E: Practitioner Review of Pharmacy Denials	X		X		
UM4F: Use of Board-Certified Consultants	X	X	X		
UM4G: Affirmative Statement About Incentives	X	X	X		
UM4H: Appropriate Classification of Denials	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	X		X		
UM5D: Notification of Behavioral Healthcare Decisions	X		X		
UM5E: Timeliness of Pharmacy UM Decision Making	X		X	X	
UM5F: Notification of Pharmacy Decisions	X		X	X	

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Domain/ Element Name	CalOptima	HN	Kaiser	MedImpact	Comments CO=CalOptima; P&P = Policies & Procedures
UM5G: UM Timeliness Report	X	X	X		HN Factor1 & Factor2. Factor5; CO Factor6
UM6A: Relevant Information for Non-Behavioral Decisions	X	X	X		
UM6B: Relevant Information for BH Decisions	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	X		X		
UM7E: Written Notification of BH Denials	X		X		
UM7F: BH Notice of Appeal Rights/Process	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	

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Domain/ Element Name	CalOptima	HN	Kaiser	MedImpact	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	X		X		
UM12B: Supervision and Oversight	X		X		
UM13A: Delegation Agreement	X				

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Domain/ Element Name	CalOptima	HN	Kaiser	MedImpact	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		CO responsibility P&P, even if delegated
CR1B: Practitioner Rights	X	X	X		CO responsibility P&P, even if delegated
CR2A: Credentialing Committee	X	X	X		
CR3A: Verification of Credentials	X	X	X		
CR3B: Sanction Information	X	X	X		
CR3C: Credentialing Application	X	X	X		
CR4A: Recredentialing Cycle Length	X	X	X		
CR5A: Ongoing Monitoring and Interventions	X	X	X		
CR6A: Actions Against Practitioners	X	X	X		CO responsibility P&P, even if delegated

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Domain/ Element Name	CalOptima	HN	Kaiser	MedImpact	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		CMS/DHCS Requirement
CR1D: Contracts Opt-Out Provisions (CMS)	X	X	X		CMS Requirement
CR1E: Medicare-Exclusions/Sanctions (CMS)	X	X	X		CMS Requirement
CR3D: Hospital Admitting Privileges (CMS/DHCS)	X	X	X		CMS/DHCS Requirement
CR6B: Monitoring Medicare opt Out (CMS)	X	X	X		CMS Requirement
CR6C: Monitoring Medi-Cal Suspended and Ineligible Provider Reports (DHCS)	X	X	X		DHCS Requirement

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Domain/ Element Name	CalOptima	HN	Kaiser	MedImpact	Comments CO=CalOptima; P&P = Policies & Procedures
CR7F: Appeals Process for Termination/Suspension (CMS)	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		
MEM1A: Health Appraisal (HA) Components	X		X		
MEM1B: HA Disclosure	X		X		
MEM1C: HA Scope	X		X		

2018 Delegation Grid

“Appendix B”

Domain/ Element Name	CalOptima	HN	Kaiser	MedImpact	Comments CO=CalOptima; P&P = Policies & Procedures
MEM1D: HA Results	X		X		
MEM1E: Formats	X		X		
MEM1F: Frequency of HA Completion	X		X		
MEM1G: Review and Update Process	X		X		
MEM2A: Topics of Tools	X		X		
MEM2B: Usability Testing	X		X		
MEM2C: Review and Update Process	X		X		
MEM2D: Formats	X		X		
MEM3B: Functionality: Telephone Requests	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		

2018 Delegation Grid

"Appendix B"

Domain/ Element Name	CalOptima	HN	Kaiser	MedImpact	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		
MEM5C: Quality and Accuracy of Information	X	X	X		HN 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				

2018 Delegation Grid

“Appendix B”

Domain/ Element Name	CalOptima	HN	Kaiser	MedImpact	Comments CO=CalOptima; P&P = Policies & Procedures
MED1B: Second Opinion	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				

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 1, 2018 **Regular Meeting of the CalOptima Board of Directors**

Consent Calendar

4. Consider Approval of the 2018 CalOptima Utilization Management (UM) Program

Contact

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

Recommended Action

Recommend approval of the 2018 Utilization Management (UM) Program.

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 for systematically coordinating, managing and monitoring these processes to achieve positive member outcomes.

CalOptima staff has updated the 2018 UM Program Description to ensure that it is aligned to reflect 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 2018 Utilization Management Program is based on the Board-approved 2017 Utilization Management Program and describes: (i) the scope of the program; (ii) the program 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.

The revisions are summarized as follows:

1. Aligned program descriptions and committee references with the Quality Improvement Program

2. Updated program to reflect the transition of mild to moderate mental health benefit administration for the Medi-Cal program from Magellan to CalOptima, including a description of processes and resources implemented to support the transition.
3. Incorporated new health network risk structures (models) to reflect changes since the 2017 Program Description.
4. Updated description of responsibilities for various key positions.
5. Modified the description of Managed Long-Term Services and Supports to reflect In Home Support Services reverting to the County of Orange administrative responsibility.

The recommended changes are designed to better review, analyze, implement and evaluate the components of the UM Program, and 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. 2018 Utilization Management Program Description Summary of Changes
2. Proposed 2018 Utilization Management Program

/s/ Michael Schrader
Authorized Signature

2/21/2018
Date

Utilization Management (UM) Program 2018

Executive Summary of Revisions

1. Aligned program descriptions and committee references with the Quality Management Program
2. Updated program to reflect the transition of mild to moderate mental health benefit administration for the Medi-Cal program from Magellan to CalOptima, including a description of processes and resources implemented to support the transition.
3. Updated Committee Structure Organization Chart, reflecting new structure and operational unit support
4. Incorporated new health network risk structures (models) to reflect changes since the 2017 Program Description.
5. Updated description of responsibilities for various key positions.
6. Modified the description of Managed Long-Term Services and Supports to reflect In Home Support Services reverting to the County of Orange administrative responsibility.



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2018⁷

UTILIZATION MANAGEMENT PROGRAM DESCRIPTION





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**2018 UTILIZATION MANAGEMENT
PROGRAM
SIGNATURE PAGE**

Utilization Management Committee Chairperson:

Francesco Federico, M.D.

Date

Utilization Management Medical Director

Board of Directors' Quality Assurance Committee Chairperson:

Paul Yost, M.D.

Date

Board of Directors Chairperson:

Paul Yost, MD

Date

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~~20187 UTILIZATION MANAGEMENT~~

~~PROGRAM DESCRIPTION~~

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 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, Provider Advisory Committee, Quality Assurance Committee and Finance and Audit Committee meetings are open to the public.

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

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

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

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

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

We are “Better. Together.”

We cannot achieve our mission and our vision alone. We must work together with providers, community health centers, county agencies, 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 long-standing 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 IT IS both a public agency and a community health plan.

As both, CalOptima must:

- Provide quality health care to ensure optimal health outcomes for our members
- Support member and provider engagement and satisfaction
- Be good stewards of public funds by making the best use of our resources and expertise

- Ensure transparency in our governance procedures, including providing opportunities for stakeholder input
- Be accountable for the decisions we make

WHAT 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 grew by an unprecedented 49 percent between 2014 and 2016!

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 reside in Orange County 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.

<u>Acupuncture</u>	<u>Hospice care</u>	<u>Outpatient mental health services – limited</u>
<u>Adult preventive services</u>	<u>Hospital/inpatient care</u>	<u>Pediatric preventive services</u>
<u>Community-based adult services</u>	<u>Immunizations</u>	<u>Child health and disability prevention (CHDP)</u>
<u>Doctor visits</u>	<u>Laboratory services</u>	<u>Physical therapy</u>
<u>Durable medical equipment</u>	<u>Limited allied health services</u>	<u>Prenatal care</u>
<u>Emergency care</u>	<u>Medical supplies</u>	<u>Specialty care services</u>
<u>Emergency transportation</u>	<u>Medications</u>	<u>Speech therapy</u>
<u>Non-emergency medical transportation (NEMT) and non-medical transportation (NMT)</u>	<u>Newborn care</u>	<u>Substance use disorder preventive services – limited</u>
<u>Hearing aid(s)</u>	<u>Nursing facility services</u>	<u>Vision care</u>
<u>Home health care</u>	<u>Occupational therapy</u>	

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 and Case Management (CM) 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 OC HCA, CCS and the Regional Center of Orange County (RCOC).

Medi-Cal Managed Long-Term Services and Supports

Since July 1, 2015, DHCS integrated Long-Term Services and Supports (LTSS) benefits for CalOptima Medi-Cal members. CalOptima ensures LTSS services are available to members who have health care needs and meet the program eligibility criteria and guidelines.

These integrated LTSS benefits include three programs:

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

OneCare (HMO SNP)

Our OneCare members have Medicare and Medi-Cal benefits covered in one single plan, making it easier for our members to get the health care they need. Since 2005, CalOptima has been offering OC to low-income seniors and people with disabilities who qualify for both Medicare and Medi-Cal. OC has extensive experience serving the complex needs of the frail, disabled, dual eligible members in Orange County. With the start of OneCare Connect (OCC) in 2015, only individuals not eligible for OCC can enroll in OneCare.

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

<u>Acupuncture and other alternative therapies</u>	<u>Gym membership</u>	<u>Prescription drugs</u>
<u>Ambulance</u>	<u>Hearing services</u>	<u>Preventative care</u>
<u>Chiropractic care</u>	<u>Home health care</u>	<u>Prosthetic devices</u>
<u>Dental services – limited</u>	<u>Hospice</u>	<u>Renal dialysis</u>

Diabetes supplies and services	Inpatient hospital care	Skilled nursing facility
Diagnostic tests, lab and radiology services, and X-rays	Inpatient mental health care	Transportation 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 \(Medicare-Medicaid Plan\) 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 benefits such as vision care, 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 in a better, more efficient and higher quality health care experience for the member.](#)

[To join 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:

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

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

In 2013, CalOptima launched the 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.

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

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, dietitians, physical therapists, occupational therapists, home-care staff, activity staff and transportation staff who are committed to planning, coordinating and delivering the most fitting and personalized health care to our participates.

PACE provides all the acute and long-term care services covered by Medicare and Medi-Cal. The services are arranged for participants, based on their needs as indicated by the 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 ON OUR HORIZON

Whole-Person Care

Whole-Person Care is a five-year pilot established by DHCS as part of California’s Medi-Cal 2020 strategic plan and led by the Orange County Health Care Agency. It will focus on improving health care outcomes for members who frequently visit the emergency department and are either homeless or have a serious mental illness.

WHOM WE WORK WITH:

Contracted Health Networks/Contracted Network Providers

Providers have several options for participating in CalOptima’s programs to provide health care to Orange County’s Medi-Cal members. Providers can contract with a CalOptima health network, and/or participate through CalOptima Direct, and/or the CalOptima Community Network. CalOptima members can choose one of 15 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 14 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 dual-eligibles (those with both Medicare and Medi-Cal who elect not to participate in CalOptima’s MA SNP), share of cost members, and members residing outside of Orange County. Members enrolled in CalOptima Direct are not health network eligible.

Health Networks

CalOptima contracts with a variety of health network models to provide care to members. Since 2008, CalOptima’s HNs consist of Health Maintenance Organizations (HMOs), Physician/Hospital Consortia (PHCs), and Shared Risk Medical Groups (SRGs). Through these HNs, CalOptima members have access to more than 1,593 Primary Care Providers (PCPs), nearly 6,092 specialists, 30 hospitals, and 36 clinics. New health 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:

<u>Health Network/Delegate</u>	<u>Medi-Cal</u>	<u>OneCare</u>	<u>OneCare Connect</u>
<u>AltaMed Health Services</u>	<u>SRG</u>	<u>SRG</u>	<u>SRG</u>
<u>AMVI/Prospect</u>		<u>SRG</u>	
<u>AMVI Care Health Network</u>	<u>PHC</u>		<u>PHC</u>
<u>Arta Western Health Network</u>	<u>SRG</u>	<u>SRG</u>	<u>SRG</u>
<u>CCN</u>			
<u>CHOC Health Alliance</u>	<u>PHC</u>		
<u>Family Choice Health Network</u>	<u>PHC</u>	<u>SRG</u>	<u>SRG</u>
<u>Heritage</u>	<u>HMO</u>		<u>HMO</u>
<u>Kaiser Permanente</u>	<u>HMO</u>		
<u>Monarch Family HealthCare</u>	<u>HMO</u>	<u>SRG</u>	<u>HMO</u>
<u>Noble Mid-Orange County</u>	<u>SRG</u>	<u>SRG</u>	<u>SRG</u>
<u>OC Advantage Medical Group</u>	<u>PHC</u>		<u>PHC</u>
<u>Prospect Medical Group</u>	<u>HMO</u>		<u>HMO</u>
<u>Talbert Medical Group</u>	<u>SRG</u>	<u>SRG</u>	<u>SRG</u>
<u>United Care Medical Group</u>	<u>SRG</u>	<u>SRG</u>	<u>SRG</u>

Upon successful completion of readiness reviews and audits, the 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

~~ABOUT 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.~~

~~ONECARE CONNECT — ONECARE CONNECT CAL MEDICONNECT PLAN (MEDICARE MEDICAID PLAN) A DEMONSTRATION PROGRAM FOR LOW INCOME PEOPLE WHO QUALIFY FOR MEDICARE AND 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.~~

~~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 20187 QUALITY IMPROVEMENT PROGRAM PAGES 1-8.~~
UTILIZATION MANAGEMENT PROGRAM DESCRIPTION

UM Purpose

The purpose of the Utilization Management (UM) Program Description is to define ~~the~~ CalOptima's structures and processes ~~within the UM department~~ to review health care services, ~~in order to~~ treatment and supplies, 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 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 of the UM Program is to manage appropriate utilization of medically necessary, covered services to optimize members' health status. We achieve this by providing members with a sense of well-being and productivity through ensure access to quality and cost-effective health care for CalOptima members. ~~Concurrently, there is active management of 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 in accordance with state and federal laws, regulations, contract requirements, National Committee for Quality Assurance (NCQA) Standards as indicated by evidence based clinical criteria and 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 concerns about access, availability, and timeliness of care.
- Clearly define staff responsibility for ~~clinical~~ activities specifically regarding decisions based on ~~on~~ medical necessity.
- Establish and maintain the processes used to review ~~and approve the provision of~~ medical and behavioral health care service requestss, including timely notification to members and/or providers of ~~an~~ appeal rights when an adverse benefit determination is made. ~~process for adverse determinations.~~
- Identify and refer high-risk, high cost members for referral to the ~~to the~~ Care Coordination Management and Care Coordination Programs, including Complex Case Management, Long-Term Services and Supports (LTSS), Behavioral Health and/or ~~the~~ Health Education & Disease Management Programs as appropriate. ~~— when indicated and provided by CalOptima.~~
- Promote a high level of satisfaction across members, practitioners and stakeholders satisfaction, ~~and client organizations.~~
Comply with all applicable regulatory and accrediting agency rules, regulations and standards, and applicable state and federal laws that govern the UM process.
- Protect the confidentiality of member protected health information and other personal/~~provider~~ information.
- Provide a mechanism and process for iIdentifying potential quality of care issues and referreporting them to the Quality Improvement department for further action ~~when necessary.~~
- Identify and resolve problems and issues that contribute result to ~~in~~ over or under utilization underutilization or ~~and~~ the inefficient or inappropriate used ~~delivery~~ of health care services.
Identify opportunities to optimize the health of members through quality initiatives for 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).
- Promotes improved ~~Optimize the~~ member's health and well-being by ~~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), County Specialty Mental Health and California Children's Services (CCS).

~~and Multipurpose Senior Services Program, (MSSP).~~

- Educate practitioners ~~and~~; providers, ~~including delegated Health Networks~~HMOs, PHCS, SRGs and PMGs on CalOptima's UM ~~Program~~, policies ~~and~~; 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 ~~from the norm~~standard practice that may indicate need for additional education or support. ~~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 HMOs, PHCs, and SRGs. CalOptima's HMOs, PHCs, and SRGs include over 3,500 primary care providers (PCPs) and 30 hospitals and clinics. New networks that demonstrate the ability to comply with CalOptima's delegated requirements will be added as needed.~~

Delegation of UM functions

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

- ~~UM 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 ~~Program Description~~~~an and~~ ~~and CalOptima~~ policies and procedures. ~~CalOptima conducts ongoing oversight on a regular basis and performs an annual review of each delegate's UM Program.~~ Delegation is dependent upon the following factors:

- A pre-delegation review to determine the ability to accept assignment of the delegated function(s).
- Executed Delegation Agreement with the organization to which the UM activities have been delegated 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' written UM program description/plan are reviewed annually and approval by CalOptima's Quality Improvement Committee (QIC). Submission of required monthly reports which include but are not limited to: UM data, denial information and quality assurance/improvement issues and activities.~~

CalOptima retains accountability for all delegated functions and services, and monitors the performance of the delegated entity through the following processes:

~~Annual approval of the delegate's UM program (or portions of the program that are delegated); as well as any significant program changes that occur during the contract year.~~

- Monthly Routine-reporting of key performance metrics that are required and/or developed by CalOptima's Audit and Oversight department, UM Committee (UMC) and/or QIC.

- Regular audits of delegated HNs utilization management activities by the Audit and Oversight Department to ensure accurate and timely completion of delegated activities. Annual or more frequent evaluation to determine whether the delegated activities are being carried out according to CalOptima standards and state program requirements.
- 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.
- ~~Annual or more frequent evaluation to determine whether the delegated activities are being carried out according to CalOptima standards and state program requirements.~~

In the event ~~that~~ the delegated provider does not adequately perform contractually specified delegated duties, CalOptima ~~may~~ takes further action, ~~up to and including~~ selected increasing the frequency or number of focused audits/reviews, requiring the delegate to implement corrective actions, imposing ~~sanctions~~, capitation adjustments, probation, suspension or de-delegation.

At the time of pre-delegation, CalOptima evaluates the compatibility of the delegate's UM program with CalOptima's UM Program. Once delegation is approved, CalOptima requires that the delegate provide the appropriate reports as determined by CalOptima to monitor the delegate's continued compliance with the needs of CalOptima. CalOptima annually review ongoing accreditation status and compliance. Oversight for all delegated activities is performed by CalOptima's Audit and Oversight department.

Medi-Cal Managed Long-Term Services and Supports

Beginning July 1, 2015, Long Term Services and Support

is 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 includes both institutional and community based services. has two primary components with four programs.

Nursing Facility Services for Long-Term Care: Nursing Facility:

- CalOptima is responsible for clinical review and medical necessity determination for the following levels of care:
 - Nursing Facility Level B
 - Nursing Facility Level A
 - Subacute Adult and Pediatric
 - Intermediate Care Facility / Developmentally Disabled, (ICF/DD)
 - Intermediate Care Facility / Developmentally Disabled Habilitative, (ICF/DD-H)
 - Intermediate Care Facility / Developmentally Disabled Nursing, (ICF/DD-N)
- Nursing Facility Services for Long Term Care Services: Medical necessity for LTC is evaluated based upon the 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, 51118, 51120, 51121, 51124, 51212, 51215, 51334, 51335, 51343, 51343.1 and 51343.2 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

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

Home and Community Based Services:

- ~~Community Based Adult Services (CBAS): An outpatient, facility-based program that offers health and social services to seniors and persons with disabilities. CalOptima evaluates medical necessity for services provides CBAS as a health plan benefit. CalOptima utilizes the DHCS approved CBAS using the CBAS Eligibility Determination Tool (CEDT) criteria to assess a member's health condition and make a medical determination for the program. 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 Home and community based care coordination of a wide range of services and equipment to support members in their home and avoid the need for long term nursing facility care integrated services within the MSSP site. The CalOptima MSSP site adheres to the California Department of Aging contract and eligibility determination criteria. IHSS: CalOptima and the health networks are responsible for identification, referral and care coordination. CalOptima collaborates with Orange County Social Services Agency (SSA), IHSS, Orange County Public Authority and health networks to ensure members receive appropriate level of care services.~~

Behavioral Health Services

Medi-Cal Outpatient 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, psychology, psychiatric consultation, medication management, and psychological testing when clinically indicated to evaluate a mental health condition.

CalOptima directly manages all administrative functions of the Medi-Cal mental health benefits including utilization management, claims, credentialing the provider network, member services, and quality improvement.

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

Behavioral health services within the scope of practice for primary care physicians (PCPs), ~~may include offering~~ screening, brief intervention, and referral to treatment (SBIRT) services to members 18 and older who may 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. In addition, PCPs frequently manage the treatment of their patients' mental health conditions.

Beginning in 2018, CalOptima will directly manage all administrative functions of the Medi-Cal

~~behavioral health benefits including utilization management, claims, credentialing the provider network, member services, and quality improvement. CalOptima members can access behavioral health services by calling the CalOptima Behavioral Health Line toll free at 855-877-3885. By selecting the Medi-Cal option, the member will be connected to a CalOptima representative for behavioral health triage.~~

~~If a member needs behavioral health office-based services not provided by their PCP are appropriate, the member will be, CalOptima members can access behavioral health services directly, without a physician referral by contacting the CalOptima representative for behavioral health assistance. The member will be provided with several behavioral health practitioners contact information, based upon geographic proximity to the member's residence and their clinical needs. If the member meets criteria for Specialty Mental Health Services, the member is referred to the Orange County Mental Health Plan. Specialty Mental Health Services are not the responsibility of CalOptima~~

~~In addition, CalOptima covers behavioral health treatment (BHT) for members 20 years of age and younger with a diagnosis of Autism Spectrum Disorder (ASD), provided with options of behavioral health practitioners. If the member meets criteria for Specialty Mental Health Services, the member is referred to the Orange County Mental Health Plan. Specialty Mental Health Services are not the responsibility of CalOptima.~~

~~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 members access Behavioral Health Services by calling the CalOptima Behavioral Health Phone Line toll free at 855-877-3885. If office based services are appropriate, the member is registered in the Magellan system and referrals to an appropriate provider are given to the member. If the member meets criteria for Specialty Mental Health Services, the member is referred to the County Mental Health Plan. Specialty Mental Health Services are not the responsibility of CalOptima.~~

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.

Services Not Provided by CalOptima

~~Under its Medi-Cal program, CalOptima provides a comprehensive scope of acute and preventive care services for Orange County's Medi-Cal and dual eligible populations. Certain health care services are not provided by CalOptima, as determined by law and contract.~~

~~Other services may be provided by different agencies including those indicated below: Specialty mental health services are administered by the Orange County Health Care Agency (HCA) County Mental Health Plan.~~

~~Dental services are provided through California's Denti-Cal program.~~

~~California Children's Services (CCS) is a statewide program managed by 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 is a local agency contracted 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

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 Health Care Agency's California Children's Services, Orange County Department of Mental Health, and the Regional Center of Orange County. The UM staff and delegated entity practitioners are responsible for identification of such cases, and coordination of referral to appropriate state agencies and specialist care when the benefit coverage of the member dictates. The UM department coordinates activities with the Case Management and/or Disease Management departments to assist members with the transition to other care, if necessary, when benefits end. This may include informing the member about ways to obtain continued care through other sources, such as community resources.

OneCare and OneCare Connect Behavioral Health Services

CalOptima has contracted with Magellan Health Inc. for the behavioral health services portion of OneCare and OneCare Connect. Functions delegated to Magellan include utilization management, credentialing, and customer service.

CalOptima OneCare and OneCare Connect members can access bBehavioral hHealth sServices by calling the CalOptima Behavioral Health LineMagellan at 855-877-3885. By selecting the OneCare or andOneCare Connect option, the member will be transferred to a Magellan representative for behavioral health triage. If office-based services are appropriate, the member is registered and given referrals to an theappropriate provider are given to the member. If ambulatory Specialty Mental Health needs are identified, services may be rendered through at the Orange County Mental Health Plan.

CalOptima offers screening, brief intervention, and referral to treatment (SBIRT) services to members 18 and older who may 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 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 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 (members eligible with both Medicare and Medi-Cal), retro-assigned, and out-of-Orange 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 (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 is open to participation of any willing and qualified provider. CalOptima already contracts with a variety of providers: PHCs, HMOs, and SRGs. With CCN, individual providers 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 20187 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 state Medicaid include a review of income, assets, and in some cases, medical condition.

The threshold languages spoken by the majority of OneCare members are English, Spanish, Farsi, Vietnamese, Korean, and Chinese, and Arabic, Vietnamese. OneCare members represent over twenty ethnic groups including White, Asian/Pacific Islander, Alaskan native, American Indian, African American 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. CalOptima performs concurrent review for members who are admitted to out-of-area hospitals.

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, but is not limited to Meals on Wheels, Dayle MacIntosh Developmental Center, Orange County Social Service Agency, and Orange County Goodwill. It also includes 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 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.

OneCare Connect

CalOptima's OneCare Connect (Cal MediConnect) program, is a three-year demonstration project 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, LTSS and CBAS for dual-eligible beneficiaries. A key feature of 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 20187 Quality Improvement Program, pages 6–7.

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 Contracts and Memoranda of Understanding (MOUs) with other community agencies and programs, such as the Orange County Health Care Agency's California Children's Services, Orange County Department of Mental Health, and the Regional Center of Orange County. The UM staff and delegated entity practitioners are responsible for identification of such cases, and coordination of referral to appropriate state agencies and specialist care when the benefit coverage of the member dictates. The UM department coordinates activities with the Case Management and/or Disease Management departments to assist members with the transition to other care, if necessary, when benefits end. This may include informing the member about ways to obtain continued care through other sources, such as community resources.

Services Not Provided by CalOptima

Under its Medi-Cal program, CalOptima provides a comprehensive scope of acute and preventive care services for Orange County's Medi-Cal and dual eligible populations. Certain health care services are not provided by CalOptima, as determined by law and contract.

Other services may be provided by different agencies including those indicated below:

- Specialty mental health services are administered by the Orange County Health Care Agency (HCA) County Mental Health Plan.
- Dental services are provided through California's Denti-Cal program.
- California Children's Services (CCS) is a statewide program managed by 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 is a local agency contracted 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
 - Residential Services
 - Psychological, Counseling and Behavioral Services
 - Medical and Dental Services
 - Equipment and Supplies
 - Social and Recreational Services

CALOPTIMA'S UTILIZATION MANAGEMENT PROGRAM~~**IN ADDITION, CALOPTIMA PROVIDES LINKAGES WITH COMMUNITY PROGRAMS TO ENSURE THAT MEMBERS WITH SPECIAL HEALTH CARE NEEDS, OR HIGH RISK OR COMPLEX MEDICAL AND DEVELOPMENTAL CONDITIONS, RECEIVE WRAP AROUND SERVICES THAT ENHANCE THEIR MEDICAL BENEFITS. THESE LINKAGES ARE ESTABLISHED THROUGH SPECIAL PROGRAMS, SUCH AS THE CALOPTIMA COMMUNITY LIAISONS, AND SPECIFIC PROGRAM MEMORANDA OF UNDERSTANDING (MOU) WITH OTHER COMMUNITY AGENCIES AND PROGRAMS,**~~

~~SUCH AS THE ORANGE COUNTY HEALTH CARE AGENCY'S CALIFORNIA CHILDREN'S SERVICES, ORANGE COUNTY DEPARTMENT OF MENTAL HEALTH, AND THE REGIONAL CENTER OF ORANGE COUNTY. THE UM STAFF AND DELEGATED ENTITY PRACTITIONERS ARE RESPONSIBLE FOR IDENTIFICATION OF SUCH CASES, AND COORDINATION OF REFERRAL TO APPROPRIATE STATE AGENCIES AND SPECIALIST CARE WHEN THE BENEFIT COVERAGE OF THE MEMBER DICTATES. THE UM DEPARTMENT COORDINATES ACTIVITIES WITH THE CASE MANAGEMENT AND/OR DISEASE MANAGEMENT DEPARTMENTS TO ASSIST MEMBERS WITH THE TRANSITION TO OTHER CARE, IF NECESSARY, WHEN BENEFITS END. THIS MAY INCLUDE INFORMING THE MEMBER ABOUT WAYS TO OBTAIN CONTINUED CARE THROUGH OTHER SOURCES, SUCH AS COMMUNITY RESOURCES.~~

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 UM Program is delegated by the Board of Directors to the Board's Quality Assurance Committee (QAC). The Board holds the Chief Executive Officer (CEO) and the Chief Medical Officer (CMO) accountable and responsible for the quality of care and service provided to members. The responsibility for the direction and management of the UM Program has been delegated to the Chief Medical Officer (CMO). Before coming to the Board of Directors for approval, the UM Program is reviewed and approved by the [Utilization Management Subcommittee](#) (UMC), the Quality Improvement Committee (QIC) and the Quality Assurance Committee (QAC) on an annual basis.

CalOptima Officers and Directors

CalOptima's CMO, Deputy CMO, and Executive Director of Clinical Operations, and/or any designee as assigned by CalOptima's CEO are the senior executives responsible for implementing the UM Program, including appropriate use of health care resources, medical and behavioral quality improvement, medical and behavioral utilization review and authorization, case management, disease management and health education program implementations, with successful operation of the UMC, QIC and QAC and UMC.

Chief Medical Officer

The Chief Medical Officer (CMO), along with the Deputy Chief Medical Office (DCMO) oversees the UM Program, including the strategies, programs, policies and procedures as they related to CalOptima's medical care delivery system. has operational responsibility for and provides support to. The CMO and DCMO oversee CalOptima's UM Program. CalOptima's CMO, Deputy CMO, and Executive Director of Clinical Operations, and/or any designee as assigned by CalOptima's CEO are the senior executives responsible for implementing the UM Program including appropriate use of health care resources, medical and behavioral quality improvement, medical and behavioral utilization review and authorization, case management, disease management and health education program implementations, with successful operation of the QIC, QAC and UMC.

Deputy Chief Medical Officer

The Deputy Chief Medical Officer (DCMO). along with the Chief Medical Office (CMO) oversees the strategies, programs, policies and procedures as they relate to CalOptima's medical care delivery system. The CMO and DCMO oversee CalOptima's UM Program.

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 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 plan members;~~
 - ~~Participates in and provides oversight to the UMC and all other physician committees or subcommittees;~~
 - ~~Recommends and assists in monitoring corrective actions, as appropriate, for practitioners with identified deficiencies related to UM;~~
 - ~~Serves as a liaison between UM and other plan departments;~~
 - ~~Educates practitioners regarding UM issues, activities, reports, requirements, etc.;~~
- ~~Reports UM activities to the QIC as needed.~~

Executive Director of Clinical Operations (EDCO) is responsible for oversight of all operational aspects of key Medical Affairs functions including: the Utilization Management, Case Management, and 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, DCMO and the ED of QA, 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 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, appointed by the CMO and/or DCMO, is responsible for the direction of the UM Program objectives to drive the organization's mission, strategic goals and processes to provide high quality care to CalOptima members in a compassionate and cost-effective manner. The Medical Director 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 UM also provides supervisory oversight and administration of the UM Program. HeThe Medical Director of UM also oversees all clinical decisions rendered for concurrent, prospective and retrospective reviews that support UM medical management decisions. -Medical Director of UMHe provides clinical education and in-services to staff weekly and on an as needed basis, presenting 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. The Medical Director of UM ensures physician availability to staff during normal business hours and on-call after hours. He or she serves as the Chair of the Utilization Management Committee and the Benefit Management Subcommittee, and participates in the CalOptima Medical Directors Forum and Quality Improvement Committee. -assists in the development and implementation of the 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 UM also provides supervisory oversight and administration of the UM Program. 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. Serves on the Utilization and Quality Improvement Committees, serves as the Chair of the 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 UM. In this role, the Medical Director oversees the 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 the 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.~~

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 UM. In this role, the Medical Director oversees the 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 the UM process. Ensures availability to staff during normal business hours and on-call after hours.

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. The Medical Director provides clinical and operational oversight for behavioral health benefits and services provided to members. The Medical Director 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.

Medical Director, Senior Programs is a key member of the medical management team and is responsible for the Medi-Medi programs (OneCare and OneCare Connect), Managed LTSS (MLTSS) programs, ~~and~~ Case Management and Transitions of Care programs. ~~She~~The Medical Director ~~provides~~ physician leadership in the Medical Affairs division, including acting as liaison to other CalOptima operational and support departments. The Medical Director ~~is also expected to work~~ in collaboration with the other Medical Directors and the clinical staff within Disease Management, Grievance and Appeals, and Provider Relations. The Medical Director works closely with the nursing and non-clinical leadership of these departments.

Medical Director Disease Management/Health Education/Program for All Inclusive Care for the Elderly (PACE) Programs is responsible for providing physician leadership in the clinical and operational oversight of the development and implementation of disease management and health education programs, while also providing clinical quality oversight of the PACE Program.

Director of Utilization Management ~~assists in the~~ is responsible for directing and coordinating the planning, organization, implementation and evaluation of all activities and personnel engaged in UM Departmental activities. ~~The Director~~ development and implementation of the UM Program and UM Work Plan, maintaining and updating policies, and procedures and work flows to meet regulatory, contractual and accreditation standards. ~~Ensures the appropriate use of evidenced-based clinical review criteria/guidelines for medical necessity determinations. The Director of UM also provides supervisory oversight and administration of the 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 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 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.~~

Director of Behavioral Health Services provides operational oversight for behavioral health benefits and services provided to members. ~~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 Director ~~of Behavioral Health 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, state and 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, 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 ~~and~~, SRGs ~~and~~ PMGs meet the requirements set forth by DHCS, ~~and~~ Centers for Medicare/Medicaid Services (CMS), ~~and~~ Department of Managed Health Care (DMHC). The Compliance staff works in collaboration with the CalOptima Quality Improvement department to refer any potential sustained noncompliance issues or trends encountered during audits of health networks, provider medical groups, and other functional areas, such as UM, 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 ~~SRG Physician Medical Group (PMG)~~ delegated functions with an emphasis on efficiency and effectiveness and in accordance with state/federal requirements, CalOptima policies, and industry best practices. The Director ensures that CalOptima and its subcontracted health networks perform consistently with both CMS and state requirements for all programs. Specifically, the 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 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 OneCare Connect programs. 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 Health Education & Disease Management is responsible for the development and implementation of Health Education and Disease Management programs and determines priorities for health education and member self-care management. The 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 Director is also responsible for provider clinical office education for the promotion of quality initiatives.**~~

UM Resources

The following staff positions provide support for the UM department's organizational/operational ~~UM department's~~ functions and activities:

Manager, Utilization Manager (Concurrent Review Manager [CCR]) 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 Supervisor~~ 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

- Current and unrestricted Registered Nurse (RN) or Licensed Vocational Nurse (~~LVN~~
~~license~~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 UM activities.

Supervisor, Utilization Management (Concurrent Review) provides day-to-day supervision of assigned staff, monitors and oversees daily work activities to ensure that service standards are met, makes recommendations regarding assignments based on assessment of workload. The ~~Supervisor~~Manager is a resource to the CCR 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, 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 degree or relevant experience in a health care field.
- 3 years of managed care experience preferred
- Supervisor experience in Managed Care/UM preferred.

Manager, Utilization Management (Prior Authorization [PA]), 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 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

- 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 Utilization Management activities.

Supervisor, Utilization Management (PA) provides day-to-day supervision of assigned staff, monitors and oversees assigned daily 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 degree or relevant experience in a health care field preferred.
- 3 years of managed care experience.
- Supervisor and/or Lead experience in Managed Care/UM preferred.

Notice of Action RNs drafts and evaluates denial letters for adequate documentation and utilization of appropriate criteria. (S)He 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, ensures denial reason is written in plain language that a lay person understands, and is specific to the clinical information presented and criteria referenced. (S)He 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 degree or relevant experience in a health care field preferred.
- 3 years managed care experience
- Excellent analytical and communication skills required

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, ~~and 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 provider service requests are discussed with the appropriate Medical Director, who makes the final determination.

Experience & Education

- Current and unrestricted California Board Licensed Vocational Nurse (LVN) or Registered Nurse (RN) license.
- Minimum of 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 provider service requests are discussed with the appropriate Medical Director, who makes the final determination.

Experience & Education

- High school graduate or equivalent; a minimum of 2 years of college preferred.
- 2 years of related experience that would provide the knowledge and abilities listed.

Program Specialist provides high-level administrative support to the Director of UM, the UM 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.

Pharmacy Department Resources

The following staff positions provide support for Pharmacy operations:

Director, Clinical Pharmacy 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~~third-party auditor, and has frequent interaction with external contacts, including local and state agencies, contracted service vendors, pharmacies, and pharmacy organizations.

Experience & Education

- A current, valid, unrestricted California state Pharmacy License and Pharm.D required.
- American Society of Health System Pharmacists (ASHP) accredited residency in Pharmacy Practice or equivalent experience required.
- Experience in clinical pharmacy, formulary development and implementation that would have developed the knowledge and abilities listed.

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 members enrolled in the CalOptima Delegated Health Plans and CalOptima Direct. Through various modalities (e.g., provider/plan profiling, member drug profile reviews, development and updating of drug utilization criteria, and case-by-case intervention), the Pharmacy Manager promotes clinically appropriate prescribing practices that conform to CalOptima, as well as national practice guidelines and on an ongoing basis, researches, develops, and updates drug 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~~[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.
- 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 members enrolled in the CalOptima Health Networks and CalOptima Direct. Through various modalities (e.g., provider/plan profiling, member drug profile reviews, development and updating of drug utilization criteria, and case-by-case intervention), they promote clinically appropriate prescribing practices that conform to CalOptima, as well as national, practice guideline. On an ongoing basis, research, develop, and update drug 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 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.
- 3 ~~years experience~~[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.
- 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 appropriate regulatory definitions of medical necessity and that have been approved by CalOptima's Pharmacy & 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.

LTSS Resources

The following staff positions provide support for LTSS operations:

Director, Long-Term Support Services (CBAS/~~HSS~~/LTC/MSSP) ~~will~~ develop~~s~~, manage~~s~~ and implement~~s~~ LTSS, including Long-Term Care (LTC) facilities, ~~HSS~~, CBAS and MSSP and staff associated with those programs. The Director ~~is will be~~ responsible for ensuring high quality and responsive service for CalOptima members residing in LTC facilities (all levels of care) and to those members enrolled in other LTSS programs. Develops and evaluates programs and policy initiatives affecting seniors and (SNF/Subacute/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 years of supervisory experience with experience in supervising groups of staff in a similar environment.
- Some experience in government or public environment preferred.
- Experience in the development and implementation of new programs.

Manager, Long-Term Support Services, RN (CBAS/~~HSS~~/LTC) The Manager is expected to develop and manage the LTSS department's work activities and personnel. The Manager will ensure that services standards are ~~met~~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 ~~eligible for and/or~~ receiving LTSS. The Manager must have strong team leadership, problem solving, organizational, and time management skills with the ability to work effectively with management, staff, providers, vendors, health networks, and other internal and external customers in a professional and competent manager. The Manager will work in conjunction with various department managers and staff to coordinate, develop, and evaluate programs and policy initiatives affecting members receiving LTC 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.

Supervisor, Long-Term Support Services, RN, (CBAS, ~~HSS~~, LTC) The Supervisor is responsible for planning, organizing, developing and implementing the principles, programs, policies and procedures employed in the delivery of 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: LTC, CBAS, ~~and HSS~~, and personnel, while interacting with internal/external management staff, providers, vendors, health networks, and other internal and external customers in a professional, positive and competent manner. The position's primary responsibilities are the supervision and monitoring of the ongoing and daily activities of the department's staff. In addition, the Supervisor will be resolving members and providers issues and barriers ensuring excellent customer service. Additional responsibilities include: managing staff coverage in all areas of LTSS to complete assignments, orienting, and training of new employees to ensure contractual and regulatory requirements are met.

Experience and Education

- A current unrestricted RN license in the State of California.
- A Bachelor's degree or relevant experience in a 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 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, Long-Term Support Services (MCM LTSS) (RN/LVN), 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 LTC facilities and members receiving CBAS. They review and determine medical eligibility based on approved criteria/guidelines, National Committee for Quality Assurance (NCQA) standards, Medicare and Medi-Cal guidelines, and facilitate 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 MCM LTSS provides case management in a collaborative process that includes assessment, planning, implementation, coordination, monitoring and evaluation of the member's needs. The MCM LTSS is the subject matter expert and acts as a liaison to Orange County based community agencies, CBAS centers, skilled nursing facilities, members and providers.

Experience and Education

- A current and unrestricted RN license in the State of California or 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.

Program Manager, CBAS (MSW/MS) 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 improvement, reporting requirements, reviewing monthly files audit, developing inter-rater reliability questions, performing psychosocial and functional assessments, and serving as a liaison and key contact person for DHCS, California Department Office of Aging (CDA), CBAS Coalition and CBAS centers. The CBAS Program Manager is responsible for developing strategies and solutions to effectively implement CBAS project deliverables that require collaboration across multiple agencies.

Experience & Education

- Bachelor's degree in Sociology, Psychology, Social Work or Gerontology is required.
 - Masters preferred.

- Minimum of 3 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 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~~
- ~~HIPAA 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 monitored for appropriate application of Review Criteria/Guidelines, processing referrals/service authorizations, and inter-rater reliability. Training opportunities are addressed immediately as they are identified through regular administration of proficiency evaluations. Any employee who fails the evaluation is provided additional training and provided with a work improvement process. Formal training, including seminars and workshops, are provided to all UM staff on an annual basis.~~

~~Appropriately licensed, qualified health professionals supervise the 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 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; o~~

Behavioral Health Integration (BHI) Resources

The following staff positions provide support for BHI operations:

Manager, Behavioral Health implements, manages and monitors contractual relationships with entities providing behavioral health services to CalOptima members. S/he coordinates activities between CalOptima staff, contracted providers, and health networks by providing guidance and decision support when appropriate. The position represents CalOptima and interacts with the County of Orange, contracted organizations and providers, health networks, and other stakeholders in a manner that promotes collaborative working relationships.

Experience & Education

- Master's degree in Health Administration, Social Work, Psychology, Public Health, or other related degree is required.
- 2+ years of manager or director level experience in managed care environment, with specific experience in managing the behavioral health benefit for members covered by Medicare, Medi-Cal and/or Drug Medi-Cal.
- 3+ years of experience in new program development for vulnerable populations, including strategic planning for a start-up program and implementing the program.
- Experience in behavioral health audits (including CMS, DHCS, DMHC, and NCQA).
- Experience in managing Autism Spectrum Disorder Services in a Managed Care environment.
- Experience in developing policies and procedures to meet federal and state regulatory requirements.
- Experience in developing sound and responsible business plans and financial models.

Manager, Behavioral Health, Clinical is responsible for overseeing the clinical operation of CalOptima's Behavioral Health. S/He ensures the delivery of quality and consistent clinical assessment and referrals in accordance with CalOptima policies and procedures. The manager collaborates with other internal CalOptima departments to ensure all regulatory requirements are met. S/He assists the Director of Behavioral Health Services in developing and implementing behavioral health initiatives and projects. S/He represents CalOptima interacting with the County of Orange, contracted organizations and providers, health networks, and other stakeholders in a manner that promotes collaborative working relationships.

Experience & Education

- Master's degree in Social Work, Clinical Psychology, Marriage and Family Therapy or other related degree is required.
- Licensed (LCSW, LMFT, or Licensed Psychologist) is required.
- 4+ years of supervisor or manager level experience in managed care environment, with specific experience in providing telephonic behavioral health assessment and triage required.
- Experience in behavioral health audits (including CMS, DHCS, DMHC, and NCOA).
- Experience in developing policies and procedures to meet federal and state regulatory requirements.
- Experience in developing sound and responsible business plans and financial models.

Clinicians, Behavioral Health assist and monitor clinical service relationships with practitioners providing behavioral health services to CalOptima members. The position coordinates activities between CalOptima staff, contracted providers, and health networks by providing guidance and support.

Experience & Education

- Advanced degree required such as a Master's degree in Social Work, Clinical Psychology, Marriage and Family Therapy or related field of study is required.
- License preferred.
- Minimum 5-6 years of experience is required.
- Strong written and analytical skills required.
- Bilingual in English and in one of CalOptima's defined threshold language is preferred.

Member Liaison Specialists are responsible for assisting members with behavioral health care management needs, which includes, but not limited to, securing behavioral health appointment for members, following up with members before and after appointment, providing member information and referring to community resources, conducting utilization review, and assisting members in navigating the mental health system of care. This position acts as a consultative liaison to assist members, health networks and community agencies to coordinate behavioral health services.

Experience & Education

- High school diploma or equivalent required.
- Bachelor's degree in behavioral health or related field is preferred.
- 2 years of experience in behavioral health, community services, or other social services setting required.
- Customer/member services experience preferred.
- HMO, Medi-Cal/Medicaid and health services experience preferred.
- Driver's License and vehicle or other approved means of transportation may be required for some assignments.
- Bilingual in English and in one of CalOptima's defined threshold language is preferred.

Manager, Behavioral Health (BCBA) is responsible for managing Behavioral Health Treatment (BHT) services, including Applied Behavior Analysis (ABA), for members diagnosed with Autism Spectrum Disorder (ASD). The Manager will oversee Care Managers who review assessments and treatment plans submitted by providers for adherence to ASD "best practice" guidelines. The

Manager will design and implement processes to ensure effective delivery of ABA services. The Manager will collaborate with other internal CalOptima departments to ensure all regulatory requirements are met.

Experience & Education

- Master's degree in Behavioral Health or other related degree is required.
- Board Certified Behavioral Analyst (BCBA) or BCBA-D is required.
- Licensed (LCSW, LMFT, Licensed Psychologist) is preferred.
- 4+ years of supervisor or manager level experience in clinical management of ABA services is required.
- 3+ years of experience providing ABA therapy to children diagnosed with ASD is required.
- Experience in behavioral health audits (including CMS, DHCS, DMHC, and NCQA).
- Experience in developing policies and procedures to meet federal and state regulatory requirements.

Care Manager (BCBA) is responsible for the oversight and review of ABA services offered to members with ASD, including screening, triaging, and assessing members to determine appropriate level of care based on medical necessity criteria. The Care Manager is responsible for reviewing and processing requests for authorization of ABA services from behavioral health providers. This position is also responsible for utilization management and monitoring activities of autism services provided in community based setting. The Care Manager will directly interact with provider callers, acting as a resource for their needs.

Experience & Education

- Master's degree in Behavioral Health or ~~other~~another related field is required.
- Board Certified Behavioral Analyst (BCBA) or BCBA-D is required.
- 4+ years providing ABA therapy to children diagnosed with ASD is required.
- Possess clinical, medical utilization review, and/or quality assurance experience is preferred.
- Bilingual in English and in one of CalOptima's defined threshold language is preferred.

Member Liaison Specialist (Autism) is responsible for providing care management support to members diagnosed with ASD seeking BHT, including ABA. The Member Liaison Specialist will assist members in linking ASD related behavioral health services, following up with members before and after appointment, providing members information and referral to community resources, conducting utilization review, and navigating the behavioral health system of care. This position will act as a consultative liaison to assist members, health networks and community agencies to coordinate ASD related behavioral health services.

Experience & Education

- High school diploma or equivalent is required.
- Bachelor's degree in behavioral health or related field is preferred.
- 2 years of experience in behavioral health, community services, or other social services setting required.
- Experience in working with children diagnosed with ASD.
- Customer/member services experience preferred.
- HMO, Medi-Cal/Medicaid and health services experience preferred.

- Driver's License and vehicle or other approved means of transportation may be required for some assignments.
- Bilingual in English and in one of CalOptima's defined threshold language is preferred.

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
- HIPAA 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

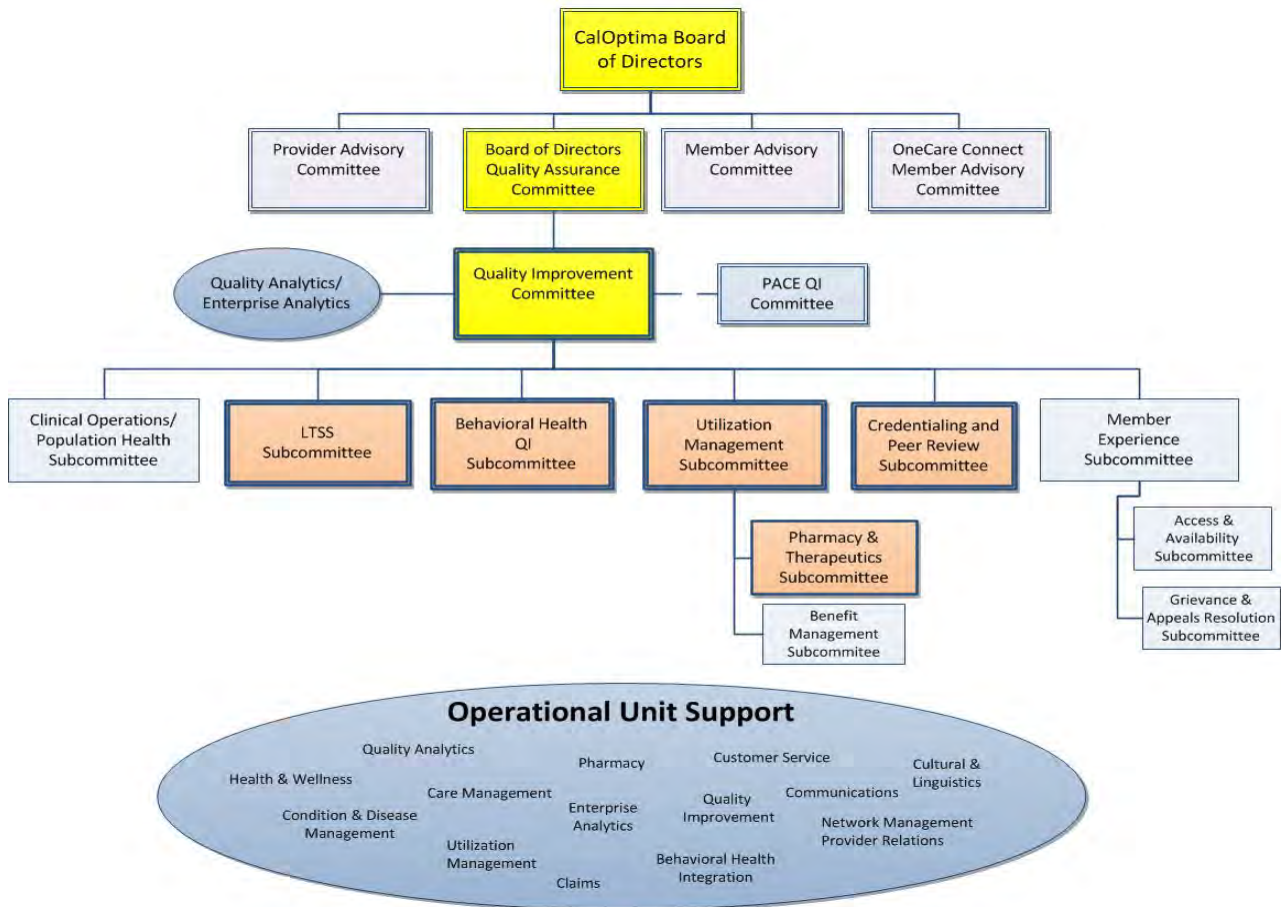
CalOptima encourages and supports continuing education and training for employees, which increases competency in their present jobs and/or prepares them for career advancement within CalOptima. Each year, a specific budget is set for continuing education for each licensed UM employee. Licensed nursing and physician staff are monitored for appropriate application of Review Criteria/Guidelines, processing referrals/service authorizations using inter-rater reliability training and annual competency testing. Training opportunities are addressed immediately as they are identified through regular administration of proficiency evaluations. Any employee who fails the evaluation is provided additional training and provided with a work improvement process. Formal training, including seminars and workshops, are provided to all UM staff on an annual basis.

Appropriately licensed, qualified health professionals supervise the 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 State of California. 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. All medical management staff is required to sign an Affirmative Statement regarding this prohibition annually.

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

- The percentage of the amount by which a claim is reduced for payment, or the number of claims or the cost of services for which the person has denied authorization or payment; or any other method that encourages the rendering of an adverse determination.

COMMITTEE STRUCTURE



Utilization Management Committee (UMC)

The UMC is responsible for the review and approval of medical necessity criteria and protocols and [the UM Program](#), policies [and](#) procedures [and](#) programs. The UMC monitors and analyzes relevant data to detect and correct patterns of under or over utilization, [ensure](#) coordination of care, [ensure](#) appropriate use of services and resources, and [improve](#) member and practitioner satisfaction with the UM process.

The UMC meets [at least](#) quarterly and coordinates an annual review and revision of the UM Program Description, Work Plan and Annual UM Program Evaluation. Before going to the Board of Directors for approval, the documents are reviewed and approved by the QIC and QAC. The Director of UM 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 [the](#) status of corrective action plans to the QIC. Daily oversight and operating authority of UM activities is delegated to the UMC which reports up through CalOptima’s QIC and ultimately to CalOptima’s QAC and the Board of Directors.

UMC Scope

- Oversees the UM activities of CalOptima ~~in regard to~~regarding compliance with ~~contractual requirements~~ federal and state statutes and regulations, and contractual and NCQA requirements;
- ~~Develops and annually r~~Reviews and /approves the UM Program Description on an annual basis;
Approves the use of medical necessity criteria;
- ~~W~~Reviews and approves the UM Work Plan on an annual basis
- Reviews progress toward UM Program Goals on a quarterly basis, providing input for improving the effectiveness of initiatives and projects
~~criteria, policies and procedures~~;
- ~~Reviews practitioner specific UM reports to identify~~ trends and/or utilization patterns presented at UMC and makes recommendations to the QIC for further action~~review~~;
~~Reviews reports specific to facility and/or geographic areas for trends and/or patterns of under or over utilization~~;
~~Examines appropriateness of care reports to identify trends and/or patterns of under or over utilization and refers identified practitioners to the QIC for performance improvement and/or corrective action~~;
- Examines results of annual member and practitioner satisfaction surveys to determine overall satisfaction with the UM Program, identify areas for performance improvement, and evaluate performance improvement initiatives;
- Communicates significant~~Provides as feedback mechanism to the QIC for communicating findings, and~~ recommendations, ~~and a plan for implementing corrective actions~~ related to UM issues to the QIC;
- 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.

UMC Members

The UMC actively involves several active network practitioners 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 following voting members:

- CMO;
- Deputy CMO;
- Executive Director, Clinical Operations;
- Six (6) participating Practitioners from the community
- CalOptima Medical Director of Behavioral Health
- CalOptima Medical Director of Senior Programs
- CalOptima Medical Director of Quality and Analytics
- ~~Health Network Medical Directors~~
- ~~Community providers~~;
- ~~CalOptima Medical Director of Prior Authorization~~
- ~~CalOptima Medical Director of Concurrent Review~~

~~In addition, the UMC is supported by the following individuals:~~

- ~~CalOptima Medical Director of Prior Authorization~~
- ~~CalOptima Medical Director of Concurrent Review~~
- ~~CalOptima UM Director~~
- ~~Director, Utilization Management~~
- ~~Director, Quality Improvement~~
- ~~Director, of Pharmacy~~
- ~~CalOptima Manager, of Prior Authorization~~
- ~~Manager, Concurrent Review~~
- ~~Utilization~~

~~, and any additional staff may also attend the UMC as appropriate.~~

Benefit Management Subcommittee (BMSC)

The Benefit Management Subcommittee is a subcommittee of the UMC. 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-Cal Managed Care Division (MMCD) All Plan Letters (APLs), and the Medi-Cal Manual.

BMSC Scope

The BMSC is responsible for the following:

- Maintain a consistent benefit set for all lines of business; and
- Revise and update CalOptima's authorization rules.
- Makes recommendations regarding the need for prior authorization for specific services;
- Clarifies financial responsibility of the benefit when needed.
- Recommends benefit decisions to the UMC; and
- Communicates benefit changes to staff responsible for implementation.

BMSC Members
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- Chairperson
- Executive Director, Clinical Operations
- Director, Utilization Management
- Director, Case Management
- Director, Healthy Education & Disease Management
- 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 ResolutionClaims
- Director, Coding Initiatives

The BMSC meets ~~sixteen~~ times per year, and recommendations from the BMSC are reported to the UMC on a Quarterly basis.

Behavioral Health Quality Improvement Committee (BHQIC)

The purpose of the Behavioral Health Quality Improvement Committee was established in 2011 with the intended

purpose of is Committee is to:

- Ensureing members receive timely and satisfactory behavioral health care services;
- Enhanceing the integration and coordination between physical health and behavioral health care providers;
- Monitoring key areas of service utilization by members and providers;
- Identifying areas of improvement; and
- Guideing CalOptima towards the vision of bi-directional behavioral health care integration.

BHQIC Scope

The BHQIC responsibilities are to:

- Ensure adequate provider availability and accessibility to effectively serve the membership
- Oversee the functions of delegated activitiesentities

- Monitor that care rendered is based on established clinical criteria, and clinical practice guidelines, and complies with regulatory and accrediting agency standards
- Ensure that member benefits and services are not underutilized, and that assessment and appropriate interventions are taken to identify inappropriate over utilization
- Utilize member and Network Provider satisfaction study results when implementing quality activities
- Maintain compliance with evolving NCQA accreditation standards
- Communicate results of clinical and service measures to Network Providers
- Document and report all monitoring activities to appropriate committees

BHQI Members

The designated Chairman of the BHQIC is the Medical Director, Behavioral Health, who is responsible ~~for chairing the Committee, reviewing information, as well as~~ reporting findings and ~~making QI recommendations, and to represent the BHQI Committee at~~ the QIC ~~meetings~~. ~~The voting members of the BHQI committee include:~~

- Chief Medical Officer/ Deputy Chief Medical Officer
- Executive Director, Clinical Operations
- Medical Director, Behavioral Health Integration
- Director of Behavioral Health Integration
- Medical Director, Medical Management
- Medical Director, Utilization Management
- Executive Director, Quality and Analytics
- Medical Director, Orange County Health Care Agency
- Medical Director, Managed Behavioral Health Organization
- Medical Director, Health Network
- Medical Director, Regional Center of Orange County ~~The composition of the BHQI Committee is defined in the BHQIC Charter.~~

The Committee may permit participation by other CalOptima staff or outside guests with relevant expertise and experience. The BHQIC meets quarterly at a minimum or more frequently as needed.

LTSS Quality Improvement Subcommittee (LTSS QISC)

~~In 2014, the LTSS QISC replaced the Long Term Care QIS.~~ The LTSS QISC was created to provide a forum for LTSS ~~programs providers~~ to share best practices, identify challenges and barriers, and ~~together identify find~~ solutions that are ~~member~~ person-centered, maximize available resources and reducing duplicate services ~~while providing quality of care and ability for members to safely reside in the least restrictive living environment.~~

The LTSS QISC Purpose

- Engage stakeholders ~~input on ways to best on strategies for~~ integrating ~~the~~ LTSS programs with ~~in the~~ managed care delivery system ~~and improved quality of care.~~
- Improving ~~and providing~~ coordination ~~of ed~~ care for CalOptima members who resides in long-term care facilities and ~~for~~ those who receive Home- and Community Based Services (HCBS).

The LTSS QISC Responsibilities

- Identify barriers to keeping members safe in their own homes or in the community, develop solutions, make appropriate recommendations to improve discharge planning process and prevent inappropriate admissions.
- Evaluate the performance, success, and challenges of LTSS program providers of the following services: CBAS, ~~HSS~~, MSSP and other HCBS.
- Monitor the important aspects of quality of care, quality of services and patient safety by collecting and ~~organizing data for all selected indicators~~ analyzing results.
- Provide input on enhancing the capacity and coordination among LTSS providers, community-based organizations, housing providers, and managed care plans to care for individuals discharged from institutions.

- Identify and recommend topics for LTSS providers workshops, educations and trainings.

The LTSS QISC Structure

- The designated Chairman of the LTSS QISC is the Medical Director, Senior Programs, who is responsible for chairing the committee.
- The LTSS QISC includes the following participants: Activity Summary is reported to QIC, and includes, but is not limited to the following:
 - Nursing Facility Administrators
 - CBAS Administrators
 - OC SSA, Deputy Director or Designee
 - 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
 - Manager(s), LTSS
 - Director, LTSS
- The LTSS QISC meets at least 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:~~
 - ~~Member review of Hospital Admission for each LTSS program;~~
 - ~~Member review of Emergency Department visit for each LTSS program;~~
 - ~~Member review for Hospital Readmissions for each LTSS program;~~
 - ~~Health Risk Assessment results for LTC OCC members;~~
 - ~~LTC Provider Annual Workshop;~~
 - ~~CBAS Provider Workshop;~~
 - ~~CBAS Centers Profile~~
 - ~~LTC Profile~~
 - ~~Care Coordination and Interdisciplinary Care Team Participation by LTSS staff;~~
- ~~Total number of participants by LTSS program~~
- ~~In addition, LTSS utilization activities' summary is reported to UMC, and includes, but is not limited to, the following:~~
 - ~~CBAS statistics such as to number of participants, assessment type, turnaround time, and denials rates;~~
 - ~~LTC statistics include, but is not limited to, bed type, turnaround time, and denials rate;~~
 - ~~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 Plan are evaluated and submitted for review and approval annually by both the CalOptima UMC, ~~the and the QIC and the QAC,~~ with final review and approval by the Board of Director's ~~QAC~~.

- Utilization data is collected, and aggregate aggregated and analyzed UM data, member grievances, including, but not limited to denials,

~~unused authorization, provider preventable conditions and trends representing potential over or under utilization and appeals are reviewed at the UMC and recommendations are presented to the 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 ~~evaluation, follow-up~~
- The QIC reports to the Board QAC.
- The UMC is a subcommittee of the QIC~~)~~ 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. CalOptima requires that all individuals who serve on Utilization Management Committee or who otherwise make decisions on utilization management, quality oversight and activities timely and fully disclose any actual, perceived, or potential conflicts of interest that arise in the course and scope of serving in such capacity. Potential conflicts of interest may occur when an individual who is able to control or influence a business or clinical decision has a personal, financial, or otherwise competing interest in the outcome of the decision.

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.~~

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 QIC 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, and Managed Behavioral

Health Organizations (MBHOs) ~~and PMGs~~ hold all information in the strictest confidence. Members of the QIC 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 LTSS Programs, Pharmacy & Therapeutics (P&T) Program, QI, Credentialing, 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 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 department in the format prescribed by CalOptima for review and resolution as needed. The CMO or Medical Director determines if the information warrants additional review by CalOptima's Peer Review or Credentialing Committee. If committee review is not warranted, the information is filed in the practitioner's folder and is reviewed at the time of the practitioner's re-credentialing.

UM policies and processes serve as integral components in preventing, detecting, and responding to Fraud and Abuse among practitioners and members. The UM 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.

UM Process

The UM process encompasses the following program components: ~~24-hour seven day week nurse triage, referral/prior authorization, concurrent review, ambulatory review, retrospective review, discharge planning and care coordination, second and 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. _

[UM policies and processes serve as integral components in preventing, detecting, and responding to fraud and abuse among practitioners and members. -The UM Department works closely with the Compliance Officer and the Fraud and Abuse Unit to resolve any potential issues that may be identified.](#)

Benefits

CalOptima administers health care benefits for members, as defined by contracts with the D-HCS (Medi-Cal), a variety of programs, regulations, policy letters and all the Center for Medicare and Medicaid Services benefit guidelines are maintained by CalOptima to support UM decisions. Benefit coverage for a requested service is verified by the UM staff during the authorization process. CalOptima has standardized authorization processes in place, and requires that all delegated entities to have similar program processes. Routine auditing of delegated entities is performed by the CalOptima Audit and Oversight department via its delegation oversight team for compliance.

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~~CMS, -DHCS, DMHC, ~~CMS~~, CDA and NCQA at least annually. Recommendations for revisions and improvements are made, as appropriate, ~~and subsequently annually~~. The UM Work Plan is based on the findings of the annual program Work 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.

The organization chart and the program Committee's reporting structure accurately reflect CalOptima's Board of Directors as the governing body, identifies senior management responsibilities, as well as committee reporting structure and lines of authority. Position job descriptions and policies and procedures define associated responsibilities and accountability. The composition and functions of the UM Workgroup (UMG), 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, the UMC and QIC. CalOptima-contracted delegates are delegated UM responsibilities, including the UM Program and Work Plans, which are presented annually to the QIC as part of CalOptima's Delegation Oversight Program. The QIC then reviews and approves or does not approve the delegate's UM Program and Work Plans.

METHODS OF REVIEW AND AUTHORIZATION OF SERVICES

Medical Necessity Review

Covered services are those medically necessary health care services provided to members as outlined in CalOptima's contract with the Centers for Medicare and Medicaid and the State of California for Medi-Cal, 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 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 or modification decisions for requested medical and behavioral health care services. The review of the denial of a pharmacy prior authorization, may be completed by a qualified Physician or Pharmacist.

CalOptima's UM department is responsible for the review and authorization of health care services for CalOptima Direct Administrative (COD-A) and CCN 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;
- Evaluation for potential transplant services for health network members;
- 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 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 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 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 documentation of an oral notification or written Notice of Action, are retained for a minimum of 10 years from the end of the fiscal year in which the date of service occurred, unless a longer period is required by law;
- The 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 with the Medical Director involved in the decision, utilizing the contact information included in the Notice of Action. A provider may

request a discussion with the Medical Director, or a copy of the specific criteria utilized.

The following is appropriate clinical information **may be** 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 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.

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-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 the Prior Authorization List in the provider section on the CalOptima website at www.caloptima.org. Clinical information submitted by

the provider justifies the rationale for the requested service through the authorization process which assesses medical necessity and appropriateness utilizing evidence-based guidelines upon which a determination is made.

CalOptima's medical management system, [Altruista/GuidingCare](#) is a 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 CalOptima Link system allows for on-line authorizations to be submitted by the health networks and processed [electronically](#). ~~The r~~[Referrals](#)[electronically](#). Referrals are auto-adjudicated through referral intelligence rules (RIR). Practitioners also [submit](#)~~send~~ referrals and requests to the UM 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. PCPs 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-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.

Pharmaceutical Management

The Pharmacy Management Program is overseen by the CMO, and CalOptima Director, 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 & Therapeutics Committee (P&T) and updated as new pharmaceutical information becomes available.

Policies and procedures for pharmaceutical management promote the clinically appropriate use of pharmaceuticals, and are made available to practitioners via the provider newsletter and/or CalOptima website.

The CalOptima 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 PBM for review. All potential authorization denials are reviewed by a Pharmacist at CalOptima, as per DHCS ~~and DMHC regulations~~ requirements. The Pharmacy Management department profiles drug utilization by members to identify instances of polypharmacy that may pose a health risk to the member. Medication profiles for members receiving multiple medication fills per month are reviewed by a Clinical Pharmacist. Prescribing practices are profiled by practitioner and specialty groups to identify educational needs and potential over-utilization. Additional prior authorization requirements may be implemented for physicians whose practices are under intensified review.

PHARMACY DETERMINATIONS

Medi-Cal

CalOptima's Pharmacy Management department delegates initial prior authorization review to the PBM based on clinical prior authorization criteria developed by the CalOptima Pharmacy Management staff and approved by the CalOptima 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. In addition, 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.
- 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 required CMS timeliness guidelines and medical necessity review criteria.

Formulary

The CalOptima drug Formularies were created to offer a core list of preferred medications to all practitioners. Local providers may make requests to review specific drugs for addition to the Formulary. The Formulary is developed and maintained by the CalOptima P&T Committee. Final approval from the P&T must be received to add drugs to the Formulary. The CalOptima Formularies are 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 ~~recommends~~ 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 is monitored according to the Audit and Oversight department's policies and procedures.

UTILIZATION REVIEW OF SUPPLEMENTAL DENTAL BENEFITS (OC, OCC)

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 UM 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 UM 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 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 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 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 10 years from the end of the fiscal year in which the date of service occurred, unless a longer period is required by law;~~
~~Requesting provider is notified, orally or in writing, of any decision to deny, approve, modify, or delay a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested;~~
~~All members are notified in writing of any decision to deny, modify, or delay a service authorization request.~~
~~All providers are encouraged to request information regarding the criteria used in making a determination. Contact can be made directly to the Medical Director involved in the decision, utilizing the contact information included in the Notice of Action. A provider may request a discussion with the Medical Director, or a copy of the specific criteria utilized.~~
~~The following is appropriate clinical information used to make medical necessity determinations and includes, but is not limited to:~~

~~Office and hospital records~~

~~A history of the presenting problem~~

~~A clinical examination~~

~~Diagnostic test results~~

~~Treatment plans and progress notes~~

~~Patient's psychological history~~

~~Information on consultations with the treating provider~~

~~Evaluations from other health care providers~~

~~Photographs~~

~~Operative and pathological experts~~

~~Rehabilitation evaluations~~

~~A printed copy of criteria related to the request~~

~~Information regarding benefits for services or procedures~~

~~Information regarding the local delivery system~~

~~Patient characteristics and information~~

~~Information from responsible family members~~

~~CalOptima's 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's program requirements, or to meet federal or state statutory or regulatory requirements. Practitioners are appropriately notified when such modifications occur.~~

Appropriate Professionals for UM Decision Process

The UM decision process requires that qualified, licensed health professionals assess the clinical information used to support UM decisions. If the clinical information included with a request for services does not meet the appropriate clinical criteria, the 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.

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 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 and SRGs Health Networks 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 Guidelines;](#)
- [Specialty Guidelines such as the American Academy of Pediatric Guidelines \(AAP\) and American Heart Association Guidelines;](#)
- [CalOptima Criteria for outpatient behavioral health services;](#)
- [CalOptima Medical Policy and Medi-Cal Benefits Guidelines;](#)
- [National and Local Coverage Determination Guidelines.](#)
- [National Guideline Clearinghouse](#)
- [Medicare Part D: CMS-approved Compendia](#)

[Delegated HMOs, PHCs and SRGs Health Networks 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.](#)

[Is There a Headline Missing Here for the Table Below?](#)

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			X
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*If Medical Necessity is not met, the request is referred to the Medical Director / Physician Reviewer for review and determination.

Long-Term Services and Supports

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.

Medi-Cal Behavioral Health Services

<u>Authorization Type*</u>	<u>Criteria Utilized</u>	<u>Medical Assistant</u>	<u>Care Manager (BCBA)</u>	<u>Medical Director / Physician Reviewer</u>
<u>Psychological Testing</u>	<u>Title 22, MCG, Medi-Cal Manual, CalOptima policy</u>		<u>X</u>	<u>X</u>
<u>Behavioral Health Treatment (BHT) services</u>	<u>Title 22, WIC Section 14132, MCG, H&S Code 1374.73, Medi-Cal Manual, CalOptima policy</u>		<u>X</u>	<u>X</u>

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, Magellan ensures there are peer reviewers/clinical consultants. Peer reviewers are behavioral health professionals who are qualified, as determined by Magellan'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 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 members in accordance with [CalOptima Policy GG.1534 Evaluation of New Technology and Uses](#).

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 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, adaptation 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 Guidelines;

Specialty Guidelines such as the American Academy of Pediatric Guidelines (AAP) and American Heart Association;

CalOptima Criteria for outpatient behavioral health services;

CalOptima Medical Policy and Medi-Cal Benefits Guidelines;

National (CMS) and local (state) Determination Guidelines;

National Guideline Clearinghouse

Medicare Part D: CMS approved Compendia

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 UM 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 UM department. The manual also outlines CalOptima's UM policies and procedures. Similar information is found in the Member Handbook and on the CalOptima website at www.caloptima.org.

Inter-Rater Reliability

At least annually, the CMO and Executive Director of Clinical Operations assess the consistency with which Medical Directors and other UM staff making clinical decisions, apply UM criteria in decision-making. The assessment is performed as a periodic review by the Executive Director of Clinical Operations or designee to compare how staff members manage the same case or some forum in which the staff members and physicians evaluate determinations, or they may perform periodic audits against criteria. When an opportunity for improvement is identified through this process, CalOptima's 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 **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 **800-735-2929**. The phone numbers for these are included in the Member Handbook, on the web, and in all member letters. Additionally, language assistance for members to discuss UM issues is provided either by bilingual staff or through Language Line services.

Inbound and outbound communications may include directly speaking with practitioners and members, or faxing, electronic or telephone communications (e.g. sending email messages or leaving voicemail messages). Staff identifies themselves by name, title and CalOptima UM department when both making and receiving phone calls regarding UM processes. After normal business hours and on holidays, calls to the UM department are automatically routed to an on-call contracted vendor. The vendor is not a delegated UM entity and therefore, does not make authorization decisions. The vendor staff takes authorization information for the next business day response by CalOptima or notifies CalOptima on-call nurse in cases requiring immediate response. A log is forwarded to the UM department daily identifying those issues that need follow-up by the UM staff the following day.

Access to Physician Reviewer

The CalOptima Medical Director or appropriate practitioner reviewer (behavioral health and pharmacy) serves as the point of contact for practitioners calling in with questions about the UM process and/or case determinations. Providers are notified of the availability of the appropriate practitioner reviewer to discuss any UM denial decisions through the Provider Manual, New Provider Orientation, and the provider newsletter. Notification of the availability of an appropriate practitioner reviewer to discuss any UM denial decision, and how to contact a reviewer for specific cases, is also provided verbally and/or in the written notification at the time of an adverse determination. The CalOptima Medical Director may be contacted by calling CalOptima's main toll-free phone number and asking for the CalOptima Medical Director. A CalOptima Case Manager may also coordinate communication between the CalOptima Medical Director and requesting practitioner.

The Medical Directors are responsible for providing clinical expertise to the UM 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 SRGs 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.

Requesting Copies of Medical Records

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 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.

TIMELINESS OF UM DECISIONS

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 (Medi-Cal) <u>Clinical Medical</u> — Decision Making	OneCare (Medicare) and OneCare Connect <u>Clinical Medical</u> — Decision Making
<ul style="list-style-type: none"> • Performed by <u>Processed by</u> CalOptima UM department staff for <u>COD-A and CCN</u> members in direct or non-delegated network • Performed <u>Processed</u> by <u>Health Network</u> UM department at the PMGs staff for <u>HN</u> members <ul style="list-style-type: none"> ○ <u>Requests for transplant services for HN members are performed by CalOptima UM staff</u> • <u>Qualified physician review for</u> any modifications or denials • <u>Qualified psychologist or psychiatrist review for modifications or denials of behavioral health services</u> • <u>Qualified pharmacist review for</u> any <u>pharmacy modifications</u> or denials 	<ul style="list-style-type: none"> • <u>Performed by CalOptima UM staff for CCN members</u> • <u>Performed by Health Network UM staff for HN members</u> <ul style="list-style-type: none"> ○ <u>For OneCare HN members Medi-Cal “wrap” benefits and requests for out of area services (SRGs only) are performed by CalOptima UM staff. Processed by UM department at the Physician Medical Groups</u> • <u>Behavioral Health Determinations Performed by Managed Behavioral Health Organization</u> <u>Processed by Case Management department at CalOptima for out of area and Medi-Cal wrap authorizations</u> • <u>Qualified physician review for any modifications or denials</u> • <u>Qualified psychologist or psychiatrist review for modifications or denials of behavioral health services</u> • <u>Qualified pharmacists or physician review for</u> any pharmaceutical partial approvals or denials

<p align="center"><u>Medi-Cal</u> <u>Timeframes for Decision</u> <u>Timeframes for Decision</u></p>	<p align="center"><u>OneCare and OneCare Connect</u> <u>Timeframes for Decision</u> <u>Timeframes for Decision</u></p>
<p>Timeframes for Determinations: Routine: <u>-5 business days from receipt of all medically necessary information to make a determination, not to exceed 14 calendar days from receipt of request and -5 business days from receipt of all medically necessary information to make a determination</u></p> <p>Urgent: 72 hours <u>from receipt of request</u></p> <p>Retrospective: 30 <u>calendar days from receipt of request</u></p> <p>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.</p>	<p>Routine (Non-Urgent): Pre-Service Extension Needed: Provider: Within 24 hours ___ of making the Timeframes for Determinations (non-Part B):- Routine: 14 calendar days <u>from receipt of request and 5 business days from receipt of request.</u></p> <p>Routine- Extension Needed:- <u>May extend for an additional 14 days if additional information may result in an approval.</u></p> <ul style="list-style-type: none"> <u>—Provider: Within 24 hours of extension decision</u> <u>Member:- Within 24 hours of extension decision</u> <p>Urgent: 72 hours</p> <p>-Retrospective: 30 <u>calendar days from receipt of request</u></p> <p>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 <u>2 working days from making the decision, not to exceed 14 days from after receipt of the request.</u></p>

<p align="center"><u>Medi-Cal</u> <u>Timeframes for Notification</u></p>	<p align="center"><u>OneCare and OneCare Connect</u> <u>Timeframes for Notification (non-Part D)</u></p>
<p>Routine: Provider: Verbal/ Electronic: within 24 hours of</p>	<p>Standard (Routine): Provider: Written notification must be sent</p>

decision
Written: within 2 working days of the decision, if verbal previously given

Member: Verbal not required
Written: (Required only for delay, modification or denial). Within 2 working days of the decision, not to exceed 14 calendar days from the receipt of the request.

Expedited (Urgent):
Provider: Verbal Electronic: within 72 hours from the receipt of the request; must include expedited appeal rights.
Written (if verbal notification given): Within 2 working days of the decision

Member: Verbal: not required
Written: (Required only for delay, modification or denial) Within 2 working days of making the decision.

within three days of decision.

Member: Notified of the decision no later than 2 working days from the decision, not to exceed 14 days from receipt of the request.

Expedited (Urgent):
Provider: Verbal/ Electronic: notification 72 hours from the receipt of the request; must include expedited appeal rights.
Written (If verbal notification given): Within 2 working days of the decision

Member: Verbal: Within 24 hours of decision
Written: Within 2 working days of making the decision

<p><u>Routine:</u> Provider: Verbal/ Electronic within 24 hours of decision Written: within 2 working days of the decision, if verbal previously given</p> <p>Member: Verbal not required Written (Required only for delay, modification or denial). Within 2 working days of the decision, not to exceed 14 calendar days from the receipt of the request.</p> <p><u>Expedited (Urgent):</u> Provider: Verbal/Electronic: Within 72 hours from the receipt of the request; must include expedited appeal rights. Written (if verbal notification given): Within 2 working days of the decision</p> <p>Member: Verbal: not required Written: (Required only for delay, modification or denial) Within 2</p>	<p><u>Standard (Routine):</u> Provider: Written notification must be sent within three days of decision.</p> <p>Member: Notified of the decision no later than 2 working days from the decision, not to exceed 14 days from receipt of the request.</p> <p><u>Expedited (Urgent):</u> Provider: Verbal/ Electronic notification 72 hours from the receipt of the request; must include expedited appeal rights. Written (If verbal notification given): Within 2 working days of the decision</p> <p>Member: Verbal: Within 24 hours of decision Written: Within 2 working days of making the decision</p>
<p><u>Medi-Cal</u></p>	<p><u>OneCare and OneCare Connect Timeframes for Notification (non-Part D) (cont.)</u></p>

<p align="center"><u>Timeframes for Notification</u></p> <p align="center"><u>(cont.)</u></p>	<p><u>Concurrent:</u></p>
<p><u>Concurrent:</u></p> <p><u>-Practitioner: -Verbal/ Electronic: Within 24 hours of making the decision</u></p> <p><u>Written (if verbal notification): -</u></p> <p><u>Within 2 working days of the decision.</u></p> <p><u>Following completion of treatment, an authorization summary is provided within 2 working days.</u></p> <p><u>-Member: -Verbal: -Not required.</u></p> <p><u>Written: (Required only for delay, modification or denial). -Within 2 working days of decision</u></p> <p><u>-</u></p> <p><u>Retrospective:</u></p> <p><u>-Practitioner: Verbal: -not required</u></p> <p><u>Written: (Required only for modification or denial): Within 30 days of receipt of information necessary to make the determination</u></p> <p><u>Member: Verbal: Not required</u></p> <p><u>Written: (Required only for modification or denial): Within 30 days of receipt of information necessary to make the determination</u></p>	<p><u>-Practitioner: - Verbal/ electronic: -Within 24 hours of making the decision</u></p> <p><u>Written (if verbal notification): -Within 2 working days of the decision.-</u></p> <p><u>Following completion of treatment, an authorization summary is provided within 2 working days.</u></p> <p><u>-Member: -Verbal: Not required.</u></p> <p><u>Written: (Required only for denial). - Within 2 working days of decision</u></p> <p><u>Retrospective:</u></p> <p><u>-Practitioner: Verbal: Not required</u></p> <p><u>Written: (Required only for denial):-</u></p> <p><u>Within 30 days of receipt of information necessary to make the determination</u></p> <p><u>Member: Verbal: Not required</u></p> <p><u>Written: (Required only for denial):</u></p> <p><u>Within 30 days of receipt of information necessary to make the determination</u></p> <p><u>Notice requirement: -CMS "Medicare Notice of -Non-Coverage" including specific language for expedited appeal for expedited initial- organization determination</u></p>

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 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.

<p>decision.</p> <p>NOTE: For Provider and Member: If oral notification is given within 24 hours of request, written notification must be given no later than 3 working days after the oral notification.</p> <p>Post Service—Retrospective Review: (Oral or Electronic)</p> <p>Member and Provider: None specified</p> <p>Written Notification of Denial or Modification: Provider and Member: Within 30 calendar days of receipt of request.</p> <p>Post Service—Extension Needed: (Oral or Electronic)</p> <p>Provider and Member: None specified</p> <p>Written Notification of Denial or Modification: Provider and Member: Within 30 calendar days of receipt of the information necessary to make the determination</p>	
<p>Denial Letter/Member Notification</p> <p>State mandated “Notice of Action”</p>	<p>Denial Letter/Member Notification</p> <p>CMS mandated “Medicare Notice of Non-Coverage” including specific language for expedited appeal for expedited initial organization determination</p>

Medi-Cal and OneCare Connect (Medi-Cal) <u>Pharmaceutical — Decision Making</u>	OneCare (Medicare) and OneCare Connect <u>Pharmaceutical — Decision Making</u> (Medicare)
<p>Pharmaceutical — Decision Making</p> <ul style="list-style-type: none"> Processed by CalOptima Pharmacy Management department or Pharmacy Benefits Manager Qualified <u>pharmacist or physician</u> review for any modifications or denials Qualified pharmacist review for any modifications or denials Qualified physician review for any appeal- denials 	<p>Pharmaceutical — Decision Making</p> <ul style="list-style-type: none"> <u>Processed by CalOptima Pharmacy Management department or Pharmacy Benefits Manager</u> <u>Qualified pharmacist or physician review for any modifications or denials</u> <u>Qualified physician review for any appeals</u> <ul style="list-style-type: none"> Processed by Pharmacy Management department at CalOptima Qualified physician review for any appeals

<u>Medi-Cal</u> <u>Pharmacy — Timeframes for Determinations</u>	<u>OneCare and OneCare Connect</u> <u>Pharmacy — Timeframes for Determinations (Part D):</u>
<p>Pharmacy — Timeframes for Determinations</p> <p>÷</p> <p><u>Standard (Non-urgent)</u> <u>Preservice:Response (approval, Deferral, Denial) Wwithin 24 _hours a decision to approve, modify, —deny or defer is required.</u></p> <p><u>Standard (Non-urgent) Preservice,</u> <u>Extension Needed:- Within 5 working days of receiving needed information, but no longer than 14 calendar days or next business day of receiving the request.</u> <u>Approvals or Denials</u> <u>Routine 5 business days</u> <u>Urgent 72 hours</u> <u>Retrospective 30 days</u> <u>Expedited (Urgent) Preservice: Wwithin 24 —hours a decision to approve, modify, —deny or defer is required.</u></p>	<p>—Timeframes for Determinations (Part D):</p> <ul style="list-style-type: none"> Routine: 72 hours Urgent: 24 hours <u>Retrospective: 14 days</u> <p>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</p>

Expedited (Urgent) Preservice, Extension Needed:- Within 72 hours of the initial request

Concurrent: A deferral must be made within 24 hours if indicated. Approval, modification or denial within 72 hours.

Post-Service/Retrospective: ~~W~~ within 30 days of receipt

Pharmacy: 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
Timeframes for Notification
Medi-Cal

Standard (Non-Urgent) Pre-Service (for modifications or denials only):

Provider: Electronic/written: within 2 business days of the decision-

Member: written: within 2 business days of the decision

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: Electronic/written: within 2 business days of the decision, not to exceed 14 calendar days from the receipt of request.

Within 24 hours of making the decision:

Member: Written: within 2 business days of the decision, not to exceed 14 calendar days from the receipt of request.

None specified

Written Notification of Denial or Modification:-
Provider: Within 2 working days of making the

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.

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: Electronic/written: Within 2-
_____ working business days of making the
decision:~~

~~_____ Member: Written: Within 2 business-
working days _____ of making the decision.~~

**~~Expedited (Urgent) Preservice, Extension
Needed: 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.~~**

~~_____ Provider: Electronic/written: within 2-
business days of the decision~~

~~_____ Member: Written: within 2 business days
of the decision~~

~~Concurrent:~~

~~_____ Provider: Electronic/written: Within 24-
_____ hours of making the decision.~~

~~_____ Member: Written: Within 24 hours
_____ of making the decision.~~

~~Post Service/ Retrospective~~

~~Review: (Oral or Electronic)~~

~~Member and Provider: None
specified~~

~~Written Notification of Denial or
Modification:-~~

~~_____ Practitioneovider and~~

~~Member: Written: within 30-
calendar days of receipt of request.~~

~~Member: Written: within 30 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~~

<p align="center"><u>Medi-Cal Pharmacy — Timeframes for Notification</u></p>	<p align="center"><u>OneCare and OneCare Connect Pharmacy — Timeframes for Notification (Part D)</u></p>
<p><u>Routine (Non-Urgent): Pre-Service Extension Needed:</u> <u>Provider: Electronic/written: Within 2 business days of the decision, not to exceed 14 calendar days from the receipt of request.</u> <u>Member: Written: Within 2 business days of the decision, not to exceed 14 calendar days from the receipt of request.</u></p> <p><u>Expedited Authorization (Pre-Service): Notification of Denial or Modification</u> <u>Provider: Electronic/written: Within 2 business days of making the decision.</u> <u>Member: Written: Within 2 business days of making the decision.</u></p> <p><u>Expedited (Urgent) Preservice, Extension Needed:</u> <u>Provider: Electronic/written: Within 2 business days of the decision</u> <u>Member: Written: Within 2 business days of the decision</u></p> <p><u>Concurrent:</u> <u>Provider: Electronic/written: Within 24 hours of making the decision.</u> <u>Member: Written: Within 24 hours of making the decision.</u></p> <p><u>Post Service/ Retrospective Review:</u> <u>Practitioner: Written: Within 30 days of receipt of request.</u> <u>Member: Written: Within 30 days of receipt of request.</u></p>	<p><u>Authorization Request Type:</u></p> <p><u>For expedited requests:</u> <u>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.</u></p> <p><u>For standard requests:</u> <u>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.</u></p> <p><u>For retrospective requests:</u> <u>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.</u></p>

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

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 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 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—How should the HE be represented here with CareNet?~~

~~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 bilingual staff of 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 Advice Phone Line also helps support CalOptima member’s comprehensive needs by cross referring members to existing programs such as case or disease management, Perinatal Support Services, IHSS, MSSP, Health~~

| ~~Education, and local resources available in the community.~~

| ~~_____~~

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 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 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 UM Medical Director, a Notice of Action (NOA) letter is issued immediately by fax or via overnight certified mail to the attending physician, hospital and the member.

The need for case management, disease management, or discharge planning services is assessed during the admission review and each concurrent review, meeting the objective of planning for the most appropriate and cost-efficient alternative to inpatient care. If at any time the UM staff become aware of potential quality of care issues, the concern is referred to CalOptima QI department for investigation and resolution.

Hospitalist/SNFist Program

The goal of the Hospitalist/SNFist Program is for early identification and management of members, either in the Emergency Room or inpatient setting, with prompt linkage to an identified hospitalist/SNFist to ensure that the member receives the appropriate care in the most appropriate setting. Appropriate setting is determined by medical providers using established evidence based clinical and administrative criteria. Other program objectives include:

Initiate appropriate care plan consistent with:

- Established estimated length of stay criteria
- Medical necessity criteria to establish appropriate level of care
- Member psychosocial needs impacting ongoing care
- Communication of current and ongoing needs impacting discharge planning and after-care requirements to PCP and others involved in the members care
- Facilitation of transfer of members from non-contracted facilities to facilities with a

contracted hospitalist team

Contracted hospitalist groups, facilities case management staff, and Emergency Room personnel receive training from CalOptima staff on:

- Early identification of CalOptima Direct (COD) members
- Process for notification of hospitalists
- Face sheet and/or telephonic notification to CalOptima
- Care Plan development and implementation
- Discharge Planning

The role of the hospitalist is to work together with the Emergency Department team to determine the optimal location and level of care for the member's treatment needs. If, based on clinical information and medical necessity criteria, the member requires admission to the facility; the hospitalist assumes primary responsibility for the member's care as the admitting physician and will coordinate the member's care together with CalOptima medical management staff. If at any time the member is appropriate for transfer to a lower level of care, whether directly from the emergency room or after admission, the hospitalist will facilitate the transfer to the appropriate setting, in concert with the accepting facility and with CalOptima staff.

Discharge Planning Review

Discharge planning begins within 48 hours of an inpatient admission, and is designed to identify and initiate a cost effective, quality driven treatment intervention for post-hospital care needs. It is a cooperative effort between the attending physician, hospital discharge planner, UM staff, health care delivery organizations, and community resources to coordinate care and services.

Objectives of the Discharge Planning Review are:

- Early identification during a member's hospitalization of medical/psycho-social issues with potential for post-hospital intervention;
- Development of an individual care plan involving an appropriate multi-disciplinary team and family members involved in the members care;
- Communication to the attending physician and member, when appropriate, to suggest alternate health care resources;
- Communication to attending physician and member regarding covered benefits, to reduce the possibility of a financial discrepancy regarding non-covered services and denied days of hospitalization;
- Coordination of care between the member, PCP, attending physician, specialists, hospital UM/Discharge Planning staff, and UM staff.

The UM staff obtains medical record information and identifies the need for discharge to a lower level of care based on discharge review criteria/guidelines. If the attending physician orders discharge to a lower level of care, the UM staff assists the hospital UM/Discharge Planner in coordinating post-hospital care needs. The same process is utilized for continued stay approval or denial determinations by the UM 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.

UM Grievance Appeals Process

CalOptima has a comprehensive review system to address matters when Medi-Cal, OneCare or OneCare Connect members wish to exercise their right to review of a 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. Grievance Appeals for members enrolled in COD, or one of the contracted HMOs, PHCs, and SRGs and PMGs, are submitted to CalOptima's GARS. The process is designed to handle individual disagreements in a timely fashion, and to ensure an appropriate resolution. The grievance 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 grievance 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 grievance UM appeal process for COD, HMOs, PHCs and SRGs is handled by CalOptima 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.

Grievance UM appeals can be initiated by a member, a member's representative or a practitioner. Pre-service appeals may be processed as expedited or standard appeals, while post-service appeals will be processed as standard appeals only.

All medical necessity decisions are made by a licensed physician reviewer. Grievance 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 ~~grievances~~~~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~~ regulatory time lines~~limits~~. If the denial was upheld, even in part, the letter includes the appropriate appeal language to comply with applicable regulations.

When quality of care issues are identified during the investigation process, further review of the matter is indicated. This portion of the review is conducted under the Peer Review process.

Upon request, members can have access to and copies of all documents relevant to the member’s appeal by calling the CalOptima Customer Service department.

A Member ~~Grievance~~Grievance Resolution Letter will be sent within thirty (30) calendars after receipt of the grievance.

Expedited Grievances ~~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. Health care acquired conditions (HCAC) occurring in inpatient acute care hospitals, and
2. Other provider-preventable conditions (OPPC), which are reported when they occur in any health care setting.

Once identified, the PPC is reported to CalOptima's QI department for further research and reporting to government and/or regulatory agencies.

LONG-TERM SERVICES AND SUPPORTS

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 MSSP, IHSS or to a CBAS facility. In addition, the LTC staff provides education to facilities and staff through monthly onsite visits, quarterly and annual workshops, or in response to individual facility requests, and when new programs are implemented.

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.

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.

IHSS

CalOptima is responsible [for member referral to for payment of services for CalOptima members who receive services from](#) the IHSS program (which is operated by the County of Orange) [for individuals who may qualify for services](#). 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 determines eligibility under the program. It also determines the number of hours that an individual can receive services. Under an MOU with the county, CalOptima works 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, UM or designee, reviews the request for retrospective authorization. If supporting documentation satisfies the administrative waiver of notification [requirements](#) 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 or designee requests a Medical Director review. The request for a retrospective review must be made within 60 days of the service provided. The decision, to authorize or deny, is made within thirty (30) calendar days of receipt.

Transitions of Care (TOC)

TOC is a 4-week patient-centered intervention, managed by the Case Management department, which employs a coaching, rather than doing, approach. It provides patients or caregivers with tools and support to encourage and sustain self-management skills in an effort to minimize a possible readmission and optimize the member's quality of life.

TOC focuses on four conceptual areas determined to be crucial in preventing readmission. These are:

- **Knowledge of Red Flags**: Patient is knowledgeable about indications that their condition is worsening and how to respond;
- **Medication Self-Management**: Patient is knowledgeable about medications and has a medication management system;
- **Patient-Centered Health Record**: Patient understands and uses a Personal Health Record (PHR) to facilitate communication with their health care team and ensure continuity of care across providers and settings;
- **Physician Follow-Up**: Patient schedules and completes follow-up visit with the primary care physician or specialist physician and is empowered to be an active participant in these interactions.

The program is introduced by the TOC coach, typically, at four touch points over one month: a pre-discharge hospital visit, a post-discharge home visit, and two follow-up phone calls. Coaches are typically community workers, social workers or nurses.

Complex Case Management

The Case Management Program is an ongoing outpatient collaborative process that strives to assure the delivery of health care services in a responsible, optimally cost-efficient manner. Case Management is a distinct and unique program that identifies eligible persons, with specific health care needs, in order to facilitate the development and implementation of a care plan to efficiently use health care resources to achieve optimum member outcomes. Case Management activities are complimentary, not duplicative, of UM activities.

Case Managers are licensed nurses with caseloads that are variable, depending on the complexity of the cases managed.

The case management program includes:

- Standardized mechanisms for member identification through use of data;
- Multiple avenues for referrals to case management;
- Following members across the continuum of health care from outpatient or ambulatory to inpatient settings;
- Use of evidence-based clinical practice guidelines or algorithms;
- Initial assessment and ongoing management process;
- Developing, implementing and modifying an individualized care plan through an interdisciplinary and collaborative team process, in conjunction with the member and/or his or her family and/or care giver(s);
- Developing comprehensive long and short-term goals;
- Analyzing all data for formulating appropriate recommendations;
- Coordinating services for members for appropriate levels of care and resources;
- Documenting all findings;
- Monitoring, reassessing, and modifying care to ensure quality, timeliness, and effectiveness of services;
- Mechanism for identification and referral of quality of care issues to QI department;
- Assessing the outcomes of case management and presenting findings to the Medical Director of Case Management.

Case Management Process

The Case Manager is responsible for planning, organizing and coordinating all necessary services required or requested, and facilitating communication between the member's PCP, the member, family members (at the member's discretion), other practitioners, facility personnel, other healthcare delivery organizations and community resources, as applicable.

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 2018~~7~~ Case Management Program document.

Transplant Program

The CalOptima Transplant Program is coordinated by CalOptima's Medical Director and managed by in collaboration with the Case Management department's ~~collaboration~~. Transplants for Medi-Cal only members are not delegated to the HMOs, PHCs or, SRGs ~~and PMGs~~, other than Kaiser Foundation Health Plan. The Transplant Program provides the resources and ~~tools~~ education needed to proactively manage members identified as potential transplant candidates. The CalOptima Case Management department works in conjunction with the contracted practitioners and the DHCS Center(s) of Excellence, or CMS Center(s) of Excellence for OneCare, as needed to assist members through the transplant review process. Patients are monitored on an inpatient and outpatient basis, and the member, physician, and facilities are assisted in order to assure timely, efficient, and coordinated access to the appropriate level of care and services within the member's benefit structure. In this manner, the Transplant Program benefits the member, the community of transplant

staff, and the facilities. CalOptima monitors and maintains oversight of the Transplant Program, and reports to the UMC 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 Case Management, both during inpatient acute episodes of care as well as for complex or special needs cases which are referred to the Case Management ~~and/or Disease Management~~ department for follow-up after discharge. Coordination of care encompasses synchronization of medical, social, and financial services, and may include management across payer sources. The Case Manager must promote continuity of care by ensuring appropriate referrals and linkages are made for the member to the applicable provider or community resource, even if these services are outside of the required core benefits of the health plan or the member has met the benefit limitation. Because Medicaid is always the payer of last resort, CalOptima must coordinate benefits with other payers including Medicare, Worker's Compensation, commercial insurance, etc. in order to maintain access to appropriate services.

Other attempts to promote continuity and coordination of care include member notifications to those affected by a PCP or practice group termination from CalOptima. CalOptima assists the member as needed to choose a new PCP and transfer the medical records to the new PCP. If the provider is not termed due to a quality issue, the health plan may also authorize continued treatment with the provider ~~under-in~~ certain situations. CalOptima also coordinates continuity of care with other Medicaid health plans when a new member comes ~~o~~into CalOptima or a member terminates from CalOptima to a new health plan.

Disease Management (DM)

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 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 Programs emphasize prevention, and members are expected to play an active role in managing their diseases.

DM Process

CalOptima's DM Programs are disease specific and evaluated for relevance to CalOptima's membership demographics and utilization patterns. DM Programs may include, but are not limited to: Asthma, Chronic Kidney Disease, COPD, Diabetes, Pregnancy Management, and Depression. The major components of each disease management program include:

- Identification of members with specified diagnosis;
- Stratification or classification of these members according to the severity of their disease, the appropriateness of their treatment, and the risk for complications and high resource utilization;
- Provision of proven interventions that will improve the clinical status of the member and reduce the risk for complications and long-term problems;
- Involvement of the member, family/caregiver(s), and physician to promote appropriate use of resources;
- Education of patient and family/caregiver(s) to promote increased understanding of the

- disease and increase self-management of the disease in an effort to decrease exacerbations;
- Ongoing measurement of the process and its outcomes in order to document successes and/or identify necessary revisions of the program.

Members with a potential diagnosis applicable to the specific DM Program are identified through various sources, including, but not limited to: inpatient census reports, medical claims data (office, emergency department, outpatient, and inpatient levels of care), pharmaceutical claims data, health risk assessments (HRA) results, laboratory reports, data from UM/CM processes, new member welcome calls, member self-referral, and physician referral.

Based on the data received during the identification phase, members are stratified into risk groups that guide the care coordination interventions provided. Members are stratified into Low, Moderate, or High-Risk categories. Definitions for each risk category are program specific and are outlined in the program's description document. Members may change between risk groups based on data retrieved during each reporting period, as well as through collaboration/interaction with the member or PCP. Members enrolled into a disease management program receive some level of intervention, which may include, but is not limited to: identification, assessment, disease specific education, reminders about preventive/monitoring services, assistance with making needed appointments and transportation arrangements, referral to specialists as needed, authorization for services and/or medical equipment, coordination of benefits, and coordination with community based resources. Education is a crucial component of the disease management program. Education is presented to members and their treating physician(s) and may be provided through mailings, telephone calls, or home visits.

High-risk members are referred to CalOptima's Complex Case Management Program for development of an individualized care plan. Both the member/family/caregiver(s) and the physician will be included in the development of the care plan. Including the member/family/caregiver(s) in the development of the individualized goals and interventions promotes ownership of the program and stimulates a desire for success. Care plan goals and interventions are reviewed routinely and [CalOptima the plan](#) of care is adjusted as necessary by the care coordinator to assure an optimal outcome for the member.

Measuring Effectiveness

Effectiveness of both the Complex Case Management and DM 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 [QIUM](#) Program evaluation.

Over/under utilization monitoring is tracked by UM and reported to UMC. Measures are monitored and reviewed for over and underutilization, [and/or](#) 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:

- ER admissions
- Bed Days
- Admits per 1000
- 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)

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 SNF, home health agency (HHA) or a comprehensive outpatient rehabilitation facility (CORF). TCMS contracts with a Quality Improvement Organizations (QIO) to conduct the reviews. OneCare is notified when a request is made by a member or member representative. OneCare supports the process with providing the medical records for the QIO'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 [UM Medical Director](#) and [Executive Director of Utilization Management](#) evaluate the impact of the UM Program by using:

- Member complaint, grievance and appeal data
- The results of member satisfaction surveys
- Practitioner complaint, and practitioner satisfaction surveys
- Relevant UM data
- Practitioner profiles
- Drug Utilization Review (DUR) profiles (where applicable)

The evaluation covers all aspects of the UM Program. Problems and/or concerns are identified and recommendations for removing barriers to improvement are provided. The evaluation and recommendations are submitted to the UMC for review, action and follow-up. The final document is then submitted to the Board of Directors through the QIC [and QAC](#) for approval.

SATISFACTION WITH THE UM PROCESS

CalOptima provides an explanation of the GARS process, [Administrative Fair Hearing](#), [and 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 QI department for investigation and resolution.

Annually, CalOptima evaluates both members' and providers' satisfaction with the UM process. Mechanisms of information gathering may include, but are not limited to: member satisfaction survey results (CAHPS), member/provider complaints and appeals that relate specifically to UM, provider satisfaction surveys with specific questions about the UM process, and soliciting feedback from members/providers who have been involved in appeals related to UM. When analysis of the information gathered indicates that there are areas of dissatisfaction, CalOptima develops an action plan and interventions to improve on the areas of concern which may include staff retraining and member/provider education.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 1, 2018 **Regular Meeting of the CalOptima Board of Directors**

Consent Calendar

5. Consider Approval of the 2018 CalOptima Program of All-Inclusive Care for the Elderly (PACE) Quality Assessment and Performance Improvement Plan

Contact

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

Recommended Action

Recommend approval of the 2018 CalOptima PACE Quality Assessment and Performance Improvement (QAPI) Plan.

Background

The Board of Directors first authorized the Chief Executive Officer to submit CalOptima's application to become a PACE Provider on October 7, 2010. The CalOptima PACE program opened its doors for operation in October of 2013. PACE is viewed as a natural extension of CalOptima's commitment to integration of acute and long-term care services for its members. This program provides the link between our healthy, elderly seniors with those seniors who need costly long-term nursing home care. PACE is a unique model of managed care service delivery in which the PACE organization is a combination of the health plan and the provider who provides direct service delivery. PACE takes care of the frail elderly by integrating acute, chronic, and long-term care for nursing home certified seniors. The goals of PACE are to prevent unnecessary institutionalization and maintain or improve the functional status of the program's participants. CalOptima's program is the first PACE program offered to Orange County residents and continues to grow. As of December 31st, 2017, CalOptima PACE had 236 members enrolled. Independent evaluations of PACE have consistently shown that it is a highly effective program for its target population that delivers high quality outcomes.

Discussion

PACE organizations are required to have a written Quality Assessment and Performance Improvement (QAPI) Plan that is reviewed and approved annually by the PACE governing body and, if necessary, revised. The QAPI Plan reflects the full range of services furnished by CalOpima PACE. The goal of the QAPI Plan is to improve future performance through effective improvement activities driven by identifying key, objective performance measures, tracking them and reliably reporting them to decision-making and care-giving staff.

The 2018 CalOptima PACE QAPI Plan is based on CalOptima's first four full years of data collection, review and analysis with specific data driven goals and objectives. The work plan elements were developed based on the opportunities for quality improvement that were revealed in the 2017 CalOptima PACE QAPI Plan Evaluation. For the 2018 QAPI work plan, five new elements were added, and one element removed. The added elements are HEDIS and/or STAR measures whose focus are on diabetes care, potentially harmful drug-disease interactions in the elderly and transitions of care. These elements allow the quality of care being delivered at PACE to be compared against

other state and national programs. The one element removed was not found to be useful in ongoing oversight and management of the PACE program. The target goals are based on national benchmarks, CalPACE data, or internal CalOptima PACE metrics.

Fiscal Impact

The recommended action to approve the 2018 CalOptima PACE QAPI Plan does not have a fiscal impact.

Rationale for Recommendation

PACE organizations are required to establish a Quality Assessment and Performance Improvement (QAPI) program. Through 42 CFR §460.132(b), the Centers for Medicare & Medicaid Services (CMS) requires PACE Organizations to have their QAPI plan reviewed annually by the PACE governing body and, if necessary, revised. As per 42 CFR §460.132(a) and (b), the PACE organization leadership presents their QAPI plan and any revisions to their governing body for annual approval to assure effective organizational oversight. CMS and the State will review the plan during subsequent monitoring visits.

Concurrence

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

Attachment

Proposed 2018 CalOptima PACE Quality Assessment Performance Improvement (QAPI) Plan and QAPI Work Plan

/s/ Michael Schrader
Authorized Signature

2/21/2018
Date

CALOPTIMA PACE

QUALITY ASSESSMENT

PERFORMANCE IMPROVEMENT PLAN

20187

Quality Improvement Subcommittee Chairperson:

Richard Helmer, M.D.
Chief Medical Officer

Date

Board of Directors' Quality Assurance Committee Chairperson:

Paul Yost, M.D.

Date

Board of Directors Chairperson:

Paul Yost, M.D. ~~Mark Refowitz~~

Date

Introduction

The Quality Assessment Performance Improvement Plan (QAPI) at CalOptima's Program of All Inclusive Care for the Elderly (PACE) is the data-driven assessment program that drives continuous quality improvement for all the PACE organizations' services. It is designed and organized to support the mission, values, and goals of CalOptima PACE.

Overview

- The goals of the CalOptima PACE QAPI Plan is to improve future performance through effective improvement activities, driven by identifying key objective performance measures, tracking them and reliably reporting them to decision-making and care-giving staff.
- The CalOptima PACE QAPI Plan is developed by the PACE Quality Improvement Committee (PQIC). As CalOptima's governing body, the Board of Directors has the final authority to review, approve and, if necessary, revise the QAPI Plan annually. (See Appendix A) It is comprised of both the Program Description and specific goals and objectives described in the Work Plan. (See Appendix B)
- The PACE Medical Director has oversight and responsibility for implementation of the PACE QAPI Plan. The PACE QI Coordinator will ensure timely collection and completeness of data.
- CalOptima PACE QAPI Committee will complete an annual evaluation of the approved QAPI Plan. This evaluation and analysis will help to find opportunities for quality improvement and will drive appropriate additions or revisions in the QAPI Plan goals and objectives for the following year.

Goals

- To provide quality health care services for all CalOptima PACE participants through comprehensive service delivery leading to improved clinical outcomes
- To coordinate all QAPI activities into a well-integrated system that oversees quality of care services
- To achieve a coordinated ongoing and effective QAPI Program that involves all providers of care
- To ensure that all levels of care are consistent with professionally recognized standards of practice
- To assure compliance with regulatory requirements of all responsible agencies.
- To promote continuing education and training of staff, practitioners, administration and the executive board
- To analyze data and studies for outcome patterns and trends
- To annually assess the effectiveness of the QAPI Plan and enhance the program by finding opportunities to improve the CalOptima PACE QAPI Plan

Objectives

- Improve the quality of health care for participants
 - Involve the physicians and other providers in establishing the most current, evidenced-based clinical guidelines to ensure standardization of care. Professional standards of CalOptima PACE Staff will be measured against those outlined by their respective licensing agency in the State of California (i.e. The State Board of Nursing of California).
 - Implement population health management techniques for specific participant populations, such as immunizations.
 - Identify and address areas for improvement that arise from unusual incidents, sentinel events, and annual death review.
 - Meet or exceeds minimum levels of performance on standardized quality measures as established by CMS and the SAA which includes achieving an immunization rate for both influenza and pneumococcal vaccinations of 80% for the participant population that is appropriate.

- Improve on the patient experience
 - Use the annual participant satisfaction survey, grievances and appeals, and feedback from participant committees to identify areas for improvement related to participant experience.
 - Provide education to staff on the multiple dimensions of patient experience.
 - Identify and implement ways to better engage participants in the PACE experience, i.e., menu selection, PACE Member Advisory Committee (PMAC).

- Ensure appropriate use of resources
 - Review and analyze utilization data regularly including hospital admissions, hospital readmissions, ER visits, and hospital 30-day all-cause readmission.

- Provide oversight of contracted services
 - Meet or exceed community standards for credentialing of licensed providers and perform due diligence in assuring that contracted facilities meet community and regulatory standards for licensure.
 - Evaluate customer service, access, and timeliness of care provided by contracted licensed providers.
 - Review documentation and coordination of care for participants receiving care in institutional settings and perform site visits on an ongoing-basis.
 - Monitor staff and contractors to ensure that appropriate standards of care are met.

- Communication of Quality and Process Improvement Activities and Outcomes
 - Communicate all QAPI activities and outcomes to the PACE staff and contractors, the PACE Member Advisory Committee, and the Board of Directors.
 - Results of QAPI-identified benchmarks are shared with staff and contracted providers at least annually.

- Reduce potential risks to safety and health of PACE participants through ongoing Risk Management
 - Every member of the PACE staff organization has responsibility for risk assessment and management.
 - Monitor, analyze and report the aggregated data elements required by CMS via the Health Plan Management System in order to identify areas needing of quality improvement.
 - Monitor, report and perform a Root Cause Analysis on all participant-involved events, resulting in a significant adverse outcome for the purpose of identifying areas for quality improvement.

Organizational and Committee Structure (See Appendix A for Organizational Chart)

CalOptima Board of Directors provides oversight and direction to CalOptima PACE Organization. The Board has the final authority to ensure that adequate resources are committed and that a culture is created that allows the QAPI Plan efforts to flourish. The Board, while maintaining ultimate authority, has delegated the duty of immediate oversight of the quality improvement programs at CalOptima. This includes the CalOptima PACE QAPI Program, to the CalOptima Board of Director’s Quality Assurance Committee (QAC), which performs the functions of the Quality Improvement Committee (QIC) described in CalOptima’s State and Federal contracts, and to CalOptima’s Chief Executive Officer who is responsible to allocate operational resources to fulfill quality objectives.

The CalOptima Board of Director’s QAC is a subcommittee of the Board and consists of currently active Board members. The CalOptima Board of Director’s QAC reviews the quality and utilization data that are discussed during the PACE Quality Improvement Committee (PQIC). The CalOptima Board of Director’s QAC provides progress reports, reviews the annual PACE QAPI Plan and makes recommendations to the full Board regarding these items, which are ultimately approved by the Board.

CalOptima PACE Quality Improvement Committee (PQIC)

Purpose

This committee provides oversight for the overall administrative and clinical operations of the organization. The PQIC may create new committees or task forces to improve specific clinical or administrative processes that have been identified as critical to participants, families or staff. ~~On a quarterly basis~~, [Twice a quarter](#), the PQIC will review all QAPI Plan initiatives, review the results of monitoring activities, provide oversight for proposed changes to improve quality of service and review follow-up of all changes implemented. The PQIC may create Ad Hoc Focus Review Committees for limited time periods in order to address quality problems in any clinical or administrative process. It will also discuss Level One data and Level Two incidents. Potential areas for improvement will be identified through analysis of the data and through Level Two root cause analysis. This meeting will be facilitated by the PACE Medical Director who will report its activities up to the CalOptima Board of Director’s QAC, who will then report up to the Board. The PACE Director or the PACE QA Coordinator may report up to the CalOptima Board of Director’s QAC if the PACE Medical Director is not available.

Membership

Membership shall be comprise of the PACE Medical Director, PACE Program Director, PACE Center Manager, PACE Clinical Operations Manager, [PACE Clinical Medical Director](#), [PACE QA Manager and the QA](#) Coordinator, and Intake/Enrollment Manager. At least four regular members shall constitute a quorum. The PACE Medical Director will act as the standing Chair of the committee. See Appendix C for QI Committee Minutes Template.

CalOptima PACE Focused Review Committees

Purpose

These committees will be formed to respond to or to proactively address specific quality issues which rise to the level of warranting further study and action. Key performance elements are routinely reviewed by administrative staff as part of ongoing operations, including, but not limited to, deaths and other adverse outcomes, inpatient utilization and other clinical areas that indicate significant over/under utilization.

Membership

Membership will be flexible based on those with knowledge of the specific issues being addressed, but will consist of at least four members to include at least two of the following positions and/or functions: PACE Medical Director, [PACE Clinical Medical Director](#), [PACE QA Manager](#), PACE Program Director, [PACE](#) Center Manager, [PACE](#) Clinical Operations Manager, [PACE](#) QA Coordinator, and Intake/Enrollment Coordinator or direct care staff. The Committee will be chaired by the PACE Medical Director, [PACE Clinical Medical Director](#), [PACE Director or PACE QA Manager](#). ~~If the PACE Medical Director is not a member of the committee, then the committee will be chaired by the PACE Director.~~ The chair will report on activities and results to the PQIC. The committee will meet on an ad hoc basis as needed to review those critical indicators assigned to them by the PQIC. This Committee will be responsible for managing all peer review activities performed by independent reviewers related to adverse outcomes.

CalOptima PACE Member Advisory Committee (PMAC)

Purpose

This committee provides advice to the Board on issues related to participant care concerns that arise with participant care decisions and program operations from a community perspective. A member of the PMAC shall report its activities to both the PQIC and the CalOptima Board of Directors' QAC, which then will be reported to the Board.

Membership

The PMAC comprises representatives of participants, participants' families, and communities from which participants are referred. Participants and representatives of participants shall constitute a majority of membership. The committee will be comprised of at least seven members. At least four regular members shall constitute a quorum. The PACE Program Director will act as the standing Chair and will facilitate for the committee.

~~CalOptima PACE Ethics Advisory Committee~~

~~Purpose~~

~~The purpose of this committee is to provide a forum to discuss ethical dilemmas in the provision of care and to respond to participant, family member or staff requests for information on ethical aspects of participant care. It allows for a case review and non-binding recommendations to the Interdisciplinary Team (IDT). The committee or consultants will report and advise the IDT and the~~

~~PQIC. In addition, it can advise the Board on policy development related to ethics.~~

Membership

~~It will be composed of five members. The PACE Director will act as the standing Chair of the committee. Community professionals with expertise in geriatrics and long term care, and who do not have a significant affiliation with CalOptima PACE, will compose at least one half of the membership Committee seats. At least 3 members will constitute a quorum of the Ethics Committee.~~

Quality and Performance Improvement Activities, Outcomes and Reporting

Quality Indicators and Opportunities for Improvement

Routine quality indicators appropriate the CalOptima PACE population are identified on analysis and trending of data related to the care and services provided at PACE. Other indicators and opportunities for performance improvement are identified through:

- Utilization of Services
 - CalOptima PACE will collect, analyze and report any utilization data it deems necessary to evaluate both quality of care and fiscal well-being of the organization including:
 - Hospital Bed Days
 - ER Visits
 - 30-Day All-Cause Readmissions
 - ☐ Participants residing in Long Term Care
 - Data analysis will allow for analyzing both over and under utilization for areas of quality improvement
- Participant and Caregiver Satisfaction
 - The organization shall survey the participants and their caregivers on at least an annual basis. Additionally, we will continue to look for other opportunities for feedback in order to improve quality of services.
 - Due to the nature of the participants in PACE, caregiver feedback is an integral part of our data elements.
 - The PACE Member Advisory Committee shall provide direct feedback on satisfaction to both the PACE leadership staff and the CalOptima Board of Directors, Quality Assurance Committee.
- Outcome Measures From the QAPI work plan elements as well as the clinically relevant HPMS data. Data Collected During Patient Assessments
 - This will include the CMS mandated immunization elements
 - HEDIS metrics relevant to the PACE population including:
 - Comprehensive Diabetes Care (CDC)
 - Potentially Harmful Drug-Disease Interactions in the Elderly (DDE)
 - ☐ Medication Reconciliation Post Discharge (MRP) would include evaluations from all Interdisciplinary Team Members.
 - Physiological and clinical well-being, functional status, cognitive functioning, and emotional and mental health status assessments may be used. Standardized, evidenced based assessments will be used whenever available.
- Effectiveness and safety of staff-provided and contract-provided services

- This will be measured by participants' ability to achieve treatment goals as reviewed by the Interdisciplinary Team with each reassessment, review of medical records, and success of infection control efforts
- All clinical and certain non-clinical positions have competency profiles specific to their positions
- CalOptima PACE staff will monitor providers by methods such as review of providers' quality improvement activities, medical record review, grievance investigations, observation of care, and interviews
- Unannounced visits to inpatient provider sites will be made by CalOptima PACE staff as necessary
- Non-clinical areas
 - The PACE PQIC has oversight to all activities offered by PACE
 - Member Grievances will be forwarded to the QA Coordinator for tracking, trending and data gathering. These results will be forwarded to the PACE Director ~~and PACE Medical Director~~ for review and further direction on any corrective actions that may be implemented. Participants and caregivers will be informed of decisions and will be assisted with furtherment of the process as needed. Results will also be reported to the PQIC for direction on how appropriate staff should implement any corrective actions.
 - Member Appeals will be forwarded to the QA Coordinator for tracking, trending and data gathering ~~and the~~ ~~– This will be forwarded to the~~ PACE Director ~~and PACE Medical Director~~ for review. If the PACE Director determines that the appeal is for clinical services, it will be forwarded to the PACE Medical Director for review. If the PACE Director or PACE Medical Director disagrees with decision made by the IDT, they will approve the service and communicate this decision to IDT. If the PACE Director or PACE Medical Director agrees with IDT's decision, the case will be forwarded to a third party for review. –The third party review's decision shall be reviewed by either the PACE Director or the PACE Medical Director and will be immediately and decision implementation and shared with the Interdisciplinary Team who will inform caregivers and participants of the decisions and assist them with furtherment of the process as needed.
 - Transportation services will continue to be monitored through monthly metrics, ~~and~~ grievance trending, and a transportation incident log. The monthly report generated by the transportation vendor will be reviewed at the monthly transportation leadership meeting and will be –and reported via quarterly to the PQIC meetings. The PACE QI department will validate the transportation data by comparing the raw GPS data and unannounced ride along data against the reports submitted.
 - Meal quality will be monitored through daily checks of food temperatures as well as comments solicited by the CalOptima PACE Member Advisory Committee.
 - Life safety will be monitored internally via quarterly fire drills and annual mock code and mock disaster drills as well as regulatory agency inspections.
 - Plans of correction on problems noted will be implemented by center staff and reviewed by the PACE Program Director, PACE Medical Director or the PACE QA Manager and will be presented to the PQIC.
 - The internal environment will be monitored through ongoing preventive maintenance of equipment and through repair of equipment or physical plant issues as they arise.

Priority setting for performance improvement initiatives is based on

- Potential impact on quality of care, clinical outcomes, improved participant function and improved participant quality of life
- Potential impact on participant access to necessary care or services
- Potential impact on participant safety
- Participant, caregiver, or other customer satisfaction
- Potential impact on efficiency and cost-effectiveness
- Potential mitigation of high risk, high volume, or high frequency events
- Relevance to the mission and values of CalOptima PACE

External Monitoring and Reporting

CalOptima PACE will report both aggregate and individual-level data to CMS and State Administering Agencies to allow them to monitor CalOptima's PACE performance. This includes Level One and Level Two Reporting, Health Outcomes Survey Modified (HOS-M) participation, and any other required reporting elements. Certain data elements are tracked in response to federal and state mandates and will be reported up through the PACE monitoring module of the Health Plan Management System (HPMS). ~~CMS implemented changes to the level I event reporting structure. On a quarterly basis, the~~ The following Level One events are reported to CMS via the Health Plan Management System (HPMS):

- Grievances
- Appeals
 - Level II events, formerly known as sentinel events, are reported as they occur.
- Burns
- Medication Errors
 - Immunizations (evaluated in the Quality of Care section of this report)
- Enrollment/Disenrollment (evaluated previously in this report)
- Falls without Injury
 - ER Visits (evaluated in the Utilization Management section of this report)
- Kennedy Terminal Ulcer (not implemented)

- Level One Reporting Indicators
 - Routine Immunizations
 - Grievances and Appeals
 - Enrollments
 - Disenrollments
 - Prospective Enrollees
 - Readmissions
 - Emergency (Unscheduled) Care
 - Unusual Incidents
 - Deaths

Level Two Reporting Indicators

- When unusual incidents reach specified thresholds, CalOptima must notify CMS and the State Administering Agency in the required timetables, complete a Root Cause Analysis and

present the results of the analysis on a conference call with both agencies as well as internally at the PACE QIC. The goal of this analysis is to identify systems failures and improvement opportunities. Examples of Level Two Events are:

- Deaths related to suicide or homicide, unexpected and with active coroner investigation
- Falls that result in death, a fracture or an injury requiring hospitalization related directly to the fall
- Infectious disease outbreak that meet the threshold of three or more cases linked to the same infectious agent within the same time frame
- Pressure ulcer acquired while enrolled in the PACE Program
- Traumatic injuries which result in death or hospitalization of five days or more or result in permanent loss of function
- Any elopement
- Health Outcomes Survey-Modified (HOS-M)
 - CalOptima PACE will participate in the annual HOS-M to assess the frailty of the population in our center
- Other External Reporting Requirements
 - Suspected elder abuse shall be reported to appropriate state agency
 - Equipment failure or serious adverse reaction to any administered medications will be reported to the FDA
 - Any infectious disease outbreak will be reported to the CDC

Corrective Action Plans

- When opportunities for improvement are identified, a corrective plan will be created.
- Each corrective plan will include an explanation of the problem, the individual who is responsible for implementing the corrective plan, the time frame for each step of the plan, and an evaluation process to determine effectiveness
- Corrective Action Plans from contracted providers will be requested by the QA Manager or other member of the PQIC, as appropriate

Urgent Corrective Measures

- Problems that are found to threaten the immediate health and safety of participants or staff will be reported immediately to the CalOptima PACE Medical Director and the CalOptima PACE Director
- The QA Manager or QA Coordinator will consult with relevant CalOptima PACE staff and be responsible for developing an appropriate corrective plan within 24 hours of notification
- Urgent corrective measures will be discussed during IDT morning meetings and, when appropriate, with participants
- Disciplinary action and/or the use of appropriate community resources such as Adult Protective Services, notification and cooperation with law enforcement agencies, emergency placement of participants, etc. will be implemented immediately

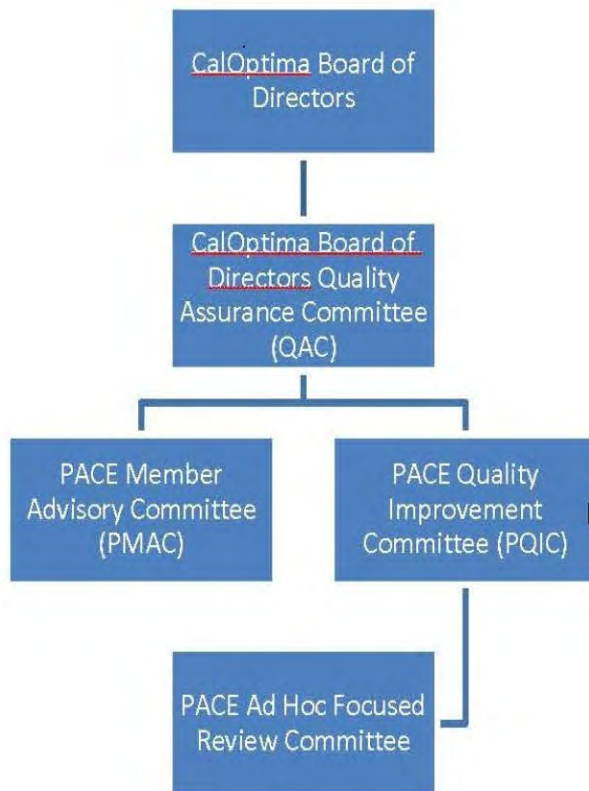
Re-Evaluation and Follow-up

- Monitoring activities will be conducted to determine the effectiveness of plans of action. The timeliness of follow-up is dependent upon the following:
 - Severity of the problem
 - Frequency of occurrence
 - Impact of the problem on participant outcomes
 - Feasibility of implementation
- If follow-up shows the desired results have been achieved, the issue will be re-evaluated on a periodic basis to ensure continued improvement
- If follow-up indicates that the desired results are not being achieved, then a more in-depth analysis of the problem and further determination of the source of variation are needed. A subcommittee of the PQIC or other workgroup may be established to address specific problems.
- All quality assessment and improvement steps and follow-up results will be shared with appropriate staff for discussion.

Annual Review of PACE QAPI Plan

- The PACE QAPI Plan will be assessed annually for effectiveness
- Enhancements to the plan will be made through appropriate additions and revisions to the specific goals and objectives in the QAPI Plan
- The CalOptima Board of Directors will review, revise and approve the CalOptima PACE QAPI Plan to assure organizational oversight and commitment

Appendix A: 20186 CalOptima PACE QAPI Program Reporting Structure



Proposed 2018 CalOptima PACE Quality Assessment Performance Improvement (QAPI) Work Plan

QAPI Item#	Area	Description	Objective	Activity	Goal	Responsible Person	Reporting Frequency	Target completion	Q1 Results	Q2 Action	Q2 Results	Q3 Action	Q3 Results	Q4 Action	Q4 Results	EOY Total	MET/NO MET
QAPI18.01	Quality of Care	2017 PACE QAPI Plan and Work Plan Annual Evaluation	PACE QAPI Plan and Work Plan will be evaluated for effectiveness on an annual basis.	PACE QAPI Plan and Work Plan will be evaluated for effectiveness on an annual basis.	Annual Evaluation	PACE Medical Director	Annually	March, 2018									
QAPI18.02	Quality of Care	2018 PACE QAPI Plan and Work Plan Annual Oversight	PACE QAPI Plan and Work Plan will be reviewed and updated annually.	PACE QAPI Work Plan will be approved and signed on an annual basis.	Annual Adopt on	PACE Medical Director	Annually	March, 2018									
QAPI18.03	Quality of Care	Influenza Immunization Rates	Increase influenza immunization rates for all eligible PACE participants	Improve compliance with influenza immunization recommendations	> 80% of members will have influenza vaccination	Clinical Operations Manager	Quarterly	12/31/2018									
QAPI18.04	Quality of Care	Pneumococcal Immunization Rates	Increase Pneumococcal immunization rates for all eligible PACE participants	Improve compliance with pneumococcal immunization recommendations	> 80% of members will have pneumococcal vaccination	Clinical Operations Manager	Quarterly	12/31/2018									
QAPI18.05	Quality of Care	Infection Control	Reduce common infections in PACE participants (Respiratory and Skin)	Monitor and analyze the incidence of Respiratory and Skin infections in the elderly at PACE and compare against national benchmark to find opportunities for quality improvement.	Maintain common infection rates less than the following national benchmark: Respiratory Tract 0.1 episodes/1000 participant days episodes/1000 participant days	Clinical Operations Manager	Quarterly	12/31/2018									
QAPI18.06	Quality of Care	Care for Older Adults: Advance Directive Planning	Increase POLST utilization of PACE participants	Ensure all PACE members who have been sponsored to meet and every six months until they have one completed in order to improve POLST utilization	>75% of members who have been sponsored to meet and every six months until they have one completed in order to improve POLST utilization	PACE Center Manager	Quarterly	12/31/2018									
QAPI18.07	Quality of Care	Care for Older Adults: Medication Review (COA)	Increase the percentage of PACE participants who have their medications reviewed	Ensure all PACE participants have a medication review	>95% (2018 Star Ratings Cut Point)	PACE Center Manager	Quarterly	12/31/2018									
QAPI18.08	Quality of Care	Care for Older Adults: Functional Status Assessment (COA)	Ensure all PACE participants have a functional status assessment completed by the required disciplines every 6 months	Ensure all PACE participants have a functional status assessment completed by the required disciplines every 6 months	100% (CMS Requirement)	PACE Center Manager	Quarterly	12/31/2018									
QAPI18.09	Quality of Care	Care for Older Adults: Pain Screening (COA)	Increase the percentage of PACE participants who are screened regularly for pain	Ensure all PACE participants have a pain screening	> 95% (2018 Star Ratings Cut Point)	PACE Center Manager	Quarterly	12/31/2018									
QAPI18.10	Quality of Care	Comprehensive Diabetes Care (CDC): Diabetic Eye Exams	Increase the percentage of PACE participants who have a diabetic eye exam completed annually	PACE participants with diabetes will be monitored by the PACE CI department who will work with the inter-specialty and clinical teams to develop strategies for improvement	> 85.10% (MEDICARE Quality Company - 2016 HEDIS 90th percentile)	PACE Medical Director	Quarterly	12/31/2018									
QAPI18.11	Quality of Care	Comprehensive Diabetes Care (CDC): Nephropathy Monitoring	Increase the percentage of PACE participants who have a nephropathy monitoring	PACE participants with diabetes will be monitored by the PACE CI department who will work with the inter-specialty and clinical teams to develop strategies for improvement	> 68.30% (MEDICARE Quality Company - 2016 HEDIS 90th percentile)	PACE Medical Director	Quarterly	12/31/2018									
QAPI18.12	Quality of Care	Comprehensive Diabetes Care (CDC): Blood Pressure Control (<140/90 mm Hg)	Increase the percentage of PACE participants with diabetes who have controlled blood pressure (<140/90 mm Hg)	PACE participants with diabetes will be monitored by the PACE CI department who will work with the inter-specialty and clinical teams to develop strategies for improvement	> 70.32% (MEDICARE Quality Company - 2016 HEDIS 90th percentile)	PACE Medical Director	Quarterly	12/31/2018									
QAPI18.13	Quality of Care	Potentially Harmful Drug/Order Interactions in the Elderly (DDE): Falls plus Tricyclic Antidepressants or Anticholinergics	Reduce potentially harmful drug-drug interactions	PACE participants with a history of falls will be monitored by the PACE CI department who will work with the inter-specialty and clinical teams as well as the PACE pharmacist to develop strategies for improvement	< 8.91% (MEDICARE Quality Company - 2016 HEDIS 90th percentile)	PACE Pharmacist	Quarterly	12/31/2018									
QAPI18.14	Quality of Care	Potentially Harmful Drug/Disease Interactions in the Elderly (DDE): Chronic Renal Failure + Nonaspirin NSAIDs or COX2 selective NSAIDs	Reduce potentially harmful drug-disease interactions	PACE participants with a diagnosis of dementia will be monitored by the PACE CI department who will work with the inter-specialty and clinical teams as well as the PACE pharmacist to develop strategies for improvement	< 37.50% (MEDICARE Quality Company - 2016 HEDIS 90th percentile)	PACE Pharmacist	Quarterly	12/31/2018									
QAPI18.15	Quality of Care	Potentially Harmful Drug/Disease Interactions in the Elderly (DDE): Chronic Renal Failure + Nonaspirin NSAIDs or COX2 selective NSAIDs	Reduce potentially harmful drug-disease interactions	PACE participants with a diagnosis of Chronic Renal Failure will be monitored by the PACE CI department who will work with the inter-specialty and clinical teams as well as the PACE pharmacist to develop strategies for improvement	< 3.70% (MEDICARE Quality Company - 2016 HEDIS 90th percentile)	PACE Pharmacist	Quarterly	12/31/2018									
QAPI18.16	Quality of Care	Medication Reconciliation Post Discharge (MRP)	Increase the percentage of participants for whom medications were reconciled within 30 days of hospital discharge	The PACE CI Department will work with the PACE Interdisciplinary Team, Pharmacist and Providers to develop strategies for improvement	> 90%	PACE Pharmacist	Quarterly	12/31/2018									
QAPI17.17	Access and Availability	Specialty Care	Improve access to specialty practices	Appointments for specialty care will be scheduled for the next business day or access to specialty care for initial consultations	> 90% of specialty care appointments scheduled within 10 days	PACE Clinical Operations Manager	Quarterly	12/31/2018									
QAPI17.18	Utilization Management	Acute Hospital Day Utilization	Reduce the rate of acute hospital days by PACE participants	PACE participants hospital days will be monitored and analyzed by the PACE CI department who will work with the inter-specialty and clinical teams to develop strategies to lower that rate through preventative care and education	< 2.10 hospital days per 1000 per year (2018 CalPACE Average)	PACE Medical Director	Quarterly	12/31/2018									
QAPI17.19	Utilization Management	Emergency Room Utilization	Reduce the rate of ER utilization by PACE participants	ER utilization by PACE participants will be monitored and analyzed by the PACE CI department who will work with the inter-specialty and clinical teams to develop strategies to lower that rate through preventative care and education	< 58 emergency room visits per 1000 per year (2016 CalPACE Average)	PACE Medical Director	Quarterly	12/31/2018									

Proposed 2018 CalOptima PACE Quality Assessment Performance Improvement (QAPI) Work Plan

QAPI Item#	Area	Description	Objective	Activity	Goal	Responsible Person	Reporting Frequency	Target completion	Q1 Results	Q1 Action	Q2 Results	Q2 Action	Q3 Results	Q3 Action	Q4 Results	Q4 Action	EOY Total	ME/TNO T MET
QAPI17.20	Utilization Management	30 Day All Cause Readmission Rates	Reduce the 30-day all cause readmission rates by PACE participants	Study all cause readmission rates for hospitalized PACE participants who work with PACE QI department who will be monitored and analyzed by the PACE QI department who will work with PACE inter disciplinary and clinical improvement opportunities for quality improvement	<13.6% 30-day all cause readmission (2018 CalPACE Average)	PACE Medical Director	Quarterly	12/31/2018										
QAPI17.21	Utilization Management	Long Term Care Placement	Decrease the percentage of participants who are placed in a long term care facility	PACE participants placed in long term care will be monitored and analyzed by the PACE QI department who will work with the PACE inter disciplinary and clinical teams to develop strategies for long term care through preventative care and education.	< 4% of members (2018 CalPACE Average) will be able in long term care	PACE Center Manager	Quarterly	12/31/2018										
QAPI17.22	Participant Satisfaction	Disenrollments	Reduce the percentage of participants who disenroll from the PACE program within the first 90 days of enrollment.	Review and analyze the participants who disenroll from the PACE program and develop strategies for improvement	Reduce the annualized rate below 01/year (20% reduction from 2017 Goal)	PACE Center Manager	Quarterly	12/31/2018										
QAPI17.23	Participant Satisfaction	Overall Satisfaction	Increase the overall satisfaction of participants and their families with the CalOptima PACE program	Review and analyze the annual satisfaction survey and implement interventions to improve the participant and their families satisfaction with the PACE program	>88% will answer "Good, Very Good or Excellent" on this question (2017 CalPACE average)	PACE Director	Annually	12/31/2018										
QAPI17.24	Delegation Oversight	Transportation	Improve PACE Transportation ride times to less than 60 minutes per trip	Ensure all PACE participants are on the vehicle for less than 60 minutes per trip. Monitor and analyze one-hour v. 15-minute ride times for maintain compliance with regulation	0 trips > 60 minutes in duration	PACE Director	Quarterly	12/31/2018										
QAPI17.25	Delegation Oversight	Transportation	Improve participant experience by providing timely transportation services	Review and analyze transportation records by trip type and duration to identify areas for improvement and update reports by sampling GPS records and monthly ride-along	>90% on-time performance	PACE Director	Quarterly	12/31/2018										

Appendix C: PACE QAPI Committee Meeting Minutes Template

PACE Quality Improvement Committee Meeting Minutes		
Date		
Time:		
Place: PACE conference Room 109		
Meeting Attendees: PACE Medical Director, PACE Program Director, PACE Center Manager, PACE Clinical Operations Manager, PACE QA Coordinator, and the PACE Intake/Enrollment Manager.		
Meeting Notes Taker: QA Coordinator		
Topic	Presentation/Discussion	Recommendation/Action
Roll Call and Introduction		
Review and Approval of Last PQIC Meeting Minutes		
Old Business:		
New Business:		
Level II Issues		
HPMS Data Analysis		
Standing Agenda Item		
Clinical Logs and Updates		
Operational Logs and Updates		
Site Logs and Updates		
PMAC Update Report		

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 1, 2018 **Regular Meeting of the CalOptima Board of Directors**

Consent Calendar

6. Consider Ratification of Increased Payment to Primary Care Physicians for the Depression Screening Incentive Program Funded by Intergovernmental Transfer (IGT) 1

Contact

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

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

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

Recommended Actions

1. Ratify a \$20 increase per depression screening to \$50 for all screens completed by physicians for eligible member retroactively to May 1, 2017; and
2. Authorize incentive payments of \$50 per depression screening for members prospectively through May 2019, or until available funding has been exhausted, whichever comes first.

Background

In 2015, CalOptima identified five health needs based on inputs and recommendations from CalOptima's internal and external stakeholders as to the areas of greatest concerns to CalOptima members in the community. They are adult mental health, children mental health, childhood obesity and diabetes, strengthening the safety net and improving children's health. Staff began to develop IGT funded initiatives to address these areas including a program to address depression in adolescents.

Around the same time, Kaiser Permanente had implemented a screening program for 11-year olds aimed at identifying adolescents at risk for depression, anxiety, and dysthymia. CalOptima staff met with Kaiser to learn more about the scope of their program. Kaiser screening process consists of four components: completion of the screening tool, use of mental health resources, parental inputs, and discussion concerning the results of the screen. All four parts need to be documented to ensure the screening is completed appropriately. Based on Kaiser's input, staff believed that the physician's role in screening for depression is extensive and requires additional training and support.

As CalOptima staff moved forward with the development of the program, new requirements regarding depression screening for adolescent continue to emerge. In February 2016, the U.S. Preventive Services Task Force (USPSTF) published a final recommendation for screening depression in children and adolescents. USPSTF concluded with moderate certainty that screening for Major Depression Disorder in adolescents aged 12 to 18 years has a moderate net benefit. In 2017, the Healthcare Effectiveness Data and Information Set (HEDIS) introduced the Depression Screening and Follow-up for Adolescents and Adults (DSF) measure. This measure requires members to be screened for clinical depression using a standardized tool and, if screened positive, to receive follow-up care. The Department of Health Care Services (DHCS) has also selected DSF as part of the External Accountability Set (EAS) to evaluate the quality of care delivered by CalOptima to its members.

On December 1, 2016, CalOptima staff presented to the Board a proposed physician incentive program aimed to increase the rate of depression screenings conducted during annual wellness visits for members ages 12 to 18. The Board authorized the reallocation of \$1,000,000 from 2010-11 IGT 1 funds to support the program. At that time, \$30 per screening was approved as the incentive payment amount to be made directly to primary care physicians (PCPs).

Discussion

Internally, the Behavioral Health Integration (BHI) Department, in collaboration with the Provider Relations Department, began the implementation of the depression screening incentive program in January 2017. To maximize the potential impact of the program, staff recommended to start the program by focusing on members turning 12 in 2017 (16,670 members). Approximately 641 PCPs were identified as serving these members, with 40 of them serving over 100 members. An informational packet was developed to educate PCPs about the program and the expected additional role. The packet included a cover letter describing the program, the Patient Health Questionnaire (PHQ-9) Adolescent version, scoring instruction, instructions on coding and interpreting the results with recommended next steps, and a CalOptima Outpatient Mental Health Services flyer.

Leveraging the experience of working with PCPs on previous incentive programs, Staff communications with providers from the outset was that the incentive payments would be \$50 per depression screening under the program, rather than \$30 as had been approved. This rate was intended to encourage provider participation and to provide adequate funding to support depression screening within their practice.

In April 2017, Staff distributed the depression screening informational packet to 641 PCPs. The Provider Relations Department followed up with visits to the office of 40 PCPs with the highest number of eligible members to provide additional training on utilization of the screening tool and claim processing. The program was also highlighted in the provider newsletters and email campaigns. Staff launched the program in May 2017, and CalOptima began to process claims for completed depression screenings (at the \$50 level) with date of service starting in May.

Between May and December 2017, 1,948 incentive payments were paid to PCPs at \$50 per screen totaling \$97,400.00. Of these members, 307 were screened positive for depression. When the result is positive, PCPs are advised to take additional steps that include watchful waiting, supportive counseling, consider medication management, and referral to mental health providers. Based on the current utilization pattern, we anticipate the annual screening rate will be approximately 20% (3,300 depression screenings). CalOptima staff is encouraged by the early findings. The incentive encourages PCPs to evaluate their patients for depression and has the potential to make a significant impact on children's mental and overall health. Response to the program from PCPs has been overwhelmingly positive.

In January 2018, the discrepancy between the Board approved \$30 per screen amount and the actual \$50 per incentive payment per screen gained broader visibility within the organization. Based on the screenings completed to date, the rate change has resulted in an increase in payment of \$38,960, or 66% through December 2017. The annual increase in payment is projected to be \$66,000. With an annual utilization rate of approximately 20%, the \$50 incentive payment per screen will only use approximately 33% of the \$1,000,000 allotted to the program within a two-year period. While one option would be to attempt to recoup the \$20/screening paid above the amount authorized by the Board, staff believes that

ratifying the higher incentive payments and authorizing payments at the higher level going forward, will enable CalOptima to build on the momentum created during the first eight months of the program.

Staff will continue to monitor the volume of screenings and depression diagnosis, and will keep the Board updated on the program, and return with further recommendations. In addition, Staff will implement internal validation and control measures to ensure that system and process implementations are consistent with Board-approved actions.

Fiscal Impact

As of December 2017, total actual expenses for Depression Screening Incentive Program payments was \$97,400. Staff estimates the projected annual cost for the incentive payments at \$50 per depression screening is \$165,000. Pursuant to the recommended action, incentive payments will continue through May 2019, or until available IGT funding is exhausted, whichever comes first. If additional unexpended funds remain at that time, staff will return to the Board with further recommendations. Since the recommended action is funded by IGT 1 funds authorized by the Board at the December 1, 2016, meeting, the recommended action has no fiscal impact to CalOptima's operating budget. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima members, and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

Staff recommends approval of the proposed recommendation to maintain the early success of the program and to support increased needs for mental health screening in primary care setting. CalOptima will provide QAC an update of the program in Q3 2018.

Concurrence

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

Attachments

1. Depression Screening Informational Packet
2. Depression Screening Incentive Program 2017 Quarterly Status Reports
3. Board Action dated December 1, 2016, Consider Authorization of the Expenditure Plan for Available Intergovernmental Transfer (IGT) Funds, Including Reallocation of Dollars from IGT 1, IGT 2, and IGT 3, and Allocation of Dollars from IGT 4 and IGT 5

/s/ Michael Schrader
Authorized Signature

2/21/2018
Date



[Date]

[Provider First name, Last Name] [Title][Address 1] [Address 2]
[City], CA [Zip]

Re: IGT 4 Project - Depression Screening for Members 12 Years of Age

Dear Providers:

CalOptima is launching a project on Screening for Clinical Depression in Adolescents and we would like to collaborate with you. This project is designed to increase the rate of depression screening during annual visit of **12-year-old members**, the beginning stage of adolescence. Pediatricians will receive an incentive pay of **\$50.00** upon completion of the screening and submission of a separate claim to CalOptima.

You are receiving this packet because we have identified that you have members who are turning 12 years old this year. We expect that a good portion of these members may be contacting you for school required vaccinations (Senate Bill 277) when they schedule their physical exams this year.

Attached are the materials you will need to incorporate the depression screening tool into office visits:

- Patient Health Questionnaire for Adolescents (PHQ-A)
- Administering and Scoring the PHQ-A Screening Questionnaire
- Instructions on coding & interpreting the score
- Information on making a referral to CalOptima Behavioral Health provider

If you have questions regarding the program, utilization of the assessment tools, claims or need additional materials, please contact CalOptima's Behavioral Health Integration department at 657-900-1097 or send us an email at behavioralhealth@caloptima.org.

Sincerely,

A handwritten signature in black ink, appearing to read "D. Sharps", is written over a white background.

Donald Sharps, M.D.
Medical Director, Behavioral Health Integration
Enclosures

Administering and Scoring the PHQ-A Screening Questionnaire

Administering

- Patient checks in at the Reception desk.
- Reception will present the PHQ-A (PHQ-9 modified for Adolescents) Questionnaire using the script below:
“We are screening for symptoms of depressed mood at all 12-year-old physical exams. Please have your child fill out this questionnaire if he/she wants to, or we can administer the form for him/her. Dr. _____ (or state the name of the provider or NP if the provider is an NP) will discuss the results with all of you together during the appointment.”
- The PHQ-A (PHQ-9 modified for Adolescents) takes less than five minutes to complete and score.
- If patient decides to complete the PHQ-A by himself/herself, he/she should be left alone to complete the PHQ-A in a private area, such as an exam room or a private area of the waiting room.
- The PHQ-A can also be administered and scored by a nurse, medical technician, physician assistant, physician or other office staff.
- Patients should be informed of their confidentiality rights before the PHQ-A is administered.
- It is recommended that parents are informed that a mental health checkup will be administered as part of the exam.
- Office staff will give the completed PHQ-A to the provider as it may have comments on it, and unclear marks made by the patient can be reviewed.

Scoring

- Each item on the PHQ-A is scored as follows:
Not at all = 0 Several Days = 1 More than half the days = 2 Nearly every day = 3
- To calculate the score, add all of the item scores together:

Item	Number of Items	Weight	Weighted Score
Not at all		X 0	
Several Days		X 1	
More than half the days		X 2	
Nearly every day		X 3	
		TOTAL	

Instructions on coding and interpreting the scores

Coding

- HCPCS outcome codes used to bill for administering the PHQ-A Screening Questionnaire:

PHQ-A Scored POSITIVE for Depressive Symptoms ≥ 5	PHQ-A scored NEGATIVE for Depressive Symptoms $\leq 0-4$
G8431 Follow-up plan by PCP or referral to BH provider	G8510 A follow-up plan is not required

Interpreting the scores:

	Total score	Recommended Next Steps
None or Minimal depressive symptoms	0-4	<ul style="list-style-type: none"> PCP reviews with patient Confirms negatives Option to discuss additional issues Considers other diagnosis (ADHD, etc) and treats accordingly, if applicable
Mild to Moderate depressive symptoms	5-14	<ul style="list-style-type: none"> Watchful waiting Supportive counseling Educate member to call if symptoms deteriorate Repeat PHQ-A at PCP follow-up Consider referral if PHQ-A scores fall in high risk areas
Moderate to severe depressive symptoms	15-19	<ul style="list-style-type: none"> Consider anti-depressant medication management through PCP (w/ consultation if needed) Consider referral/linkage to community-based organizations, school-based counseling, etc Consider referral to psychiatrist for medication and/or to therapist for therapy services
Severe depressive symptoms	20-27	<ul style="list-style-type: none"> Immediate referral to CalOptima Behavioral Health Line at 1-855-877-3885

- Patients that score positive on their PHQ-A should be evaluated by the primary care provider (PCP) to determine if the symptoms endorsed on the questionnaire are significant, causing impairment and warrant a referral to a mental health specialist or follow-up or treatment by the PCP.
- For patients who score negative on the PHQ-A, it is recommended that the PCP briefly review the symptoms marked as “sometimes” and “often” with the patient.

Please complete the CMS 1500 Health Insurance Claim form and mail it to:

CalOptima Claims Department
PO Box 11037
Orange, CA 92856

Engaging and Informing Parents

- Inform parents of the screening results (positive or negative), and recommendations for referral, treatment or follow-up.
- Provide parents with information about the next steps and offer support and assistance with finding or making an appointment with a behavioral health specialist.
- Give information to parents about why the referral is being made, how the services you are referring can help, and details about where you are sending them.
- Compile a list of appropriate referral resources in the community and share that list with families of patients that receive a referral.

PHQ-A (Adolescent)

Name: _____ Clinician: _____ Date: _____

Instructions: How often have you been bothered by each of the following symptoms during the past **two weeks**? For each symptom put an "X" in the box beneath the answer that best describes how you have been feeling.

	(0) Not At All	(1) Several Days	(2) More Than Half the Days	(3) Nearly Every Day
1. Feeling down, depressed, irritable, or hopeless?				
2. Little interest or pleasure in doing things?				
3. Trouble falling asleep, staying asleep, or sleeping too much?				
4. Poor appetite, weight loss, or overeating?				
5. Feeling tired, or having little energy?				
6. Feeling bad about yourself - or feeling that you are a failure, or that you have let yourself or your family down?				
7. Trouble concentrating on things like school work, reading, or watching TV?				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?				
9. Thoughts that you would be better off dead, or of hurting yourself in some way?				

In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes?

Yes No

If you are experiencing any of the problems on this form, how **difficult** have these problems made it for you to do your work, take care of things at home or get along with other people?

Not difficult at all Somewhat difficult Very difficult Extremely difficult

Has there been a time in the **past month** when you have had serious thought about ending your life?

Yes No

Have you **EVER**, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt?

Yes No

Office use only:

Severity score:

--

Outpatient Mental Health Services



These services are for the treatment of mild to moderate mental health conditions, which include:

- Individual and group mental health treatment (psychotherapy)
- Psychological testing to evaluate a mental health condition
- Outpatient services that include lab work, drugs and supplies
- Outpatient services to monitor drug therapy
- Psychiatric consultation

You can still get specialty mental health services from the Orange County Mental Health Plan.

th toll-free at

1-855-877-3885

This number is available 24 hours a day, 7 days a week.
TDD/TTY users can call toll-free at **1-800-735-2929**.

The people in the photographs that appear in this document are models and used for illustrative purposes only.



IGT Project Status Report - Depression Screenings

IGT Year	Budget	Status Date	Project Lead(s)	Start Date	End Date	Category
IGT 4 (2014)	\$1,000,000	Q1 2017	Dr. Sharps; Edwin Poon	1/1/2017	3/31/2019	Children's Mental Health
Project Description			Milestones	Start Date	End Date	% Complete
<p><i>Short but clear definition of the project including purpose and benefit to the organization</i></p> <p><i>Physician incentive payment program to increase the rate of depression screenings conducted during annual wellness visits for members aged 12. Subject to regulator approval, as applicable, incentive payments per screening will be \$50 and made directly to primary care providers upon submission of a HCPCS code that indicates the screening was performed and was negative or a HCPCS code that indicates the screening was performed and was positive. Beginning with Year 2 of the project, it is preferred that a sufficient process/infrastructure be in place to collect more detailed depression screening scores in addition to the positive/negative scoring HCPCS claims from providers in order for incentive payment to be made.</i></p>			Educate pediatricians on depression screening	1/1/2017	3/31/2017	25%
			Identify additional resources needed	1/1/2017	3/31/2017	75%
			Evaluate impact of pilot to inform continuation	10/1/2017	1/31/2019	0%
			Submit final report	2/1/2019	3/31/2019	0%
						0%
						0%
						0%

Quarterly Summary

Executive briefing of the quarter's successes and any major challenges

On 1/1/2017, BHI team started planning, developing, and creating materials that will be disseminated to pediatricians as outlined in the project description. Initial research was done with regard to the number of enrollees who belong in the 11-12 year old range and their respective pediatricians. Data was then used to develop a comprehensive list of targeted members sorted by their providers. During this reporting period, depression screening tool and supporting materials were designed and developed. This informational packet and support will be provided to pediatricians to optimize the implementation of the project. Direct mailing will be used as a method of dissemination. Additionally, BHI team interfaced with various departments affected by the project which includes Claims, IS and Provider Network. The goal is to launch the project on May 1, 2017.

The main challenge that we have encountered is the various codes reported in the system. BHI team had to investigate what codes are being used and billed for by providers for Medi-Cal line of business. The complexity of these codes has resulted in an increased time and effort in establishing the codes that will be used for the project. However, BHI team has overcome this challenge by enabling cross-department collaboration.

Current Quarter Accomplishments

- Designed, developed and evaluation of informational packet for providers
- Coordinated with other departments and verified current internal processes and procedures of providers when submitting claims
- Assessment of Medi-Cal members who are turning 12 years old and assigned pediatricians by running data to capture the information required for the project
- Developed a mailing list of providers

Next Quarter's Planned Activities

- Dissemination of Depression Screening tool (PHQ-A) and its accompanying materials to identified providers
- May 1, 2017 - Implementation of the project with the supporting packet
- Training of Top 50 high volume providers by health managers to ensure successful utilization of screening tool
- BHI team will work closely with Health Network Provider Relations to ensure that project's objectives are met

Risk/Issues	Mitigation/Resolution Steps		Owner	Target Date
New process for providers	Meet with providers and provide training for proper utilization of the screening tool		Dr. Sharps; Edwin Poon	June 1, 2017-onwards

IGT Project Status Report - Depression Screenings

IGT Year	Budget	Status Date	Project Lead(s)	Start Date	End Date	Category
IGT 4 (2014)	\$1,000,000	Q2 2017	Dr. Sharps; Edwin Poon	1/1/2017	3/31/2019	Children's Mental Health
Project Description			Milestones	Start Date	End Date	% Complete
<p><i>Short but clear definition of the project including purpose and benefit to the organization</i></p> <p><i>Physician incentive payment program to increase the rate of depression screenings conducted during annual wellness visits for members aged 12. Subject to regulator approval, as applicable, incentive payments per screening will be \$50 and made directly to primary care providers upon submission of a HCPCS code that indicates the screening was performed and was negative or a HCPCS code that indicates the screening was performed and was positive. Beginning with Year 2 of the project, it is preferred that a sufficient process/infrastructure be in place to collect more detailed depression screening scores in addition to the positive/negative scoring HCPCS claims from providers in order for incentive payment to be made.</i></p>			Identify additional resources needed	1/1/2017	5/31/2017	100%
			Dissemination of informational packets to providers	5/1/2017	5/19/2017	100%
			Translation of the Depression Screening tool in Spanish and Vietnamese languages	6/1/2017	6/28/2017	100%
			Developed a list of providers by health network for provider outreach	6/1/2017	6/28/2017	100%
			Educate pediatricians on depression screening	1/1/2017	8/31/2017	50%
			Evaluate impact of pilot to inform continuation	10/1/2017	1/31/2019	25%
			Submit final report	2/1/2019	3/31/2019	0%
						0%

Quarterly Summary

Executive briefing of the quarter's successes and any major challenges:

This reporting quarter included the dissemination of informational packets regarding the Depression Screening Initiative. A total of 641 provider packets were mailed to providers who are seeing an estimate of 16,760 members who will be turning 12 years old in 2017. Mailing has to be done in two batches due to a large volume of recipients. All identified providers received an informational packet and guidelines for future reference. Providers have expressed their support and indicated that finally something is being done to raise awareness about depression screening in adolescents. Behavioral Health Integration department provided additional resources by creating a Frequently Asked Question (FAQ) document to help providers get answers to frequently asked questions, and help initiate an effective response in a timely manner. This was shared to the providers via newsletters and e-mail campaigns. Effective coordination with Health Network Relations has led the providers to a better understanding of the initiative. BHI team has also extended campaign on the provider initiative by doing presentations at CalOptima advisory committee meetings such as PAC, MAC, and QIC. Additionally, BHI team created a list of providers that will be disseminated to the health networks to support their provider outreach efforts. During this quarter, the depression screening tool was translated in two (2) most common languages, Spanish and Vietnamese. This was aimed at reaching CalOptima members that speak the other threshold languages.

Current Quarter Accomplishments

- Distributed a total of 641 informational packets to identified providers
- Created an FAQ (Frequently Asked Questions) document that will help providers address common questions about the initiative
- Translated the depression assessment tool (PHQ-A) into Spanish and Vietnamese for members who speak these threshold languages
- Developed a list of providers to support health networks with their provider outreach

Next Quarter's Planned Activities

- Ongoing monitoring to ensure project's objectives are met
- BHI team will actively collaborate with Health Network Relations by providing resources as needed
- Work with Provider Relations team to train the top 40 providers by scheduling in-person meetings by end of July

Risk/Issues	Mitigation/Resolution Steps	Owner	Target Date
New process for providers	Meet with providers and provide training for proper utilization of the screening tool	Dr. Sharps; Edwin Poon	June 1, 2017-onwards

IGT Project Status Report - Depression Screenings

IGT Year	Budget	Status Date	Project Lead(s)	Start Date	End Date	Category
IGT 4 (2014)	\$1,000,000	Q3 2017	Dr. Sharps; Edwin Poon	1/1/2017	3/31/2019	Children's Mental Health
Project Description						
<p><i>Short but clear definition of the project including purpose and benefit to the organization</i></p> <p><i>Physician incentive payment program to increase the rate of depression screenings conducted during annual wellness visits for members aged 12. Subject to regulator approval, as applicable, incentive payments per screening will be \$50 and made directly to primary care providers upon submission of a HCPCS code that indicates the screening was performed and was negative or a HCPCS code that indicates the screening was performed and was positive. Beginning with Year 2 of the project, it is preferred that a sufficient process/infrastructure be in place to collect more detailed depression screening scores in addition to the positive/negative scoring HCPCS claims from providers in order for incentive payment to be made.</i></p>						
Milestones						
Educate pediatricians on depression screening				Start Date	End Date	% Complete
Evaluate impact of pilot to inform continuation				10/1/2017	1/31/2019	50%
Submit final report				2/1/2019	3/31/2019	0%
Tracking of depression outcomes				8/1/2017	3/31/2017	25%
Follow up analysis on positive screenings by reviewing subsequent BH claims				8/1/2017	3/31/2017	25%

Quarterly Summary

Executive briefing of the quarter's successes and any major challenges:

The third quarter of 2017 saw a steady increase in depression screening utilization. To date, 1,324 screenings have been performed by 88 providers since project's inception five months ago. Of which 1,088 claims were paid for a total of \$54,400 claims payment. IS developed a CORE utilization report that outlines submitted claims (denied vs. paid) and screenings (positive and negative). This report also includes information on claims which will help BHI identify factors that led to claims denial and spot some of the more common billing errors from providers. IS reprocessed and paid the initial 123 claims that were denied due to other services that were billed. A number of providers are still unaware of the requirements and claims submission process. Several efforts were made to address the issue. Information about claims submission was sent through provider newsletters and e-mail campaigns on a regular basis. In August, Provider Relations conducted in-person outreach/training to all 20 physicians with the highest eligible members. Feedback has been overwhelmingly positive. BHI will continue to assist providers who have questions about the incentive program and provide additional packets if requested. Tracking of depression outcomes is scheduled for the 4th quarter of 2017. This includes follow up analysis on positive screenings and monitor BH claims for members who had follow-up services.

Current Quarter Accomplishments

- IS developed a CORE report that outlines the depression screenings utilization
- Reprocessed and paid denied claims that were submitted with other services
- Constant communication to providers through provider newsletters and email campaigns
- In-person training to all 20 physician offices with the highest eligible members

Next Quarter's Planned Activities

- Tracking of depression screening outcomes using the PHQ-A questionnaire
- Follow-up analysis on positive screenings by reviewing subsequent BH claims
- BHI will continue to promote the initiative through provider newsletters, e-mail campaigns, and community presentations
- Schedule another round of in-person trainings to pediatricians if needed

Risk/Issues	Mitigation/Resolution Steps	Owner	Target Date
New process for providers	Meet with providers and provide training for proper utilization of the screening tool	Dr. Sharps; Edwin Poon	June 1, 2017-onwards

IGT Project Status Report - Depression Screenings

IGT Year	Budget	Status Date	Project Lead(s)	Start Date	End Date	Category
IGT 4 (2014)	\$1,000,000	Q4 2017	Dr. Sharps; Edwin Poon	1/1/2017	3/31/2019	Children's Mental Health
<p>Project Description</p> <p>Short but clear definition of the project including purpose and benefit to the organization</p> <p>Physician incentive payment program to increase the rate of depression screenings conducted during annual wellness visits for members aged 12. Subject to regulator approval, as applicable, incentive payments per screening will be \$50 and made directly to primary care providers upon submission of a HCPCS code that indicates the screening was performed and was negative or a HCPCS code that indicates the screening was performed and was positive. Beginning with Year 2 of the project, it is preferred that a sufficient process/infrastructure be in place to collect more detailed depression screening scores in addition to the positive/negative screening HCPCS claims from providers in order for incentive payment to be made.</p>						
<p>Milestones</p> <p>Educate pediatricians on depression screening</p> <p>Evaluate impact of pilot to inform continuation</p> <p>Submit final report</p> <p>Tracking of depression outcomes</p> <p>Follow up analysis on positive screenings by reviewing subsequent BH claims</p>						
				Start Date	End Date	% Complete
				1/1/2017	8/31/2017	100%
				10/1/2017	3/31/2019	50%
				2/1/2019	3/31/2019	0%
				8/1/2017	3/31/2019	25%
				8/1/2017	3/31/2019	50%

Quarterly Summary

Executive briefing of the quarter's successes and any major challenges:

Progress was made during this reporting period. As of 12/31/17, there were 2,044 total number of members screened for depression, for a total of 1,948 paid claims. There were 20 members with positive results who had follow up services. The use of the PHQ-A depression assessment tool facilitated the screening process. BHI maintained its support to providers by providing information and resource materials about depression. To date, 16% of members screened received positive results (317/2,044).

Challenge still remains with a few providers who continue to send claims that are billed with other services. Providers are still unfamiliar with the billing process as they continue to submit incorrect service information or bill for members outside the set age range that result in denials. Through ongoing data collection and analysis, we are pleased to report that we are already seeing a huge success with the project and we anticipate an increase in the number of members that will be screened for depression this year. Even though this initiative is for members 12 years of age, we will continue to encourage providers to screen their patients (other than 12) for depression on a routine basis. This will help identify those at risk for depression and refer them for support and possible engagement in behavioral health treatment.

Current Quarter Accomplishments

- Reviewed processed claims to evaluate payment discrepancies
- Tracked the utilization report on an ongoing basis
- Constant communication to providers through provider newsletters and email campaigns
- PR provided in-person meetings at provider offices to provide guidance on how to bill

Next Quarter's Planned Activities

- In-person follow-up visits from PR staff to explain billing/payment procedures
- Work with PR staff to conduct another round of training to pediatricians
- Review the claims and payment procedure and reclassify the spent funds to the appropriate IGT account
- Follow-up analysis on positive screenings by reviewing subsequent BH claims

Risk/Issues	Mitigation/Resolution Steps	Owner	Target Date

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 1, 2016 **Regular Meeting of the CalOptima Board of Directors**

Report Item

15. Consider Authorization of the Expenditure Plan for Available Intergovernmental Transfer (IGT) Funds, Including Reallocation of Dollars from IGT 1, IGT 2 and IGT 3, and Allocation of Dollars from IGT 4 and IGT 5

Contact

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

Recommended Actions

1. Approve expenditure plan for reallocation of IGT 1-3 funds in the amount of \$5,820,020 and allocation of IGT 4 and 5 funds in the amount of \$21,966,208 to include projects consistent with the original CMS-approved expenditure categories, and that support CalOptima Board-approved funding categories;
2. Authorize the CEO to execute agreements as necessary to distribute IGT funds for Board approved projects and initiatives supporting the approved funding priorities;
3. Authorize a timeline extension for the expenditure of \$50,000 in IGT 1 funds for OneCare Personal Care Coordinators (PCC) through June 30, 2017 or until funds have been exhausted, whichever occurs earlier; and
4. Direct staff to return to the Board with further IGT expenditure recommendations as they are developed; all IGT specific programs and initiatives remain subject to Board approval.

Background/Discussion

CalOptima began participating in the rate range IGT program for Rate Year 2010-2011 (IGT 1) to secure additional Medicaid program dollars for Orange County. Including the estimated amount of the currently pending IGT 5 transaction, CalOptima's share of the five IGT transactions will total approximately \$48 million. Numerous Board-approved projects have been launched with IGT 1-3 funds within the regulator-approved categories, and most have been completed or are on track for completion. There are a small number of projects that have been postponed or eliminated and these dollars are available for the Board's reallocation. Allocations for IGT 4 and IGT 5 funds have yet to be approved by the Board.

1. Staff has developed recommendations to reallocate \$5.8 million in unspent funds from IGTs 1-3. Recommendations have also been developed for expenditure of the \$22 million in available funds from IGT 4 and IGT 5.
2. The proposed \$27.8 million in recommended expenditures will be utilized to support one or more of the original CMS-approved and CalOptima Board-approved expenditure categories (see Attachment 2. IGT 1 – 5 Summary Tables of Expenditures by CMS/DHCS (and CalOptima Board) Approved Funding Categories) as appropriate.

IGT Ad Hoc Committee

The Board of Directors' IGT Ad Hoc committee appointed by the Board Chair met on November 14, 2016, to review the IGT expenditure plan as recommended by staff. The ad hoc committee consists of Supervisor Do, Director Nguyen, and Director Schoeffel. Recommendations from the Ad Hoc committee include the following:

1. Approve \$12.8 million for projects within the approved funding categories as listed below, to improve services and quality of care for Medi-Cal member, support providers, and make infrastructure investments for the benefit Medi-Cal members.
2. Complete a comprehensive Member Health Needs Assessment, results of which will be used to inform development of Community Grant RFPs.
 - a. Member Health Needs Assessment to be conducted within a 3-6 month timeframe, with the assistance of a consultant (procured according to appropriate policy and RFP processes).
3. Staff will return with recommendations for Board approval on specific programs and initiatives on the expenditure of an additional \$15 million in IGT funds following completion of the Member Health Needs Assessment;

Funding Allocations and Projects to be Supported

The table below illustrates the recommended funding reallocations from IGTs 1-3 projects and allocation of IGT 4 and 5 funds:

FROM (Project/IGT)	Amount to be (Re)allocated	TO Recommended Projects	Project Funding Amount
Telemedicine/ IGT 1 <i>(Enhance provider reimbursement rates)</i>	\$1,000,000	Depression Screenings	\$1,000,000
Telemedicine/ IGT 1 <i>(Strengthen delivery system)</i>	\$69,190	Provider Portal Communications & Interconnectivity	\$1,500,000
IGT 4	\$1,430,810		
IGT 4	\$250,000	Member Health Homes	\$250,000
IGT 4	\$750,000	UCI Observation Stay Payment Pilot	\$750,000
IGT 4	\$500,000	Member Health Needs Assessment	\$500,000
IGT 4	\$3,550,000	Personal Care Coordinators (PCCs)	\$7,000,000
Pay-for-Performance for PCPs/ IGT 3 <i>(Care Coordination)</i>	\$3,450,000		
Pay-for-Performance for PCPs/ IGT 3 <i>(Improve information services infrastructure)</i>	\$750,000	Data Warehouse Expansion	\$750,000
Case Management System/ IGT1 <i>(Strengthen delivery system)</i>	\$3,620	Facets System Upgrade and Reconfiguration	\$506,620
Provider Network Management Solution/	\$500,000		

FROM (Project/IGT)	Amount to be (Re)allocated	TO Recommended Projects	Project Funding Amount
IGT 2 <i>(Enhance information technology infrastructure)</i>			
Security Audit Remediation/ IGT2 <i>(Enhance information technology infrastructure)</i>	\$3,000		
Additional Unallocated Funds/ IGT 1	\$28,231	IGT Program Administration (Grants Management Software, staffing and administrative costs)	\$529,608
Additional Unallocated Funds/ IGT 2	\$427		
Additional Unallocated Funds/ IGT 3	\$15,552		
IGT 4	\$485,398		
Subtotal			\$12,786,228
IGT 5 (Anticipated amount)	\$15,000,000	Community Grants (pending completion of Member Health Needs Assessment)	\$15,000,000
Total			\$27,786,228

The details of the above recommended projects are as follows:

- Depression Screenings (up to \$1,000,000): Physician incentive payment program to increase the rate of depression screenings conducted during annual wellness visits for members ages 12-18 over two years. Subject to regulator approval, as applicable, incentive payments per screening will be \$30 and made directly to primary care providers. Beginning with Year 2 of the project, and again, subject to regulator approval as appropriate, a sufficient process/infrastructure must be in place to collect depression screening scores in addition to the claims from providers in order for incentive payment to be made. This project addresses the “Children’s Mental Health” funding category.
- Provider Portal Communications and Interconnectivity (up to \$1,500,000): Develop and implement a web-based provider portal strategy that will support real time bi-directional electronic communication between CalOptima and community partners/providers. Project includes an initial pilot with designated community agencies to evaluate and incorporate feedback prior to implementation with CCN Network Providers. This project addresses the “Pilot Program Planning and Implementation” funding category, as bi-directional data sharing and exchange between CalOptima and providers is a required component of the Whole Person Care pilot in which CalOptima is a key participant, and will be an important asset to the upcoming Health Homes Program.
- Health Homes Program (HHP) (up to \$250,000): CalOptima is implementing the "Health Homes for Patients with Complex Needs Program” (HHP), a new DHCS program for Medi-Cal and Cal Medi-Connect plans. This program requires plans to engage Community-Based

Care Management Entities (CB-CMEs) to provide HHP services. DHCS requires plans to assess organizations in the community that may offer HHP services and use this information in development of the local delivery model. Health Homes Program payments do not cover the cost of such activities, and IGT funds will be used to complete this one-time environmental assessment and development of tools to select, contract and determine readiness of organizations to provide HHP services. These activities may be conducted by a consultant, temporary staff or other resource (procured according to appropriate policy and RFP processes). This project addresses the “Pilot Program Planning and Implementation” funding category.

- UCI Observation Stay Payment Pilot (up to \$750,000): Assuming terms and can be reached with UCI within 90 days, funds will support a pilot project with UC Irvine Health to test cost effectiveness of emergency department observation unit (EDOU) care and demonstrate potential return on investment for such care. This project will include tracking of specific CalOptima member information, including diagnosis, protocol, time in EDOU, discharge diagnosis, discharge status and readmission rates. UCI and CalOptima will conduct monthly utilization review. If terms cannot be reached within this time period, staff will return to the Board with further recommendations. This project addresses the “Pilot Program Planning and Implementation” funding category.
- Member Health Needs Assessment (up to \$500,000): Conduct a county-wide Medi-Cal member health needs assessment. Funds will support assistance from a consultant (procured according to appropriate policy and RFP processes) and associated costs for assessment activities such as surveys, focus group meetings and survey completion incentives etc. Results and recommendations from the completed assessment will inform RFP development of targeted Community Grant funding to support the needs of Medi-Cal beneficiaries in Orange County. This project addresses the “Strengthening the Safety Net” funding category by providing information that will more effectively align funding investments with the needs of our Medi-Cal members.
- Personal Care Coordinators (PCCs) (up to \$7,000,000): Funds will support Health Network and CalOptima PCCs to assist members in navigating the health care system. Funding covers PCCs for the following member populations: duals (OneCare and OneCare Connect), Medi-Cal Seniors and Persons with Disabilities, and other vulnerable populations (e.g. homeless, those with serious and persistent mental illness, transitioning from Regional Center services, etc.). Funding includes support for the cost of services to complete an evaluation of the PCC program, to be completed no later than June 2018. Evaluation activities may be conducted by a consultant, temporary staff or other resource (procured according to appropriate policy and RFP processes). This project addresses the “Strengthening the Safety Net” funding category as PCCs assist members in navigating the health care system.
- Data Warehouse Expansion (\$750,000): Integrate various data sources (e.g. pharmacy, claims, case management system, accounting and budget data) into the Clinical Data Warehouse to provide the capability to build complete member claims and pharmacy histories, analyze data

and produce an integrated performance/financial impact analysis package. This project is anticipated to be completed in two years or less and may include the use of contract services and information systems upgrades procured according to appropriate policy and RFP processes. This project addresses the “Pilot Program Planning and Implementation” funding category, as data integration is a fundamental component of the Whole Person Care pilot, Health Homes Program, and Whole Child initiatives.

- Facets System Upgrade and Reconfiguration (up to \$506,620): Improve operational efficiencies of Facets claims and member management system with additional hardware and vendor service purchases. This work supports optimizing data storage requirements and prevents data loss, adding test environments for program implementation to mitigate negative impact to production, system load balancing to support growth in membership and claims data, and improving performance and batch processing to optimize server distribution. This project addresses the “Enhance core data analysis and exchange systems” funding category, being continued from IGT 2.
- IGT Program Administration (up to \$529,608): Funds will support purchase and ongoing maintenance of Grant Administration software (procured according to appropriate policy and RFP processes) to facilitate management and oversight of IGT projects and community grants. Funding will also support staffing and administrative costs to manage the IGT transaction process, and provide IGT project and expenditure oversight over two years. Administrative functions are an allowable use of IGT funds and support the funding category of “Strengthening the Safety Net” by providing oversight of the entire IGT process and ensuring that funding investments are effectively aligned with the needs of our members.
- Addressing Gaps and Barriers facing Orange County Medi-Cal members (approximately \$15,000,000): \$15,000,000 in anticipated funds from IGT 5 to be allocated for targeted community needs in one or more of the funding priority areas above after completion of a Member Health Needs Assessment. Staff will return to the Board with recommendations following completion of the Health Needs Assessment.

IGT 1 Project Timeline Extension

As part of this expenditure plan recommendation, staff also requests a timeline extension for an expenditure of \$50,000 in IGT 1 funds for OneCare Personal Care Coordinators (PCC) which was authorized through December 31, 2016 (see Attachment 14, Board Action dated March 3, 2016 - Authorize Extension and Reallocation of OneCare PCC Funds for CY 2016). Extension for use of these funds is requested through June 30, 2017 or until funds have been exhausted, whichever occurs earlier.

Fiscal Impact

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

Rationale for Recommendation

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

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. PowerPoint Presentation: IGT Update and Expenditure Plan
2. IGT 1 – 5 Summary Tables of Expenditures by CMS/DHCS (and CalOptima Board) Approved Funding Categories
3. Board Action dated March 7, 2013: Approve Proposed Use of \$12.4 Million in FY 2010-11 Intergovernmental Transfer (IGT) Funds; Authorize the Chief Executive Officer (CEO) to Initiate Required Process for FY 2011-12 IGT Funds and Execute Required IGT Documents
4. Board Action dated June 6, 2013: Approve Work Plan and Timeline for Implementation of FY 2010-11 Intergovernmental Transfer (IGT) Funds
5. Board Action dated March 6, 2014: Approve Final Expenditure Plan for Use of FY 2010-11 Intergovernmental Transfer (IGT) Funds; Approve Expenditure Plan for Use of FY 2011-12 Intergovernmental Transfer (IGT) Funds; Authorize the Chief Executive Officer (CEO) to Initiate Required Process for FY 2012-13 IGT Funds and Execute the Standard Required Application Documents
6. Board Action dated September 4, 2014: Authorize and Direct the Chairman of the Board of Directors to Enter into the Necessary Agreements with the University of California at Irvine (UCI) and the California Department of Health Care Services (DHCS) to Secure Additional Medi-Cal Funds Through an Intergovernmental Transfer (IGT) for Fiscal Year (FY) 2012-13, Including Approval of Proposed Funding Categories; Recommend Board of Directors Approval of an Updated Expenditure Plan for FY 2011-12 IGT (IGT 2) Funds; and Consider Allocation of \$900,000 of IGT 2 Funds and Authorize Procurement Process for School-Based Vision and Dental Wraparound Services
7. Board Action dated October 2, 2014: Approve Grant Awards to Designated Organizations in Support of New and Prospective Federally Qualified Health Centers (FQHCs)
8. Board Action dated December 4, 2014: Authorize Grant Awards in Support of Prospective Federally Qualified Health Centers (FQHCs) and Funding for Expert Consultation to Manage and Ensure Satisfactory Progress on Clinic Grants
9. Board Action dated December 4, 2014: Authorize Expenditure of Intergovernmental Transfer (IGT) Funds for Post Acute Inpatient Hospital Recuperative Care for Members Enrolled in CalOptima Medi-Cal; Authorize Amendments to CalOptima Medi-Cal Hospital Contracts as Required for Implementation
10. Board Action dated April 2, 2015: Authorize Reallocation of OneCare Personal Care Coordinator (PCC) Funding to Cover the Cost of the Program
11. Board Action dated April 2, 2015: Approve the Allocation of Intergovernmental Transfer (IGT) Funds for Personal Care Coordinators (PCC) for the OneCare Connect (OCC) Program Including for OCC Members in the CalOptima Community Network

12. Board Action dated May 7, 2015: Authorize Agreements Necessary to Secure Additional Medi-Cal Funds Through an Intergovernmental Transfer (IGT) for Fiscal Year (FY) 2013-14 (IGT 4); Consider Approval of a Modification of Eligible Use for IGT 2 Funds Allocated to Support Federally Qualified Health Centers (FQHCs)
13. Board Action dated October 1, 2015: Consider Updated Revenue Expenditure Plans for Intergovernmental Transfer (IGT) 2 and IGT 3 Projects
14. Board Action dated March 3, 2016: Authorize Extension of Expenditures of Fiscal Year 2010-11 Intergovernmental Transfer Funds for OneCare Personal Care Coordinators (PCC) through December 31, 2016; and Authorize the Reallocation of OneCare Connect PCC Funding to Cover the Cost of the OneCare PCC Program through Calendar Year 2016

/s/ Michael Schrader
Authorized Signature

11/23/2016
Date



CalOptima
Better. Together.

IGT Update & Expenditure Plan

**Board of Directors Meeting
December 1, 2016**

**Cheryl Meronk
Director, Strategic Development**

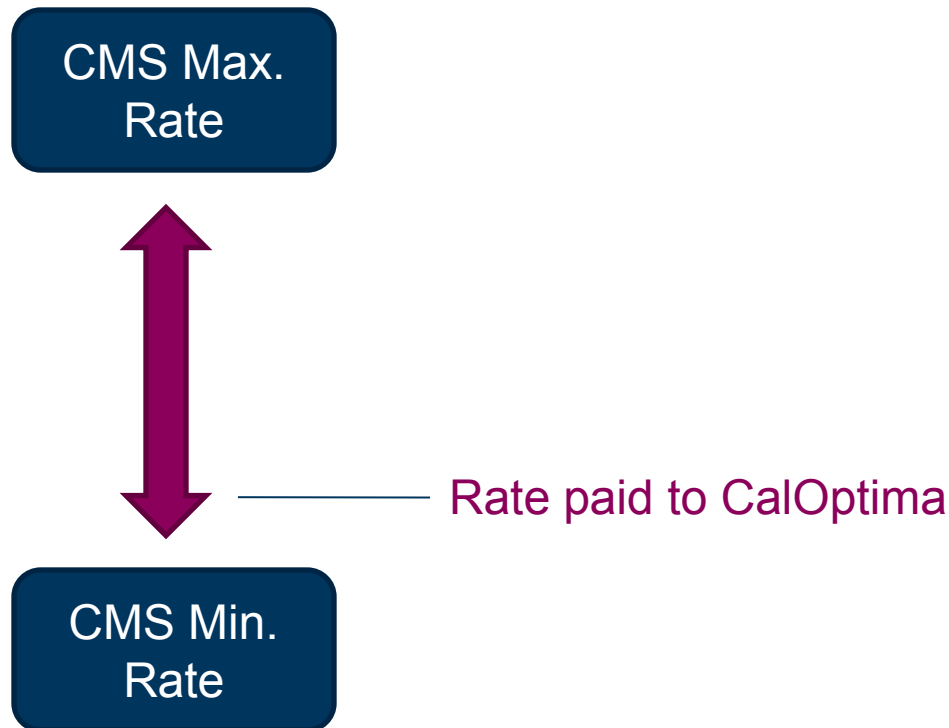
Intergovernmental Transfers (IGT)

Background

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

Low Medi-Cal Managed Care Rates

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



IGT Funds Availability and Process

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

CalOptima Share Totals for IGT 1–5

IGTs	CalOptima Share
IGT 1	\$12.52 M
IGT 2	\$8.60 M
IGT 3	\$4.88 M
IGT 4	\$7 M
IGT 5	≈\$15 M
Total	\$48 M*

**Estimated total*

IGT 1 Status*

Project	Budget	Balance	Notes
Personal Care Coordinators	\$3,850,000	\$110,000	Complete by 2/28/2017
Case Management System	\$2,099,000	\$3,500	Completed
Strategies to Reduce Readmissions	\$533,585	\$443,000	Complete by 12/1/2016
Program for High-Risk Children	\$500,000	\$500,000	Complete by 10/31/2018
Telemedicine	\$1,100,000	\$1,100,000	To be reallocated
Case Management System Consulting	\$866,415	\$218,000	Complete by 12/31/2017
OCC PCC Program	\$3,550,000	\$2,085,000	Complete by 2/28/2017
Total	\$12.5 M	\$4.4 M	Total Reallocation Amount: \$1.1 M

*As of 8/31/2016 – balance figures rounded

IGT 2 Status*

Project	Budget	Balance	Notes
Facets System Upgrade & Reconfiguration	\$1,250,000	\$265,000	Complete by 12/31/2016
Security Audit Remediation	\$101,000	\$0	Completed
Continuation of COREC	\$1,000,000	\$517,000	Complete by 6/30/2017
OCC PCC Program	\$2,400,000	\$2,400,000	Complete by 3/31/2018
Children's Health/ Safety Net Services	\$1,300,000	\$126,000	Complete by 5/31/2017
Wraparound Services	\$1,400,000	\$487,000	Complete by 11/1/2017
Recuperative Care	\$500,000	\$318,500	Complete by 3/1/2017
Provider Network Management Solution	\$500,000	\$500,000	To be reallocated
Project Management	\$100,000	\$17,000	Complete by 9/30/2016
PACE EHR System	\$50,000	\$1,000	Complete by 12/31/2016
Total	\$8.6 M	\$4.6 M	Total Reallocation Amount: \$0.5 M

*As of 8/31/2016 – balance figures rounded

IGT 3 Status*

Project	Budget	Balance	Notes
Pay for Performance for PCPs	\$4,200,000	\$4,200,000	To be reallocated
Recuperative Case (Phase 2)	\$500,000	\$500,000	Complete by 6/30/2018
Project Management	\$165,000	\$165,000	Complete by 12/31/2017
Total	\$4.8 M	\$4.8 M	Total Reallocation Amount: \$4.2 M

*As of 8/31/2016 – balance figures rounded

IGT 4 Status*

Project	Budget	Balance	Notes
Unallocated Funds	\$7,000,000	\$7,000,000	To be allocated
Total	\$7 M	\$7 M	Total Allocation Amount: \$7 M

*As of 8/31/2016 – balance figures rounded

IGT 5 Status*

Project	Budget	Balance	Notes
Unallocated Funds	≈\$15,000,000	≈\$15,000,000	To be allocated
Total	≈\$15 M	≈\$15 M	Total Allocation Amount: ≈\$15 M

**Not yet received*

Total Funds to Reallocate or Allocate

IGT	Funds Available
IGT 1	\$1.1 M
IGT 2	\$0.5 M
IGT 3	\$4.2 M
IGT 4	\$7 M
IGT 5	≈\$15 M
Total	\$27.8 M*

**Estimate dependent on total IGT 5 amount*

IGT Approved Funding Categories*

Adult Mental Health

Children's Mental Health

Childhood Obesity

Strengthening the Safety Net

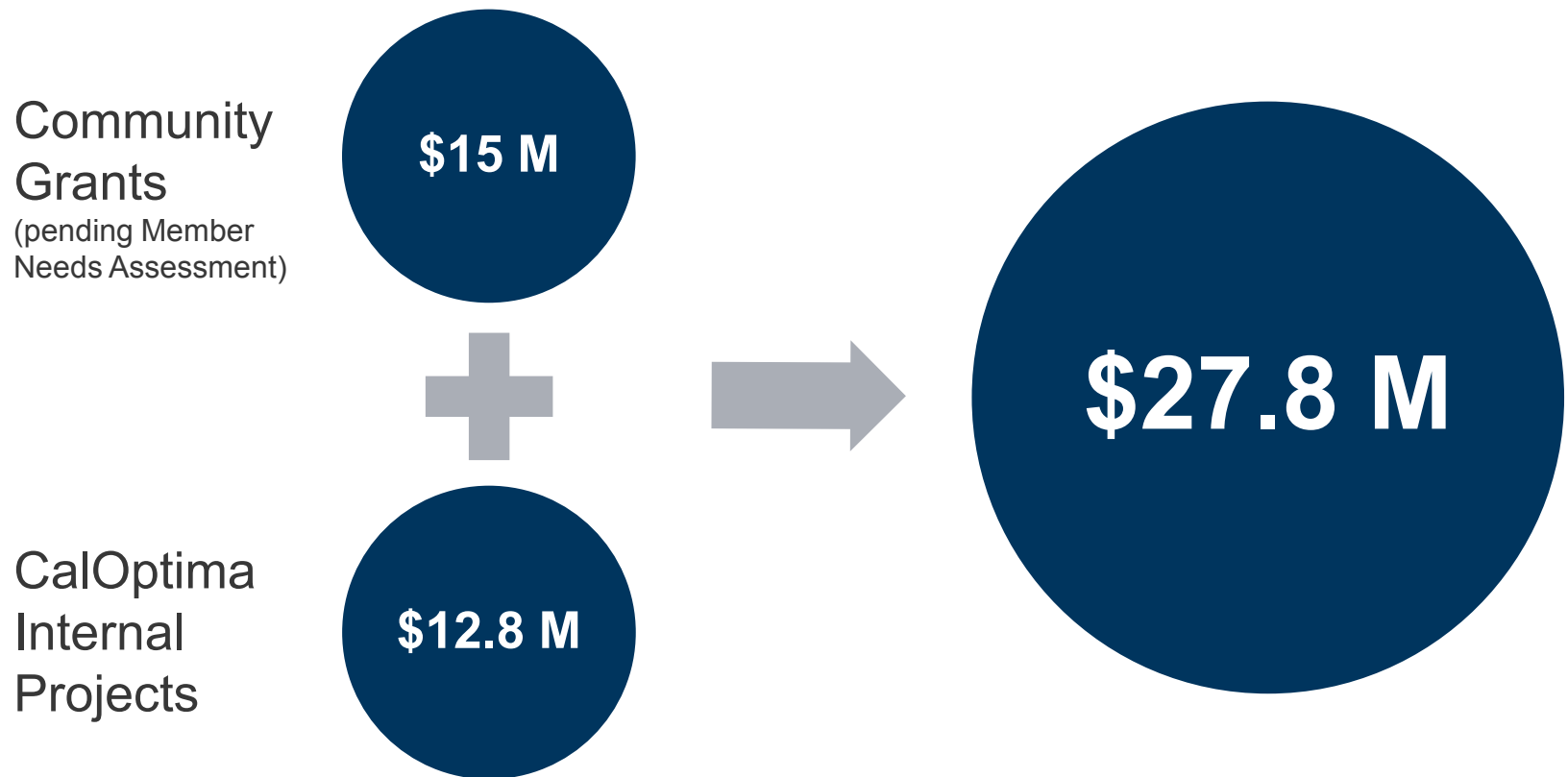
Improving Children's Health

Pilot Program Planning & Implementation

**IGTs 4 and 5 only*

Purpose of IGT Funds

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



Recommended Internal Expenditures

Expenditures	Funding Amount
Data Warehouse Expansion	\$750,000
Depression Screenings Ages 12–18	\$1,000,000
Facets System Upgrade and Reconfiguration	\$500,000
Health Homes Program	\$250,000
Health Needs Assessment	\$500,000
IGT Program Administration (grant management software, staff and administrative costs over two years)	\$530,000
Personal Care Coordinators (PCCs) <ul style="list-style-type: none"> • Duals (OneCare and OneCare Connect) • Medi-Cal Seniors and Persons with Disabilities • Other Populations (Homeless/SPMI, RCOC, etc.) 	\$7,000,000
Provider Portal Communications and Interconnectivity	\$1,500,000
UCI Observation Stay Payment Pilot	\$750,000
Total	\$12,780,000

External Community Grant Support

- Comprehensive Member Health Needs Assessment to inform Grant RFP development
 - Fill gaps in services and improve health outcomes for CalOptima members
 - Improve access to services
 - Address social determinants of health
- Orange County's Medi-Cal delivery system relies heavily on safety net system
 - Community health centers
 - Community-based organizations

IGT Timeline

Date	Activity
September 15	FAC Update and Review
September 21	QAC Update and Review
November 10 and 17	PAC/MAC/OCC MAC Review
November 14	IGT Ad Hoc
December 1	Board of Directors Presentation
January – June 2017	Conduct Member Health Needs Assessment
Fall 2017	Development and Release of Community Grant RFPs

**IGT 1-5 Summary Tables of Expenditure by CMS/DHCS (and CalOptima Board)
Approved Funding Categories**

IGT 1 Funding Categories: (CalOptima Board Approved on March 7, 2013)

- Enhance provider reimbursement rates based on rewards for increased access, which includes, but is not limited to, the following:
 - Open access scheduling
 - Same day appointment availability
 - Participation in medical homes
 - Specialist recruitment for increased access
- Strengthen the delivery system to include, but no be limited to, increased member education and previously unused or underused resources such as the following:
 - 24/7 clinical call center
 - Minute clinics
 - Telemedicine
 - E-consults
 - Complex case management

Project	Amount	Funding Category
OneCare Personal Care Coordinators	\$3,850,000	Strengthen the delivery system
Case Management System	\$2,099,000	Strengthen the delivery system
Strategies to Reduce Re-admissions	\$533,585	Strengthen the delivery system
Program for High Risk Children	\$500,000	Strengthen the delivery system
Telemedicine	\$1,100,000	Enhance provider reimbursement rates
Case Management System Consulting	\$866,415	Strengthen the delivery system
OCC PCC Program	\$3,550,000	Strengthen the delivery system
Total Allocation	\$12.5 M	

IGT 2 Funding Categories: (CalOptima Board Approved on March 6, 2014)

- Enhance CalOptima’s core data analysis and exchange systems and management information technology infrastructure to facilitate improved coordination of care for Medi-Cal members;
- Continue and/or expand on services and initiatives developed with 2010-11 IGT funds;
- Provided wraparound services and optional benefits for members in order to address critical gaps in care, including, but not limited to, behavioral health integration, preventative dental services and supplies, and incentives to encourage members to participate in initial health assessment and preventative health programs.

Project	Amount	Funding Category
Facets System Upgrade & Reconfiguration	\$1,250,000	Enhance information technology infrastructure
Security Audit Remediation	\$101,000	Enhance information technology infrastructure
Continuation of COREC	\$1,000,000	Enhancement to core data systems
OCC PCC Program	\$2,400,000	Strengthen the delivery system
Children's Health/Safety Net Services	\$1,300,000	Strengthen the delivery system
Wraparound Services	\$1,400,000	Wraparound services
Recuperative Care	\$500,000	Strengthen the delivery system
Provider Network Management Solution	\$500,000	Enhancement to core data systems
Project Management	\$100,000	Administration
PACE EHR System	\$50,000	Enhance information technology infrastructure
Total Allocation	\$8.6 M	

IGT 3 Funding Categories: (CalOptima Board Approved on September 4, 2014)

- Services related to care coordination and case management for CalOptima members;
- Expansion of optional benefits for CalOptima members potentially including but not limited to vision, dental, and prevention and treatment of chronic disease;
- Innovation and enhancement of the health care delivery model
- Continuing improvements to information services infrastructure and applications to enhance services to CalOptima members.

Project	Amount	Funding Category
Pay for Performance for PCPs	\$4,200,000	Care coordination
Recuperative Case (Phase 2)	\$500,000	Strengthen the delivery system
Project Management	\$165,000	Administration
Total Allocation	\$4.8 M	

IGT 4 Funding Categories: (CalOptima Board Approved on May 7, 2015)

- Community health investments to improve adult mental health, children's mental health, reduce childhood obesity, strengthen the safety net, and improve children's health;
- Planning and implementing innovative programs required under the Health Homes and the 1115 Waiver initiatives. This would be one-time funding allocation for planning and implement pilot programs as required.

Project	Amount	Funding Category
Unallocated Funds	\$7,000,000	To be distributed across categories
Total Allocation	\$7 M	

IGT 5 Funding Categories: (CalOptima Board Approved on April 7, 2016)

- Adult Mental Health
- Childhood Obesity
- Children’s Mental Health
- Improving Children’s Health
- Strengthening the Safety Net
- Pilot Program Planning and Implementation

Project	Amount	Funding Category
Unallocated Funds	\$15,000,000	To be distributed across categories
Total Allocation	\$15 M	

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 7, 2013 **Regular Meeting of the CalOptima Board of Directors**

Report Item

VII. A. Approve Proposed Use of \$12.4 Million in FY 2010-11 Intergovernmental Transfer (IGT) Funds; Authorize the Chief Executive Officer (CEO) to Initiate Required Process for FY 2011-12 IGT Funds and Execute Required IGT Documents

Contact

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

Recommended Actions

1. Approve proposed use of \$12.4 Million in FY 2010-11 Intergovernmental Transfer (IGT) funds; and
2. Authorize the CEO to initiate the required process for FY 2011-12 IGT funds and execute required IGT documents.

Background

On March 3, 2011, the CalOptima Board approved staff to enter into agreements to secure an IGT with the Regents of the University of California/University of California, Irvine (UCI) for Fiscal Year (FY) 2010-11. CalOptima retained \$12.4 million through the IGT transaction. The funds were received in late August 2012, and UCI's portion was disbursed in September.

IGTs are transfers of public funds between governmental entities. The revenue generated through IGTs is potentially non-recurring since there is no guarantee of future IGT agreements. Thus, funds are best suited for one-time investments or as seed capital for new services or initiatives. Ultimately, IGT-funded programs or services must be self-sustaining and not reliant on IGT funds for ongoing operation.

In approving the IGT, the Centers for Medicare & Medicaid Services (CMS) authorized the use of IGT funds to fulfill one or more of the options under the following categories, as approved by the CalOptima Board of Directors:

Category 1: Enhance provider reimbursement rates based on rewards for increased access, which includes, but is not necessarily limited to, the following:

- a. Open access scheduling
- b. Same day appointment availability
- c. Participation in medical homes
- d. Specialist recruitment for increased access

Category 2: Strengthen the delivery system to include, but not be limited to, increased member education and previously unused or underused resources such as the following:

- a. 24/7 clinical call center
- b. Minute clinics
- c. Telemedicine

- d. e-Consult
- e. Complex case management

Discussion

CalOptima sought input from the Member Advisory Committee (MAC) and Provider Advisory Committee (PAC) regarding the relative priority of each potential use. In response to a request from both committees for a cost analysis of the CMS-approved uses, Manatt, an interdisciplinary policy and business advisory consultancy firm, was engaged to research and prepare the requested analyses within an accelerated timeframe. A copy of Manatt’s analysis is attached.

The MAC and the PAC met twice and formed ad hoc groups to review Manatt’s analysis and provide recommendations for use of the funds. Based on this input, staff developed a proposal that is presented in the attached presentation.

Prior to moving forward, staff will return to the Board for approval of a proposed implementation plan.

Proposed Uses	Recommended Allocation
Complex Case Management – Part 1 <ul style="list-style-type: none"> • Case management for high-risk members across various care settings 	Year 1: \$5.1M Year 2: \$4.2M
Complex Case Management – Part 2 <ul style="list-style-type: none"> • Improved health network documentation of clinical needs 	Year 1: \$1.8M Year 2: \$200K
Expanded Access Pilots <ul style="list-style-type: none"> • Pilot selected strategies with documented Return on Investment, such as e-consults, telemonitoring and alternative access points 	Year 1: \$450K Year 2: \$650K
Total Budget	\$12.4 M

UCI has indicated interest in entering into an agreement for a second IGT for FY 2011-12. As proposed, CalOptima plans to begin working with UCI on the required process.

Fiscal Impact

FY 2010-11 IGT funding provides \$12.4 million to improve the quality of care and cost effectiveness of CalOptima and its delegated network. Potential funds for FY 2011-12 are unknown at this time.

Rationale for Recommendation

The recommendations above are expected to generate the most positive impact on members, CalOptima and its delegated networks while also providing a sustainable return on investment for the future.

CalOptima Board Action Agenda Referral
Approve Proposed Use of \$12.4 Million in FY 2010-11 IGT
Funds; Authorize the CEO to Initiate Required Process for
FY 2011-12 IGT Funds and Execute Required IGT Documents
Page 3

Concurrence

Gary Crockett, Chief Counsel
Michael Ewing, Chief Financial Officer

Attachments

FY 2010-11 IGT Recommendations Presentation
Manatt Cost Analysis dated January 10, 2013

/s/ Michael Schrader
Authorized Signature

3/1/2013
Date



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Recommendations for FY 2010-11 Intergovernmental Transfer (IGT) Funds

Board of Directors Meeting

March 7, 2013

Ilia Rolon, MPH

Manager, Strategic Operations

Planning Process

- Engaged Manatt Consulting to:
 - Estimate upfront costs, costs to sustain
 - Identify implementation barriers and opportunities
- Presented analysis to Provider Advisory Committee (PAC) and Member Advisory Committee (MAC) in January 2013
- C and MAC
 - Held ad hoc meetings in January to review analysis in more depth and receive staff input
 - Met in February to vote on priority of options and finalize recommendations to CalOptima Board
 - Consensus reached between PAC and MAC regarding top four priorities

Options

Previous Name	New Name
Complex case management	<ul style="list-style-type: none"> •Complex case management
Open access scheduling	<ul style="list-style-type: none"> •Extended hours
Same day appointment availability	<ul style="list-style-type: none"> •Combined with above
Participation in medical homes	<ul style="list-style-type: none"> •Medical home infrastructure support
Specialist recruitment	<ul style="list-style-type: none"> •Specialist recruitment and retention
24/7 clinical call center	<ul style="list-style-type: none"> •Clinical call center
Minute clinics	<ul style="list-style-type: none"> •Alternative access points
Telemedicine	<ul style="list-style-type: none"> •Remote visits •Telemonitoring
E-Consults	<ul style="list-style-type: none"> •Specialty Care Consults

Comparison of Recommendations

Priority	Provider Advisory Committee	Member Advisory Committee
1	Complex Case Management	Complex Case Management
2	Specialty Care Access -- Planning & Pilots	Extended Hours
3	Extended Hours Access	Alternative Access Points
4	Alternative Access Points – Planning and Pilots	Specialty Care Access – Planning & Pilots
5		Remote Visits
6		Medical Home Infrastructure Support
7		Telemonitoring

* Bold type indicates consensus

Staff Recommendations

Proposed Uses	Recommended Allocation
<p>Complex Case Management – Part 1</p> <ul style="list-style-type: none"> • Case management for high-risk members across various care settings 	<p>Year 1: \$5.1M Year 2: \$4.2M</p>
<p>Complex Case Management – Part 2</p> <ul style="list-style-type: none"> • Improved health network documentation of clinical risk 	<p>Year 1: \$1.8M Year 2: \$200K</p>
<p>Expanded Access Pilots</p> <ul style="list-style-type: none"> • Pilot selected strategies with documented ROI, such as e-consults, telemonitoring and alternative access points 	<p>Year 1: \$450K Year 2: \$650K</p>
<p>Total Budget</p>	<p>\$12.4 M</p>

Complex Case Management – Part 1

- Recommended Allocation: \$9.3 Million
- Description
 - Case management and care coordination services for high-need members across various provider settings (e.g., primary and specialty care, inpatient, skilled nursing)
 - A platform for IGT-funded services: Case Management team determines which other services the member needs
- Pricing Elements
 - Approximately 15 positions (HIT staff, RNs, data analysis, patient navigators)
 - New or enhanced technology for:
 - care coordination
 - clinical decision support
 - data repository
 - electronic health record (EHR) integration
 - predictive modeling

Complex Case Management – Part 2

- Recommended Allocation: \$2 Million
- Description
 - Improvement of Health Networks' ability to accurately document clinical need
- Pricing Elements
 - Gap analysis
 - Risk documentation software
 - Staffing for provider technical assistance and education

Expanded Access Pilots

- Proposed Allocation: \$1.1 Million
- Objectives
 - Reduction in visits to emergency departments
 - Decreased wait times for specialty care
 - Improved member satisfaction
- Potential Pilots
 - E-Consultation: Enables PCP to meet and share information with specialist via web connection and refer electronically for treatment, thus reducing need for specialty care
 - Incentivizing providers to see patients during evening and weekend hours
 - Developing alternative access points
 - Telemonitoring

Next Steps

- Approve Staff Recommendation for use of IGT funds
- Receive implementation plan in April / May 2013

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 6, 2013
Regular Meeting of the CalOptima Board of Directors

Report Item

VII. E. Approve Work Plan and Timeline for Implementation of FY 2010-11 Intergovernmental Transfer (IGT) Funds

Contact

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

Recommended Action

Approve work plan and timeline for proposed use of \$12.4 million of FY 2010-11 Intergovernmental Transfer (IGT) funds.

Background

On March 3, 2011, the CalOptima Board authorized staff to enter into agreements to secure an IGT with the Regents of the University of California/University of California, Irvine (UCI) for Fiscal Year (FY) 2010-11. CalOptima retained \$12.4 million through the IGT transaction.

Subsequent to receiving the funds in late August 2012, CalOptima sought input from the Member Advisory Committee (MAC) and Provider Advisory Committee (PAC) regarding the relative priority of each CMS-approved potential use. In response to a request from both committees for a cost analysis of the potential uses, Manatt, an interdisciplinary policy and business advisory consulting firm, was engaged to research and prepare the requested analyses. The MAC and the PAC reviewed Manatt's analysis and provided recommendations for use of the funds. Based on this input, staff developed a proposal for best use of the funds.

On March 7, 2013, the CalOptima Board approved three main uses of the funds to improve the quality of care and cost effectiveness of CalOptima and its delegated network, as shown in the table below. The approved uses are expected to generate the most positive impact on members, CalOptima and its delegated networks, while also providing a sustainable return on investment for the future.

Approved Uses	Allocation
Complex Case Management – Part 1 <ul style="list-style-type: none">• Case management for high-risk members across various care settings	Year 1: \$5.1M Year 2: \$4.2M
Complex Case Management – Part 2 <ul style="list-style-type: none">• Improved health network documentation of clinical needs	Year 1: \$1.8M Year 2: \$200K
Expanded Access Pilots <ul style="list-style-type: none">• Pilot selected strategies with documented Return on Investment, such as e-consults, telemonitoring and alternative access points	Year 1: \$450K Year 2: \$650K
Total Budget	\$12.4 M

Discussion

The largest portion of FY 2010-11 IGT funds is allocated to the enhancement of complex case management services for high-risk members across various care settings. Per the medical literature, the success of such programs is highly dependent on who is targeted, the program's design, and how success is measured. To derive maximum benefit from its investment in disease and case management services, CalOptima will first seek to strengthen the existing infrastructure in the following two areas: 1) improvement of data integrity and completeness; and, 2) implementation of predictive modeling to further inform the enrollment of members in disease and complex case management programs. In Phase Two, staff will use improved data to design complex case management program enhancements and determine the optimal delegation arrangement for these services.

IGT funds were also earmarked for pilot projects that expand access to healthcare services, particularly for medically vulnerable members. In FY 2013-14, CalOptima will implement a pilot to enhance communication between primary and specialty care providers through electronic referrals and consultations. The goals of the pilot are to mitigate specialty care service capacity issues and increase the ease and efficiency with which members who need specialty care services are able to access those services.

A more detailed work plan and timeline is included in the attached presentation. Staff will provide quarterly reports on the implementation progress.

Fiscal Impact

Implementation plan is consistent with previously approved IGT for FY 2010-11.

Rationale for Recommendation

The recommendations above are expected to generate the most positive impact on members, CalOptima and its delegated networks while also providing a sustainable return on investment for the future.

Concurrence

Gary Crockett, Chief Counsel
Michael Ewing, Chief Financial Officer

Attachment

FY 2010-11 Intergovernmental Transfer (IGT) Implementation Plan

/s/ Michael Schrader
Authorized Signature

5/31/2013
Date



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FY 2010-11 Intergovernmental Transfer (IGT) Implementation Plan

**Board of Directors Meeting
June 6, 2013**

**Ilia Rolon, MPH
Director, Strategic Development**

Background

March 2013 Board Actions

- Approved use of IGT funds as follows:
 - Complex Case Management (CCM) 1: Case management for high-risk members across various care settings
 - Year 1: \$5.1M
 - Year 2: \$4.2M
 - CCM 2: Improved health network documentation of clinical risk
 - Year 1: \$1.8M
 - Year 2: \$200K
 - Pilot selected expanded access strategies such as e-consults, telemonitoring, and alternative access points
 - Year 1: \$450K
 - Year 2: \$650K
- Directed staff to return with implementation plan

Key Planning Assumptions

- Success of case and disease management programs is highly dependent on who is targeted, how program is designed and how success is measured*
- Allocation of funding should be data-driven
 - Begin by strengthening CalOptima's ability to accurately identify patients that fall within targeted risk score range
- Resources should follow the critical mass of at-risk members

* Source: "Complex Puzzle: How Payers are Managing Complex and Chronic Care," Issue Brief, California Healthcare Foundation, April 2013

Work Plan and Timeline

- **Strengthen complex case management infrastructure**

- Improve data integrity and completeness

- **Q3 2013** Assess current CalOptima data integrity; Issue RFP for vendor to provide technical assistance to health networks (HN) and providers for improved documentation of risk (CCM 1 & 2)
- **Q4 2013** Upon selection of vendor, enroll interested HNs and conduct assessments (CCM 2)
- **Q1 2014** Based on assessment results, identify opportunities for improvement and offer consultative assistance to HNs (CCM 2)
- **Q2 2014** Use improved data to design, implement CCM program enhancements and determine delegation arrangement (CCM1)

- Implement predictive modeling to further inform enrollment in complex case management programs (CCM 1)

- **Q2 2014** Issue RFP
- **Q3 2014** Select vendor and begin implementation and training
- **Q4 2014** Implement enhancements to member enrollment

Work Plan and Timeline (Cont.)

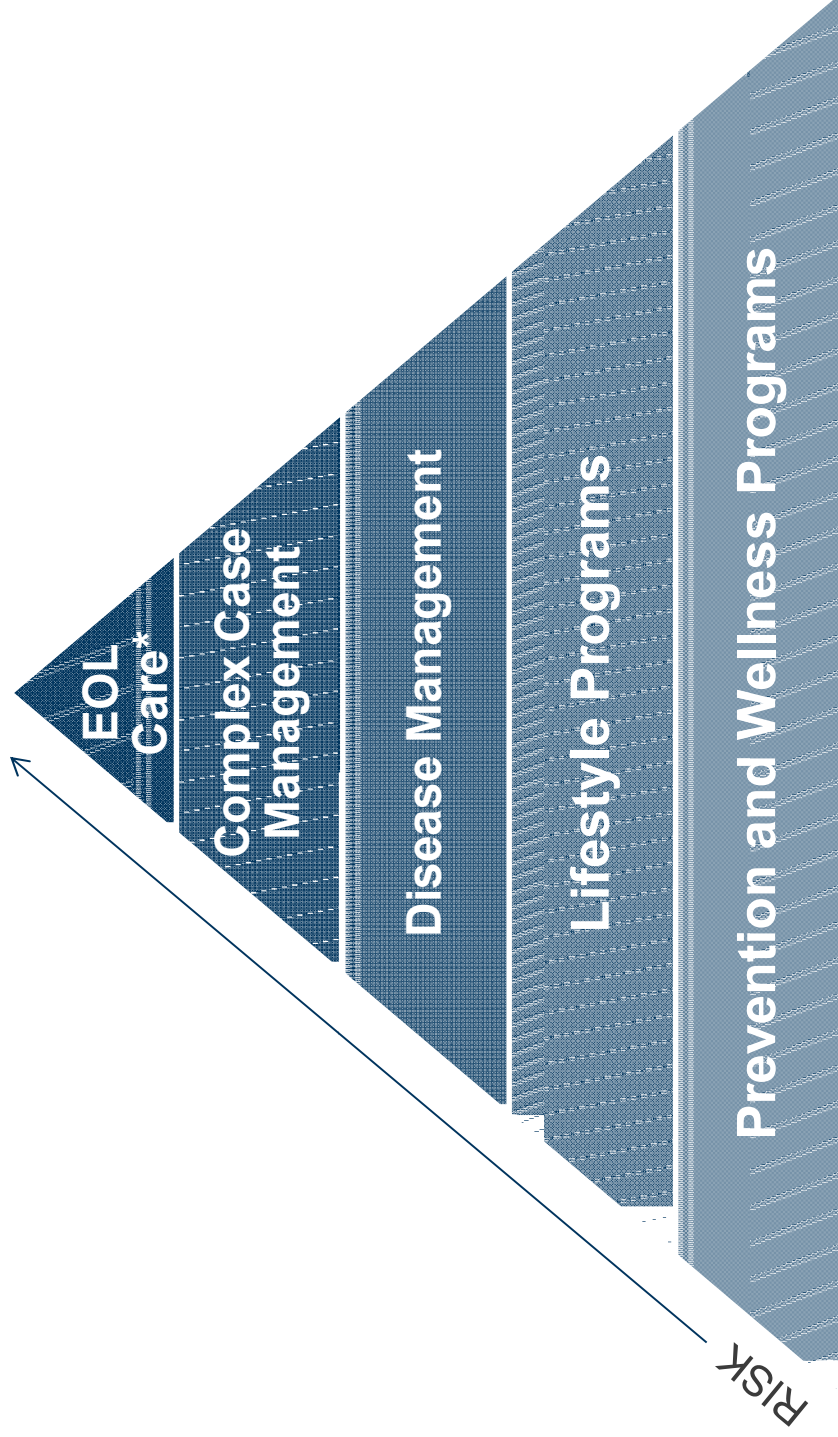
- **Enhance referral and consultation communication between primary and specialty care providers**
 - **Q3 2013** Assess current health information exchange capabilities (CalOptima web portal, OCPRHIO*) and determine buy or build
 - **Q4 2013** Issue RFP for e-consult platform, if needed
 - **Q1 2014** Install components
 - **Q2 2014** Pilot with 1 health network and select CCN providers
 - **Q2-Q3 2014** Enroll other interested health networks and CCN providers

* Orange County Partnership Regional Health Information Organization

Appendix

- Types of Care Management Programs
- California Healthcare Foundation Recommendations

Types of Care Management Programs



* End-of-life care (may be considered part of complex case management or may be separate program)

Source: Booz Allen Hamilton, 2012



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California Healthcare Foundation Recommendations

- Use analytic tools to better identify the population that would most benefit from interventions
 - *Predictive modeling*: Statistical technique of analyzing data to predict which members may be at greater risk for high-cost care, esp. hospitalization
- Adjust program design to engage and activate the patient by experimenting with a wide range of tools
 - “Low-touch”: Tech solutions such as mobile apps, text messaging
 - “High-touch”: Coaching or case management
- Better integrate disease management and complex case management programs with the treating provider or PCP
 - Use contracting arrangements to better align financial incentives and outcome measurement
 - Test a range of provider engagement tools, such as health information exchanges (HIEs), provider portals and embedding of care managers

Source: “Complex Puzzle: How Payers are Managing Complex and Chronic Care,” Issue Brief, California Healthcare Foundation, April 2013



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Intergovernmental Transfers (IGT)

Board of Directors Meeting
March 7 6, 2014

Ilia Rolon
Director, Strategic Development



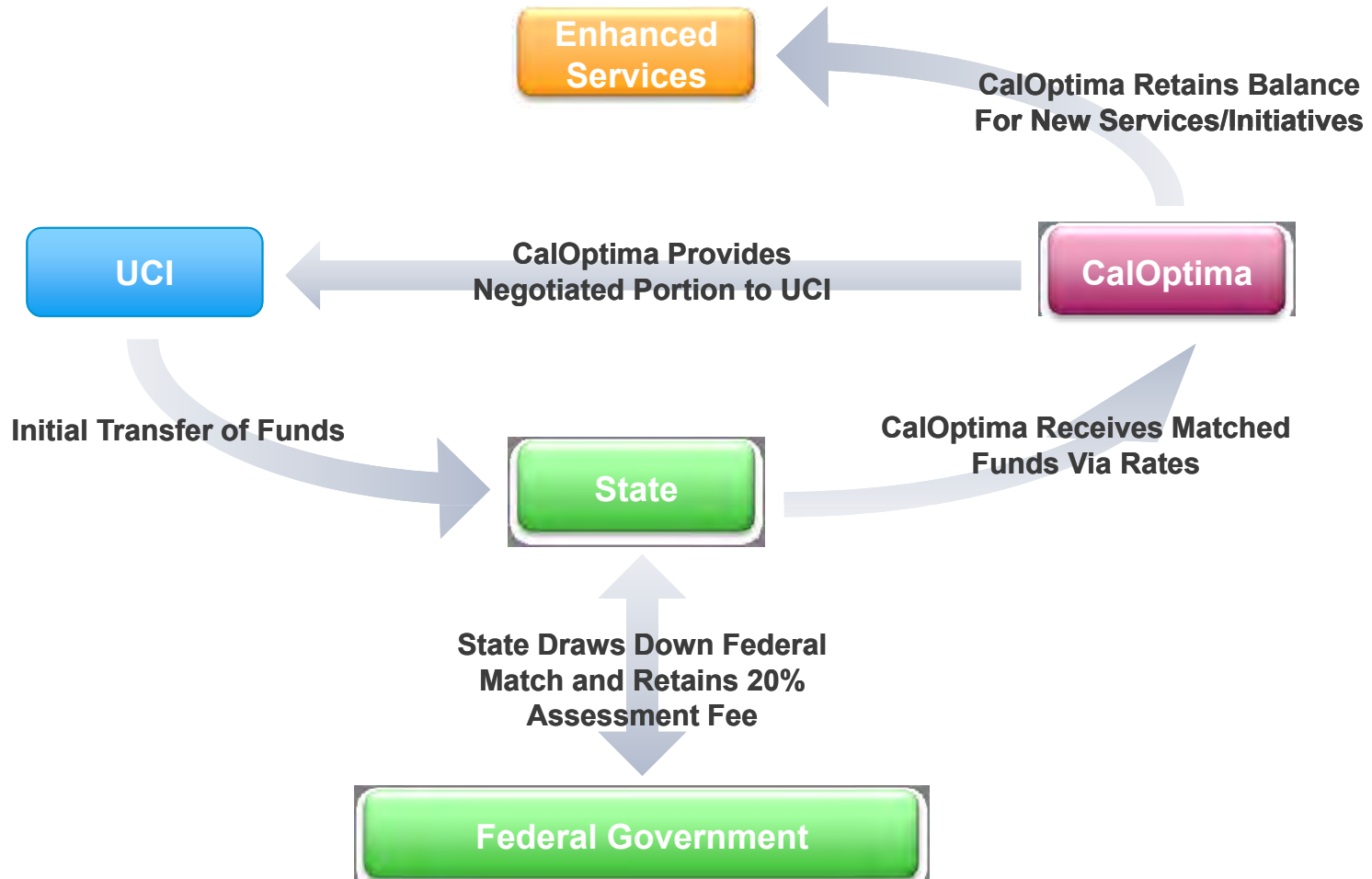
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Background

About IGTs

- Intergovernmental Transfers (IGTs) are transfers of public funds between governmental entities
- Extensive precedent of IGTs among managed care plans in California
- California managed care plans have historically saved state/federal governments millions in health care costs
 - Federal Medical Assistance Percentage (FMAP): Amount of federal match for states' expenditures on social, medical services
 - California: 50%
 - Mississippi: 73%
- IGTs are a means of leveling the field and ensuring continued investment in our healthcare systems

IGT Transaction Overview



Use of Funds

- Revenue must be used to finance improvements in services for Medi-Cal beneficiaries
- No guarantee of future IGT agreements -- thus funds are best suited for one-time investments or as seed capital for new services or initiatives
- Budgeted uses for current IGTs are consistent with system improvements that will support successful response to OneCare audit
- Agreements are silent on deadline for use of funds

IGTs Received to Date

Funding Source	Claim Year	Year Received	CalOptima Amount	UCI Amount	State Amount	Total
IGT 1	FY 10-11	2012	\$12.4 M	\$8.4 M*	\$3.1 M	\$23.9 M
IGT 2	FY 11-12	2013	\$7.4 M	\$4.8 M	\$5.4 M	\$17.6 M
Total Funds			\$19.8 M	\$13.2 M	\$8.5 M	\$41.5 M

- IGT 1 included a one-year community vetting process; proposed uses for IGTs 2 and 3 are consistent with results of this earlier process
- Status of IGT Year 1 expenditures: \$2 M contract award for new case management system; agreements with health networks for approximately \$2 M in funding for personal care coordinators pending

* UCI's net revenue was \$3.4 Million due to exclusion from approximately \$5.0 million in state disproportionate share (DSH) payments



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Proposal

IGT 1 Expenditure Plan

Proposed Uses	Year 1	Year 2	Impacted Programs	Timing	Description
Complex Case Management I	\$5.1 M	\$4.2 M	–	–	
Personal Care Coordinators	\$1.85 M	\$1.95 M	CMC	CY 14	Additional PMPM line item payment to networks
Case Management System	\$2.0 M	\$0	All	CY 14	Replace existing case management system
Strategies to Reduce Readmission	\$1.0 M	\$2.0 M	MC, CMC OneCare	CY 14	Post-discharge follow up; transitions of care
Program for High-Risk Children	\$250 K	\$250 K	MC	FY 14/15	Services for children affected by both obesity and asthma
Complex Case Management II	\$1.8 M	\$200,000	N/A	N/A	Merge this category with CCM 1
Access Strategies	\$450,000	\$650,000	–	–	
e-Referral/ Telemedicine	TBD	TBD	All	CY 14	Dermatology project in development
Total Funds	\$7.35 M	\$5.05 M			

Proposed IGT 2 Expenditure Plan

CMS and CalOptima Board Approved Categories	Proposed Allocation
Enhanced Core Systems <ul style="list-style-type: none"> • Facets system upgrade and reconfiguration • Provider network management solution • Security audit remediation • Funding to continue COREC services for two years 	\$3.0 M
Continued / Expanded IGT 1 Services <ul style="list-style-type: none"> • Personal care coordinators • Strategies to reduce hospital readmissions 	\$3.0 M
Wraparound Services & Optional Benefits <ul style="list-style-type: none"> • To be developed further. • May include: school-based vision and dental services for children; recuperative care for homeless members discharged from hospital; and/or backfilling Medi-Cal cuts to payments and/or benefits. 	\$1.4 M
Total Funds	\$7.4 M

} 60% for direct services

Next Steps

- Execute approved expenditure plan for IGT 1
- Begin implementation of IGT 2 funded activities
- Initiate process to explore feasibility of securing third IGT
- Periodic Board updates on progress

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 6, 2014 **Regular Meeting of the CalOptima Board of Directors**

Report Item

VI. C. Approve Final Expenditure Plan for Use of FY 2010-11 Intergovernmental Transfer (IGT) Funds; Approve Expenditure Plan for Use of FY 2011-12 Intergovernmental Transfer (IGT) Funds; Authorize the Chief Executive Officer (CEO) to Initiate Required Process for FY 2012-13 IGT Funds and Execute the Standard Required Application Documents

Contact

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

Recommended Actions

1. Approve final expenditure plan for \$12.4 Million in FY 2010-11 Intergovernmental Transfer (IGT) funds;
2. Approve expenditure plan for \$7.4 Million in FY 2011-12 IGT funds;
3. Authorize the CEO to initiate the required process for FY 2012-13 IGT and execute the required application documents consistent with Board approved terms.

Background

CalOptima has partnered with the Regents of the University of California/University of California, Irvine (UCI) to secure two IGTs to date. The two transactions are summarized below:

- IGT 1 was authorized by the CalOptima Board on March 3, 2011, and covers the claiming period of Fiscal Year (FY) 2010-11. CalOptima retained \$12.4 Million, UCI retained \$8.4 Million, and the state disbursed the funds in August 2012.
- IGT 2 was authorized by the CalOptima Board on March 7, 2013 for the FY 2011-12 claiming period. CalOptima retained \$7.4 million, UCI retained \$4.8 Million, and the state disbursed the funds in June 2013.

IGTs are transfers of public funds between governmental entities. The revenue generated through the CalOptima /UCI IGTs must be used to finance improvements in services for Medi-Cal beneficiaries. Funds are potentially non-recurring, since there is no guarantee of future IGT agreements. Thus, these funds are best suited for one-time investments or as seed capital for new services or initiatives for Medi-Cal beneficiaries.

The present item seeks: 1) authorization to adjust the expenditure plan for IGT 1 to reflect the final funding distribution needed to fully implement the approved uses; 2) approval of the proposed expenditure plan for IGT 2; and 3) authorization to initiate the process to secure a third IGT.

Discussion

Final Expenditure Plan for IGT 1

On March 7, 2013, the CalOptima Board approved the following expenditure plan for IGT 1:

Table 1. Approved Expenditure Plan for IGT 1	Budget
Complex Case Management – Part 1 <ul style="list-style-type: none"> Case management for high-risk members across various care settings 	Year 1: \$5.1M Year 2: \$4.2M
Complex Case Management – Part 2 <ul style="list-style-type: none"> Improved health network documentation of clinical needs 	Year 1: \$1.8M Year 2: \$200K
Expanded Access Pilots <ul style="list-style-type: none"> Pilot selected strategies with documented Return on Investment, such as e-consults, telemonitoring and alternative access points 	Year 1: \$450K Year 2: \$650K
Total Budget	\$12.4 M

As reported at the February 2014 CalOptima Board meeting, recent data analyses indicate that the need for improved health network documentation of clinical needs (i.e., Complex Case Management – Part 2 in the above table) is not consistent among the networks, and thus will not require the entire budgeted amount. At the same time, full implementation of the uses proposed under Complex Case Management – Part 1, including reimbursement of health networks for enhanced care coordination, requires more funding than originally budgeted. To allow for greater efficiency and ensure that funds are used most effectively, staff recommends merging the two Complex Case Management budget categories, as reflected in Table 2 below.

Table 2. Final Expenditure Plan for IGT 1	Budget
Complex Case Management <ul style="list-style-type: none"> Case management for high-risk members across various care settings, including improved documentation of clinical risk 	Year 1: \$6.9M Year 2: \$4.4M
Expanded Access Pilots <ul style="list-style-type: none"> Pilot selected strategies with documented Return on Investment, such as e-consults, telemonitoring and alternative access points 	Year 1: \$450K Year 2: \$650K
Total Budget	\$12.4 M

Proposed Expenditure Plan for IGT 2

As previously stated, CalOptima retained \$7.4 million from the second IGT. Per the state’s agreement with the Centers for Medicare and Medi-Cal (CMS), funds must be used for any of three Board-approved general purposes:

1. Enhance CalOptima’s core data systems and information technology infrastructure to facilitate improved member care;
2. Continue and/or expand on services and initiatives developed with FY 2010-11 IGT funds; and/or
3. Provide wraparound services and optional benefits for members in order to address critical gaps in care, including, but not limited to, behavioral health, preventive dental services and supplies, and incentives to encourage members to participate in preventive health programs.

Based on an analysis of current and emerging priorities, staff proposes the budget allocation plan presented in the attached presentation and summarized below:

Table 3. Proposed Expenditure Plan for IGT 2	Budget
Enhancement of Core Data Systems	\$3.0 M
Continuation/Expansion of IGT 1 Initiatives	\$3.0 M
Wraparound Services/Optional Benefits to Address Critical Gaps	\$1.4 M
Total Budget	\$7.4 M

Proposed FY 2012-13 IGT

UCI has notified CalOptima of its interest to secure a third IGT for FY 2012-13. The Department of Health Care Services (DHCS) is in the process of calculating the amount of funds that would be available for this transaction. Authorization is requested to begin working with UCI to determine feasibility of securing a third IGT under the same general terms as the prior two IGTs, and to initiate the process. If IGT 3 is secured, funds will be applied to uses consistent with the categories outlined in Table 3 above.

Fiscal Impact

The recommended action is to be funded from DHCS capitation receipts which are currently reserved. Expenditure of IGT funds is for restricted, one-time purposes and does not commit CalOptima to future budget allocations. It should be noted that the proposed expenditures under IGTs 1 and 2 are aligned with many of the system improvements required in response to the recent CMS audit.

Rationale for Recommendation

The recommendations above are expected to generate the most positive impact on members, CalOptima and its delegated networks while also providing a sustainable return on investment for the future.

CalOptima Board Action Agenda Referral
Approve Final Expenditure Plan for Use of FY 2010-11 IGT
Funds; Approve Expenditure Plan for Use of FY 2011-12 IGT
Funds; Authorize the CEO to Initiate Required Process for
FY 2012-13 IGT Funds and Execute the Standard Required
Application Documents
Page 4

Concurrence

Gary Crockett, Chief Counsel

Attachments

None

/s/ Michael Schrader
Authorized Signature

2/28/2014
Date

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 4, 2014 **Regular Meeting of the CalOptima Board of Directors**

Report Item

VII. B. Authorize and Direct the Chairman of the Board of Directors to Enter into the Necessary Agreements with the University of California at Irvine (UCI) and the California Department of Health Care Services (DHCS) to Secure Additional Medi-Cal Funds Through an Intergovernmental Transfer (IGT) for Fiscal Year (FY) 2012-13, Including Approval of Proposed Funding Categories; Recommend Board of Directors Approval of an Updated Expenditure Plan for FY 2011-12 IGT (IGT 2) Funds; and Consider Allocation of \$900,000 of IGT 2 Funds and Authorize Procurement Process for School-Based Vision and Dental Wraparound Services

Contact

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

Recommended Actions

1. Authorize the Chairman of the Board of Directors to execute an amendment to the primary agreements among DHCS, UCI, and CalOptima for the upcoming FY 2012-13 IGT (IGT 3), including approval of proposed general use categories;
2. Approve final IGT 2 budget of \$8.7 million and allocate the additional \$1.3 Million to children's health and/or safety net services; and
3. Consider proposal for school-based vision and dental wraparound services for children enrolled in Medi-Cal, in amounts not to exceed \$500,000 for vision services and \$400,000 for dental services.

Background

CalOptima has partnered with the Regents of the University of California/University of California, Irvine (UCI) to secure two IGTs to date, with a third IGT pending for FY 2012-13.

Presently staff recommends two actions related to the pending IGT 3 transaction, and two pertaining to FY IGT 2 revenue. Approval of these recommendations is requested in order to implement programmatic priorities.

Discussion

IGT 3 Application

On June 20, 2014, CalOptima and UCI submitted a proposal to DHCS for a third IGT. If approved, the proposed IGT will result in revenue of approximately \$4.8 million each to UCI and CalOptima. Our understanding is that DHCS anticipates disbursement of an IGT payment to CalOptima in September 2014. At this time, staff requests authorization to amend the primary agreement between the DHCS and CalOptima for purposes of accepting an increased rate that includes IGT 3 funding. Additionally, consistent with the proposal to DHCS submitted in June 2014, staff requests approval of four general categories of uses for IGT 3 revenue as follows:

1. Services related to care coordination and case management for CalOptima members;
2. Expansion of optional benefits for CalOptima members potentially including but not limited to vision, dental, and prevention and treatment of chronic disease;

CalOptima Board Action Agenda Referral
Authorize and Direct the Chairman of the Board of Directors to
Enter into the Necessary Agreements with UCI and the DHCS to
Secure Additional Medi-Cal Funds Through an IGT for FY 2012-13,
Including Approval of Proposed Funding Categories; Recommend
Board of Directors Approval of an Updated Expenditure Plan for
FY 2011-12 IGT (IGT 2) Funds; and Consider Allocation of \$900,000 of
IGT 2 Funds and Authorize Procurement Process for School-Based
Vision and Dental Wraparound Services
Page 2

3. Innovation and enhancement of the health care delivery model;
4. Continuing improvements to information services infrastructure and applications to enhance services to CalOptima members.

A budget allocation for the proposed categories will be presented at a future Board meeting after the transaction has received federal approval and funds have been received from the state.

Additional IGT 2 Revenue

The current Board approved budget for IGT 2 is based on an original revenue estimate of \$7.4 million, while actual revenue received was \$8.7 million. Based upon discussion and direction provided at the August 27, 2014, Quality Assurance Committee, staff recommends allocating the additional \$1.3 million for children's health and/or support of the safety net. For children's health services, priority could be given to addressing pediatric obesity and expanding access to children's health services. Safety net support could include, but not limited to, assisting safety net provider in their sustainability efforts.

Staff will present a proposed plan and recommendations for the additional funding allocation for Board consideration at a future meeting.

Plan for Wraparound Services

As discussed above, the Board-approved IGT 2 budget includes an allocation of \$1.4 million for wraparound services and optional benefits for CalOptima members. The intent of these funds is to help address recognized gaps in services, as well as barriers to accessing preventive care and treatment.

The Board previously identified children's dental and vision services as priorities for this category of IGT funding, given the historically low utilization of these services. For example, only 54% of the nearly 190,000 Orange County children enrolled in Denti-Cal, which is administered directly by the state on a fee for service basis, had a dental visit in the previous year.¹ Similarly, only 52% of CalOptima's population under 19 years of age received a vision screening through a CalOptima provider in 2011. Lack of transportation; language barriers; inconvenient office hours; difficulty locating a provider that accepts Denti-Cal or Medi-Cal/Vision Services Plan (VSP); and parental beliefs regarding the timing of the first dental visit or vision screening are some reasons for the low utilization rates.

To help inform a funding plan to begin addressing these gaps, staff consulted with Kids Vision for Life, a non-profit dedicated to prevention of vision problems in children; Dr. Marc Lerner, Medical Officer, Center for Healthy Kids and Schools, Orange County Department of Education; and the

¹ "Why kids in Denti-Cal are feeling the pain," Children Now, 2013.

CalOptima Board Action Agenda Referral
Authorize and Direct the Chairman of the Board of Directors to
Enter into the Necessary Agreements with UCI and the DHCS to
Secure Additional Medi-Cal Funds Through an IGT for FY 2012-13,
Including Approval of Proposed Funding Categories; Recommend
Board of Directors Approval of an Updated Expenditure Plan for
FY 2011-12 IGT (IGT 2) Funds; and Consider Allocation of \$900,000 of
IGT 2 Funds and Authorize Procurement Process for School-Based
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Page 3

Children and Families Commission of Orange County, all of which have extensive expertise in these subjects, as well as deep knowledge regarding service gaps and access barriers affecting Orange County children.

At this time, staff recommends the Board consider expenditure of \$900,000 for school-based children's dental and vision services, in amounts not to exceed \$500,000 for vision services and \$400,000 for dental. If approved, the recommended action will be accomplished in accordance with approved CalOptima Procurement Policy. Conditions for selection will include previous experience providing services at Orange County schools in high-need areas, as well as willingness to partner and coordinate with other providers for co-deployment of vision and dental services.

Children's Vision Services – \$500,000

- Conduct school-based vision screening and assessment and supply eyeglasses to children with vision problems as medically recommended, with priority given to schools with the highest concentration of Medi-Cal eligible pupils;
- Provide referrals to local vision care providers and conduct follow-up to encourage families to connect with these providers for their children's ongoing vision care.

Children's Dental Services – \$400,000

- Conduct school-based dental screening, education and preventive care, with priority given to schools with the highest concentration of Medi-Cal eligible pupils;
- Provide referrals to local dentists and conduct follow-up to encourage families to connect with these providers for their children's ongoing dental care.

If approved, staff anticipates selection of service providers, and inception of services, during the current (2014-15) school year. Moreover, staff will work with the selected vision and dental health partners to monitor and evaluate outcomes, and evaluation reports will be submitted to the Board's Quality Assurance Committee (QAC) for review. Upon completion of both programs, proof of concept data will be submitted to the Department of Health Care Services for its consideration of future reimbursement to providers of school-based vision and dental care.

As a separate but complementary effort, staff is also exploring opportunities to pilot incentives for pediatric primary care providers to provide basic oral health education and make timely referrals for dental care.

Another wraparound service being explored is pediatric obesity prevention and treatment. FY 2010-11 (IGT 1) funds were set aside for this purpose by prior Board action. However, given the complexity of this health issue and the dearth of effective models, staff brought this topic to the August meeting of the Board's QAC for discussion and direction. Dr. Candice Taylor Lucas, a noted expert on pediatric

CalOptima Board Action Agenda Referral
Authorize and Direct the Chairman of the Board of Directors to
Enter into the Necessary Agreements with UCI and the DHCS to
Secure Additional Medi-Cal Funds Through an IGT for FY 2012-13,
Including Approval of Proposed Funding Categories; Recommend
Board of Directors Approval of an Updated Expenditure Plan for
FY 2011-12 IGT (IGT 2) Funds; and Consider Allocation of \$900,000 of
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obesity, provided guidelines and recommendations to the QAC. Based on input from this group, staff anticipates presenting funding recommendations for the Board's consideration in October.

Quality Assurance Committee Action

At its August meeting, the Board's Quality Assurance Committee approved the recommended Board of Directors approval of requested actions, but did not take action on proposed school-based services due to lack of consensus regarding whether schools are the most effective platform for children's vision and dental services, and whether IGT funds should be expended on these services.

Fiscal Impact

The recommended actions are consistent with the Board's previously identified funding priorities for use of IGT 2 funds. Expenditure of IGT funds is for restricted, one-time purposes, and does not commit CalOptima to future budget allocations.

Rationale for Recommendations

The final budget for IGT 2 incorporates additional funds received in a manner consistent with prior Board actions. Funding for vision and dental wraparound service was approved by prior Board action and will provide enhanced services to current CalOptima members not available through current covered benefits, a key requirement for the use of IGT funds. Proposed funding categories for IGT 3 allow for continued support of key organizational priorities and programs.

Concurrence

Gary Crockett, Chief Counsel

Attachments

None

/s/ Michael Schrader
Authorized Signature

8/29/2014
Date

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

VII. E. Approve Grant Awards to Designated Organizations in Support of New and Prospective Federally Qualified Health Centers (FQHCs)

Contact

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

Recommended Actions

Approve grant awards in the aggregate amount of up to \$200,000 to designated community health centers to support new and prospective Federally Qualified Health Centers (FQHCs) in Orange County, to be funded with Intergovernmental Transfer (IGT) 2 funds.

Background

Through recent discussions with representatives of Orange County's community health centers, CalOptima learned that several health centers have an urgent need for specialized technical assistance to ensure successful attainment of, and transition to, Federally Qualified Health Center (FQHC) designation. FQHCs are vital to Orange County's safety net because they provide comprehensive healthcare for low-income residents, including a significant number of current and future CalOptima Medi-Cal members. There are currently 10 FQHCs in the county, and collectively they operate 26 sites.

To qualify for FQHC designation, clinics must be located in or serve a community that has been designated a Medically Underserved Area or Population by the federal government; be governed by a community board; provide comprehensive primary health care; and provide services to all, with fees adjusted based on ability to pay. Prospective FQHCs often begin by applying to become a Non-grant-supported Health Center, more commonly known as an FQHC "look-alike." This interim designation confers many of the same benefits as full FQHC status, with the exception of the annual \$650,000 grant that full FQHCs receive from the Health Resources and Services Administration (HRSA) to offset the cost of uncompensated care. Additional benefits of FQHC status are listed in the attachment to this item.

According to the Coalition of Orange County Community Health Centers, there are currently two look-alikes in the county; both are preparing to submit an application for full designation by the October 7th federal deadline. Existing FQHCs are also required to submit an application in order to expand to new sites; three Orange County FQHCs plan to apply for a New Access Points grant in October, with new sites planned for Tustin, Santa Ana and Lake Forest.

Prospective FQHCs, and those that wish to expand, must submit a successful application to HRSA's Bureau of Primary Health Care. There is typically no more than one application cycle per year. During the rigorous federal application process, prospective FQHCs often need specialized technical assistance to prepare the required application, and to conduct thorough financial analysis and planning to avoid adverse fiscal impact during the implementation period. In addition, newly-designated FQHCs derive long-term benefit from technical assistance with state and federal rate setting negotiations,

which help ensure a sustainable business model. Centers also need infrastructure support, such as information technology consultation and capital support, to meet more stringent federal guidelines.

Discussion

Five (5) Orange County health centers are preparing to submit applications by the next federal deadline of October 7, 2014. Clinics will be notified of the application outcome no later than June 30, 2015, and most likely in the Spring. A total of eight (8) grant recipients are proposed. Of those, six (6) are prospective FQHCs, applicants for new access points, or “look-alikes” upgrading to full FQHC status, as follows:

1. VNCOC Southland Health Center: FQHC “look-alike” applying for full designation;
2. North Orange County Regional Health Foundation: “look-alike” applying for full designation;
3. Camino Health Center: Full FQHC applying for a new access point in Lake Forest;
4. Friends of Family Health Center: Full FQHC applying for a new access point in Tustin;
5. Share Our Selves (SOS): Full FQHC applying for a new access point in Santa Ana; and
6. La Amistad / Puente a la Salud: New applicant.

In addition, two other clinics that received FQHC designation in 2013, Nhan Hoa Comprehensive Health Care Clinic and Serve the People, are scheduled for HRSA site visits in late 2014, which they must pass in order to successfully complete the federal designation process.

At this time, staff recommends a grant to up to eight (8) community health centers for an individual allocation not to exceed \$30,000 per organization and a total aggregate amount not to exceed \$200,000. In approving the staff recommendation, the Board would be making a finding that the proposed expenditures are in the public good and consistent with CalOptima’s statutory purpose. The proposed grants are to be used to assist new and prospective FQHCs with consulting costs, such as for rate negotiations and HRSA site visit preparation, but shall not be used for centers’ administrative costs or staff time. The proposed grants are expected to lead to enhancements to the safety net and its ability to serve the Orange County Medi-Cal population. In addition, terms of the funding agreements will require a detailed scope of services and prior approval of all contracts and subcontractors utilized for the specialized technical assistance.

CalOptima is committed to working with community health centers to explore additional opportunities to support the safety net during this period of rapid change and increased demand in the healthcare sector, and will return to the Board with recommendations at a future meeting.

Fiscal Impact

The recommended action is consistent with the Board’s previously approved IGT 2 allocation of \$1.3 million for children’s health or support of the safety net. Expenditure of IGT funds is for restricted, one-time purposes, and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

FQHCs are vital to Orange County’s safety net; the proposed support for new and prospective FQHCs has the potential to enhance access to comprehensive health services for current CalOptima Medi-Cal members.

CalOptima Board Action Agenda Referral
Approve Grant Awards to Designated Organizations in
Support of New and Prospective FQHCs
Page 3

Concurrence

Gary Crockett, Chief Counsel

Attachments

Benefits of FQHC Status

/s/ Michael Schrader
Authorized Signature

9/26/2014
Date

Benefits of Federally Qualified Health Center (FQHC) Designation

- Section 330 grant funds to offset the costs of uncompensated care and other key enabling services (Health Center Program grantees receive these grant funds. Look-alikes are eligible to compete for them.)
- Access to medical malpractice coverage under Federal Tort Claims Act (FTCA) (Look-alikes are not eligible for this benefit.)
- Prospective Payment System reimbursement for services to Medicaid patients
- Cost-based reimbursement for services to Medicare patients
- PHS Drug Pricing Discounts for pharmaceutical products under the 340B Program
Federal loan guarantees for capital improvements (Look-alikes are not eligible for this benefit.)
- Access to on-site eligibility workers to provide Medicaid and Child Health Insurance Program (CHIP) enrollment services
- Reimbursement by Medicare for “first dollar” of services because deductible is waived if FQHC is providing services
- Access to Vaccines for Children Program for uninsured children
- The National Health Service Corps (NHSC) can help health centers, look-alikes, and free clinics recruit and retain qualified providers who care about communities in need and choose to work where they are needed most.

Source: U.S. Department of Health and Human Services, Health Resources and Services Administration. *Primary Care: The Health Center Program: Program Benefits*. Downloaded from <http://bphc.hrsa.gov/about/benefits/>.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 4, 2014 **Regular Meeting of the CalOptima Board of Directors**

Report Item

VII. C. Authorize Grant Awards in Support of Prospective Federally Qualified Health Centers (FQHCs) and Funding for Expert Consultation to Manage and Ensure Satisfactory Progress on Clinic Grants

Contact

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

Recommended Actions

1. Authorize grant awards in the aggregate amount of up to \$200,000 to eligible community health centers for Phase 2 of the Safety Net Program to support prospective Federally Qualified Health Centers (FQHCs) in Orange County, to be funded with Intergovernmental Transfer (IGT) 2 funds; and
2. Approve \$25,000 for an expert consultant to monitor grant recipients' performance and assess progress toward FQHC designation, to be funded with Intergovernmental Transfer (IGT) 2 funds.

Background

In October 2014, the CalOptima Board of Directors approved grant awards for specified new and prospective community health centers to address clinics' need for specialized technical assistance to attain, or transition to, Federally Qualified Health Center (FQHC) designation. A total of \$200,000 in FY 2012-13 Intergovernmental Transfer (IGT 2) funds was approved for eight (8) centers for Phase I of this initiative.

For Phase 2 of CalOptima's safety net support initiative, staff proposes grant awards for clinics that are interested in applying for FQHC designation, but were not ready for the 2014 cycle and would benefit from funding support to assist with costs related to feasibility analysis; FQHC application development; and/or capital improvements to meet more stringent federal requirements (such as implementation of an electronic health record system or improvements to clinics' waiting rooms).

FQHCs are vital to Orange County's safety net because they provide comprehensive healthcare for low-income residents, including a significant number of current and future CalOptima members. There are currently 10 FQHCs in the county, and collectively they operate 26 sites. To qualify for FQHC designation, clinics must be located in or serve a community that has been designated a Medically Underserved Area or Population by the federal government; be governed by a community board; provide comprehensive primary health care; and provide services to all, with fees adjusted based on ability to pay.

Prospective FQHCs must submit a successful application to HRSA's Bureau of Primary Health Care. There is typically no more than one application cycle per year. During the rigorous federal application process, prospective FQHCs often need specialized technical assistance to prepare the required application, and to conduct thorough financial analysis and planning to avoid adverse fiscal

impact during the implementation period. Centers also need infrastructure support, such as information technology consultation and capital support, to meet more stringent federal guidelines.

Discussion

Based on discussions with the Coalition of Orange County Community Health Centers, it is understood that at least three (3) Orange County health centers are interested in pursuing FQHC designation. Hence, for Phase 2 of CalOptima's safety net support initiative, staff recommends grant awards for up to four (4) community health centers for an individual allocation not to exceed \$50,000 per organization, and a total aggregate amount not to exceed \$200,000.

At this time, Sierra Health Center, Korean Community Services and Laguna Beach Clinic would be eligible for Phase 2 support. The final selection of health centers would be based upon a staff assessment of readiness and a commitment by the health center to undertake the necessary process for the grant award. However, community health centers currently included in Phase 1 would not be eligible for Phase 2 support.

The proposed grants are to be used to assist prospective FQHCs with consulting costs, such as for feasibility assessment and financial analysis, work plan development, and formulation of HRSA application, or for infrastructure or capital improvements that may be needed for readiness to submit a HRSA application. Funds shall not be used for general operating support. A key early deliverable for these grants will be a clinic self-assessment and written plan for moving toward FQHC designation. The proposed grants are expected to lead to enhancements to the safety net and its ability to serve the Orange County Medi-Cal population.

Staff also recommends that an additional \$25,000 of IGT 2 funds be set aside for a consultant with expertise in FQHCs to assist CalOptima in monitoring grant recipients' performance toward grant objectives; assessing grantees' progress toward attainment of FQHC designation; and making recommendations for any needed future support to prospective FQHCs. Qualified consultants are currently conducting the work required for Phase I of the Safety Net FQHC support and staff would procure needed services from one or more of the current vendors consistent with CalOptima procurement policy.

In approving the staff recommendations, the Board would be making a finding that the proposed expenditures are in the public interest and consistent with CalOptima's statutory purpose.

Fiscal Impact

The recommended action is consistent with the Board's previously approved IGT 2 allocation of \$1.3 million for children's health or support of the safety net. Expenditure of IGT funds is for restricted, one-time purposes, and does not commit CalOptima to future budget allocations or expenditures.

Rationale for Recommendation

FQHCs are vital to Orange County's safety net; the proposed support for prospective FQHCs has the potential to enhance access to comprehensive health services for current CalOptima Medi-Cal members.

Concurrence

Gary Crockett, Chief Counsel

Attachments

None

/s/ Michael Schrader
Authorized Signature

11/26/2014
Date

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 4, 2014 **Regular Meeting of the CalOptima Board of Directors**

Report Item

VII. F. Authorize Expenditure of Intergovernmental Transfer (IGT) Funds for Post Acute Inpatient Hospital Recuperative Care for Members Enrolled in CalOptima Medi-Cal; Authorize Amendments to CalOptima Medi-Cal Hospital Contracts as Required for Implementation

Contact

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

Recommended Actions

1. Authorize expenditures of up to \$500,000 in Fiscal Year (FY) 2011- 12 Intergovernmental Transfer Funds (IGT 2) for the provision of Recuperative Care to homeless members enrolled in CalOptima Medi-Cal after discharge from an acute care hospital facility, subject to required regulator approval(s), if any; and
2. Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to amend Medi-Cal Hospital contracts covering Shared Risk Group, Physician Hospital Consortia, CalOptima Direct and CalOptima Care Network members, to include Recuperative Care services.

Revised
12/4/14

Background

At the November 6, 2014 meeting of the CalOptima Board of Directors, staff presented an overview of a proposed program to provide acute and post-acute medical care for homeless persons who are too ill or frail to recover from a physical illness or injury on the streets but who are not ill enough to be hospitalized. This program is to be funded with IGT 2 revenue.

Recuperative care currently exists in Orange County and received partial funding from the MSI program. With Medi-Cal expansion, many of the MSI members were transitioned to CalOptima and no longer have access to these services.

Proposed services to be included in the Recuperative Care Program include: housing in a motel; nurse-provided medical oversight; case management/social services; food and supplies; warm handoff to safe housing or shelters upon discharge; and communication and follow-up with referring hospitals.

Staff now requests the Board authorize the expenditure of IGT 2 funding for recuperative care services for Medi-Cal members and amending hospital contracts to facilitate referrals to and payment of this program.

Discussion

Staff requests authority by the Board of Directors to allocate up to \$500,000 of IGT 2 funds to a Recuperative Care services funding pool. Funding is a continuation of IGT 1 initiatives intended to reduce hospital readmissions and reduce inappropriate emergency room use by CalOptima members experiencing homelessness.

CalOptima staff proposes to amend existing hospital contracts to allow reimbursement for hospital discharges for recuperative care services for Medi-Cal homeless members that qualify for such service. Hospitals will be required to contract and refer homeless members who can benefit from this service to a Recuperative Care provider of the hospital's choice. The hospital will facilitate the transfer of the members to the appropriate Recuperative Care provider. The referring hospital will pay the Recuperative Care provider for services rendered based on need to facilitate a safe hospital discharge as determined by the hospital and the provider.

Contracted hospitals will be required to invoice CalOptima for services rendered, CalOptima will, in turn, reimburse contracted hospitals from the Recuperative Care fund pool for services rendered. Reimbursement by CalOptima to hospitals for Recuperative Care services will stop when the \$500,000 recuperative services pool has been depleted. Staff will provide oversight of the program and will implement a process to track the utilization of funds.

Fiscal Impact

A total of up to \$500,000 in IGT 2 funds are proposed for this initiative. Based on an estimate of \$150 per day for recuperative for up to a 10 day stay per member, this funding is expected to fund approximately 330 cases. The proposed funding level is a cap. If exhausted prior to the end of FY 2014-15, no additional funding for recuperative care will be available without further Board approval. Should the proposed IGT 2 funds not be exhausted on services provided during FY 2014-15, the remaining funds will be carried over to the following fiscal year.

The recommended actions are consistent with the Board's previously identified funding priorities for use of IGT 2 funds. Expenditure of IGT funds is for restricted, one-time purposes, and does not commit CalOptima to future budget allocations

Rationale for Recommendation

With Medi-Cal expansion, CalOptima is serving more members who are homeless. These members experience twice as many readmissions and twice as many inpatient days when discharged to the street rather than to respite or recuperative care. In addition, homeless members remain in acute care hospitals longer rather than being discharged due to a lack of residential beds.

Evaluation by the U.S. Department of Health and Human Services Agency for Healthcare Research and Quality of an existing program administered by the Illumination Foundation, showed: decreased emergency room use; reduced inpatient stays; and stable medical condition for homeless members post discharge. These results are consistent with the IGT 2, as a continuation of IGT 1 funding initiatives, to reduce readmissions to hospitals.

Concurrence

Gary Crockett, Chief Counsel

CalOptima Board Action Agenda Referral
Authorize Expenditure of IGT Funds for Post Acute
Inpatient Hospital Recuperative Care for Members Enrolled in
CalOptima Medi-Cal; Authorize Amendments to CalOptima
Medi-Cal Hospital Contracts as Required for Implementation
Page 3

Attachments

None

/s/ Michael Schrader
Authorized Signature

11/26/2014
Date

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Consent Calendar

VII. G. Authorize Reallocation of OneCare Personal Care Coordinator (PCC) Funding to Cover the Cost of the Program

Contact

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

Recommended Action

Authorize the reallocation of OneCare PCC funds from Year 2 to Year 1 in order to compensate delegated OneCare Physician Medical Groups (PMGs) for the month of March 2015.

Background

At its March 6, 2014, meeting, the CalOptima Board of Directors (Board) approved the final expenditure plan for \$12.4 million in Fiscal Year (FY) 2010-11 Intergovernmental Transfer (IGT) funds. The expenditure plan included an initiative, Complex Case Management – Part 1, to provide case management for high-risk members across various care setting. As part of this initiative CalOptima and PMGs would hire PCCs for up to two (2) years. Within the PMG, PCCs would serve as a single point of contact for OneCare members and assist members in navigating the healthcare delivery system, facilitating access to care and services.

On April 3, 2014, the Board authorized the CEO, with the assistance of legal counsel, to execute OneCare PMG contract amendments to provide funding to PMGs to hire and retain PCCs. The Board authorized the expenditure of FY 2010-11 IGT funds over a two-year period, with a total of up to \$1.85 million expended in Year 1, and up to \$1.95 million expended in Year 2 as authorized by the Board in March 2014.

Discussion

The Board authorized \$1.85 million to fund PCCs in Year 1. However, due to a higher than expected retention of membership in OneCare, the funding allocation was depleted when the February 2015 PCC capitation payment was made to contracted OneCare PMGs.

Management requests that the Board approve a budget reallocation of approximately \$200,000 from the \$1.95 million budget allocation in Year 2 to make the March 2015 PCC capitation payment. Staff estimates that the remaining funding for the PCC program in Year 2, which was authorized through March 31, 2016, will be sufficient since OneCare members will transition to OneCare Connect in December 2015.

Fiscal Impact

The recommended action will reallocate \$200,000 in FY 2010-11 IGT funds from Year 2 to Year 1, and is consistent with the expenditure plan previously approved by the Board on March 6, 2014. Expenditure of IGT funds is for restricted, one-time purposes, and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

CalOptima staff recommends this action in support the OneCare PCC program, which is an integral component of the enhanced Model of Care that has been developed for the OneCare Program and expands our ability to apply best practices in care coordination for CalOptima's Medicare members.

Concurrence

Gary Crockett, Chief Counsel

Attachments

None

/s/ Michael Schrader
Authorized Signature

3/27/2015
Date

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Consent Calendar

VII. H. Approve the Allocation of Intergovernmental Transfer (IGT) Funds for Personal Care Coordinators (PCC) for the OneCare Connect (OCC) Program Including for OCC Members in the CalOptima Community Network

Contact

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

Recommended Actions

1. Approve \$3.6 million in Fiscal Year (FY) 2010-11 IGT funds for Complex Case Management for PCCs in the OneCare Connect Program, including for OCC members in the CalOptima Community Network:
 - a. Allocate \$1.15 million from ‘PCC supplemental’;
 - b. Allocate \$500,000 from ‘General Contingency’; and
 - c. Reallocate \$1.95 million from “Strategies to Reduce Readmissions.”
2. Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to execute OneCare Connect Health Network contracts that include funding to hire, train and retain PCCs for the period of July 1, 2015, through June 30, 2016.
3. Authorize CalOptima staff to hire, train and retain PCCs to support OneCare Connect members in the CalOptima Community Network during the July 1, 2015 through June 30, 2016 period.

Background

In actions taken at the January 3, 2013, February 7, 2013, and December 5, 2013, meetings, the CalOptima Board of Directors (Board) authorized the CEO to develop a provider delivery system for implementation of the Duals Demonstration, also now known in the state as the Cal MediConnect Program and branded by CalOptima as OneCare Connect.

At its March 6, 2014, meeting, the Board authorized the expenditure of IGT funds to support the hiring of PCCs by both CalOptima and Physician Medical Groups (PMGs) for up to two (2) years to provide services to OneCare members. Within the PMG, PCCs would serve as a single point of contact for OneCare members and help members navigate the healthcare delivery system, facilitating access to care and services.

Subsequently, at the April 3, 2014, meeting, the Board authorized the CEO, with the assistance of legal counsel, to execute amendments to OneCare PMG contracts to include funding for hiring, training, and retention of PCCs. The Board approved funding for the PCCs at a rate of \$14.53 per member per month (PMPM). PCC payments rates are further adjusted according to performance metrics established by CalOptima and described in a CalOptima PCC Policy and Procedure.

Discussion

The Board has authorized the use of up to \$3.8 million in FY 2010-11 IGT funds over a two-year period to hire PCCs to support the execution of the OneCare Model of Care by delegated PMGs. The creation of the position proved to be an integral part of the remediation of the OneCare audit findings. CMS found CalOptima's PCC Program to be a best practice among Medicare Advantage plans. The PCC program launch has exceeded expectations, and is an integral feature of the approved Model of Care for OneCare Connect, and is no longer an optional component.

Management recommends the Board to approve this action to effectuate the implementation of the successful PCC program for the Cal MediConnect Program, which CalOptima has branded as OneCare Connect. CalOptima would require OneCare Connect contracted Health Networks to hire and retain PCCs. The OneCare Connect contracts will stipulate the conditions for the funding of the PCC positions and will provide the parameters and expectations of the PCC program. Management is requesting \$3.6 million in total FY 2010-11 IGT funds for PCCs for OneCare Connect Program from the following:

- Allocate \$1.15 million from 'PCC supplemental';
- Allocate \$500,000 from 'General Contingency'; and
- Reallocate \$1.95 million from "Strategies to Reduce Readmissions."

Management requests funding the program with IGT funds for FY 2015-16, with additional funding subject to future Board approval and IGT fund availability. Funds will be used for the creation of the PCC position by the delegated health networks and the CalOptima Community Network in order to execute the OneCare Model of Care for OneCare Connect and provide ongoing funding of the PCC positions for the next year of the OneCare Connect program. After this time, CalOptima will evaluate if these positions will be self-funding following the first year based upon improved clinical outcomes and lower utilization costs. In addition, the PCCs will support preventive and chronic disease services that results in improvement in HEDIS scores and an anticipated improvement in OneCare Connect's quality rating. Finally, PCCs will improve data capture that support appropriate Hierarchical Condition Category (HCC) scores for OneCare Connect.

The PCC positions hired by CalOptima to serve OneCare Connect members in the CalOptima Community Network will be funded in the same manner as CalOptima's delegated Health Networks.

Fiscal Impact

The recommended action will result in the expenditure of IGT funds in FY 2015-16 of \$3.6 million in FY 2010-11 IGT funds. Expenditure of IGT funds is for restricted, one-time purposes and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

CalOptima staff recommends this action in support of the expenditure of IGT funds as approved at the March 2014 Board Meeting. In addition, the PCCs are an integral component of the enhanced Model of Care that has been a successful program in OneCare and will an important component of the OneCare Connect Program that will expand CalOptima's ability to apply best practices in care coordination for CalOptima's members eligible for Medi-Cal and Medicare.

CalOptima Board Action Agenda Referral
Approve the Allocation of IGT Funds for PCC for the
OCC Program Including for OCC Members in the
CalOptima Community Network
Page 3

Concurrence

Gary Crockett, Chief Counsel

Attachments

None

/s/ Michael Schrader
Authorized Signature

3/27/2015
Date

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 7, 2015 **Regular Meeting of the CalOptima Board of Directors**

Report Item

- VIII. B. Authorize Agreements Necessary to Secure Additional Medi-Cal Funds Through an Intergovernmental Transfer (IGT) for Fiscal Year (FY) 2013-14 (IGT 4); Consider Approval of a Modification of Eligible Use for IGT 2 Funds Allocated to Support Federally Qualified Health Centers (FQHCs)

Contact

Lindsey Angelats, Director of Strategic Development, (714) 246-8400

Recommended Actions

1. Authorize and direct the Board Chair to execute an amendment to the primary agreements among the California Department of Health Care Services (DHCS), the Regents of the University of California on behalf of the University of California, Irvine, and CalOptima for the purpose of securing an IGT for the upcoming Rate Year 2013-14 IGT (IGT 4); and
2. Approve modification in eligible uses for IGT 2 funds designated to support Federally Qualified Health Centers in Orange County.

Background

CalOptima began participating in the rate range IGT program for its rate year that began July 1, 2010. This IGT arrangement involves an approved government entity (“funding entity”) providing non-federal funds to serve as a match to allow the State to draw down the difference between the highest and lowest actuarially approved Medi-Cal reimbursement rate from the Center for Medicare and Medicaid Services (CMS). Management’s understanding is that rate range IGTs are currently in place in all managed care counties in California. Eligible funding entities include but are not limited to county governments, district hospitals, and UC hospitals. Funds are potentially non-recurring, since there is no guarantee of future IGT agreements. Thus, these funds are best suited for one-time investments or as seed capital for new services or initiatives, which enhance care to Medi-Cal members.

CalOptima has partnered with the Regents of the University of California on behalf of UCI to secure three IGTs to date, and staff has started the process for a fourth proposed IGT for Rate Year 2013-14. This IGT arrangement involves UCI providing the non-federal funds for the rate increase to CalOptima and the administrative fee charged by DHCS. A high-level progress update for each of these IGTs is attached.

The CalOptima Board approves all proposed uses and authorizes the plan to participate in each available IGT. Per the State’s agreement with the Centers for Medicare and Medi-Cal (CMS), funds must finance improvements in services for Medi-Cal members. The approved uses are intended to generate a positive impact on members, CalOptima and its delegated networks, while also providing a sustainable return on investment for the future.

Presently, staff recommends one action related to the proposed IGT 4 transaction and one modification to a program funded by IGT 2 revenue. Approval of these recommendations is requested in order to implement programmatic priorities.

IGT	Rate Year	IGT Funds Received by CalOptima (\$)
IGT 1	2010-2011	12.4M
IGT 2	2011-2012	8.7M
IGT 3	2012-2013	4.8M
IGT 4	2013-2014	5.5M (projected)

Discussion

IGT 4 Application

On April 24, 2015, CalOptima and UCI submitted a proposal to DHCS for a fourth IGT. If approved, the proposed IGT will result in revenue of approximately \$5.5 million each to UCI and CalOptima. Our understanding is that DHCS anticipates disbursement of an IGT payment to CalOptima in or about September 2015. At this time, staff requests authorization to amend the primary agreement between the DHCS and CalOptima for purposes of accepting an increased rate that includes IGT 4 funding. Additionally, consistent with the proposal to DHCS submitted in April 2015, staff recommends two general categories of use for IGT 4 revenue as follows:

1. Community health investments to improve adult mental health, children’s mental health, reduce childhood obesity, strengthen the safety net, and improve children’s health, consistent with the Board’s March 2015 approval of these five priority areas;
2. Planning and implementing innovative programs required under the Health Homes and the 1115 Waiver initiatives. This would be one-time funding allocation for planning and to implement pilot programs as required.

Staff will develop a budget allocation for the proposed categories to be presented at a future Board meeting after the transaction has received federal approval and funds have been received from the State. Staff will continue to gather information on whether there may be additional acceptable funding entities in Orange County with the capacity to partner to participate in future rate range transfer processes. The intent is to allow CalOptima to draw down maximum available rate range eligible funding to support Medi-Cal enrollees. For example, in the most recently proposed IGT 4, the State indicated that funding entities in Orange County could provide up to \$28M as the non-federal source; UCI Health was able to provide \$13.7M tied to uncompensated care rendered by UCI Physicians to CalOptima members. After factoring in the available federal match and required state fees, it is possible that CalOptima could have accessed an additional \$11M in net revenue to support Medi-Cal members for this rate year.

Potential IGT 4 Funding Needs/Priorities

Health Homes

The Medicaid Health Home State Plan Option, under the Affordable Care Act (Section 2703), enables states to design health homes to provide comprehensive care coordination for Medicaid beneficiaries

with chronic conditions, including homelessness and/or mental illness. California's Health Homes Program is intended to serve eligible Medi-Cal beneficiaries with multiple chronic conditions who are frequent utilizers and may benefit from enhanced care management and coordination. On April 20th, 2015, the DHCS indicated its intent to require participation from all counties effective 2016, with the benefit implemented through the managed care organizations who will then contract with community organizations. Staff is monitoring the development of final program regulations and will provide details on specific projects in the future as additional information becomes available.

1115 Waiver

California's existing Bridge to Reform 1115 Waiver expires on October 31, 2015. DHCS will seek approval of the new Waiver by November 2015 from CMS. At this time, the State's Waiver application proposes key delivery system transformations, including but not limited to changes for counties with public hospitals, regional incentives among managed care organizations, providers and counties behavioral health systems, workforce development initiatives, access to housing and supportive services, and whole person care pilots to improve and integrate physical and behavioral health. Staff will continue to monitor the development of final program regulations and will keep the Board apprised as new information becomes available.

As additional details become available, staff will return to the Board as appropriate with recommendations on the possible use of one-time IGT funded to launch potential early implementation projects to prepare for these critical programmatic changes.

Approve modification of IGT 2 funds designated to support Federally Qualified Health Centers (FQHC)

The Board approved \$200,000 in funding in the *Strengthening the Safety Net* priority area at its October 2014 meeting. Specifically, the funding was designated to support engagements with qualified consultants/vendors to partner with up to eight named Orange County community clinics to support their conversion to FQHC status from FQHC "look-alike" status. To date, staff have received formal submissions from seven eligible clinics, with an additional application in progress. The ultimate goal was to contribute to a robust and sustainable system of care for vulnerable CalOptima members who access care at community clinics. Receipt of FQHC status will allow clinics to receive critical and stabilizing federal funds. A second cycle of funding (FQHC Phase 2) was designated for clinics in earlier stages of readiness to apply. The status of IGT-funded Safety Net projects is listed in the attachment.

At this time, staff recommends broadening eligible expenses to include permitting funding for one-time costs associated with merging with an existing FQHC or consulting costs associated with adding a critical new service that will facilitate greater access to care and a more robust reimbursement rate.

No funds will be used to support staff costs or recurring expenses. Currently, funds are designated for consulting services only. Specifically, staff has learned that one area clinic has elected to merge with an existing FQHC to achieve its sustainability goals. Effective May 2015, L'Amistad Health Center will be part of St. Jude Neighborhood Centers, which was not named as one of the eight clinics in the original Board approval. What is being proposed is a modification to enable St. Jude's to receive

support in lieu of L'Amistad. This funding will address the project management expense associated with bringing L'Amistad on to St. Jude Neighborhood Center existing electronic health record at a cost of \$12,000, an expense within the maximum amount allowable for each clinic under the grant program. This modification is recommended as the expense is consistent with the Board's intent of accelerating sustainability and access. Likewise, a modification is recommended to enable clinics to allocate eligible consulting hours to prepare for a scope of service request in conjunction with preparation for new access point submission. This proposed change will provide an avenue for greater access to critical services such as dental or behavioral health in underserved communities.

Fiscal Impact

Fiscal Year (FY) 2013-14 IGT (IGT 4)

The recommended action to execute the FY 2013-14 IGT will provide approximately \$5.5 million in one-time IGT revenue. Management will present an expenditure plan for Board approval at an upcoming meeting.

FY 2011-12 IGT (IGT 2)

The recommended action to permit St. Jude's to act as an eligible recipient under the Phase 1 FQHC program is budget neutral, as St. Jude's Neighborhood Clinic will replace L'Amistad as one of the eight eligible grantees. Expenditure of IGT funds is for restricted, one-time purposes, and does not commit CalOptima to future budget allocations.

Rationale for Recommendations

Proposed funding categories for IGT 4 would allow for continued support of key organizational priorities and programs. Modification to IGT 2 is proposed to ensure broad participation from area community clinics in the FQHC grant cycle.

Concurrence

Gary Crockett, Chief Counsel

Attachments

Presentation: IGT Progress Report

Authorized Signature

Date



CalOptima
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Intergovernmental Transfers (IGT): Progress

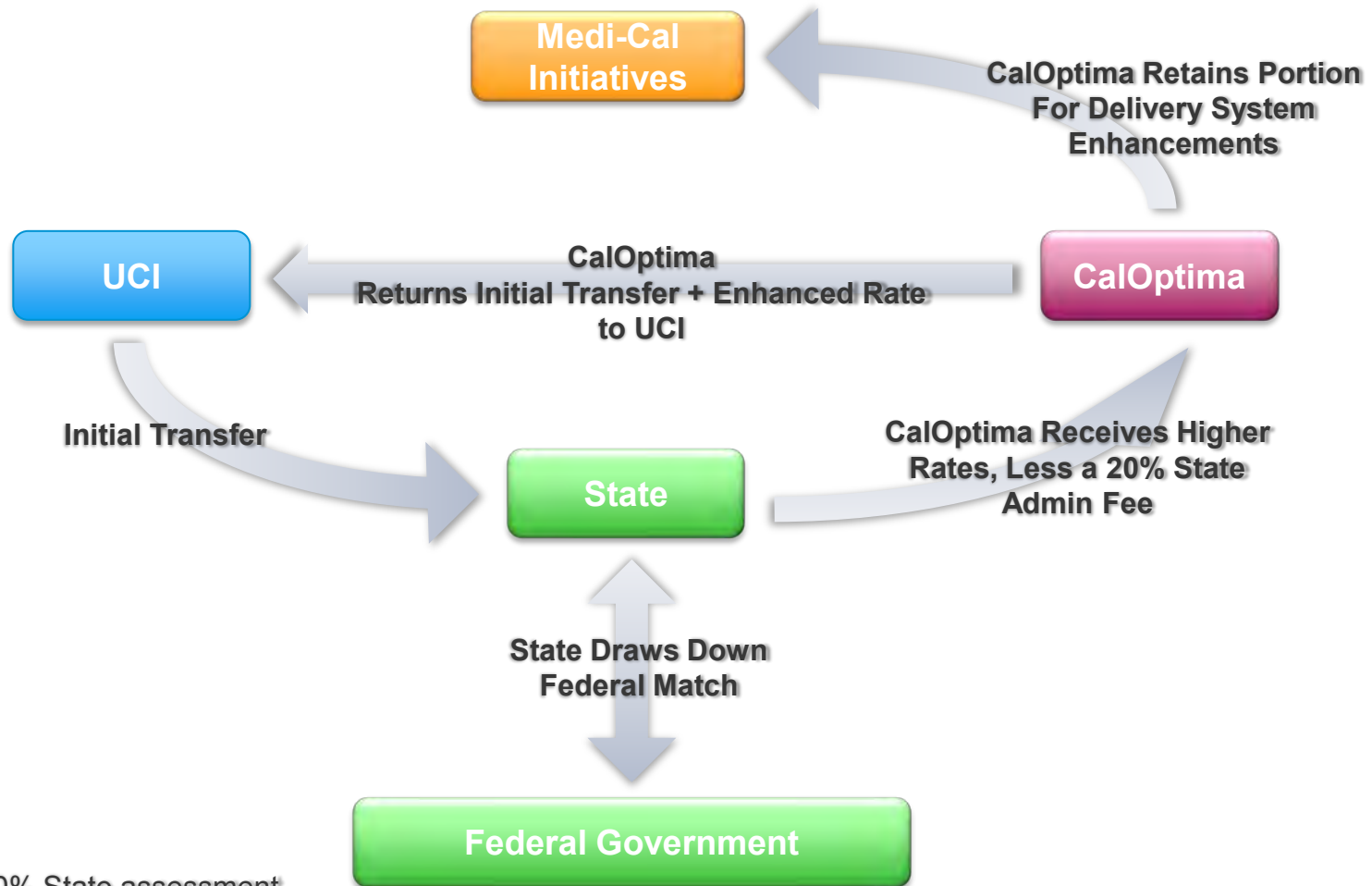
Board of Directors Meeting

May 7, 2015

Lindsey Angelats

Director, Strategic Development

Overview of CalOptima/UC Irvine IGT



* Includes 20% State assessment fee

IGTs Purpose and Restrictions

- Revenue generated through IGTs must be used to finance enhancements in services for Medi-Cal members
 - Support enhanced Medi-Cal program
 - Enable CalOptima to pay providers designated by the funding entity (UCI is currently the only funding entity used)
- Funds are potentially non-recurring, since there is no guarantee of future IGT agreements; funds are suited for one-time investments or as seed capital for new initiatives for members
- CalOptima is only plan allowed to retain funds. This process is consistent with state and federal rules and was approved by DHCS and CMS.

IGTs Completed and In Progress

All IGTs	Fiscal Year Received	CalOptima Amount
IGT 1	12-13	\$12.4 M
IGT 2	13-14	\$8.7 M
IGT 3	14-15	\$4.8 M
IGT 4	15-16*	(Est. \$5.5 M)*
Total Funds Received		\$25.9 M

* Transaction has received state and federal approval but funds have not been received yet.

IGT Presentation Timeline

	May	June	July	Aug	Sept	Oct
Board		IGT 3 Budgeting; IGT 1-2 Progress Report				IGT 3 Budgeting; IGT 1-3 Progress Report
QAC	IGT 3 Budgeting				IGT 4 Budgeting	
FAC	IGT 3 Budgeting				IGT 4 Budgeting	

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 1, 2015 Regular Meeting of the CalOptima Board of Directors

Report Item

VIII. D. Consider Updated Revenue Expenditure Plans for Intergovernmental Transfer (IGT) 2 and IGT 3 Projects

Contact

Lindsey Angelats, Director of Strategic Development, (714) 246-8400

Recommended Actions

1. Approve updated expenditure plan for IGT 2 projects, including investments in personal care coordinators (PCC), grants to Federally Qualified Health Centers (FQHC), and autism screenings for children, and authorize expenditure of \$3,875,000 in IGT 2 funds to support this purpose; and
2. Approve expenditure plan for IGT 3 projects, including investments in recuperative care and provider incentive programs, and authorize expenditure of \$4,880,000 in IGT 3 funds to support this purpose.

Background / Discussion

To date, CalOptima has partnered with the University of California, Irvine (UCI) Medical Center on a total of four IGTs. These IGTs generate funds for special projects that benefit CalOptima members. A progress report detailing the use of funds is attached. Three IGTs have been successfully completed, securing \$26.0 million in project funds, and a fourth IGT is pending, which is estimated to secure an additional \$5.5 million in project funds. Collectively, the four IGTs represent \$31.5 million in available funding. A breakdown of the total amount of IGT funds is listed below:

All IGTs	Total Amount
IGT 1	\$12.4 million
IGT 2	\$8.7 million
IGT 3	\$4.9 million
IGT 4	\$5.5 million*
Total	\$31.5 million

*The IGT 4 funds figure is an estimate. These funds have not yet been received by CalOptima.

As part of this proposed action, staff is requesting Board approval of the updated expenditure plan for IGT 2, as well as the expenditure plan for IGT 3. The allocation of these funds will be in accordance with the Board's previously approved funding categories for both IGT 2 and IGT 3, and will support staff-identified projects, as specified.

IGT 2 Updated Expenditure Plan

At its September 4, 2014, meeting, the Board approved the final expenditure plan for IGT 2. Since that time, staff has been able to identify further detailed projects to implement the Board approved allocations. Staff recommends the use of \$3,875,000 in IGT 2 funds to support the following projects:

- \$2,400,000 previously approved for the ‘Expansion of IGT 1 Initiatives’ will be used to sustain the use of PCCs in the OneCare Connect program in FY 2016-17. Current funding for PCCs expires at the end of the 2015-16 fiscal year. This proposed action will extend funding for PCCs for one additional year and allow CalOptima and the health networks to better evaluate the long-term sustainability of PCCs for members.
- \$100,000 previously approved for the ‘Expansion of IGT 1 Initiatives’ will provide IGT project administration and oversight through a full-time staff person and/or consultant for FY 2015-16.
- \$875,000 previously approved for ‘Children’s Health/Safety Net Services’ will be used for grant funding for the expansion of behavioral health and dental services at FQHCs and FQHC look-alikes. Grant funding will be awarded to up to five eligible organizations for a two-year period in order to launch the new services.
- \$500,000 previously approved for ‘Wraparound Services’ will be used to support a provider incentive program for autism screenings for children. It is estimated that up to 3,600 screenings could be covered with this funding, in addition to costs of training for providers to deliver the screenings.
- Staff also request a modification to the Board’s December 4, 2014 action, which allocated grant funding in support of community health centers. Specifically, staff requests an increase in the maximum threshold for clinic grants from \$50,000 up to \$100,000. No new funds will be utilized for this change, but this change will allow two existing grantees (Korean Community Services and Livingstone) to double their grant award amounts from \$50,000 to \$100,000. Staff recommends this modification to address the fact that while the previously approved IGT 2 expenditure plan allowed up to four clinics to receive grants, only the two aforementioned organizations formally submitted grant proposals. If the proposed increase is approved, the additional funds will be used for consulting services to finalize the clinics’ FQHC Look-Alike applications as well as upgrades to their IT systems to meet FQHC requirements.

IGT 3 Expenditure Plan

For the \$4,865,000 funds remaining under IGT 3, staff proposes to support ongoing projects as follows:

- \$4,200,000 to support a pay-for-performance program for physicians serving vulnerable Medi-Cal members, including seniors and person with disabilities (SPD). The program will offer incentives for primary care providers to participate in interdisciplinary care teams and complete an individualized care plan for SPD members, in accordance with CalOptima’s Model of Care.

\$500,000 to continue funding and broaden recuperative care for homeless Medi-Cal members. This proposed action would provide an additional investment in recuperative care in addition to the Board’s previously approved funding. In addition, going forward, hospitals would be eligible to receive reimbursement for recuperative care for homeless patients following an emergency department visitor observation stay; currently, reimbursement is limited to services following an inpatient stay only. As proposed, the maximum duration for recuperative care will increase from 10 days up to 15 days to more effectively link patients to needed services.

These recuperative care services would be made available subject to required regulator approval(s), if any.

- \$165,000 to provide IGT project administration and oversight through a full-time Manager, Strategic Development for FY 2016-17. The manager will project manage IGT-funded projects, complete regular progress reports, and submit required documents to DHCS.

Staff is not proposing use of IGT 4 funds at this time, but will return to the Board at a later date for approval of an expenditure plan after funds have been received from the state.

Finally, the requests outlined above have been thoroughly vetted by the CalOptima Member Advisory Committee (MAC) and Provider Advisory Committee (PAC) during their respective meetings on September 10, 2015.

Fiscal Impact

The recommended action implement an updated expenditure plan for the FY 2011-12 IGT is budget neutral. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima members, and does not commit CalOptima to future expenditures.

The recommended action to approve the expenditure plan of \$4,865,000 from the FY 2012-13 IGT is consistent with the general use categories previously approved by the Board on August 7, 2014.

Rationale for Recommendation

Staff recommends approval of the proposed expenditure plans for IGT 2 and IGT 3 in order to continue critical funding support of projects that benefit CalOptima Medi-Cal members by addressing unmet needs. Approval will help ensure the success of ongoing and future IGT projects.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. IGT Expenditure Plan (PowerPoint presentation)
2. IGT Progress Report

/s/ Michael Schrader
Authorized Signature

9/25/2015
Date



CalOptima
Better. Together.

IGT Progress Report and Proposal

Board of Directors Meeting
October 1, 2015

Lindsey Angelats
Dir, Strategic Development

IGTs Completed and In Progress

All IGTs	Fiscal Year Received	CalOptima Amount	% Amount Programmed
IGT 1	12-13	\$12.4 M	100%
IGT 2	13-14	\$8.7 M	55%
IGT 3	14-15	\$4.8 M	0%
IGT 4	15-16*	(Est. \$5.5 M)*	NA
Total Funds Received or Anticipated		\$31.4 M	

* Transaction has received state and federal approval but funds have not yet been received

Considerations for IGT Outstanding Funds

- **New or pending State and Federal initiatives increasingly focused on integration and coordination**
 - 1115 Waiver and Whole Person Care
 - Behavioral Health Integration
 - Health Homes
 - Capitation Pilot for Federally Qualified Health Centers

- **Value in supporting providers serving more vulnerable members with greater needs: *(examples)***
 - Investment in ICTs for providers serving Seniors and Persons with Disabilities
 - Continuation/expansion of Personal Care Coordinators

IGT Investment Parameters and Requirements

Time
Limited/
Sustainable

Evidence-
Informed

Measureable
Impact (e.g.
Access,
Quality,
Cost)

- IGTs must be used to finance enhancements in services for Medi-Cal beneficiaries
- Projects must be one-time investments or as seed capital for new services or initiative, since there is no guarantee of future IGT agreements

Recommended Use of IGT 2 Funds (\$3.875M Outstanding)

Category	Board Approval Date of Category	Proposed Project	Proposed Investment	Regulatory Driver	Anticipated Impact
Continuation of IGT 1 Initiatives	03/06/14	Sustain Personal Care Coordinators (PCCs) for the One Care Connect program in FY16-17	\$2.4M	Coordinated Care Initiative	Providers and members receive timely support
Children's Health/Safety Net Services	10/02/14; 12/04/14	Supporting behavioral health and dental service expansion at FQHC and FQHC look-a-likes via one-time competitive grants	\$875K	Alternative Payment Pilot	FQHCs launch critical services that can be sustained through higher PPS rates
Wraparound Services	8/7/14	Provider incentive for Autism Screening and provider training to promote access to care	\$500K	Autism Benefits in Managed Care	Earlier identification and treatment for the 1 in 68 children with autism
Continuation of IGT 1 Initiatives	03/06/14	Full-time IGT project administrator/ benefits (pro-rated for 11/1/15 start; represents 23% admin costs)	\$100K	Intergovernmental Transfers	Faster launch of IGT funded projects to support members and physicians

Recommended Use of IGT 3 Funds (\$4.88M Outstanding)

Regulatory Driver	CalOptima Priority Area	Proposed Project	Proposed Investment	Anticipated Impact
1115 Waiver	Adult Mental Health	Continue recuperative care to reduce hospital readmissions by providing safe housing, temporary shelter, food and supplies to homeless individuals	\$500K	Support for improved and integrated care for vulnerable members
Integrated Care	Support Primary Care Access	Support increased funding (pay for performance) for physicians serving vulnerable members, including Seniors and Persons with Disabilities (ICPs + Integrated Health Assessments for new SPDs)	\$4.2M	Support for improved and integrated care for vulnerable members
Intergovernmental Transfers		Full-time IGT project administrator (represents 2% admin costs)	\$165K	Faster launch of IGT funded projects to support members and physicians

Recommended Next Steps

- **Timing**

- November: Development of project plans and launch

- **Accountability**

- Staff provide quarterly Board reports sharing progress and outcomes for current and new projects; Jan 2016

- **Engagement**

- Review IGT 4 with PAC/MAC in October; Staff proposes options focus on improved care for those with serious mental illness and support for providers to screen adolescents for depression

- **Maximization/Leverage**

- In Fall 2015, staff will pursue additional Funding Entity partnerships with eligible organizations (County, Children and Families Commission, others) to draw down additional funds in 2016, based on recommendation from consultant Mr. Stan Rosenstein

**Board of Directors Meeting
October 1, 2015**

Intergovernmental Transfer (IGT) Funds Progress Report

Discussion

To date, CalOptima has participated in four IGT transactions with the University of California, Irvine; at this time, IGT 1 and IGT 2 funds are supporting Board-designated projects to improve care for members. Staff presented the following information on the status IGT-funded projects to the Provider Advisory Committee and Member Advisory Committee on September 10, 2015.

IGT 1 Active Projects					
Description	Objective	Budget	Board Action	Duration	% Complete
New Case Management System	To enhance management and coordination of care for vulnerable members	\$2M	03/06/14	2 years	75%
Personal Care Coordinators for OneCare members	To help OneCare members navigate healthcare services and to facilitate timely access to care	\$3.8M	04/03/14	3 years	50%
OneCare Connect Personal Care Coordinators	To help OneCare Connect members navigate health services and to facilitate timely access to care	\$3.6M	04/02/15	1 year	25%
Strategies to Reduce Readmission	To reduce 30-day all cause (non maternity related) avoidable hospital readmissions	\$1.05 M	03/06/14	2 years	25%
Complex Case Management Consulting	Staffing and data support for case management system	\$350K	03/06/14	2 years	50%
Telemedicine	Expand access to specialty care	\$1.1M	03/07/13	2 years	25%
Program for High Risk Children	CalOptima pediatric obesity and pediatric asthma planning and evaluation	\$500K	03/06/14	3 years	25%

IGT 2 Active Projects					
Description	Objective	Budget	Board Action	Duration	% Complete
Facets System Upgrade & Reconfiguration	Upgrade and reconfigure software system used to manage key aspects of health plan operations, such as claims processing,	\$1.25M	03/06/14	2 years	75%
Continuation of the CalOptima Regional Extension Center	Sustain initiative to assist in the implementation of EHRs for individual and small group local providers	\$1M	04/03/14	3 years	25%
Enhancing the Safety Net	To assist health centers to apply for and prepare for Federally Qualified Health Center (FQHC) designation or expansion	\$200K	10/02/14	2 years	50%
Enhancing the Safety Net	To support an FQHC readiness analysis for community health centers to enhance the Orange County safety net and its ability to serve Medi-Cal beneficiaries	\$225K	12/04/14	2 years	25%
Recuperative Care	To help reduce hospital readmissions by providing safe housing, temporary shelter, food and supplies to homeless individuals	\$500K	12/04/14	1 year	25%
Facets System Upgrade & Reconfiguration	Upgrade and reconfigure software system used to manage key aspects of health plan operations, such as claims processing,	\$1.25M	03/06/14	2 years	75%
School-Based Vision	Increase access to school-based vision, which can be difficult for Medi-Cal beneficiaries to access	\$500K	09/04/14	2 years	25%
School-Based Dental	Increase access to school-based dental, which can be difficult for Medi-Cal beneficiaries to access	\$400K	09/04/14	2 years	25%
Provider Network Management Solution	Enhance CalOptima's core data systems and information technology infrastructure to facilitate improved member care	\$500K	03/06/14	1 year	25%
Security Audit Remediation	To increase protection of CalOptima member data	\$200K	03/06/14	1 year	85%

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 3, 2016 **Regular Meeting of the CalOptima Board of Directors**

Consent Calendar

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

Contact

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

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

Recommended Actions

1. Extend the authorization of expenditures of Fiscal Year (FY) 2010-11 Intergovernmental Transfer (IGT) Funds (IGT 1) for OneCare Personal Care Coordinators (PCC) from April 1, 2016 through December 31, 2016; and
2. Authorize the reallocation of \$50,000 in OneCare Connect PCC funds from IGT 1 to OneCare PCC in order to compensate delegated OneCare health networks for the period of April 1, 2016, through December 31, 2016.

Background

At the March 6, 2014, meeting, CalOptima's Board of Directors approved the final expenditure plan for \$12.4 million for IGT 1. The expenditure plan included an initiative, Complex Case Management – Part 1, to provide case management for high-risk members across various care settings. As part of this initiative, CalOptima and health networks would hire PCCs for up to two years. At the health network level, the PCC serves as a single point of contact for OneCare members and assist members in navigating the healthcare delivery system, facilitating access to care and services.

On April 3, 2014, the Board authorized the CEO, with the assistance of legal counsel, to execute OneCare health network PMG contract amendments to provide funding to health networks to hire and retain PCCs. The Board authorized the expenditure of IGT 1 funds over a two-year period, with a total of up to \$1.85 million expended in Year 1, and up to \$1.95 million expended in Year 2 as authorized by the Board in March 2014. The end date of the two-year authorization is March 31, 2016.

At the April 2, 2015, meeting, the Board authorized reallocation of \$200,000 from the \$1.95 million budget allocation in Year 2 to make the March 2015 OneCare PCC capitation payment.

CalOptima Board Action Agenda Referral
Authorize the Extension of Expenditures of FY 2010-11
IGT Funds for OneCare PCC through December 31, 2016, and
Authorize the Reallocation of OneCare Connect PCC
Funding to Cover the Cost of the OneCare PCC Program through
Calendar Year 2016

Page 2

Discussion

On January 1, 2016, the majority of OneCare members were passively enrolled into the OneCare Connect program. However, not all OneCare members were eligible for this transition, and these members still remain in OneCare. As of January 2016, there were approximately 1,238 active OneCare members. In order to maintain similar practices for OneCare and OneCare Connect, so that OneCare members receive the same quality of care as OneCare Connect members, staff proposes to continue the PCC program for the remaining OneCare members through December 31, 2016.

Staff estimates the monthly expenditures for OneCare PCCs is approximately \$20,000. As of January 31, 2016, \$175,401 remains in IGT 1 funds for the OneCare PCC program. Assuming the same level of funding through the rest of the calendar year, the projected shortfall for the OneCare PCC capitation payments by December 31, 2016, will be approximately \$44,599. To cover this shortfall, Management recommends that the Board approve a budget reallocation of \$50,000 from OneCare Connect PCC funds from IGT 1 to OneCare PCC in order to compensate delegated OneCare health networks for the period of April 1, 2016 through December 31, 2016.

Fiscal Impact

The recommended actions to extend authorization of expenditures for the OneCare PCC program through December 31, 2016 and to reallocate \$50,000 from the OneCare Connect PCC program to the OneCare PCC program is expected to have a neutral fiscal impact to CalOptima. Expenditure of IGT funds is limited to providing enhanced benefits to CalOptima Medi-Cal beneficiaries, and has been restricted to one-time purposes, and does not commit CalOptima to future funding or budget allocations.

Rationale for Recommendation

CalOptima staff recommends this action in support of the OneCare PCC program, which is an integral component of the enhanced Model of Care that has been developed for the OneCare program and expands our ability to apply best practices in care coordination for CalOptima's Medicare members.

Concurrence

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

Attachments

None

/s/ Michael Schrader

Authorized Signature

02/26/2016

Date

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 1, 2018 **Regular Meeting of the CalOptima Board of Directors**

Consent Calendar

7. Consider Approval of CalOptima Policy GG.1656, Quality Improvement and Utilization Management Conflicts of Interest

Contact

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

Recommended Action

Authorize the Chief Executive Officer to approve new Policy GG.1656, Quality Improvement and Utilization Management Conflicts of Interest.

Background

This policy describes CalOptima's requirement that all individuals serving in an appointed, volunteer or employed position in the Quality Improvement (QI) or Utilization Management (UM) departments or otherwise carrying out quality improvement or utilization management oversight activities, including but not limited to serving on QI or UM committees or subcommittees or who otherwise make decisions regarding quality or utilization management oversight or activities, fully disclose any actual, perceived, or potential Conflicts of Interest (s) that arise in the course and scope of serving in such a capacity. The purpose of this policy is to provide guidance regarding the identification, disclosure, and evaluation of conflicts of interest in order to resolve and/or avoid them in a manner consistent with legal and ethical standards, statutes and regulations.

On an annual basis each participant involved in CalOptima QI or UM decisions shall sign a Conflict of Interest Attestation and complete a Conflict of Interest Disclosure Form identifying any activities, interests, relationships, or financial holdings that create or have a potential to create a Conflict of Interest for the participant.

Discussion

This new Conflict of Interest policy was developed in response to a DHCS/CMS contract requirement which states that the CalOptima Quality Improvement Committee is responsible for maintaining a process to ensure rules of confidentiality in quality improvement discussions as well as avoidance of conflict of interest on the part of committee members. CalOptima has a policy to ensure rules of confidentiality are met (GG.1620), and CalOptima has an existing Human Resource policy (GA.8012) that ensures that all designated CalOptima employees in positions listed in the CalOptima Conflict of Interest Code shall complete Form 700 Statement of Economic Interest and the Supplement to Form 700. Designated employees include employees who make decisions which foreseeably may have a substantial economic impact. This policy however is applicable only to CalOptima designated employees and members of the Board of Directors. Therefore, a new policy was created to ensure that the Quality Improvement Committee and its subcommittees, who oversight quality and utilization activities, fully disclose any actual or perceived conflicts of interest. The Quality Improvement

Committee and subcommittee members will annually sign a Conflict of Interest attestation as well as a CalOptima Conflict of Interest Disclosure Form.

Fiscal Impact

There is no fiscal impact for the recommended action to approve the Conflict of Interest Policy.

Concurrence

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

Attachments

CalOptima Policy GG.1656: Quality Improvement and Utilization Management Conflicts of Interest policy with three attachments:

1. Conflict of Interest Attestation (Quality Improvement Committee/Subcommittee(s))
2. Conflict of Interest and Non-Discrimination Attestation (Credentialing and Peer Review Committee)
3. CalOptima Conflict of Interest Disclosure Form

/s/ Michael Schrader
Authorized Signature

2/21/2018
Date

Policy #: GG.1656
Title: **Quality Improvement and Utilization Management Conflicts of Interest**
Department: Medical Affairs
Section: Quality Improvement

CEO Approval: Michael Schrader _____

Effective Date: TBD
Last Review Date: Not Applicable
Last Revised Date: Not Applicable

Applicable to: Medi-Cal
 OneCare
 OneCare Connect
 PACE

1 **I. PURPOSE**

2
3 This policy describes CalOptima’s requirement that all individuals serving in an appointed, volunteer,
4 or employed position in the Quality Improvement (QI) or Utilization Management (UM) Departments
5 or otherwise carrying out quality improvement or utilization management oversight activities,
6 including, but not limited to serving on QI or UM committees or subcommittees or who otherwise
7 make decisions regarding quality or utilization management oversight or activities fully disclose any
8 actual, perceived, or potential Conflicts of Interest(s) that arise in the course and scope of serving in
9 such a capacity. The purpose of this policy is to provide guidance regarding the identification,
10 disclosure, and evaluation of conflicts of interest in order to resolve and/or avoid them in a manner
11 consistent with legal and ethical standards, statues, and regulations.

12
13 **II. POLICY**

- 14
15 A. It is the policy of CalOptima to promote the best interests of its Members. All decisions
16 concerning the safe care, quality of treatment, and services provided to CalOptima’s Members
17 must be made solely with the intent to meet the needs of those Members and without any actual,
18 perceived, or potential conflicts of interest. Under no circumstances may a Participant place his/her
19 own financial interests above the welfare of CalOptima’s Members.
20
21 B. Participants shall conduct their affairs so as to avoid or minimize Conflicts of Interest, and must
22 appropriately disclose when Conflicts of Interest arise.
23
24 C. Participants have a continuing obligation to disclose the existence and nature of any actual,
25 perceived, or potential Conflicts of Interest to CalOptima in accordance with this Policy.
26
27 D. The Chief Medical Officer and/or committee chairperson shall evaluate all Conflicts of Interest
28 and determine whether a Conflict of Interest exists, with the assistance of legal counsel, as
29 necessary. The Chief Medical Officer and/or committee chairperson will resolve all conflicts and
30 impose safeguards, as necessary, to appropriately manage Conflicts of Interest.
31
32 E. Delegated Health Networks shall have policies and procedures consistent with this policy in order
33 to identify, avoid and/or manage Conflicts of Interest, as appropriate.
34

1 **III. PROCEDURE**

2
3 **A. Conflict of Interest**

- 4
5 1. A Conflict of Interest depends on the situation and not on the character of the individual.
6 Conflicts of Interest may arise where a Participant and/or a Related Party or an entity directly
7 controlled by them:
8
9 a. Receives material compensation (e.g., gifts, grants, stipends, amenities) from any
10 individual (and/or his employer) or entity that is the subject of a CalOptima QI or UM
11 review;
12 b. Has an ownership interest in any entity that is the subject of a CalOptima QI or UM
13 review;
14 c. Has a past or present personal relationship with the subject of a CalOptima QI or UM
15 review; and/or
16 d. Has a financial interest in any consultant that is engaged and/or contracted by CalOptima
17 to assist it with a QI or UM review and/or investigation.
18
19 2. The following are examples of Conflicts of Interest:
20
21 a. A Participant considers or makes decisions with respect to a credentialing or peer review
22 matter where the provider who is the subject of the peer review matter is a direct
23 competitor of the Participant or an individual with whom the Participant previously had a
24 personal, employment, or financial relationship.
25
26 b. A Participant has an ownership or financial interest in the consulting firm engaged by
27 CalOptima to review medical records in connection with a peer review matter.
28
29 c. A Participant receives monetary or non-monetary compensation from a Pharmaceutical
30 manufacturer whose drug is reviewed for listing on the CalOptima Formulary.
31
32 d. A Participant holds a fiscal or management position or role at CalOptima and participates
33 in utilization management decisions (e.g., approving, modifying, deferring, or denying
34 requested services, establishing drug formularies, conducting drug utilization reviews).
35
36 e. A Participant considers and makes decisions regarding the CalOptima credentialing
37 application of a physician where the Participant was a member of a judicial review
38 committee that ruled on a prior hospital peer review matter involving the same physician.
39

40 **B. Conflict of Interest Disclosure Process**

- 41
42 1. On an annual basis, each Participant who is involved in CalOptima QI or UM decisions shall
43 sign a Conflict of Interest Attestation and complete a Conflict of Interest Disclosure Form
44 identifying any activities, interests, relationships, or financial holdings that create or have the
45 potential to create a Conflict of Interest for the Participant.
46
47 2. Upon appointment and prior to serving on any QI or UM committee or subcommittee, each
48 Participant shall sign a Conflict of Interest Attestation and complete a Conflict of Interest

1 Disclosure Form, identifying any activities, interests, relationships, or financial holdings that
2 create or have the potential to create a Conflict of Interest for the Participant.

3 3. If a Participant believes that he/she may have a potential, perceived, or actual Conflict of
4 Interest prior to a committee, or subcommittee, meeting, he/she will provide written notice to
5 the committee, or subcommittee, chairperson disclosing the potential, perceived, or actual
6 Conflict of Interest.

7
8 4. Whenever a Participant believes that he/she may have a potential, perceived, or actual Conflict
9 of Interest during a committee, or subcommittee, meeting, he/she will immediately alert the
10 committee, or subcommittee, chairperson that he/she may have a potential, perceived, or actual
11 Conflict of Interest. Before leaving the meeting, the Participant may be asked, and may
12 answer, any questions concerning the Conflict of Interest.

13
14 5. In all other situations, whenever a Participant realizes that he/she may have a potential or
15 actual Conflict of Interest, he/she will provide written notice to the Chief Medical Officer
16 disclosing the potential, perceived, or actual Conflict of Interest.

17
18 6. To the extent the QI Department and/or UM Department engages an external reviewer or
19 expert consultant for peer review or other QI or UM purposes, that individual shall be required
20 to sign a Conflict of Interest Statement and complete a Conflict of Interest Disclosure Form
21 prior to performing any services for CalOptima.

22
23 **B. Management and Resolution of the Conflicts of Interest**

24
25 1. The Chief Medical Officer or the committee chairperson will review and evaluate all written
26 disclosures thoroughly for conflicts. For any decision involving a CalOptima employee, the
27 Chief Medical Officer shall involve Legal Counsel before taking any action.

28
29 2. The applicable committee or subcommittee chairperson shall resolve any issue over the
30 existence of a Conflict of Interest involving a Participant who is a committee or subcommittee
31 member. All other Conflict of Interest issues shall be resolved by the Chief Medical Director.
32 CalOptima shall verify that no unresolved Conflicts of Interest exist prior to retaining the
33 external reviewer or expert consultant.

34
35 3. If it is determined that there is no conflict, then the Participant can continue to be involved in
36 the matter, subject to any limitations imposed by the Chief Medical Officer or committee or
37 subcommittee chairperson.

38
39 4. If it is determined that there is a Conflict of Interest, the Participant may be excluded from
40 participation in the matter that gave rise to the Conflict of Interest.

41
42 5. The committee chairperson and/or Chief Medical Officer may resolve the conflict, if and when
43 appropriate, by imposing limitations in where there is a determination that a Conflict of
44 Interest does not prohibit the Participant's continued involvement in the matter. These
45 limitations may include, but are not limited to, requiring that the Participant abstain from
46 voting with regard to the matter, or prohibiting the Participant from participating in any
47 investigation of the matter.

- 1 6. If a Participant disagrees with a committee chairperson’s decision regarding a Conflict of
2 Interest, he/she can request that the Chief Medical Officer review the Conflict of Interest.
3

4 D. Record Retention

- 5
6 1. The Quality Improvement and Utilization Management Departments, as applicable, shall keep
7 copies of all Conflict of Interest Disclosure Forms and any written information disclosing a
8 Conflict of Interest in accordance with applicable regulatory record retention requirements.
9
10 2. Credentialing and Peer Review Committee (CPRC) minutes shall reflect the disclosure of
11 Conflicts of Interest and any abstentions from voting on actions.
12

13 E. Non-Compliance with Conflicts of Interest Policy

- 14
15 1. Suspected violations of this Policy should be reported to the Chief Medical Officer . Such
16 reports may be made confidentially.
17
18 2. The failure of a Participant to disclose a Conflict of Interest when it is known or reasonably
19 should be known to the Participant may result in actions against the Participant, including, but
20 not limited to disciplinary action, sanctions, removal, dismissal, and/or termination from a
21 committee or subcommittee. The matter may also be referred to the CalOptima Office of
22 Compliance and/or Human Resources Department for further action as appropriate.
23

24 **IV. ATTACHMENTS**

- 25
26 A. Conflict of Interest Attestation
27 B. Conflict of Interest and Non-Discrimination Attestation (CPRC)
28 C. Conflict of Interest Disclosure Form
29

30 **V. REFERENCES**

- 31
32 A. Cal MediConnect Quality Improvement TAG QI-001
33 B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare
34 Advantage
35 C. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
36 D. CalOptima PACE Program Agreement
37 E. CalOptima Three-Way Contract with the Centers for Medicare and Medicaid Services (CMS)
38 and DHCS for Cal MediConnect
39 F. Health and Safety Code §1367(g)
40 G. Title 42, Code of Federal Regulations (C.F.R.), §422.205
41 H. Title 28, California Code of Regulations, §1300.67.3
42

43 **VI. REGULATORY AGENCY APPROVALS**

44
45 None to Date
46

47 **VII. BOARD ACTIONS**

48
49 TBD

Policy #: GG.1656
Title: Quality Improvement and Utilization Management
Conflicts of Interest

Effective Date: TBD

1 **VIII. REVIEW/REVISION HISTORY**
2

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	TBD	GG.1656	Quality Improvement and Utilization Management Conflicts of Interest	Medi-Cal OneCare OneCare Connect PACE

3

DRAFT - QAC - 20180220

1 IX. GLOSSARY
2

Term	Definition
Conflict of Interest	A conflict of interest may occur whenever an individual who is in a position to control or influence a business or clinical decision has a personal, financial, or otherwise competing interest in the outcome of the decision. A conflict of interest may arise when there is a divergence between an individual's private interests and his/her professional obligations, such that an independent observer might reasonably question whether the individual's professional actions or other decisions are determined by considerations of personal gain, financial or otherwise.
Formulary	The approved list of outpatient medications, medical supplies and devices, and the Utilization and Contingent Therapy Protocols as approved by the CalOptima Pharmacy & Therapeutics (P&T) Committee for prescribing to Members without the need for Prior Authorization.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Member	An enrollee-beneficiary of a CalOptima program.
Participant	Any individual serving in an appointed, volunteer, or employed position in CalOptima QI and/or UM Departments and/or on any QI or UM committees or subcommittees. This includes, but is not limited to, those individuals making decisions in connection with member quality of care complaints and grievances, provider credentialing and re-credentialing, and/or peer review activities.
Related Party	The Participant's spouse, domestic partner, civil union partner, natural or adoptive parents, step-parents, children, step-children, siblings, step-siblings, nieces/nephews, aunts/uncles, grandparents, grandchildren, in-laws, son-in-law, daughter-in-law, brother-in-law, sister-in-law, or the spouse of a grandparent.

3

DRAFT

Conflict of Interest Attestation

[Quality Improvement Committee/Sub-Committee(s)]

I, _____, agree and attest as follows:

1. I am a member of the following CalOptima [Quality Improvement Committee/Sub-Committee(s)]: _____.
2. I understand CalOptima requires that all individuals who serve on [Quality Improvement Committee/Sub-Committee(s)] or who otherwise make decisions on quality oversight and activities (“Participant”), timely and fully disclose any actual, perceived, or potential conflicts of interest that arise in the course and scope of serving in such capacity.
3. I understand that a conflict of interest occurs whenever an individual who is in a position to control or influence a business or clinical decision has a personal, financial, or otherwise competing interest in the outcome of the decision including:
 - a. when there is a divergence between the Participant’s private interests and his/her professional obligations, such that an independent observer might reasonably question whether the Participant’s professional actions or other decisions are determined by considerations of personal gain, financial or otherwise;
 - b. when a decision may have an effect on the financial interests of the Participant, any member of the Participant’s immediate family (spouse, domestic partner, civil union partner, natural or adoptive parents, step-parents, children, step-children, siblings, step-siblings, nieces/nephews, aunts/uncles, grandparents, grandchildren, in-laws, son-in-law, daughter-in-law, brother-in-law, sister-in-law, or the spouse of a grandparent), or the Participant’s employers, partners, or other business associates; and
 - c. when medical decisions are unduly influenced by fiscal and administrative management.

4. I understand all decisions concerning the safe care, quality of treatment, and services provided to CalOptima's patients must be made solely with the intent to meet the needs of those patients and without any actual, perceived, or potential conflicts of interest.
5. That, under no circumstances, may I place my own financial interests above the welfare of CalOptima's patients.
6. In my role as a Participant, I will conduct myself so as to avoid or minimize conflicts of interest, and I will appropriately disclose all potential or actual conflicts of interest in accordance with CalOptima's policies and procedures.
7. I will refrain from participation, including voting, discussing, or in any way trying to influence the outcome of the decision, in any matter in which I have a conflict of interest.
8. I will comply with all CalOptima decisions regarding the resolution of conflicts and/or CalOptima's imposition of safeguards (e.g., abstention from voting, non-participation in reviews) deemed necessary and appropriate to manage conflicts of interest.

Signature

Printed Name

Date

Conflict of Interest and Non-Discrimination Attestation

Credentialing and Peer Review Committee

I, _____, agree and attest as follows:

1. I am a member of the CalOptima Credentialing and Peer Review Committee (CPRC).
2. I understand CalOptima requires that all individuals who serve on the CPRC (“Participant”), timely and fully disclose any actual, perceived, or potential conflicts of interest that arise in the course and scope of serving in such capacity.
3. I understand that a conflict of interest occurs whenever an individual who is in a position to control or influence a business or clinical decision has a personal, financial, or otherwise competing interest in the outcome of the decision including:
 - a. when there is a divergence between the Participant’s private interests and his/her professional obligations, such that an independent observer might reasonably question whether the Participant’s professional actions or other decisions are determined by considerations of personal gain, financial or otherwise;
 - b. when a decision may have an effect on the financial interests of the Participant, any member of the Participant’s immediate family (spouse, domestic partner, civil union partner, natural or adoptive parents, step-parents, children, step-children, siblings, step-siblings, nieces/nephews, aunts/uncles, grandparents, grandchildren, in-laws, son-in-law, daughter-in-law, brother-in-law, sister-in-law, or the spouse of a grandparent), or the Participant’s employers, partners, or other business associates; and
 - c. when medical decisions are unduly influenced by fiscal and administrative management.
4. I understand all decisions concerning the safe care, quality of treatment, and services provided to CalOptima’s members must be made solely with the intent to meet the needs of those members and without any actual, perceived, or potential conflicts of interest.
5. That, under no circumstances, may I place my own financial interests above the welfare of CalOptima members.

6. In my role as a Participant, I will conduct myself so as to avoid or minimize conflicts of interest, and I will appropriately disclose all potential or actual conflicts of interest in accordance with CalOptima's policies and procedures.
7. I will refrain from participation, including voting, discussing, or in any way trying to influence the outcome of the decision, in any matter in which I have a conflict of interest.
8. I will comply with all CalOptima decisions regarding the resolution of conflicts and/or CalOptima's imposition of safeguards (e.g., abstention from voting, non-participation in reviews) deemed necessary and appropriate to manage conflicts of interest.
9. I acknowledge that Federal law prohibits CalOptima from discriminating, in terms of participation, against any health care professional who acts within the scope of his or her license or certification under State law, solely on the basis of the license or certification category but that this prohibition does not preclude actions designed to maintain quality of care.
10. I acknowledge and understand that I may not base credentialing or re-credentialing recommendations or decisions and/or peer review recommendations or decisions on a provider's race, ethnic/national identity, gender, age, sexual orientation or patient type (e.g., Medicaid) and I agree that I will not discriminate against any CalOptima provider in making such recommendations or decisions.

Signature

Printed Name

Date

CALOPTIMA CONFLICT OF INTEREST DISCLOSURE FORM

Quality Improvement and Utilization Management Departments, Committees and Subcommittees

Name: _____

Department: _____

Committee/Subcommittee: _____

Please complete the information below. The terms “Conflict of Interest” and “Related Party” as used in this Conflict of Interest Disclosure Form are defined below.

Definitions:

A. **Conflict of Interest:** A conflict of interest may occur whenever an individual who is in a position to control or influence a business or clinical decision has a personal, financial, or otherwise competing interest in the outcome of the decision. A conflict of interest may arise when there is a divergence between an individual’s private interests and his/her professional obligations, such that an independent observer might reasonably question whether the individual’s professional actions or other decisions are determined by considerations of personal gain, financial or otherwise.

B. **Related Party:** The Participant’s spouse, domestic partner, civil union partner, natural or adoptive parents, step-parents, children, step-children, siblings, step-siblings, nieces/nephews, aunts/uncles, grandparents, grandchildren, in-laws, son-in-law, daughter-in-law, brother-in-law, sister-in-law, or the spouse of a grandparent.

Conflict of Interest Disclosures:

Please answer all questions below to the best of your knowledge. Indicate by marking YES or NO if any of the questions apply to you or to any Related Party. Please attach supplementary pages if you have additional disclosures that will not fit in the space below.

1. Do you and/or any Related Party currently have, or within the last five (5) years had, ownership, employment, contractual and/or other interest or affiliation in any clinic, medical group, Independent Practice Association (IPA) and/or Health Maintenance Organization?

Yes No

If yes, please complete the information below.

<u>Entity</u>	<u>Role</u>	<u>Remuneration Type</u>

2. Do you and/or any Related Party currently have, or within the last five (5) years had, any ownership, employment, contractual and/or other interest or affiliation in any company, vendor or organization that conducts provider peer review, credentialing/re-credentialing, quality assurance, utilization review medical record review, hearing officer/judicial review committee services, expert witness services and/or similar activities or services?

Yes No

If yes, please complete the information below.

<u>Entity</u>	<u>Your Role</u>	<u>Nature of Services</u>

3. Do you or any Related Party currently have, or within the last five (5) years had, any ownership interest in or receive any payment(s) or other remuneration from a pharmaceutical, medical device or supply, biotechnology, or medical consulting, manufacturing or distributing company (including, but not limited to, any salary, commission, advance, interest, rent, gift, loan, loan forgiveness, payment of indebtedness, rebate, payment or reimbursement of expenses, fees for consulting, speaker's bureaus, advisory boards or other committees)?

Yes No

If yes, please complete the information below.

<u>Entity</u>	<u>Role</u>	<u>Remuneration Type</u>

4. Do you and/or any Related Party currently have, or within the last five (5) years had, any ownership interest in or receive any equity, including stock, stock options, or venture capital funds from a pharmaceutical, medical device, biotechnology, or medical consulting, manufacturing or distributing company? (Mutual funds and publicly traded stock are excluded).

Yes No

If yes, please complete the information below.

<u>Entity</u>	<u>Role</u>	<u>Remuneration Type</u>

5. Do you and/or any Related Party currently have, or within the last five (5) years had, rights to medical intellectual property, including patent rights or royalty income?

Yes No

If yes, please complete the information below.

<u>Entity</u>	<u>Nature and Amount of Interest</u>	<u>Medical Company</u>

6. Do you and/or any Related Party receive any payment(s) or other remuneration for research, including any grants within the last five (5) years?

Yes No

If yes, please complete the information below.

<u>Entity</u>	<u>Role</u>	<u>Remuneration Type</u>

7. Do you and/or any Related Party currently hold, or within the last five (5) years held, any position as an officer, director, partner, or manager in a hospital, ambulatory surgery center, pharmaceutical, medical device, or biotechnology manufacturing, distributing, or consulting company?

Yes No

If yes, please complete the information below.

<u>Entity</u>	<u>Role</u>	<u>Remuneration Type</u>	<u>Annual Dollar Value</u>

8. Do you have any other potential or actual Conflict(s) of Interest?

Yes No

If yes, please describe below.

I acknowledge and agree that I have received, reviewed, understand and will comply with, CalOptima's Conflicts of Interest Policy No. [REDACTED]. I further acknowledge and agree that I have disclosed all known Conflicts of Interest below.

By my signature below, I understand and acknowledge that I have an ongoing obligation to disclose any known Conflicts of Interest that arise while participating in any capacity in the Quality Improvement and/or Utilization Management Departments and/or during my participation on any CalOptima Quality Improvement and/or Utilization Management committee or subcommittee and that I will promptly disclose the existence and nature of any potential or actual Conflicts of Interest.

Signature: _____

Date: _____

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 1, 2018 **Regular Meeting of the CalOptima Board of Directors**

Consent Calendar

8. Consider Ratification of CalOptima's Pharmacy Management Residency Program and Approval of Related Policy

Contact

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

Kris Gericke, Pharm.D, Director, Pharmacy Management, (714) 246-8400

Recommended Action

Recommend ratification of CalOptima's Pharmacy Management Residency Program, and approve Policy GG.1426: Residency Program, Pharmacy Management.

Background

CalOptima's Pharmacy Management Residency Program (Residency Program) was started in 2010 by staff. At this time, staff is requesting ratification of the existing program and approval of a policy formalizing program requirements and responsibilities.

Residency Programs are intended to provide organized, systematic, directed postgraduate training that centers on developing the knowledge, skills, and abilities needed to achieve professional competence in the delivery of patient-centered care and in pharmacy operational services in managed care organizations (MCOs) and settings.

Residents are licensed pharmacists who provide several contributions to CalOptima at a much-reduced direct cost. By the roles they can assume, residents can facilitate the redeployment of existing pharmacists to other areas, tasks, or projects, thereby expanding the capabilities of pharmacist roles in other parts of the organization. The residents play an integral role in embodying CalOptima's mission as an organization. Their contributions over the years to our members and the health system include some of the following: reduction of opioid overutilization, promotion of opioid rescue therapy in high risk members, medication reviews aimed to decrease high risk medication use in the elderly, and implementation of clinical training programs for CalOptima staff. These contributions have direct impacts on safe, effective, and rational use of medications which leads to improved outcomes for our members and reduced cost.

Due to the robust nature of the Residency Program training, past Pharmacy Residents are ideal candidates to transition into vacant full-time staff positions with minimal training required. To date, the pharmacy department employs four prior residents: two managers and two staff.

As detailed in the proposed policy, in conjunction with HR, Pharmacy Management Department serves as the designated point of contact to coordinate and administer the Residency Program. The Resident position is full time for a one-year period beginning in July. As proposed, CalOptima may offer two

paid one-year Pharmacy Resident positions at the discretion of the Human Resources and Pharmacy Management Departments to provide licensed practitioners with training and experience in essential areas of managed care pharmacy's responsibilities and functions that would be characterized as part of a managed care pharmacist generalist's practice.

A number of other Medi-Cal Managed Care Plans also have pharmacy residency programs, including Inland Empire Health Plan, LA Care, San Francisco Health Plan, and Health Plan of San Joaquin.

The Pharmacy Resident Program is included in the 2017 CalOptima Utilization Management Program.

Discussion

Pharmacy Residents rotate through various areas in Pharmacy Management as well as complete a longitudinal drug utilization review (DUR) project that contributes to CMS and DHCS DUR requirements. The Residency Program year includes the following experiences:

- Interdisciplinary Care Team (ICT) participation as lead Clinical Pharmacist
- Comprehensive and Targeted Medication Reviews; Medication Therapy Management (MTM) Program
- Quarterly opioid prescribing summary creation and distribution
- Monthly Provider Newsletters aimed at educating providers in various clinical topics
- Medicare coverage determination and Medi-Cal prior authorization reviews
- PACE medication profile reviews

Projects and Assignments

- Drug Monograph completion and presentation at quarterly Pharmacy and Therapeutics Meeting
- Prior authorization criteria development
- Updating clinical guidelines
- Drug Information projects
- MTM member education newsletters
- In-service interdepartmental clinical trainings for CalOptima staff
- Part D formulary submissions
- Pharmacy Benefits Manager (PBM) oversight

Through the experiences outlined above, the Pharmacy Residents have consistently engaged in quality improvement and assessment activities, assisted in staff development, and have supported innovative approaches to care that have positively impacted our members in a cost-effective and compassionate manner.

In addition to contributions Residents make to organizations through staffing and projects, staff pharmacists involved with Residency Programs have been found to experience a greater degree of job satisfaction and higher employee retention rates. CalOptima's Residency Program is intended to increase the number of well-trained pharmacists prepared to work in expanding patient care roles, and also provides opportunities to recruit well-trained pharmacists. CalOptima has hired four of our past residents as clinical pharmacists over the past seven years.

The Residency Program is currently not accredited, but Pharmacy Management is evaluating whether to seek accreditation by the American Society of Hospital Pharmacists (ASHP). If a decision to seek accreditation is made in the future, staff will return to your Board with the necessary policy changes and costs associated with such a decision.

Fiscal Impact

The two resident positions are budgeted items in the CalOptima Fiscal Year 2017-18 Operating Budget approved by the CalOptima Board of Directors on June 1, 2017. The annual salary and benefit cost for both residents is estimated at \$191,436.

Rationale for Recommendation

Staff recommends ratification of CalOptima's Pharmacy Management Residency Program, and approval of the related Policy GG.1426, Residency Program, Pharmacy Management to provide training opportunities for new pharmacists and ensure continued staffing of critical areas.

Concurrence

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

Attachment

CalOptima Policy GG.1426: Residency Program, Pharmacy Management

/s/ Michael Schrader
Authorized Signature

2/21/2018
Date

Policy #: GG.1426PP
 Title: **Pharmacy Management Residency Program**
 Department: Medical Affairs
 Section: Pharmacy Management

CEO Approval: Michael Schrader _____

Effective Date: TBD
 Last Review Date: Not Applicable
 Last Revised Date: Not Applicable

1 **I. PURPOSE**

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 3 This policy describes CalOptima’s Pharmacy Management Residency Program, an organized,
 4 systematic, directed postgraduate training program that centers on developing the knowledge, skills, and
 5 abilities needed to achieve professional competence in the delivery of patient-centered care and in
 6 pharmacy operational services in managed care organizations (MCOs) and settings.
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8 **II. POLICY**

- 9
 10 A. CalOptima may offer paid Pharmacy Resident positions at the discretion of the Human Resources
 11 and Pharmacy Management Departments, and in accordance with U.S. Department of Labor (DOL)
 12 Fair Labor Standards Act (FLSA) guidelines, to provide licensed practitioners with training and
 13 experience in those essential areas of managed care pharmacy’s responsibilities and functions that
 14 would be characterized as part of a managed care pharmacist generalist’s practice.
 15
 16 B. The CalOptima Pharmacy Management Residency Program is not accredited.
 17
 18 C. The Pharmacy Management Department shall be responsible for administering the Residency
 19 Program and ensuring that the following Residency Program guidelines are followed:
 20
 21 1. The Pharmacy Management Department may provide Resident positions to qualified candidates
 22 meeting the education, qualifications, and experience required by the Pharmacy Management
 23 Department.
 24
 25 2. The Resident position is full-time for a one (1) year period beginning in July of the current
 26 calendar year unless otherwise terminated by either CalOptima or the Resident.
 27
 28 D. Residents will be required to:
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 30 1. Pass a background investigation, including, but not limited to, a criminal investigation, a review
 31 of the Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE), the
 32 General Services Administration’s (GSA) System for Award Management (SAM) OIG/SAM,
 33 and the Medi-Cal Suspended & Ineligible (“S&I”) Website;
 34
 35 2. Meet the CalOptima requirements for the Residency program, including proof of California
 36 Board of Pharmacy Pharmacist Licensure within ninety (90) calendar days of entering the
 37 Residency Program;
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 39 3. Submit an application, resume and letter of intent to CalOptima;

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4. Submit letters of recommendation to the Residency Coordinator;
5. Submit official pharmacy school transcripts to the Residency Coordinator;
6. Submit a signed acknowledgment confirming the Resident understands:
 - a. The expectations;
 - b. That the Resident is not entitled to a job at the conclusion of the Residency;
 - c. That the Resident is in a voluntary, at-will relationship, which can be terminated at any time; and
 - d. The Resident agrees to comply with all CalOptima Policies and Procedures and understands that CalOptima may prohibit a Resident from continuing in the program, regardless of whether the individual has completed personal objectives.
7. Complete HIPAA and compliance training programs, along with tuberculosis (TB) or health screening requirements for the position, where applicable; and
8. Sign CalOptima's confidentiality agreement.

E. Residency Program Oversight

1. The Pharmacy Management Department shall be the designated point of contact to address questions, maintain consistency, and coordinate and administer the Residency Program.
2. The Pharmacy Management Department shall be responsible for coordinating with the Human Resources Department and designating a Pharmacy Management Department contact to serve as the Residency Coordinator.
3. The designated Residency Coordinator should be someone who possesses expertise in the area in which the Resident will work; has the time to invest in the Resident; and will oversee and assign the Resident's work.
4. Weekly meetings between the Resident and the Residency Coordinator should be held to discuss what has been learned the prior week and what is expected the next week. The Residency Coordinator shall document such meetings. The Residency Coordinator or department manager shall sign the department Resident evaluations.
5. At the conclusion of the Residency, the designated Resident supervisor shall submit a Department Resident Evaluation Form and provide a copy to the Resident.

1 **III. PROCEDURE**
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Responsible Party	Action
Resident	<ol style="list-style-type: none"> 1. The Resident is responsible for reviewing the Pharmacy Resident job description and ensuring that he or she meets the qualifications and minimum requirements for the position before submitting an application. 2. Apply for a Pharmacy Resident position through CalOptima’s applicant tracking system online. 3. Submit degree verification for Pharm.D. from an accredited college of pharmacy. 4. Submit licensure confirmation within ninety (90) calendar days of commencing the Pharmacy Residency Program. 5. Participate in an interview. 6. If accepted, complete a background check and health screening, and submit a signed Offer Letter and complete other documents, or tests, as required.
Sponsoring Department	<ol style="list-style-type: none"> 1. Administer and coordinate all Pharmacy Resident activities. 2. Coordinate with Facilities for space considerations. 3. Submit a request to fill (RTF) for the Pharmacy Resident position to the Human Resources Department, including details of the position requirements and period of time. 4. Review applications and notify the Human Resources Department to schedule an interview if applicant is qualified. 5. Interview Pharmacy Resident applicants. 6. Once a qualified Pharmacy Resident applicant has been identified and the Sponsoring Department is interested in selecting that applicant to fill the position, coordinate with the Human Resources Department to provide an Offer Letter and complete the Pharmacy Resident on-boarding process, including but not limited to, background checks. 7. Designate a contact to serve as the supervisor of Pharmacy Resident. 8. Ensure the Pharmacy Resident’s activities are within the scope of practice applicable to their license and that they perform within this scope if applicable. 9. Notify and collaborate with the Human Resources Department if the Pharmacy Resident is not adhering to the programs or agency’s policies or procedures. 10. Complete reviews and evaluations consistent with the Residency Manual and provide timely feedback to Pharmacy Resident. 11. Update the Residency Manual and Pharmacy Resident Job Description on an annual basis.
Human Resources Department	<ol style="list-style-type: none"> 1. Receive RTF for Pharmacy Resident positions from the Sponsoring Department and verify all necessary approvals, including budgeted positions, have been obtained. 2. Receive and review Pharmacy Resident applications. 3. Coordinate Pharmacy Resident interviews and on-boarding process, including but not limited to, background, reference, and review of OIG LEIE, the GSA OIG/SAM, Medi-Cal S&I Website exclusion checks, preparation of offer letters, coordinate health screening, where applicable, and coordinate the Resident’s start date with the Sponsoring Department. 4. Coordinate on-boarding activities, off-boarding activities, and all training requirements.

Responsible Party	Action
	5. Maintain all Pharmacy Resident’s records, including, but not limited to, all performance evaluations. 6. Monitor and support the Pharmacy Residency program activities and outcomes.

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IV. ATTACHMENTS

Not Applicable

V. REFERENCES

- A. CalOptima Policy GA.8018: Paid Time Off (PTO)
- B. CalOptima Policy GA.5003: Budget and Operations Forecasting
- C. Department Resident Evaluation Form
- D. Resident Agreement
- E. Resident Offer Letter
- F. Resident Program Guidelines
- G. U.S. Department of Labor (DOL) Fair Labor Standards Act (FLSA) Guidelines
- H. Title 29, Code of Federal Regulations (CFR), §553.101
- I. Title 45, Code of Federal Regulations (CFR), §160.103

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

None to Date

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	TBD	GG.1426PP	Pharmacy Management Residency Program	Administrative

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IX. GLOSSARY

Term	Definition
Job Description	A document that describes the requirements, qualifications, essential functions and responsibilities for the position.
Pharmacy Management Department	A department within CalOptima requesting a Pharmacy Resident and overseeing the management and work of the Pharmacy Resident pursuant to this policy.
Pharmacy Residency Program	A post-graduate training program offered by CalOptima which allows the Pharmacy Resident to perform as a licensed practitioner specializing in Managed Care and to train under the supervision of other experienced pharmacists.
Pharmacy Resident	The Pharmacy Resident is an employee completing a post graduate training specializing in managed care for one (1) year.
Residency Coordinator	The Clinical Pharmacist Manager responsible for direct supervision of Pharmacy Residents and the Residency Program. The Residency Coordinator will work with Pharmacy Management staff to achieve residency goals and objectives.
Residency Manual	A document outlining the purpose, program goals, program structure, core learning experiences, and project expectations for the Pharmacy Resident.

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 1, 2018 **Regular Meeting of the CalOptima Board of Directors**

Consent Calendar

9. Consider Receiving and Filing 2017 Compliance Program Effectiveness (CPE) Audit Report

Contact

Silver Ho, Compliance Officer, (714) 246-8400

Recommended Action

Consider receiving and filing 2017 Compliance Program Effectiveness (CPE) Audit Report.

Background

The Centers for Medicare & Medicaid Services (CMS) requires that all Medicare Advantage (Part C) and Prescription Drug (Part D) plan sponsors conduct an independent audit to assess the effectiveness of its Compliance Program on at least an annual basis and share the results with its Board of Directors (“Board”). As such, CalOptima selected Compliance Strategies, Inc. (“Compliance Strategies”) to evaluate its overall performance in adopting and implementing an effective compliance program to prevent, detect and correct Medicare Parts C and D program non-compliance and fraud, waste and abuse (FWA).

Compliance Strategies conducted the CPE audit using the 2017 CMS audit protocols, and requested that CalOptima provide universes of data for the time period of October 1, 2016 to September 30, 2017. Audit field work began on November 6, 2017 and concluded on November 9, 2017.

Compliance Strategies’ approach to conducting the assessment included:

- Reviewing documentation submitted by CalOptima prior to the onsite review
- Analyzing and selecting samples from data universes submitted by CalOptima prior to the onsite examination to probe for and evaluate areas of potential non-compliance
- Reviewing CalOptima data systems, operations, and documentation by conducting onsite reviews of the samples
- Interviewing CalOptima personnel

Overall, Compliance Strategies determined that CalOptima demonstrated it had an effective Compliance Program.

Discussion

Compliance Strategies selected a sample of six (6) cases, also known as tracers, from the universes to trace and test CalOptima’s response to compliance issues. Two (2) tracers were selected from each of the following universes:

- Internal Monitoring (IM): CalOptima provided a list of all monitoring activities performed during the audit period to demonstrate that its internal business and/or operational areas were in compliance with Medicare Parts C and D program requirements and to show that corrective

actions were undertaken timely and effectively.

- First Tier Entity Auditing and Monitoring (FTEAM): CalOptima provided a list of all auditing and monitoring activities performed during the audit period to demonstrate that its First-Tier Entities were in compliance with Medicare Parts C and D program requirements.
- Internal Audit (IA): CalOptima provided a list of all internal audit activities performed during the audit period to demonstrate its internal business and/or operational areas were in compliance with Medicare Parts C and D program requirements.

Although CalOptima demonstrated it had an effective Compliance Program during this audit, the following two (2) areas for improvement were noted:

- Condition #1: Plan should ensure communications to the Compliance Committee and other responsible personnel include more robust disclosure of issues, corrective actions, and level of urgency. As evidenced in several tracers, current reporting is more quantitative/key performance indicator (KPI) based versus detailed, qualitative information on issues identified.
 - *Corrective Action Plan (CAP)*: The Office of Compliance has already taken steps to report more qualitative and detailed information to the Compliance Committee by modifying its reporting template to include areas for escalation, assignment of risk level, and any recommendations for action. The Office of Compliance will continue to work with its Compliance Committee members to balance the appropriate level of information needed to make informed decisions.
- Condition #2: Plan should implement improved escalation activities to support timely CAP development and implementation.
 - *Corrective Action Plan (CAP)*: The Office of Compliance will continue to work diligently with internal departments and First Tier, Downstream, and Related (FDRs) entities to ensure corrective actions are developed and implemented timely. If the resolution to a CAP is unacceptable, or the internal department or FDR fails to timely respond to a CAP, the Office of Compliance may, as part of its CAP remediation process, escalate the issue to both senior level management and/or the Compliance Committee for further review and action.

In addition, Compliance Strategies commended CalOptima for the following two (2) best practices:

- Completing annual audits for 100% of its first-tier entities
- Utilizing a “high touch” approach in corrective action plan remediation with internal operational areas

Fiscal Impact

There is no anticipated fiscal impact for the recommendation to the Board to receive and file the 2017 CPE audit report.

Rationale for Recommendation

To ensure CalOptima meets the CMS requirement to conduct an audit of its Compliance Program on at least an annual basis, CalOptima staff recommends that the Board approve the file and receipt of the 2017 Compliance Program Effectiveness (CPE) audit report.

Concurrence

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

Attachment

Executive Summary - Medicare Advantage and Prescription Drug Program Compliance Program Effectiveness Audit Findings, Prepared by Compliance Strategies, Inc., for CalOptima, dated February 15, 2018

/s/ Michael Schrader
Authorized Signature

2/21/2018
Date

EXECUTIVE SUMMARY

Medicare Advantage and Prescription Drug Program Compliance Program Effectiveness Audit Findings

Prepared by Compliance Strategies, Inc., for CalOptima

February 15, 2018

INTRODUCTION:

The Medicare Advantage (Part C) and Prescription Drug (Part D) program, administered by the Centers for Medicare & Medicaid Services (CMS), requires Plan Sponsors have an independent review and audit of their performance. This may be accomplished by an internal source or external entity. Compliance Strategies, Inc. was selected to evaluate CalOptima's overall performance in administering the Compliance Program.

PURPOSE:

The purpose of this audit was to evaluate CalOptima's performance related to Medicare Part C and Part D Compliance Program Effectiveness (CPE) and to assess CalOptima's ability to meet its regulatory requirements and assure beneficiaries are receiving necessary health care services in a timely and appropriate manner.

CONCLUSION:

The 2017 Compliance Program Effectiveness Audit for CalOptima provided evidence that the current Compliance Program is effective. In reviewing actual cases identified during the audit period, Compliance Strategies was able to witness the process, including reviews of supporting policies and procedures, in which the CalOptima staff handled the resolution of these as dictated in its Compliance Program. CalOptima is effectively using the seven elements of an effective Compliance Program to review and address issues of non-compliance and potential fraud and abuse.

In addition, CalOptima was commended for two *best practices* in the following areas:

- Plan performs audits of all identified first tier entities (100%) and reviews/refreshes FDR inventory annually.
- Recent process/protocol of "high touch" business partnering with internal operation areas to develop CAPs in support of more timely and effective issue resolution

BACKGROUND:

The Medicare Advantage (Part C) and Prescription Drug (Part D) programs provide health and prescription drug benefits for eligible individuals 65 and older and eligible individuals with disabilities. CMS contracts with private companies, like CalOptima to administer these benefits through Medicare Advantage (MA), Medicare Advantage with Prescription Drug (MA-PD), or stand alone Prescription Drug Plans (PDPs). Both One Care and One Care Connect were part of this review and audit.

PROCESS:

CalOptima submitted data consistent with CMS CY2017 audit protocols to Compliance Strategies for review. Compliance Strategies selected six initial cases, also referred to as *tracers*, to review during the audit performed in November 2017. The tracer process requires Compliance Strategies to walk through each case to find evidence that the seven elements of an effective compliance program were considered and that appropriate preventive, detective and corrective controls were applied during issue resolution.

The tracers were selected from various areas of the organization including: Utilization Management, Pharmacy, Special Investigations Unit (2), as well as from CalOptima's First Tier Entities: MedImpact Pharmacy, Liberty Dental and Hanna Interpreting Services.

RECOMMENDATIONS:

Below is a summary of Compliance Strategies' recommendations for process changes, closing gaps, and/or additional details to further refine CalOptima's existing Compliance processes.

- Sponsor must ensure that communications to the Compliance Committee and other responsible personnel include more robust disclosure of issues, corrective actions, and level of urgency.
- Sponsor must implement improved escalation activities to support timelier CAP development and implementation.

FOR MORE INFORMATION:

Virgilio Florentino,
Principal
Compliance Strategies
virgilio@csteam.us
917-520-7866

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 1, 2018 **Regular Meeting of the CalOptima Board of Directors**

Consent Calendar

10. Consider Authorizing Proposed Budget Allocation Changes in the CalOptima Fiscal Year 2017-2018 Operating Budget

Contact

Sesha Mudunuri, Executive Director of Operations, (714) 246-8400

Recommended Actions

Recommend authorizing reallocation of budgeted but unused funds in the amount of:

1. \$150,000 from Claims Administration Purchased Services - Claims Imaging and Indexing Services to fund the annual fees through June 30, 2018 of the Claims Administration Purchased Services – Electronic Data Interchange (EDI) Clearinghouse Services; and
2. \$70,000 from Claims Administration Purchased Services – Trizetto Group for Robot Process for Rate Adjustments to fund the annual fees through June 30, 2018 of the Claims Administration Purchased Services – Electronic Data Interchange (EDI) Clearinghouse Services.

Background/Discussion

On March 1, 2012, the CalOptima Board of Directors adopted CalOptima Resolution No. 12-0301-01, which includes provisions that delegate authority to the Chief Executive Officer to make budget allocation changes within certain parameters. Pursuant to this resolution, budget allocation changes (i.e., movement of unexpended budget dollars from one Board-approved program, item, or activity to another within the same expense category) of \$100,000 or more require Board approval.

CalOptima budgets for two EDI Clearinghouse Services: Office Ally, LLC and Change Healthcare Solutions, LLC. Payments for clearing house services are calculated on a transaction volume basis. Staff projects a shortfall of nearly \$220,000 for Claims Administration Purchased Services – Electronic Data Interchange (EDI) Clearinghouse Services by June 30, 2018 due to under estimation of the expenses related to the two EDI clearinghouses. Management anticipates that the proposed budget allocations will correspond to the expected transactional volume for these services during the current fiscal year. By way of background, in FY2016-17, CalOptima budgeted \$565,000 and spent approximately \$608,000 for clearinghouse expenses. However, for FY 2017-18, these services were budgeted at \$425,000.

To address this anticipated shortfall, management proposes to make a reallocation of budgeted but unused funds within the Medi-Cal line of business of \$150,000 from Claims Administration Purchased Services - Claims Imaging and Indexing Services and unused funds of \$70,000 from Claims Administration Purchased Services – Trizetto Group for Robot Process for Rate Adjustments. The expenditures for Trizetto Group for Robot/automated process for Rate Adjustments is an exception process and used only in unique circumstances when cost effective. For the current fiscal year, there

has been less than anticipated need for such special one-time activities, resulting in unused funds related to the Robot/automated process. With respect to the Claims Imaging and Indexing Services, which are related to enhancements of the processing of crossover claims, customization activities which had been planned for the current year have been postponed due to resource prioritization focusing on the activities related to the Behavioral Health program, resulting in unused funds. The current forecasted expenses in these categories are below budget, thereby making these funds available for reallocation.

Fiscal Impact

The fiscal impact for this recommended action is budget neutral. As proposed, unspent funds of \$220,000 that were approved as part of the CalOptima FY 2017-18 Operating Budget on June 1, 2017, will fund additional expenses in Claims Administration Purchased Services – EDI Clearinghouse Services, through June 30, 2018.

Rationale for Recommendation

Staff recommends approval of the recommended action as a budget-neutral way to fund Claims Administration Purchased Services – Electronic Data Interchange (EDI) Clearinghouse Services expenses through June 30, 2018.

Concurrence

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

Attachments

None

/s/ Michael Schrader
Authorized Signature

2/21/2018
Date

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 1, 2018 **Regular Meeting of the CalOptima Board of Directors**

Report Item

11. Consider Authorizing Extension of Existing Custom Durable Medical Equipment Contracts, and Contracts with Other Qualified Rehabilitation Wheelchair Suppliers

Contact

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. Enter into amendments to extend existing contracts for Custom Durable Medical Equipment (CDME) suppliers through June 30, 2018;
2. Extend CDME provider contracts listed in Attachment 3, for additional one-year terms subject to approval by the CalOptima Board of Directors, unless terminated by either party as provided for in the contract; and
3. Enter into CDME contracts with other qualified Rehabilitation Wheelchair suppliers meeting credentialing criteria—including being on the approved panel for the California Children’s Services (CCS) program—as well as demonstrating the ability to provide specialized custom rehabilitation wheelchairs for the current CalOptima membership.

Background

Custom Durable Medical Equipment (CDME), also known as Rehabilitation Wheelchairs, are a covered benefit for qualifying members under both the Medicare and Medi-Cal programs. The equipment provided by these suppliers is highly specialized and customized for the specific mobility needs of patients that include, for example, those members diagnosed with spinal cord injuries resulting in paraplegias and/or quadriplegia. The five currently contracted CDME suppliers, listed in Attachment 3, were selected based on a Request for Proposal (RFP) process in 2010. This RFP process was used to identify qualified CDME suppliers to meet member mobility needs in a timely and cost-effective manner, as authorized by the CalOptima Board of Directors on August 6, 2009. The CDME suppliers contracts were initially effective from May 1, 2010 through April 30, 2015. In 2015, Staff reevaluated the existing CDME suppliers and the five CDME contracts were extended for additional three year terms, through April 30, 2018, as authorized by the Board on March 5, 2015.

Discussion

To date, the currently contracted network of CDME suppliers has met applicable performance and network access requirements, as monitored by CalOptima’s medical staff to assure adherence to quality standards. Monitoring involves reviewing utilization and grievances for quality and cost-effectiveness. However, in conjunction with CalOptima assuming responsibility for the CCS program effective January 1, 2019, certain services, including CDME, that are currently authorized by the County of Orange and paid for by the State of California, will become CalOptima’s responsibility. To ensure adequate access for CalOptima members and expanded services requirements for CCS, CalOptima staff recommends extension of the existing CDME contracts to align with CalOptima’s fiscal year, and on an annual basis

thereafter, subject to Board approval, as well as contracting with other qualified rehabilitation wheelchair suppliers, including those who are CCS approved and have the specialized skills necessary to meet the unique needs of CCS members and continuity of care requirements. No new suppliers would be offered contracts unless they first meet CalOptima's credentialing standards, as well as other applicable participation requirements, include the ability to meet the specialized custom needs for rehabilitation wheelchairs within the geographic covered service area. All contracted suppliers will continue to be monitored by medical staff to assure adherence to quality standards, which involves ongoing review of utilization and any member grievances.

Fiscal Impact

The CalOptima Fiscal Year 2017-18 Operating Budget approved by the Board on June 1, 2017, included expenses related to CDME. Because rates and terms of the existing contracts are expected to remain unchanged through the extension period, the recommended action to extend the CDME contracts from May 1, 2018, through June 30, 2018, is a budgeted item with no additional fiscal impact anticipated.

Management plans to include expected expenses related to CDME for each extension period in future operating budgets.

Rationale for Recommendation

To ensure that CalOptima members, including those with CCS-qualifying conditions, have adequate access to CDME suppliers, staff recommends that the Board of Directors authorize extension of CDME contracts currently expiring on April 30, 2018, through June 30, 2018, to align with CalOptima's fiscal year, to extend these contracts for an additional year, and to also contract with additional qualified CDME suppliers as needed.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated August 6, 2009, Authorize the Chief Executive Officer to release a Request for Proposal (RFP) for Custom Durable Medical Equipment (DME) Vendors and Execute Contracts with Selected DME Vendors.
2. Board Action dated March 5, 2015, Authorize Extension of Existing Custom Durable Medical Equipment (DME) Contracts
3. List of contracted Custom Medical Equipment (DME)/Rehabilitation Wheelchair Providers.

/s/ Michael Schrader
Authorized Signature

2/21/2018
Date

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 6, 2009 **Regular Meeting of the CalOptima Board of Directors**

Consent Calendar

V. G. Authorize the Chief Executive Officer to release a Request for Proposal (RFP) for Custom Durable Medical Equipment (DME) Vendors and Execute Contracts with Selected DME Vendors

Contact

Gertrude Carter, M.D., CalOptima Chief Medical Officer, (714) 246-8400

Recommended Action

Authorize CalOptima's Chief Executive Officer (CEO) to select qualified custom wheelchair vendors through a competitive procurement process and execute a contract, with the assistance of legal counsel, with the selected vendors for a period of two (2) years with up to three (3) one-year extension options.

Background

Since 2000, CalOptima has contracted with DME providers meeting specific evaluation criteria, following an RFP process, in order to assure quality provision of durable medical equipment. The Board first approved contracting with custom DME providers based on specific criteria, and authorized execution of contracts with qualified providers, in November 2000. Subsequently, in November 2002, and in November 2005, the Board again authorized execution of preferred contracts with custom DME providers.

Most recently, in January 2007, the Board authorized execution of additional DME contracts and amendments to existing DME contracts. CalOptima currently contracts with seven custom DME providers: Confidence First, Designing Mobility, Mobility Giver, National Seating and Mobility, South Bay Home Health Care, Southern California Mobility, and Superior Mobility Equipment. The contracts authorized by the Board in 2007 will expire April 30, 2010.

Discussion

In order to maintain smooth contracting operations, and ensure that CalOptima continues to contract with custom DME vendors who best meet members' mobility needs in a timely and cost-effective manner, it is appropriate to release a Request for Proposal at this time. This action will renew the Board's authorization to allow the CEO, with assistance of legal counsel, to execute new 2010 custom DME provider contracts for the Medi-Cal CalOptima Direct (COD) and OneCare lines of business following an RFP process. As in the past, and subject to State approval, CalOptima intends to contract with selected vendors for a closed network of DME wheelchair suppliers.

Fiscal Impact

Payments to custom wheelchair vendors during Fiscal Year 2008-09 totaled approximately \$525,000 for the Medi-Cal COD and OneCare lines of business. The proposed action is not expected to materially change CalOptima's per chair cost for custom wheelchairs. This item will be budgeted in FY2009-10 under medical expenses when the full operating budget is developed and presented to the Board.

Rationale for Recommendation

As the current DME vendor contracts executed under the Board of Director's authorization expire, re-authorization is required for CalOptima to contract with custom DME providers who staff has evaluated through the RFP process. Based on the qualifications and performance of potential providers, staff will identify those custom DME providers who will meet members' mobility needs in a timely and cost effective manner. CalOptima is seeking approval to execute new agreements with qualified custom DME vendors for the new contract term beginning in 2010 following completion of an RFP process.

Concurrence

Procopio, Cory, Hargreaves & Savitch LLP

Attachments

None

/s/ Richard Chambers
Authorized Signature

7/30/2009
Date

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 5, 2015 **Regular Meeting of the CalOptima Board of Directors**

Report Item

VII. A. Authorize Extension of Existing Custom Durable Medical Equipment (DME) Contracts

Contact

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

Recommended Action

Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to enter into amendments extending existing Custom Durable Medical Equipment contracts for an additional three (3)-year term, up to and including April 30, 2018.

Background and Discussion

Custom Durable Medical Equipment (DME) is a covered benefit for qualifying members under both Medicare and Medi-Cal. Currently contracted custom DME providers were selected based on an Request for Proposal (RFP) process in 2010, as authorized the CalOptima Board of Directors on August 6, 2009. The Custom DME provider contracts were effective commencing May 1, 2010, and are set to expire on April 30, 2015, based on the exercise of CalOptima's three one-year options to extend them. At this point, there are no optional renewal terms remaining.

CalOptima's medical management staff reviewed the utilization performance of the existing providers, and also evaluated the access needs of CalOptima members, and determined that the currently contracted network of providers adequately meets CalOptima's requirements. Therefore, staff recommends renewing these contracts as indicated above. The contracts will be extended under the same terms and conditions.

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.

Fiscal Impact

The recommended action is budget neutral, with no material fiscal impact anticipated to CalOptima.

Rationale for Recommendation

CalOptima staff recommends authorizing extension to existing contracts with Custom DME provider to ensure that members continue to have access to covered services.

Concurrence

Gary Crockett, Chief Counsel

Attachments

None

/s/ Michael Schrader
Authorized Signature

2/27/2015
Date

**CalOptima
Custom Durable Medical Equipment (DME)/Rehabilitation Wheelchairs
Provider Network***

PROVIDER NAME	ADDRESS
Access Medical	3266 Grey Hawk Court Carlsbad, CA 92010
National Seating and Mobility, Inc.	1125 E. Stanford Court Anaheim, CA 92805
Numotion	12627 Hidden Creek Way Cerritos, CA 90703
South Bay Home Health Care	1349 El Prado Avenue Torrance, CA 90501
Superior Mobility, Inc.	360 Maple Avenue Torrance, CA 90503

*As of 2/1/2018

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 1, 2018 Regular Meeting of the CalOptima Board of Directors

Report Item

12. Consider Ratification of Amendment to CalOptima's Contract with MedImpact for Pharmacy Benefit Manager (PBM) Services

Contact

Kristin Gericke, Director, Pharmacy Management, (714) 246-8400

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

Recommended Actions

Ratify amendment of CalOptima's contract with MedImpact for PBM Services (PBM Agreement) to:

1. Eliminate certain Medicare Part D authorization services no longer performed by the PBM and make a corresponding compensation adjustment effective April 1, 2017;
2. Include an Opioid Cumulative Dosing Program required by the Centers for Medicare & Medicaid Services (CMS) and make a corresponding compensation adjustment effective January 1, 2017; and
3. Add a \$50,000 annual service credit provided by MedImpact to CalOptima to account for services not anticipated in the PBM Agreement, effective January 1, 2018.

Background

On May 7, 2015, the CalOptima Board of Directors authorized CalOptima staff to enter into the PBM Agreement with MedImpact to serve as CalOptima's PBM effective January 1, 2016, for a three year term with two additional one-year extension options, each exercisable at CalOptima's sole discretion. MedImpact was selected and awarded the PBM Agreement through a competitive procurement process approved by the CalOptima Board on November 6, 2014.

Administrative services currently provided under the PBM Agreement include but are not limited to the following: pharmacy claims administration, prior authorization of off-formulary prescriptions, contracting with pharmacies, and management reporting services. Since the implementation of MedImpact as the PBM for CalOptima, changes have occurred to the scope of the services performed.

Discussion

Prior Authorization Workflow. Effective April 1, 2017, CalOptima transitioned from MedImpact's delegate's prior authorization system to MedImpact's in-house prior authorization system. This transition served to improve operational efficiency and enhance reporting capabilities. However, due to the MedImpact prior authorization system workflow for Medicare Part D intake and data entry, CalOptima staff began performing this function for the OneCare and OneCare Connect lines of business effective April 1, 2017. Because this function was included in the PBM Agreement as a MedImpact responsibility, staff recommends an adjustment to the administrative fee effective April 1, 2017 when CalOptima staff began performing these functions.

Opioid Cumulative Dosing Program. CMS requires Opioid Cumulative Dosing Program edits at the pharmacy for Medicare Part D. These requirements apply to CalOptima's OneCare and OneCare Connect programs. This CMS requirement implements a point-of-sale intervention identifying and denying an incoming claim when a member's morphine equivalent dose per day is equal to or exceeds a threshold across a single or multiple opioid containing claims. Effective January 1, 2017, this program, along with a change in PBM compensation, was implemented.

Service Credit. As part of PBM operations, charges for new products and services not listed in the PBM Agreement can occur from time to time. These include, but are not limited to, new programs, reports and system enhancements. To limit the number of additional charges CalOptima incurs, MedImpact has offered CalOptima an annual service allowance credit of \$50,000 to cover these extra charges. This credit can be used by CalOptima to pay for MedImpact products and services not listed and priced in the PBM Agreement. The annual service allowance credit of \$50,000 renews each calendar year but does not roll over to successive years, with any unused portion from a particular calendar forfeited.

Fiscal Impact

Revisions to the prior authorization system and order entry function resulted in a reduction in PBM administrative expenses of approximately \$0.15 per member per month (PMPM), effective April 1, 2017. This decreases OneCare and OneCare Connect administrative expenses by approximately \$37,700 for the period of April 1, 2017, through June 30, 2018. Staff will include updated PBM administrative expenses in the CalOptima Fiscal Year (FY) 2018-19 Operating Budget.

The addition of the Opioid Cumulative Dosing Program resulted in an increase in PBM administrative expenses of approximately \$0.02 PMPM, effective January 1, 2017. This increases OneCare and OneCare administrative expenses by approximately \$6,100 for the period of January 1, 2017, through June 30, 2018. Staff will include updated PBM administrative expenses in the CalOptima FY 2018-19 Operating Budget.

The annual service allowance credit of \$50,000 is budget neutral, as MedImpact will apply the credit towards future purchases of additional products and services outside of the current agreement with CalOptima. In the event CalOptima purchases additional products and services not listed in the PBM Services Agreement, Staff will return to the Board with further recommendations.

Rationale for Recommendation

Staff recommends ratification of the modifications to the PBM Agreement to assure that appropriate fees are paid to the PBM for services rendered. The implementation of the annual service allowance credit of \$50,000 cost savings to CalOptima for any additional products and services not already listed and priced in the PBM Agreement. Any unbudgeted charges in excess of the annual service allowance credit of \$50,000 will be submitted to the Board for approval.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated May 7, 2015, Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016
2. Board Action dated November 6, 2014, Authorize the Chief Executive Officer (CEO) to Amend Current Contract with CalOptima's Pharmacy Benefits Manager (PBM); Authorize the CEO to Issue a Request for Proposal for PBM Services and Enter Into a Contract with the Selected PBM.

/s/ Michael Schrader
Authorized Signature

2/21/2018
Date

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 7, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item

VIII. A. Receive Pharmacy Benefits Manager (PBM) Ad Hoc Update; Consider Selection of PBM and Authorize Contract for PBM Services Effective January 1, 2016

Contact

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

Recommended Action

Authorize the Chief Executive Officer, with the assistance of legal counsel, to enter into an agreement with MedImpact to serve as CalOptima's Pharmacy Benefits Manager (PBM) effective January 1, 2016, for a three (3) year term with two additional one-year extension options, each exercisable at CalOptima's sole discretion.

Background

The current PBM contract for administrative services for CalOptima's pharmacy program has been in place since January 1, 2012. It was awarded to PerformRx through a competitive procurement process. The contract called for a four-year base term with two one year extension options. CalOptima has not exercised the extension options, and the agreement expires on December 31, 2015.

On December 4, 2014, the CalOptima Board of Directors authorized CalOptima staff to issue a Request for Proposal (RFP) for PBM services for the contract period commencing January 1, 2016. The Cal Optima Board of Directors also approved the criteria and weighting to be used in the evaluation and scoring of the RFPs. The approved criteria and weighting consisted of the following:

Criteria	Possible Score
Qualifications, Related Experience and References	135
Clinical Services	100
Provider Network Management	75
Member Services	40
Core Services	100
Information Processing System	125
Decision Support System	100
Financial Management	100
Waste, Abuse and Fraud Protection	45
Quality Assurance	125
Account Management	90
Medicare Part D	125
Implementation and Transition	65

Following CalOptima's standard RFP process, an RFP was issued and a total of ten responses were received.

Discussion

The responses to the RFP were reviewed by an evaluation team consisting of CalOptima’s Director of Clinical Pharmacy Management, Pharmacy Managers, Finance representatives, Compliance representative, Customer Service Manager, Information Services representative, along with an independent consultant that was used to facilitate the RFP process. In addition to the criteria listed above, all vendors responded to a pricing/drug cost financial exercise and were asked to provide red line edits to the CalOptima base contract that was provided at the same time as the RFP.

Based on the evaluation teams scoring, the results for the technical components of the RFP were as follows:

Vendor	Score
MedImpact	1,137
CVS/Caremark	1,089
Catamaran	1,069
Magellan	1,063
Navitus	1,056
Argus	1,054
PerformRx	1,047
Envision	980
Script Care	961
Pinnacle	958

Based upon the weighted scores each vendor received, MedImpact finished with the highest score at 1,137 points out of a possible 1,225 for the mandatory technical components of the evaluation. CVS/Caremark finished second with a score of 1,089. For the pricing/drug cost financial exercise, CVS/Caremark finished first with the most aggressive pricing, with MedImpact finishing third.

As part of the final review, the evaluation team visited the headquarters of the two finalists to review multiple areas of the respective PBMs’ operations.

At the Board’s April 2, 2015 meeting, the Board Chair established an ad hoc of the Board to provide direction to staff and make recommendations to the full Board regarding next steps in the PBM selection process. Based on the input of the Board Ad Hoc and a review of the RFP responders’ capabilities, references, contract requirements and administrative costs, staff is recommending that the Board authorize staff to CalOptima contract with MedImpact. However, in the event that agreement cannot be reached within 30 days of CalOptima providing a response to MedImpact’s proposed contract changes, CalOptima will conduct a similar process with CVS/Caremark, and attempt to reach agreement on contract terms within a 30 day period. . If such an agreement is not reached within this time period, management will return to the Board with recommendation, potentially including requesting authorization to exercise a one year contract extension option with the current PBM.

Based on this process, staff recommends that the Board delegate authority to the CEO to enter into a three-year contract with MedImpact starting January 1, 2016, with two additional one-year extension

options, each exercisable at CalOptima's sole discretion. In the event that CalOptima cannot reach agreeable contract terms with MedImpact within 30 days as described, staff recommends that the Board authorize a similar process with alternate CVS/Caremark. If neither of these contracting efforts are successful within the respective 30 day periods, staff will return to the Board with further update and recommendations.

Fiscal Impact

The annual cost of the contract will be approximately \$6 million. The proposals from both finalists are projected to result in overall savings to CalOptima between \$1 and \$1.5 million annually.

Rationale for Recommendation

CalOptima staff believes that the contracting with the selected PBM will meet the goal of continuing to ensure that pharmacy utilization on a prospective basis will promote access to quality health care services in a cost-effective manner. CalOptima staff reviewed qualified PBM responses and identified the candidates believed to best meet CalOptima's needs for controlling medication overutilization, regulatory compliance, technological advances, administrative simplification, as well as overall cost savings. Accordingly, staff recommends that the Board authorize the CEO to contract with a new PBM as a result of completion of the RFP process authorized by the Board in December 2014.

Concurrence

Gary Crockett, Chief Counsel

Attachments

None

/s/ Michael Schrader
Authorized Signature

5/1/2015
Date

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 6, 2014 **Regular Meeting of the CalOptima Board of Directors**

Report Item

VII. G. Authorize the Chief Executive Officer (CEO) to Amend Current Contract with CalOptima's Pharmacy Benefits Manager (PBM); Authorize the CEO to Issue a Request for Proposal for PBM Services and Enter Into a Contract with the Selected PBM

Contact

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

Recommended Actions

Authorize the CEO, with the assistance of legal counsel, to:

1. Amend the current contract with CalOptima's PBM to reflect de-delegation of certain functions effective October 1, 2014 including, Medicare coverage determinations and member reimbursements and adjust PBM compensation accordingly;
2. Issue a Request for Proposal for Pharmacy Benefits Manager (PBM) services; and
3. Enter into a contract with the PBM selected based on proposed criteria and the Board-approved procurement process for dates of service commencing January 1, 2016.

Background

The current PBM contract for administrative services for CalOptima's pharmacy program has been in place since January 1, 2012. It was awarded to PerformRx through a competitive procurement process. The current contract is set to expire on December 31, 2015.

Administrative services currently provided under the PBM contract include the following: pharmacy claims administration; prior authorization of off-formulary prescriptions; contracting with pharmacies; and management reporting services.

CalOptima's primary objective in contracting with a PBM is to ensure that members have access to medically necessary pharmaceutical care. It is also incumbent upon CalOptima to assist our providers in the selection of the most cost-effective drug therapies, to avoid unnecessary utilization and expense, and to meet regulatory requirements. CalOptima can achieve these objectives through the PBM procurement process to ensure that, as a public agency, CalOptima is maximizing the value received per dollar expended. In this way, we can ensure that CalOptima procures PBM services that satisfy our contractual and regulatory requirements and are consistent with our mission, prescription drug management strategies, and commitment to be a prudent buyer.

Also of particular interest to CalOptima in managing drug costs is selecting a PBM with the ability to perform services that assist CalOptima in meeting Medicare Part D administration requirements and in helping manage appropriate utilization.

Discussion

Contract Amendment:

Management initiated delegation of certain functions effective October 1, 2014 based on changes in operations related the recent audit conducted by the Centers for Medicare & Medicaid Services, and the California Department of Health Care Services (DHCS) and the Department of Managed Health Care (DMHC). These functions include coverage determinations for Medicare and member reimbursements.

RFP Process:

With the assistance of a consultant, CalOptima staff plans to generate a Request for Proposal (RFP) to be disseminated to a list of PBMs across the country. In addition, an advertisement regarding the RFP will be placed in major local newspapers.

An evaluation team consisting of CalOptima's Director of Clinical Pharmacy Management, Chief Medical Officer, Chief Operating Officer, Procurement Manager, Contracts Manager, and Information Services representative, along with the consultant, will evaluate each of the proposals received. In addition, the evaluation team plans to visit the headquarters of the finalists to review multiple areas of functionality and will review all information acquired to date prior to making a recommendation to the Chief Executive Officer as to which PBM should be selected.

The criteria to be used by the team for scoring and selection purposes includes, but is not limited to, the PBM's ability to negotiate contracts with pharmacies, comply with applicable State and Federal requirements, develop a pharmacy network, information systems and an administrative infrastructure, including hiring, training and maintaining adequate and competent staff.

Other criteria that will be used in the section process include:

- Network Penetration – Size and scale of the PBM's contracted network
- Percentage of prescriptions filled last year that were generic
- Network management & electronic transmissions
- Formulary determination & management and the willingness to customize a formulary
- Customer service/help desk support
- Outcomes management reports – standard and customized reports to determine outcomes, trends, establish customer goals and improve outcomes
- Past CMS and State Audit findings and performance
- Service levels and performance metrics
- Specialty pharmacy management
- Experience with Medicaid, Medi-Cal and Medicare Part D
- NCQA experience
- Fraud, waste and abuse prevention and detection capabilities
- Systems capabilities (claims processing, prior authorization, reporting)
- Rebate administration and transparency
- Member Satisfaction
- Maximum Allowable Cost (MAC) pricing
- Acceptance of proposed PBM contract terms

The RFP process is anticipated to be completed by the end of March, 2015. Should the current PBM respond to the RFP and be selected, a transition timeframe will not be necessary. Should a new PBM be selected as part of the RFP process, an allocation of six to seven months for transition from the current PBM to the new PBM is recommended. The PBM must be in place and operational for a January 1, 2016 start date.

Fiscal Impact

De-delegation:

CalOptima will adjust the PBM's compensation to account for delegated functions which will now be handled by CalOptima staff. The adjustments will be in the form of a monthly credit. To offset the additional costs CalOptima will incur by moving the de-delegated functions in house, CalOptima will receive a monthly credit from the PBM of \$10,000 each calendar month beginning in October 2014, and continuing through December 2015, for a total of \$150,000.

RFP Process:

Management will include expenses associated with the new PBM contract in the CalOptima Fiscal Year (FY) 2015-16 Operating Budget, with total funds not exceeding \$12 million annually. Conducting an RFP process to award a new PBM contract will assist Management to: (1) control inappropriate prescription drug utilization; (2) proactively assist staff to implement strategies for improving quality and decreasing costs; and (3) achieve efficiencies in meeting federal and state contractual and regulatory requirements for the pharmacy program.

Management intends to use an external consultant to develop and facilitate the RFP process. The consulting expenses were included as a budgeted item in the FY 2014-15 Operating Budget approved by the Board on June 5, 2014. The budgeted amount is \$83,000.

Rationale for Recommendation

Management proposes to de-delegate OneCare Coverage Determinations (Authorizations) and Member Reimbursement, which are currently assigned to CalOptima's PBM in order to address deficiencies highlighted in the recent regulator audits. In addition, to ensure that pharmacy utilization on a prospective basis continues to promote access to high quality health care services in a cost-effective manner, CalOptima will review qualified PBM responses based on CalOptima's current needs through the procurement process. Accordingly, staff requests that the Board authorize the CEO to commence the RFP process and to authorize the selection a PBM in March 2015.

Concurrence

Gary Crockett, Chief Counsel

Attachments

None

/s/ Michael Schrader
Authorized Signature

10/31/2014
Date

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 1, 2018 Regular Meeting of the CalOptima Board of Directors

Report Item

13. Consider Authorizing Memoranda of Understanding with the County of Orange Social Services Agency Related to In-Home Support Services

Contact

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

Recommended Action

Authorize and direct the Chief Executive Officer, with the assistance of legal counsel, to execute a new Memoranda of Understanding (MOU) with the County of Orange Social Services Agency (SSA) to reflect changes to In-Home Support Services (IHSS) care coordination that became effective January 1, 2018.

Background/Discussion

In July 2012, Governor Brown signed legislation authorizing the Coordinated Care Initiative (CCI). The authority was provided in two pieces of legislation: Senate Bills 1008 and 1036. In June 2013, this authority was modified by CCI Trailer Bill (SB 94), with CCI being implemented in eight counties, including Orange County, beginning in April 2014. The CCI is comprised of two major components:

- **Duals Demonstration:** A voluntary three-year demonstration for dual eligible beneficiaries to receive coordinated medical, behavioral health, long-term institutional, and home and community-based services through a single organized delivery system. The Demonstration is now referred to as Cal MediConnect.
- **Managed Medi-Cal Long-Term Supports and Services (MLTSS):** In CCI counties, Medi-Cal beneficiaries, including dual eligible beneficiaries, are required to join a Medi-Cal managed care health plan to receive their Medi-Cal benefits, including MLTSS and Medicare wraparound benefits. MLTSS included In-Home Supportive Services (IHSS)

On May 2, 2013, the CalOptima Board of Directors authorized MOUs with the Orange County Social Services Agency (SSA) and Orange County In-Home Supportive Services Public Authority (IHSS PA). The MOUs established, among other things, provisions related to sharing confidential beneficiary information and development of care coordination and referral processes. However, when these MOUs were developed, the CCI implementation date was not known. On March 6, 2014, the CalOptima Board of Directors authorized modification of the MOUs with SSA and the IHSS PA to reflect an implementation date of no earlier than July 1, 2014. The updated MOUs expired on December 31, 2017.

Under statute, all components of CCI, including MLTSS, remained operational as long as the CCI generated net General Fund savings and was cost-effective as determined by the California Department of Finance. In January 2017, however, the administration determined that the CCI was not cost-effective and as a result, IHSS was removed from MLTSS effective January 1, 2018. Welfare and Institutions Code (WIC) section 14186, part of the original implementing CCI legislation, was amended to remove IHSS as a managed care benefit. New WIC Section 14186, subdivisions (b)(6) and (b)(9) provide that

the Legislature's intent was to allow the county and managed care plans to continue to share data as necessary "to improve care coordination, promote shared understanding of the consumer's needs, and provide appropriate coordination to IHSS and other long-term services and supports." To support this goal, the Department of Health Care Services (DHCS) is requiring plans participating in CCI to ensure that MOUs with the county IHSS administrating agency regarding information sharing and care coordination. A separate MOU with the local Public Authorities is no longer required.

Under the new statute, effective January 1, 2018, IHSS is no longer a Medi-Cal and Cal MediConnect managed care benefit; however, expectations for the plan to coordinate IHSS services with SSA continue. On December 22, 2017, DHCS released a new IHSS MOU template that is intended to assist CCI counties and managed care plans in their collaboration to complete the required MOU. CalOptima and SSA staff are working in partnership to develop the new MOU to reflect the shared needs of IHSS consumers in Orange County. Staff recommends Board of Directors' approval of the development and execution of a new CalOptima and SSA IHSS related MOU. The MOU will then be submitted to Orange County Board of Supervisors, if determined necessary by SSA.

Fiscal Impact

The recommended action to execute a new MOU with the County of Orange SSA to reflect changes to IHSS care coordination that became effective January 1, 2018 has no fiscal impact.

Rationale for Recommendation

In order to continue coordination of IHSS for CalOptima Medi-Cal and OneCare Connect beneficiaries, and to comply with DHCS requirements, DHCS is requiring CalOptima to update its MOU with SSA.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated May 2, 2013, Authorize the Chief Executive Officer to Execute Memoranda of Understanding with the County of Orange Social Services Agency and Orange County In-Home Supportive Services Public Authority in Connection with the Duals Demonstration (Cal MediConnect)
2. Board Action dated March 6, 2014, Approve the Chairman of the Board's Execution of a Three-Way Agreement with the California Department of Social Services (CDSS) and the Department of Health Care Services (DHCS) for In-Home Supportive Services (IHSS), and Authorize and Direct the Chief Executive Officer (CEO) to Amend MOUs in Connection with Cal MediConnect and the Integration of Medi-Cal Long-Term Services and Supports (MLTSS) to Reflect an Implementation Date

/s/ Michael Schrader
Authorized Signature

2/21/2018
Date

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 2, 2013 **Regular Meeting of the CalOptima Board of Directors**

Consent Calendar

VI. C. Authorize the Chief Executive Officer to Execute Memoranda of Understanding with the County of Orange Social Services Agency and Orange County In-Home Supportive Services Public Authority in Connection with the Duals Demonstration (Cal MediConnect)

Contact

Michael Schrader, Chief Executive Officer, (714) 246-8400

Recommended Action

Authorize the Chief Executive Officer (CEO) to enter into, with the assistance of legal counsel, a Memoranda of Understanding (MOU) with County of Orange (i) Social Services Agency (SSA) and (ii) In-Home Supportive Services (IHSS) Public Authority in connection with the Duals Demonstration (Cal MediConnect).

Background

In July 2012, Governor Brown signed legislation authorizing the Coordinated Care Initiative (CCI). The authority was provided in two pieces of legislation; Senate Bills 1008 and 1036. The CCI is expected to be implemented in eight counties, including Orange County, beginning in late 2013. The CCI is comprised of two major components:

- **Duals Demonstration:** A voluntary three-year demonstration for dual eligible beneficiaries to receive coordinated medical, behavioral health, long-term institutional, and home-and community-based services through a single organized delivery system.
 - **Behavioral Health:** Health plans participating in the demonstration will be responsible for providing enrollees with access to all medically necessary behavioral health (mental health and substance abuse treatment) services currently covered by Medicare and Medi-Cal. Plans will be financially responsible for all Medicare-covered behavioral health services. County health agencies will be financially responsible for some Medi-Cal specialty mental health and substance abuse services; these specialty mental health services will be carved out of the capitated payment to the participating health plans.
- **Managed Medi-Cal Long-Term Supports and Services (LTSS):** In counties participating in the Duals Demonstration, all Medi-Cal beneficiaries, including dual eligible beneficiaries, are required to join a Medi-Cal managed care health plan in order to receive their Medi-Cal benefits, including LTSS and Medicare wrap-around benefits.
- Plans will be required to have written agreements with the appropriate county agency to ensure enrollees have seamless access to Medi-Cal behavioral health services administered by the county.

Under the CCI, participating health plans will be financially responsible for all Medicare and Medi-Cal medical services applicable to Medicare Duals Special Needs Plan (D-SNP) currently. Additionally, participating plans will be financially responsible for IHSS, Community-Based Adult Services (CBAS), Multipurpose Senior Services Program (MSSP) and long-term nursing home care (jointly long-term services and supports or LTSS). The goal of shifting financial responsibility for IHSS to the plans is to motivate the health plans to work more closely with their county counterparts to maximize lower-cost home-and community-based service options, such as IHSS, to improve member outcomes, and to prevent more expensive care in hospitals or nursing homes.

IHSS is California's main community-based Medi-Cal long-term care service, providing in-home personal care services for about 440,000 consumers statewide, of whom at least 75 percent are dually eligible for Medicare and Medi-Cal. IHSS is a county-administered program designed to enable consumer self-direction of care, i.e., IHSS consumers are able to hire, fire, and manage their workers. Approximately 20,000 consumers in Orange County receive IHSS benefits.

Discussion

IHSS is scheduled to become a managed care health plan benefit in the eight CCI counties beginning no sooner than October 1, 2013. While plans are to assume financial responsibility for IHSS on the program effective date, all county administrative functions will remain unchanged in at least the first year of the CCI demonstration. The Department of Health Care Services (DHCS) has directed plans to develop and execute MOUs with county agencies that reflect an agreement between the health plan and the county agency regarding the roles and responsibilities for the first year of the CCI demonstration. To facilitate that process, DHCS provided health plans and county agencies with template MOUs, which provides guidance on MOU requirements; local modifications are permitted. In order to participate in the CCI, CalOptima must enter into an MOU with both the Orange County SSA and the Orange County Public Authority. Further, DHCS has informed plans that executed MOUs must be in place no later than June 1, 2013 in order to move forward with the CCI.

Social Services Agency

Welfare & Institutions Code section 14186, subdivision (b)(6) states that it is the intent of the Legislature that by providing IHSS as a managed care benefit "counties continue to perform functions necessary for the administration of the IHSS program, including conducting assessments and determining authorized hours for recipients." The Welfare & Institutions Code also states that participating health plans must administer the program in a specified manner, including entering into an MOU to allow the county to continue to perform specified functions. As required by law, the Orange County SSA will continue to perform tasks related to the administration of the IHSS program specified, including but not limited to:

- Assessing, approving, and authorizing each current and new member's initial and continuing need for services;
- Enrolling providers, conducting provider orientation, and retaining enrollment documentation;
- Conducting or delegating responsibility to conduct criminal background checks on all

CalOptima Board Action Agenda Referral

Authorize the Chief Executive Officer to Execute MOU with the County of Orange SSA and Orange County IHSS Public Authority in Connection with the Duals Demonstration (Cal MediConnect)

Page 3

potential providers of IHSS and exclude providers as required by current law;

- Providing assistance or delegating the responsibility to provide assistance to IHSS recipients in finding eligible providers through the establishment of a registry as well as provide training for recipients;
- Continuing to provide the local public authority with referral information of all IHSS providers;
- Pursuing overpayment recovery;
- Performing quality assurance activities;
- Sharing confidential data as necessary;
- Appointing an advisory committee;
- Additional functions as necessary.

Health plans must commit to:

- Sharing, receiving, and storing confidential beneficiary information as appropriate;
- Consulting with the county to establish referral and care coordination processes;
- Designating a contact position within the organization responsible for oversight and supervision of the terms of the MOU.

Public Authority

As required by law, the Orange County IHSS Public Authority will continue perform tasks related to the administration of the IHSS program specified in Welfare & Institutions Code section 12301.6, subdivisions (c) and (e). The proposed MOU gives the county public authority the ability to perform these functions under a managed care system. Additionally, this MOU will allow for the sharing of confidential recipient information to and from both parties to promote shared understanding of the consumer's needs and ensure appropriate access to IHSS.

Specific tasks include:

- Conducting criminal background checks on all potential providers and excluding providers as required by current law;
- Providing assistance to IHSS recipients to find eligible providers through an established provider registry;
- Providing training for providers and recipients as required by current law;
- Until the function transfers to the California IHSS Authority (a Statewide Public Authority currently under development), acting as an employer of record and providing access to training IHSS providers and back up providers;
- Additional functions as necessary.

Health plans must commit to:

- Sharing, receiving, and storing confidential beneficiary information as appropriate;
- Designating a contact position within the organization responsible for oversight and supervision of the terms of the MOU.

Next Steps

CalOptima staff must obtain final Board approval to move forward with the Duals Demonstration and execute any related agreements. Execution of these County MOUs will be contingent upon final CalOptima legal department and CEO approval. The MOUs will then be submitted to Orange County Board of Supervisors for approval. Further, the MOUs will provide that the MOU is terminated immediately if the Board does not authorize the three-way agreement with CMS and DHCS with respect to implementation of the Duals Demonstration. The state's tentative targeted timing for release/execution of the three-way contracts is June 2013.

Fiscal Impact

The MOUs under consideration do not currently contain a funding component. There is no budget for this MOU and it will have no fiscal impact. Staffing for the Duals Demonstration/CCI is covered by funding authority approved by the Board on January 3, 2013. When approval for the final Duals Demonstration contracting arrangement is considered by the Board, a budget for that program will be included in the materials provided to the Board to assist it in its decision making process.

Rationale for Recommendation

In order for CalOptima to be eligible to participate in the Duals Demonstration, it must execute MOUs with County IHSS programs no later than June 1, 2013.

Concurrence

Michael H. Ewing, Chief Financial Officer
Gary Crockett, Chief Counsel

Attachments

None

/s/ Michael Schrader
Authorized Signature

4/26/2013
Date

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 6, 2014 **Regular Meeting of the CalOptima Board of Directors**

Consent Calendar

V. F. Approve the Chairman of the Board's Execution of a Three-Way Agreement with the California Department of Social Services (CDSS) and the Department of Health Care Services (DHCS) for In-Home Supportive Services (IHSS), and Authorize and Direct the Chief Executive Officer (CEO) to Amend MOUs in Connection with Cal MediConnect and the Integration of Medi-Cal Long-Term Services and Supports (MLTSS) to Reflect an Implementation Date

Contact

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

Recommended Actions

1. Approve the Chairman of the Board's execution of a three-way agreement with CDSS and DHCS for IHSS rather than the previously approved two-way agreement between CalOptima and CDSS; and
2. Authorize and direct the CEO to execute amendments, with the assistance of legal counsel, to MOUs with the County of Orange Social Services Agency (SSA) and IHSS Public Authority (PA) for IHSS to reflect an implementation date of no earlier than July 1, 2014.

Background

In July 2012, Governor Brown signed legislation authorizing the Coordinated Care Initiative (CCI). The authority was provided in two pieces of legislation: Senate Bills 1008 and 1036. In June 2013, this authority was modified by CCI Trailer Bill (SB 94). The CCI is expected to be implemented in eight counties, including Orange County, beginning in April 2014. The CCI is comprised of two major components:

- **Duals Demonstration:** A voluntary three-year demonstration for dual eligible beneficiaries to receive coordinated medical, behavioral health, long-term institutional, and home and community-based services through a single organized delivery system. The Demonstration is now referred to as Cal MediConnect.
- **Managed Medi-Cal Long-Term Supports and Services (MLTSS):** In CCI counties, Medi-Cal beneficiaries, including dual eligible beneficiaries, are required to join a Medi-Cal managed care health plan to receive their Medi-Cal benefits, including MLTSS and Medicare wrap-around benefits.

In preparation for the CCI, on May 2, 2013, the CalOptima Board of Directors authorized the CEO to enter into the initial MOU between SSA and IHSS PA. CalOptima is now required to modify the MOUs with SSA and the IHSS PA. Additionally, on December 5, 2013, the CalOptima Board of Directors authorized and directed the Chairman of the Board of Directors to enter an agreement with CDSS. Subsequently, CalOptima was notified that the agreement must be executed by February 24,

CalOptima Board Action Agenda Referral
Approve the Chairman of the Board's Execution of a Three-Way Agreement with the California DSS and the DHCS for IHSS, and Authorize and Direct the CEO to Amend MOUs in Connection with Cal MediConnect and the Integration of MLTSS to Reflect an Implementation Date
Page 2

2014 and that the agreement would be modified to be a three-way agreement with CDSS to also include DHCS.

Discussion

CalOptima entered MOUs with SSA and the IHSS PA in 2013 regarding SSA's and IHSS PA's continuing obligations with respect to administration of the IHSS program and CalOptima's obligations with respect to integrating IHSS as a plan benefit. At the time the MOUs were developed, Cal MediConnect and MLTSS participation were linked. Cal MediConnect and MLTSS participation are no longer linked, and DHCS may choose to implement both, one or neither. Further, plans may choose not to participate in Cal MediConnect, but may still be required to participate in MLTSS.

CalOptima anticipates that MLTSS, including IHSS, will be integrated as a CalOptima Medi-Cal benefit effective no earlier than July 1, 2014. At the time the initial MOUs were developed, the effective date of MLTSS integration was not known. DHCS is now requiring CalOptima to modify its existing IHSS related MOUs to reflect the implementation date. Board of Director's approval is requested to modify the IHSS related MOUs. The MOUs will then be submitted to the Orange County Board of Supervisors for approval, if required by SSA and/or the IHSS PA.

In addition to the requirement to enter into MOUs with SSA and the IHSS PA, CalOptima had been informed that it would also be required to enter into an agreement with CDSS for IHSS. The Board of Directors authorized execution of such agreement on December 5, 2013. Subsequently, guidance was provided modifying the agreement as a three-way agreement to also include DHCS. In order to meet the February 24, 2014 regulatory deadline, CalOptima's Chairman of the Board executed the agreement on February 14, 2014. Board of Director's ratification is requested for the execution of the three-way agreement with CDSS and DHCS.

Fiscal Impact

These MOUs, as modified, do not contain a funding component. There is no budget for this MOU and it will have no fiscal impact.

Rationale for Recommendation

In order for CalOptima to participate in Cal MediConnect and integrate MLTSS benefits into Medi-Cal, execution of a three-way agreement with DHCS and CDSS was required by February 24, 2014. Also, DHCS is requiring CalOptima to amend its MOUs related to these services to reflect an implementation of no earlier than July 1, 2014.

Concurrence

Gary Crockett, Chief Counsel

CalOptima Board Action Agenda Referral
Approve the Chairman of the Board’s Execution of a Three-Way
Agreement with the California DSS and the DHCS for IHSS, and
Authorize and Direct the CEO to Amend MOUs in Connection with
Cal MediConnect and the Integration of MLTSS to Reflect an
Implementation Date
Page 3

Attachments

None

/s/ Michael Schrader
Authorized Signature

2/28/2014
Date

Board of Directors Meeting March 1, 2018

Provider Advisory Committee (PAC) Update

February 8, 2018 PAC Meeting

Eleven (11) PAC members were in attendance at the February PAC meeting. The PAC members welcomed Mary Hale, Orange County Health Care Agency Representative to her first official PAC meeting.

Michael Schrader, Chief Executive Officer, discussed the impact of a possible government shutdown and noted that the Federal Health and Human Services Agency had a contingency plan that covers Medicare and Medicaid and the Children's Health Insurance Program (CHIP) funding. Mr. Schrader also discussed the possibility of the current Medicaid Expansion rate being cut back as in prior years. The State has shared with the health plans that the payment may be similar to the Medi-Cal Adult Classic rates. He noted the worst-case scenario would be cuts that would roll back to the Adult Temporary Aid for Needy Families (TANF) rate. CalOptima hosted a CEO and leadership meeting with the health networks on February 2, 2018 where the rates were discussed. Mr. Schrader also discussed Proposition 56 Tobacco tax and how the funds would be used for Denti-Cal and Medi-Cal programs. For Denti-Cal the Department of Healthcare Services (DHCS) restored all of the benefits that were eliminated in 2009 because of the State budget crisis. Mr. Schrader also noted that there would be supplemental funding for Primary Care Physicians and Psychiatrists and the details are still being worked out on how the payments would be distributed.

Ladan Khamseh, Chief Operations Officer, discussed changes to the PM 160 Form and discussed the January 25, 2018 Whole Child Model Stakeholder Meeting and noted that six other events are scheduled for members in February 2018. Ms. Khamseh also noted that recruitment for California Children Services (CCS) Advisory Committee continues and that applications will be accepted through February 28, 2018. Ms. Khamseh shared that CalOptima is looking at delegating the health networks to pay for CHDP services through claims payments. More details will be shared, as CalOptima considers this change.

Richard Bock, M.D., Deputy Chief Medical Officer spoke on behalf on the CCS Clinical Advisory Committee. CalOptima is looking for volunteers for this new committee that will begin in the Fall of 2018. Dr. Bock also discussed the smooth transition of the Behavioral Health program and provided an update on the current flu epidemic.

Cheryl Meronk, Director, Strategic Planning provided a summary of the presentation she provided at the recent CalOptima Board meeting on February 1, 2017 on the Member Health Needs Assessment.

Dr. Anjan Batra, a current PAC member provided an interesting presentation on Tele Health in Pediatric Cardiology.

The Member Advisory Committee (MAC), OneCare Connect MAC and PAC ad hoc committees came together and met on January 11, 2018 and discussed the agenda for the upcoming meeting on March 8, 2018. Current topics include a presentation from MAC member Sr. Mary Terese Sweeny and Marshall Moncreif of the National Coalition Institute of Mental Health and Wellness, a presentation by Sandra Fair, Administrative Manager III, Behavioral Health, Orange County Health Care Agency (OCHA) on the Opioid Epidemic at the County level and other topics of mutual interest to the three committees.

PAC members formed a nominations ad hoc committee which will meet in April to review applications received from the March recruitment of the Allied Health, Behavioral Health, Health Network and Nurse seats that are opening in the coming 2018/2019 term. Additionally, the PAC Chair and Vice-Chair seats are up for nomination too.

Once again, the PAC appreciates and thanks the CalOptima Board for the opportunity to present input and updates on the PAC's current activities.



Board of Directors Meeting March 1, 2018

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

The OneCare Connect Member Advisory Committee (OCC MAC) is now meeting bi-monthly. OCC MAC members will be participating in the Joint MAC/OCC MAC/PAC meeting on March 8, 2018 and will provide the CalOptima Board with an update at the April 5, 2018 meeting.

Recruitment has begun to fill the OCC MAC seats whose terms expire on June 30, 2018. Interested candidates may access the application and appropriate forms on CalOptima's website at www.caloptima.org. OCC MAC is recruiting for the following seats: Community-Based Adult Services provider representative; Seniors representative; Long-Term Care facility representative; member advocate; and OneCare Connect (OCC) member or family member of an OCC member. The deadline to apply is March 30, 2018.

The OCC MAC appreciates the opportunity to provide the CalOptima Board with input and updates on OCC MAC activities.

**Board of Directors Meeting
March 1, 2018**

Member Advisory Committee Update

The Member Advisory Committee (MAC) did not have a meeting scheduled in February, as the committee meets bi-monthly. The next scheduled meeting is the Joint MAC/OCC MAC/PAC meeting on March 8, 2018. MAC will provide an update at the April 5, 2018 Board of Directors meeting.

Recruitment has begun to fill the MAC seats whose terms expire on June 30, 2018. Candidates interested in applying for one of the two-year seats can find application information on CalOptima's website at www.caloptima.org. The available seats include the following: Children, Consumer, Foster Children, Long-Term Services and Support, Medically Indigent People, People with Mental Illness; People with Special Needs; and Recipients of CalWORKs. The deadline to apply is March 30, 2018.

The recruitment for the Whole-Child Model Family Advisory Committee (WCM FAC), including two to four community representatives/advocates and seven to nine member/family member representatives, will continue until the seats are filled. Several promising candidates have submitted applications. Upon MAC's review and selection of prospective candidates, the MAC will forward the slate of candidates to the Board of Directors for consideration.

The MAC appreciates the opportunity to provide the CalOptima Board with input and updates on the MAC's activities.



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Financial Summary

January 2018

Board of Directors Meeting
March 1, 2018

Greg Hamblin
Chief Financial Officer

FY 2017-18: Consolidated Enrollment

- January 2018 MTD:
 - Overall enrollment was 794,957 member months
 - Actual lower than budget by 8,711 or 1.1%
 - Medi-Cal: unfavorable variance of 8,062 members
 - TANF unfavorable variance of 13,925 members
 - SPD favorable variance of 3,010 members
 - Medi-Cal Expansion (MCE) favorable variance of 2,646 members
 - LTC favorable variance of 207 members
 - OneCare Connect: unfavorable variance of 587 members
 - 3,481 or 0.4% increase from prior month
 - Medi-Cal: increase of 3,766 from December
 - OneCare Connect: decrease of 234 from December
 - OneCare: decrease of 52 from December
 - PACE: increase of 1 from December

FY 2017-18: Consolidated Enrollment

- January 2018 YTD:

- Overall enrollment was 5,533,881 member months
 - Actual lower than budget by 85,007 or 1.5%
 - Medi-Cal: unfavorable variance of 83,056 members or 1.5%
 - TANF unfavorable variance of 87,816 members
 - SPD unfavorable variance of 12,888 members
 - MCE favorable variance of 16,424 members
 - LTC favorable variance of 1,224 members
 - OneCare Connect: unfavorable variance of 2,156 members or 2.0%
 - OneCare: favorable variance of 227 members or 2.4%
 - PACE: unfavorable variance of 22 members or 1.4%

FY 2017-18: Consolidated Revenues

- January 2018 MTD:
 - Actual higher than budget by \$10.6 million or 4.2%
 - Medi-Cal: favorable to budget by \$8.6 million or 3.8%
 - Unfavorable volume variance of \$2.3 million
 - Favorable price variance of \$10.9 million due to:
 - \$6.3 million of FY18 Coordinated Care Initiative (CCI) revenues including In Home Supportive Services (IHSS) Dual and Non-Dual revenue
 - \$1.9 million of FY18 revenue for Applied Behavior Analysis (ABA) and prior year Kaiser ABA of \$2.7 million
 - \$0.4 million of Non-Medical Transportation (NMT) revenue

FY 2017-18: Consolidated Revenues (cont.)

- January 2018 MTD:
 - OneCare Connect: favorable to budget by \$2.0 million or 7.7%
 - Unfavorable volume variance of \$1.0 million due to lower enrollment
 - Favorable price variance of \$2.9 million due to FY18 rate adjustment
 - OneCare: favorable to budget by \$65.3 thousand or 4.4%
 - Unfavorable volume variance of \$56.2 thousand
 - Favorable price variance of \$121.5 thousand due to rate increase
 - PACE: favorable to budget by \$47.6 thousand or 2.9%
 - Unfavorable volume variance of \$67.6 thousand
 - Favorable price variance of \$115.2 thousand

FY 2017-18: Consolidated Revenues (cont.)

- January 2018 YTD:

- Actual higher than budget by \$66.4 million or 3.5%
 - Medi-Cal: favorable to budget by \$56.7 million or 3.3%
 - Unfavorable volume variance of \$25.6 million
 - Favorable price variance of \$82.3 million due to:
 - \$36.6 million of FY18 CCI revenue including IHSS Dual and Non-Dual
 - \$11.3 million of FY18 ABA revenue
 - \$6.0 million of FY18 LTC revenue from Non-LTC
 - \$2.8 million of FY18 NMT revenue
 - \$24.9 million of prior year revenue

FY 2017-18: Consolidated Revenues (cont.)

- January 2018 YTD:
 - OneCare Connect: favorable to budget by \$10.5 million or 5.5%
 - Unfavorable volume variance of \$3.8 million
 - Favorable price variance of \$14.3 million due to 15% rate increase
 - OneCare: Unfavorable to budget by \$1.4 million or 14.2%
 - Favorable volume variance of \$0.2 million
 - Unfavorable price variance of \$1.6 million
 - Due to Part D and Hierarchical Condition Category (HCC) reconciliation
 - PACE: favorable to budget by \$0.6 million or 5.9%
 - Favorable price variance of \$0.8 million due to Part D true-up

FY 2017-18: Consolidated Medical Expenses

- January 2018 MTD:
 - Actual higher than budget by \$13.7 million or 5.5%
 - Medi-Cal: unfavorable variance of \$12.4 million
 - Favorable volume variance of \$2.3 million
 - Unfavorable price variance of \$14.7 million
 - Professional Claims unfavorable variance of \$9.5 million due to Behavior Health Treatment (BHT) expenses of \$5.1 and Crossover expenses of \$4.1 million
 - Prescription Drugs unfavorable variance of \$4.4 million due increase in PMPM of \$10
 - Managed Long-Term Services and Support (MLTSS) unfavorable variance of \$1.3 million due to \$0.6 million for IHSS expense and \$0.4 million for CBAS expense
 - OneCare Connect: unfavorable variance of \$0.7 million
 - Favorable volume variance of \$0.9 million
 - Unfavorable price variance of \$1.6 million

FY 2017-18: Consolidated Medical Expenses (cont.)

- January 2018 YTD:

- Actual higher than budget by \$77.4 million or 4.2%

- Medi-Cal: unfavorable variance of \$73.9 million

- Favorable volume variance of \$24.6 million

- Unfavorable price variance of \$98.5 million

- MLTSS expenses unfavorable variance of \$44.5 million

- Professional Claims expenses unfavorable variance of \$21.9 million

- Provider Capitation expenses unfavorable variance of \$21.7 million

- OneCare Connect: unfavorable variance of \$5.8 million

- Favorable volume variance of \$3.5 million

- Unfavorable price variance of \$9.3 million

- Medical Loss Ratio (MLR):

- January 2018 MTD: Actual: 98.5% Budget: 97.3%

- January 2018 YTD: Actual: 96.3% Budget: 95.5%

FY 2017-18: Consolidated Administrative Expenses

- January 2018 MTD:

- Actual lower than budget by \$1.9 million or 14.9%
 - Purchased Services: favorable variance of \$0.8 million
 - Salaries, wages and benefits: favorable variance of \$0.6 million
 - Other categories: favorable variance of \$0.4 million

- January 2018 YTD:

- Actual lower than budget by \$17.8 million or 20.7%
 - Purchased Services: favorable variance of \$7.7 million
 - Salaries, wages and benefits: favorable variance of \$5.2 million
 - Other categories: favorable variance of \$4.9 million

- Administrative Loss Ratio (ALR):

- January 2018 MTD: Actual: 4.0% Budget: 4.9%
- January 2018 YTD: Actual: 3.5% Budget: 4.5%

FY 2017-18: Change in Net Assets

- January 2018 MTD:

- \$6.5 million deficit
- \$1.1 million unfavorable to budget
 - Higher than budgeted revenue of \$10.6 million
 - Higher than budgeted medical expenses of \$13.7 million
 - Lower than budgeted administrative expenses of \$1.9 million

- January 2018 YTD:

- \$16.5 million surplus
- \$15.9 million favorable to budget
 - Higher than budgeted revenue of \$66.4 million
 - Higher than budgeted medical expenses of \$77.4 million
 - Lower than budgeted administrative expenses of \$17.8 million
 - Higher than budgeted investment and other income of \$9.1 million

Enrollment Summary: January 2018

Month-to-Date				Enrollment (By Aid Category)	Year-to-Date			
Actual	Budget	Variance	%		Actual	Budget	Variance	%
67,339	64,185	3,154	4.9%	Aged	438,811	441,128	(2,317)	(0.5%)
610	618	(8)	(1.3%)	BCCTP	4,277	4,326	(49)	(1.1%)
48,666	48,802	(136)	(0.3%)	Disabled	330,900	341,422	(10,522)	(3.1%)
299,173	329,228	(30,055)	(9.1%)	TANF Child	2,254,026	2,307,514	(53,488)	(2.3%)
119,724	103,594	16,130	15.6%	TANF Adult	692,577	726,905	(34,328)	(4.7%)
3,475	3,268	207	6.3%	LTC	24,100	22,876	1,224	5.4%
239,425	236,779	2,646	1.1%	MCE	1,671,403	1,654,979	16,424	1.0%
778,412	786,474	(8,062)	(1.0%)	Medi-Cal	5,416,094	5,499,150	(83,056)	(1.5%)
14,989	15,576	(587)	(3.8%)	OneCare Connect	106,559	108,715	(2,156)	(2.0%)
236	246	(10)	(4.1%)	PACE	1,595	1,617	(22)	(1.4%)
1,320	1,372	(52)	(3.8%)	OneCare	9,633	9,406	227	2.4%
794,957	803,668	(8,711)	(1.1%)	CalOptima Total	5,533,881	5,618,888	(85,007)	(1.5%)

Financial Highlights: January 2018

Month-to-Date

Actual	Budget	\$ Variance	% Variance
794,957	803,668	(8,711)	(1.1%)
266,515,642	255,871,398	10,644,244	4.2%
262,557,290	248,902,653	(13,654,637)	(5.5%)
10,695,726	12,563,880	1,868,154	14.9%
(6,737,374)	(5,595,135)	(1,142,239)	(20.4%)
270,342	231,157	39,185	17.0%
(6,467,032)	(5,363,978)	(1,103,054)	(20.6%)
98.5%	97.3%	(1.2%)	
4.0%	4.9%	0.9%	
<u>(2.5%)</u>	<u>(2.2%)</u>	(0.3%)	
100.0%	100.0%		

Year-to-Date

	Actual	Budget	\$ Variance	% Variance
Member Months	5,533,881	5,618,888	(85,007)	(1.5%)
Revenues	1,974,426,100	1,908,034,554	66,391,546	3.5%
Medical Expenses	1,900,447,061	1,823,092,418	(77,354,643)	(4.2%)
Administrative Expenses	68,180,243	86,011,384	17,831,141	20.7%
Operating Margin	5,798,796	(1,069,248)	6,868,043	642.3%
Non Operating Income (Loss)	10,733,614	1,660,873	9,072,741	546.3%
Change in Net Assets	16,532,410	591,625	15,940,785	2694.4%
Medical Loss Ratio	96.3%	95.5%	(0.7%)	
Administrative Loss Ratio	3.5%	4.5%	1.1%	
Operating Margin Ratio	<u>0.3%</u>	<u>(0.1%)</u>	0.3%	
Total Operating	100.0%	100.0%		

Consolidated Performance Actual vs. Budget: January (in millions)

MONTH-TO-DATE				YEAR-TO-DATE		
<u>Actual</u>	<u>Budget</u>	<u>Variance</u>		<u>Actual</u>	<u>Budget</u>	<u>Variance</u>
(6.4)	(4.3)	(2.1)	Medi-Cal	(0.4)	0.6	(1.0)
0.2	(1.1)	1.3	OCC	5.5	(0.4)	5.9
(0.4)	(0.1)	(0.3)	OneCare	0.0	(0.9)	1.0
<u>(0.1)</u>	<u>0.0</u>	<u>(0.1)</u>	PACE	<u>0.6</u>	<u>(0.3)</u>	<u>0.9</u>
(6.7)	(5.5)	(1.2)	Operating	5.8	(1.0)	6.9
<u>0.3</u>	<u>0.2</u>	<u>0.1</u>	Inv./Rental Inc, MCO tax	<u>10.8</u>	<u>1.7</u>	<u>9.1</u>
0.3	0.2	0.1	Non-Operating	10.8	1.7	9.1
(6.5)	(5.4)	(1.1)	TOTAL	16.5	0.6	15.9

Consolidated Revenue & Expense: January 2018 MTD

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
Member Months	538,987	239,425	778,412	14,989	1,320	236	794,957
REVENUES							
Capitation Revenue	\$ 134,761,187	\$ 101,265,767	\$ 236,026,954	\$ 27,227,996	\$ 1,548,970	\$ 1,711,722	\$ 266,515,642
Other Income	-	-	-	-	0	-	-
Total Operating Revenues	<u>134,761,187</u>	<u>101,265,767</u>	<u>236,026,954</u>	<u>27,227,996</u>	<u>1,548,970</u>	<u>1,711,722</u>	<u>266,515,642</u>
MEDICAL EXPENSES							
Provider Capitation	37,454,275	49,844,941	87,299,216	11,954,289	478,424	-	99,731,929
Facilities	28,529,652	13,921,036	42,450,687	4,040,859	776,667	508,541	47,776,754
Ancillary	-	-	-	653,887	45,142	-	699,029
Skilled Nursing	-	-	-	-	2,309	-	2,309
Professional Claims	15,460,018	8,828,894	24,288,912	-	-	404,612	24,693,524
Prescription Drugs	23,496,538	18,290,440	41,786,979	5,758,928	444,825	151,102	48,141,834
Quality Incentives	-	-	-	-	-	-	-
MLTSS Facility Payments	32,039,588	2,430,716	34,470,304	1,432,870	-	-	35,903,174
Medical Management	1,912,687	877,227	2,789,914	1,106,786	60,232	574,130	4,531,062
Reinsurance & Other	529,520	305,255	834,775	139,549	6,595	96,756	1,077,674
Total Medical Expenses	<u>139,422,278</u>	<u>94,498,509</u>	<u>233,920,787</u>	<u>25,087,168</u>	<u>1,814,193</u>	<u>1,735,141</u>	<u>262,557,290</u>
Medical Loss Ratio	103.5%	93.3%	99.1%	92.1%	117.1%	101.4%	98.5%
GROSS MARGIN	(4,661,091)	6,767,258	2,106,167	2,140,827	(265,223)	(23,419)	3,958,352
ADMINISTRATIVE EXPENSES							
Salaries, Wages & Benefits			6,149,833	851,522	25,216	88,505	7,115,076
Professional fees			80,555	98,473	13,333	6,360	198,721
Purchased services			485,053	213,030	5,425	14,930	718,438
Printing and Postage			517,810	68,541	1,696	2,097	590,144
Depreciation and Amortization			378,850	-	-	2,168	381,018
Other expenses			1,291,354	45,636	0	7,351	1,344,341
Indirect cost allocation, Occupancy expense			(387,354)	692,184	40,057	3,101	347,988
Total Administrative Expenses			<u>8,516,100</u>	<u>1,969,387</u>	<u>85,727</u>	<u>124,512</u>	<u>10,695,726</u>
Admin Loss Ratio			3.6%	7.2%	5.5%	7.3%	4.0%
INCOME (LOSS) FROM OPERATIONS			(6,409,933)	171,441	(350,950)	(147,931)	(6,737,374)
INVESTMENT INCOME			-	-	-	-	283,128
NET GRANT INCOME			(13,021)	-	-	-	(13,021)
OTHER INCOME			236	-	-	-	236
CHANGE IN NET ASSETS			<u>\$ (6,422,719)</u>	<u>\$ 171,441</u>	<u>\$ (350,950)</u>	<u>\$ (147,931)</u>	<u>\$ (6,467,032)</u>
BUDGETED CHANGE IN ASSETS			(4,342,442)	(1,134,203)	(99,830)	(18,660)	(5,363,978)
VARIANCE TO BUDGET - FAV (UNFAV)			<u>(2,080,276)</u>	<u>1,305,644</u>	<u>(251,120)</u>	<u>(129,271)</u>	<u>(1,103,054)</u>

Consolidated Revenue & Expense: January 2018 YTD

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
Member Months	3,744,691	1,671,403	5,416,094	106,559	9,633	1,595	5,533,881
REVENUES							
Capitation Revenue	\$ 1,031,509,730	\$ 723,175,416	\$ 1,754,685,147	\$ 200,049,536	8,376,591	\$ 11,314,826	\$ 1,974,426,100
Other Income	-	-	-	-	0	-	-
Total Operating Revenues	<u>1,031,509,730</u>	<u>723,175,416</u>	<u>1,754,685,147</u>	<u>200,049,536</u>	<u>8,376,591</u>	<u>11,314,826</u>	<u>1,974,426,100</u>
MEDICAL EXPENSES							
Provider Capitation	269,980,440	351,582,832	621,563,273	78,913,739	396,342	-	700,873,354
Facilities	179,469,229	128,465,788	307,935,016	20,999,165	3,269,887	2,178,259	334,382,327
Ancillary	-	-	-	4,324,930	304,373	-	4,629,303
Skilled Nursing	-	-	-	-	139,684	-	139,684
Professional Claims	60,650,421	58,841,538	119,491,959	-	-	2,497,081	121,989,040
Prescription Drugs	129,564,121	125,549,172	255,113,293	36,329,926	3,139,421	837,972	295,420,612
MLTSS Facility Payments	354,091,958	17,713,559	371,805,517	33,388,864	-	17,511	405,211,892
Medical Management	13,477,491	5,291,602	18,769,094	7,043,209	374,195	3,718,571	29,905,068
Reinsurance & Other	3,896,116	2,094,590	5,990,706	1,165,197	51,285	688,594	7,895,781
Total Medical Expenses	<u>1,011,129,776</u>	<u>689,539,081</u>	<u>1,700,668,857</u>	<u>182,165,030</u>	<u>7,675,186</u>	<u>9,937,988</u>	<u>1,900,447,061</u>
Medical Loss Ratio	98.0%	95.3%	96.9%	91.1%	91.6%	87.8%	96.3%
GROSS MARGIN	20,379,954	33,636,336	54,016,290	17,884,506	701,405	1,376,838	73,979,039
ADMINISTRATIVE EXPENSES							
Salaries, Wages & Benefits			38,264,999	5,465,588	172,321	534,292	44,437,200
Professional fees			990,845	200,011	105,682	23,032	1,319,570
Purchased services			4,627,962	1,126,336	121,461	45,343	5,921,102
Printing and Postage			2,149,290	529,731	58,454	23,513	2,760,989
Depreciation and Amortization			2,852,820	-	-	15,104	2,867,924
Other expenses			8,039,367	287,098	(32)	97,062	8,423,495
Indirect cost allocation, Occupancy expense			(2,561,256)	4,763,132	200,887	47,201	2,449,964
Total Administrative Expenses			<u>54,364,025</u>	<u>12,371,897</u>	<u>658,773</u>	<u>785,548</u>	<u>68,180,243</u>
Admin Loss Ratio			3.1%	6.2%	7.9%	6.9%	3.5%
INCOME (LOSS) FROM OPERATIONS			(347,736)	5,512,610	42,631	591,290	5,798,796
INVESTMENT INCOME			-	-	-	-	10,763,288
NET RENTAL INCOME			-	-	-	-	54,103
NET GRANT INCOME			(84,546)	-	-	-	(84,546)
OTHER INCOME			769	-	-	-	769
CHANGE IN NET ASSETS			<u>\$ (431,512)</u>	<u>\$ 5,512,610</u>	<u>\$ 42,631</u>	<u>\$ 591,290</u>	<u>\$ 16,532,410</u>
BUDGETED CHANGE IN ASSETS			580,321	(416,537)	(935,393)	(297,639)	591,625
VARIANCE TO BUDGET - FAV (UNFAV)			<u>(1,011,833)</u>	<u>5,929,147</u>	<u>978,024</u>	<u>888,929</u>	<u>15,940,785</u>

Balance Sheet:

As of January 2018

ASSETS

Current Assets

Operating Cash	\$329,997,190
Investments	700,482,442
Capitation receivable	401,333,697
Receivables - Other	20,501,060
Prepaid Expenses	5,277,928

Total Current Assets 1,457,592,317

Capital Assets Furniture and equipment	34,039,048
Building/Leasehold improvements	6,349,733
505 City Parkway West	49,433,337
	<u>89,822,119</u>
Less: accumulated depreciation	(38,789,815)
Capital assets, net	<u>51,032,304</u>

Other Assets Restricted deposit & Other	300,000
Board-designated assets	
Cash and cash equivalents	21,541,152
Long term investments	514,116,164
Total Board-designated Assets	<u>535,657,316</u>
Total Other Assets	<u>535,957,316</u>

Deferred outflows of Resources - Pension Contributions	5,234,198
Deferred outflows of Resources - Difference in Experience	1,072,771
Deferred outflows of Resources - Excess Earnings	5,270,171

TOTAL ASSETS & OUTFLOWS 2,056,159,077

LIABILITIES & FUND BALANCES

Current Liabilities

Accounts payable	\$23,451,417
Medical claims liability	917,113,249
Accrued payroll liabilities	10,519,695
Deferred revenue	176,689,086
Deferred lease obligations	152,611
Capitation and withholds	150,487,813

Total Current Liabilities 1,278,413,871

Other employment benefits liability	29,790,886
Net Pension Liabilities	16,523,507
Long Term Liabilities	100,000

TOTAL LIABILITIES 1,324,828,265

Deferred inflows of Resources - Excess Earnings	-
Deferred inflows of Resources - Changes in Assumptions	1,340,010
Tangible net equity (TNE)	88,253,740
Funds in excess of TNE	641,737,062

Net Assets 729,990,802

TOTAL LIABILITIES, INFLOWS & FUND BALANCES 2,056,159,077

Board Designated Reserve and TNE Analysis As of January 2018

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	146,540,425				
	Tier 1 - Logan Circle	146,376,453				
	Tier 1 - Wells Capital	145,950,850				
Board-designated Reserve						
		438,867,727	300,016,071	466,417,418	138,851,656	(27,549,691)
TNE Requirement	Tier 2 - Logan Circle	96,789,588	88,253,740	88,253,740	8,535,848	8,535,848
Consolidated:						
	<i>Current reserve level</i>	535,657,315	388,269,811	554,671,158	147,387,505	(19,013,843)
		1.93	1.40	2.00		



UNAUDITED FINANCIAL STATEMENTS

January 2018

[Back to Agenda](#)

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**CalOptima - Consolidated
Financial Highlights
For the Seven Months Ended January 31, 2018**

Month-to-Date					Year-to-Date			
Actual	Budget	\$ Variance	% Variance		Actual	Budget	\$ Variance	% Variance
794,957	803,668	(8,711)	(1.1%)	Member Months	5,533,881	5,618,888	(85,007)	(1.5%)
266,515,642	255,871,398	10,644,244	4.2%	Revenues	1,974,426,100	1,908,034,554	66,391,546	3.5%
262,557,290	248,902,653	(13,654,637)	(5.5%)	Medical Expenses	1,900,447,061	1,823,092,418	(77,354,643)	(4.2%)
10,695,726	12,563,880	1,868,154	14.9%	Administrative Expenses	68,180,243	86,011,384	17,831,141	20.7%
(6,737,374)	(5,595,135)	(1,142,239)	(20.4%)	Operating Margin	5,798,796	(1,069,248)	6,868,043	642.3%
270,342	231,157	39,185	17.0%	Non Operating Income (Loss)	10,733,614	1,660,873	9,072,741	546.3%
(6,467,032)	(5,363,978)	(1,103,054)	(20.6%)	Change in Net Assets	16,532,410	591,625	15,940,785	2694.4%
98.5%	97.3%	(1.2%)		Medical Loss Ratio	96.3%	95.5%	(0.7%)	
4.0%	4.9%	0.9%		Administrative Loss Ratio	3.5%	4.5%	1.1%	
<u>(2.5%)</u>	<u>(2.2%)</u>	(0.3%)		Operating Margin Ratio	<u>0.3%</u>	<u>(0.1%)</u>	0.3%	
100.0%	100.0%			Total Operating	100.0%	100.0%		

**CalOptima
Financial Dashboard
For the Seven Months Ended January 31, 2018**

MONTH - TO - DATE

Enrollment				
	Actual	Budget		Fav / (Unfav)
Medi-Cal	778,412	786,474	↓	(8,062) (1.0%)
OneCare Connect	14,989	15,576	↓	(587) (3.8%)
OneCare	1,320	1,372	↓	(52) (3.8%)
PACE	236	246	↓	(10) (4.1%)
Total	794,957	803,668	↓	(8,711) (1.1%)

Change in Net Assets (000)				
	Actual	Budget		Fav / (Unfav)
Medi-Cal	\$ (6,423)	\$ (4,342)	↓	\$ (2,080) (47.9%)
OneCare Connect	171	(1,134)	↑	1,306 115.1%
OneCare	(351)	(100)	↓	(251) (251.5%)
PACE	(148)	(19)	↓	(129) (692.8%)
505 Bldg.	(0)	(19)	↑	19 100.0%
Investment Income & Other	283	250	↑	33 13.3%
Total	\$ (6,467)	\$ (5,364)	↓	\$ (1,103) (20.6%)

MLR				
	Actual	Budget		% Point Var
Medi-Cal	99.1%	97.4%	↓	(1.7)
OneCare Connect	92.1%	96.5%	↑	4.4
OneCare	117.1%	100.1%	↓	(17.1)

Administrative Cost (000)				
	Actual	Budget		Fav / (Unfav)
Medi-Cal	\$ 8,516	\$ 10,294	↑	\$ 1,778 17.3%
OneCare Connect	1,969	2,012	↑	43 2.1%
OneCare	86	99	↑	13 13.2%
PACE	125	159	↑	35 21.7%
Total	\$ 10,696	\$ 12,564	↑	\$ 1,868 14.9%

Total FTE's Month				
	Actual	Budget		Fav / (Unfav)
Medi-Cal	903	900		(2)
OneCare Connect	216	237		21
OneCare	3	3		(0)
PACE	56	64		8
Total	1,177	1,205		27

MM per FTE				
	Actual	Budget		Fav / (Unfav)
Medi-Cal	862	873		(11)
OneCare Connect	69	66		4
OneCare	435	457		(22)
PACE	4	4		0
Total	1,371	1,400		(29)

YEAR - TO - DATE

Year To Date Enrollment				
	Actual	Budget		Fav / (Unfav)
Medi-Cal	5,416,094	5,499,150	↓	(83,056) (1.5%)
OneCare Connect	106,559	108,715	↓	(2,156) (2.0%)
OneCare	9,633	9,406	↑	227 2.4%
PACE	1,595	1,617	↓	(22) (1.4%)
Total	5,533,881	5,618,888	↓	(85,007) (1.5%)

Change in Net Assets (000)				
	Actual	Budget		Fav / (Unfav)
Medi-Cal	\$ (432)	\$ 580	↓	\$ (1,012) (174.4%)
OneCare Connect	5,513	(417)	↑	5,929 1423.4%
OneCare	43	(935)	↑	978 104.6%
PACE	591	(298)	↑	889 298.7%
505 Bldg.	54	(89)	↑	143 160.7%
Investment Income & Other	10,763	1,750	↑	9,013 515.0%
Total	\$ 16,532	\$ 592	↑	\$ 15,941 2694.4%

MLR				
	Actual	Budget		% Point Var
Medi-Cal	96.9%	95.8%	↓	(1.1)
OneCare Connect	91.1%	93.1%	↑	2.0
OneCare	91.6%	102.5%	↑	10.9

Administrative Cost (000)				
	Actual	Budget		Fav / (Unfav)
Medi-Cal	\$ 54,364	\$ 70,703	↑	\$ 16,339 23.1%
OneCare Connect	12,372	13,565	↑	1,194 8.8%
OneCare	659	689	↑	30 4.3%
PACE	786	1,054	↑	268 25.5%
Total	\$ 68,180	\$ 86,011	↑	\$ 17,831 20.7%

Total FTE's YTD				
	Actual	Budget		Fav / (Unfav)
Medi-Cal	6,200	6,303		103
OneCare Connect	1,552	1,659		107
OneCare	21	21		(0)
PACE	377	444		67
Total	8,151	8,428		277

MM per FTE				
	Actual	Budget		Fav / (Unfav)
Medi-Cal	874	872		1
OneCare Connect	69	66		3
OneCare	449	448		1
PACE	4	4		1
Total	1,395	1,390		6

**CalOptima - Consolidated
Statement of Revenue and Expenses
For the One Month Ended January 31, 2018**

	Actual		Month Budget		Variance	
	\$	PMPM*	\$	PMPM*	\$	PMPM
Member Months**	794,957		803,668		(8,711)	
Revenues						
Medi-Cal	\$ 236,026,954	\$ 303.22	\$ 227,447,405	\$ 289.20	\$ 8,579,549	\$ 14.02
OneCare Connect	27,227,996	1,816.53	25,276,117	1,622.76	1,951,879	193.77
OneCare	1,548,970	1,173.46	1,483,716	1,081.43	65,254	92.04
PACE	1,711,722	7,253.06	1,664,160	6,764.88	47,562	488.18
Total Operating Revenue	266,515,642	335.26	255,871,398	318.38	10,644,244	16.88
Medical Expenses						
Medi-Cal	233,920,787	300.51	221,495,893	281.63	(12,424,894)	(18.88)
OneCare Connect	25,087,168	1,673.71	24,398,248	1,566.40	(688,920)	(107.31)
OneCare	1,814,193	1,374.39	1,484,738	1,082.17	(329,455)	(292.22)
PACE	1,735,141	7,352.29	1,523,774	6,194.20	(211,367)	(1,158.09)
Total Medical Expenses	262,557,290	330.28	248,902,653	309.71	(13,654,637)	(20.57)
Gross Margin	3,958,352	4.98	6,968,745	8.67	(3,010,393)	(3.69)
Administrative Expenses						
Salaries and Benefits	7,115,076	8.95	7,741,981	9.63	626,905	0.68
Professional fees	198,721	0.25	378,691	0.47	179,970	0.22
Purchased services	718,438	0.90	1,558,310	1.94	839,872	1.04
Printing and Postage	590,144	0.74	529,873	0.66	(60,271)	(0.08)
Depreciation and Amortization	381,018	0.48	463,298	0.58	82,280	0.10
Other	1,344,341	1.69	1,551,310	1.93	206,969	0.24
Indirect cost allocation, Occupancy expense	347,988	0.44	340,417	0.42	(7,571)	(0.01)
Total Administrative Expenses	10,695,726	13.45	12,563,880	15.63	1,868,154	2.18
Income (Loss) From Operations	(6,737,374)	(8.48)	(5,595,135)	(6.96)	(1,142,239)	(1.51)
Investment income						
Interest income	2,123,227	2.67	250,000	0.31	1,873,227	2.36
Realized gain/(loss) on investments	(129,584)	(0.16)	-	-	(129,584)	(0.16)
Unrealized gain/(loss) on investments	(1,710,516)	(2.15)	-	-	(1,710,516)	(2.15)
Total Investment Income	283,128	0.36	250,000	0.31	33,128	0.05
Net Rental Income	(0)	(0.00)	(18,843)	(0.02)	18,843	0.02
Total Net Operating Tax	-	-	-	-	-	-
Total Net Grant Income	(13,021)	(0.02)	-	-	(13,021)	(0.02)
QAF/IGT	-	-	-	-	-	-
Other Income	236	0.00	-	-	236	0.00
Change In Net Assets	(6,467,032)	(8.14)	(5,363,978)	(6.67)	(1,103,054)	(1.46)
Medical Loss Ratio	98.5%		97.3%		(1.2%)	
Administrative Loss Ratio	4.0%		4.9%		0.9%	

* PMPMs for Revenues and Medical Expenses are calculated using line of business enrollment

** Includes MSSP

**CalOptima - Consolidated
Statement of Revenue and Expenses
For the Seven Months Ended January 31, 2018**

	Actual		Month Budget		Variance	
	\$	PMPM*	\$	PMPM*	\$	PMPM
Member Months**	5,533,881		5,618,888		(85,007)	
Revenues						
Medi-Cal	\$ 1,754,685,147	\$ 323.98	\$ 1,698,028,315	\$ 308.78	\$ 56,656,832	\$ 15.20
OneCare Connect	200,049,536	1,877.36	189,557,543	1,743.62	10,491,993	133.74
OneCare	8,376,591	869.57	9,762,806	1,037.93	(1,386,215)	(168.36)
PACE	11,314,826	7,093.93	10,685,890	6,608.47	628,936	485.47
Total Operating Revenue	1,974,426,100	356.79	1,908,034,554	339.58	66,391,546	17.21
Medical Expenses						
Medi-Cal	1,700,668,857	314.00	1,626,744,523	295.82	(73,924,334)	(18.19)
OneCare Connect	182,165,030	1,709.52	176,408,629	1,622.67	(5,756,401)	(86.85)
OneCare	7,675,186	796.76	10,009,566	1,064.17	2,334,380	267.41
PACE	9,937,988	6,230.71	9,929,700	6,140.82	(8,288)	(89.90)
Total Medical Expenses	1,900,447,061	343.42	1,823,092,418	324.46	(77,354,643)	(18.96)
Gross Margin	73,979,039	13.37	84,942,136	15.12	(10,963,097)	(1.75)
Administrative Expenses						
Salaries and Benefits	44,437,200	8.03	49,673,493	8.84	5,236,293	0.81
Professional fees	1,319,570	0.24	2,700,328	0.48	1,380,758	0.24
Purchased services	5,921,102	1.07	13,580,860	2.42	7,659,759	1.35
Printing and Postage	2,760,989	0.50	3,728,611	0.66	967,622	0.16
Depreciation and Amortization	2,867,924	0.52	3,243,086	0.58	375,162	0.06
Other	8,423,495	1.52	10,702,087	1.90	2,278,592	0.38
Indirect cost allocation, Occupancy expense	2,449,964	0.44	2,382,919	0.42	(67,045)	(0.02)
Total Administrative Expenses	68,180,243	12.32	86,011,384	15.31	17,831,141	2.99
Income (Loss) From Operations	5,798,796	1.05	(1,069,248)	(0.19)	6,868,043	1.24
Investment income						
Interest income	15,538,420	2.81	1,750,000	0.31	13,788,420	2.50
Realized gain/(loss) on investments	(934,649)	(0.17)	-	-	(934,649)	(0.17)
Unrealized gain/(loss) on investments	(3,840,482)	(0.69)	-	-	(3,840,482)	(0.69)
Total Investment Income	10,763,288	1.94	1,750,000	0.31	9,013,288	1.63
Net Rental Income	54,103	0.01	(89,127)	(0.02)	143,230	0.03
Total Net Operating Tax	-	-	-	-	-	-
Total Net Grant Income	(84,546)	(0.02)	-	-	(84,546)	(0.02)
QAF/IGT	-	-	-	-	-	-
Other Income	769	0.00	-	-	769	0.00
Change In Net Assets	16,532,410	2.99	591,625	0.11	15,940,785	2.88
Medical Loss Ratio	96.3%		95.5%		(0.7%)	
Administrative Loss Ratio	3.5%		4.5%		1.1%	

* PMPMs for Revenues and Medical Expenses are calculated using line of business enrollment

** Includes MSSP

CalOptima - Consolidated - Month to Date
Statement of Revenues and Expenses by LOB
For the One Month Ended January 31, 2018

	<u>Medi-Cal Classic</u>	<u>Medi-Cal Expansion</u>	<u>Total Medi-Cal</u>	<u>OneCare Connect</u>	<u>OneCare</u>	<u>PACE</u>	<u>Consolidated</u>
Member Months	538,987	239,425	778,412	14,989	1,320	236	794,957
REVENUES							
Capitation Revenue	\$ 134,761,187	\$ 101,265,767	\$ 236,026,954	\$ 27,227,996	\$ 1,548,970	\$ 1,711,722	\$ 266,515,642
Other Income	-	-	-	-	0	-	-
Total Operating Revenues	<u>134,761,187</u>	<u>101,265,767</u>	<u>236,026,954</u>	<u>27,227,996</u>	<u>1,548,970</u>	<u>1,711,722</u>	<u>266,515,642</u>
MEDICAL EXPENSES							
Provider Capitation	37,454,275	49,844,941	87,299,216	11,954,289	478,424	-	99,731,929
Facilities	28,529,652	13,921,036	42,450,687	4,040,859	776,667	508,541	47,776,754
Ancillary	-	-	-	653,887	45,142	-	699,029
Skilled Nursing	-	-	-	-	2,309	-	2,309
Professional Claims	15,460,018	8,828,894	24,288,912	-	-	404,612	24,693,524
Prescription Drugs	23,496,538	18,290,440	41,786,979	5,758,928	444,825	151,102	48,141,834
Quality Incentives	-	-	-	-	-	-	-
MLTSS Facility Payments	32,039,588	2,430,716	34,470,304	1,432,870	-	-	35,903,174
Medical Management	1,912,687	877,227	2,789,914	1,106,786	60,232	574,130	4,531,062
Reinsurance & Other	529,520	305,255	834,775	139,549	6,595	96,756	1,077,674
Total Medical Expenses	<u>139,422,278</u>	<u>94,498,509</u>	<u>233,920,787</u>	<u>25,087,168</u>	<u>1,814,193</u>	<u>1,735,141</u>	<u>262,557,290</u>
Medical Loss Ratio	103.5%	93.3%	99.1%	92.1%	117.1%	101.4%	98.5%
GROSS MARGIN	(4,661,091)	6,767,258	2,106,167	2,140,827	(265,223)	(23,419)	3,958,352
ADMINISTRATIVE EXPENSES							
Salaries, Wages & Benefits			6,149,833	851,522	25,216	88,505	7,115,076
Professional fees			80,555	98,473	13,333	6,360	198,721
Purchased services			485,053	213,030	5,425	14,930	718,438
Printing and Postage			517,810	68,541	1,696	2,097	590,144
Depreciation and Amortization			378,850	-	-	2,168	381,018
Other expenses			1,291,354	45,636	0	7,351	1,344,341
Indirect cost allocation, Occupancy expense			(387,354)	692,184	40,057	3,101	347,988
Total Administrative Expenses			<u>8,516,100</u>	<u>1,969,387</u>	<u>85,727</u>	<u>124,512</u>	<u>10,695,726</u>
Admin Loss Ratio			3.6%	7.2%	5.5%	7.3%	4.0%
INCOME (LOSS) FROM OPERATIONS			(6,409,933)	171,441	(350,950)	(147,931)	(6,737,374)
INVESTMENT INCOME			-	-	-	-	283,128
NET GRANT INCOME			(13,021)	-	-	-	(13,021)
OTHER INCOME			236	-	-	-	236
CHANGE IN NET ASSETS			<u>\$ (6,422,719)</u>	<u>\$ 171,441</u>	<u>\$ (350,950)</u>	<u>\$ (147,931)</u>	<u>\$ (6,467,032)</u>
BUDGETED CHANGE IN ASSETS			(4,342,442)	(1,134,203)	(99,830)	(18,660)	(5,363,978)
VARIANCE TO BUDGET - FAV (UNFAV)			<u>(2,080,276)</u>	<u>1,305,644</u>	<u>(251,120)</u>	<u>(129,271)</u>	<u>(1,103,054)</u>

**CalOptima - Consolidated - Year to Date
Statement of Revenues and Expenses by LOB
For the Seven Months Ended January 31, 2018**

	<u>Medi-Cal Classic</u>	<u>Medi-Cal Expansion</u>	<u>Total Medi-Cal</u>	<u>OneCare Connect</u>	<u>OneCare</u>	<u>PACE</u>	<u>Consolidated</u>
Member Months	3,744,691	1,671,403	5,416,094	106,559	9,633	1,595	5,533,881
REVENUES							
Capitation Revenue	\$ 1,031,509,730	\$ 723,175,416	\$ 1,754,685,147	\$ 200,049,536	8,376,591	\$ 11,314,826	\$ 1,974,426,100
Other Income	-	-	-	-	0	-	-
Total Operating Revenues	<u>1,031,509,730</u>	<u>723,175,416</u>	<u>1,754,685,147</u>	<u>200,049,536</u>	<u>8,376,591</u>	<u>11,314,826</u>	<u>1,974,426,100</u>
MEDICAL EXPENSES							
Provider Capitation	269,980,440	351,582,832	621,563,273	78,913,739	396,342	-	700,873,354
Facilities	179,469,229	128,465,788	307,935,016	20,999,165	3,269,887	2,178,259	334,382,327
Ancillary	-	-	-	4,324,930	304,373	-	4,629,303
Skilled Nursing	-	-	-	-	139,684	-	139,684
Professional Claims	60,650,421	58,841,538	119,491,959	-	-	2,497,081	121,989,040
Prescription Drugs	129,564,121	125,549,172	255,113,293	36,329,926	3,139,421	837,972	295,420,612
MLTSS Facility Payments	354,091,958	17,713,559	371,805,517	33,388,864	-	17,511	405,211,892
Medical Management	13,477,491	5,291,602	18,769,094	7,043,209	374,195	3,718,571	29,905,068
Reinsurance & Other	3,896,116	2,094,590	5,990,706	1,165,197	51,285	688,594	7,895,781
Total Medical Expenses	<u>1,011,129,776</u>	<u>689,539,081</u>	<u>1,700,668,857</u>	<u>182,165,030</u>	<u>7,675,186</u>	<u>9,937,988</u>	<u>1,900,447,061</u>
Medical Loss Ratio	98.0%	95.3%	96.9%	91.1%	91.6%	87.8%	96.3%
GROSS MARGIN	20,379,954	33,636,336	54,016,290	17,884,506	701,405	1,376,838	73,979,039
ADMINISTRATIVE EXPENSES							
Salaries, Wages & Benefits			38,264,999	5,465,588	172,321	534,292	44,437,200
Professional fees			990,845	200,011	105,682	23,032	1,319,570
Purchased services			4,627,962	1,126,336	121,461	45,343	5,921,102
Printing and Postage			2,149,290	529,731	58,454	23,513	2,760,989
Depreciation and Amortization			2,852,820	-	-	15,104	2,867,924
Other expenses			8,039,367	287,098	(32)	97,062	8,423,495
Indirect cost allocation, Occupancy expense			(2,561,256)	4,763,132	200,887	47,201	2,449,964
Total Administrative Expenses			<u>54,364,025</u>	<u>12,371,897</u>	<u>658,773</u>	<u>785,548</u>	<u>68,180,243</u>
Admin Loss Ratio			3.1%	6.2%	7.9%	6.9%	3.5%
INCOME (LOSS) FROM OPERATIONS			(347,736)	5,512,610	42,631	591,290	5,798,796
INVESTMENT INCOME			-	-	-	-	10,763,288
NET RENTAL INCOME			-	-	-	-	54,103
NET GRANT INCOME			(84,546)	-	-	-	(84,546)
OTHER INCOME			769	-	-	-	769
CHANGE IN NET ASSETS			<u>\$ (431,512)</u>	<u>\$ 5,512,610</u>	<u>\$ 42,631</u>	<u>\$ 591,290</u>	<u>\$ 16,532,410</u>
BUDGETED CHANGE IN ASSETS			580,321	(416,537)	(935,393)	(297,639)	591,625
VARIANCE TO BUDGET - FAV (UNFAV)			<u>(1,011,833)</u>	<u>5,929,147</u>	<u>978,024</u>	<u>888,929</u>	<u>15,940,785</u>

CalOptima
Enrollment Summary
For the Seven Months Ended January 31, 2018

Month-to-Date				Enrollment (By Aid Category)	Year-to-Date			
Actual	Budget	Variance	%		Actual	Budget	Variance	%
67,339	64,185	3,154	4.9%	Aged	438,811	441,128	(2,317)	(0.5%)
610	618	(8)	(1.3%)	BCCTP	4,277	4,326	(49)	(1.1%)
48,666	48,802	(136)	(0.3%)	Disabled	330,900	341,422	(10,522)	(3.1%)
299,173	329,228	(30,055)	(9.1%)	TANF Child	2,254,026	2,307,514	(53,488)	(2.3%)
119,724	103,594	16,130	15.6%	TANF Adult	692,577	726,905	(34,328)	(4.7%)
3,475	3,268	207	6.3%	LTC	24,100	22,876	1,224	5.4%
239,425	236,779	2,646	1.1%	MCE	1,671,403	1,654,979	16,424	1.0%
778,412	786,474	(8,062)	(1.0%)	Medi-Cal	5,416,094	5,499,150	(83,056)	(1.5%)
14,989	15,576	(587)	(3.8%)	OneCare Connect	106,559	108,715	(2,156)	(2.0%)
236	246	(10)	(4.1%)	PACE	1,595	1,617	(22)	(1.4%)
1,320	1,372	(52)	(3.8%)	OneCare	9,633	9,406	227	2.4%
794,957	803,668	(8,711)	(1.1%)	CalOptima Total	5,533,881	5,618,888	(85,007)	(1.5%)

Enrollment (By Network)				Enrollment (By Aid Category)	Year-to-Date			
Actual	Budget	Variance	%		Actual	Budget	Variance	%
169,359	174,481	(5,122)	(2.9%)	HMO	1,194,219	1,219,533	(25,314)	(2.1%)
222,538	225,569	(3,031)	(1.3%)	PHC	1,559,646	1,584,770	(25,124)	(1.6%)
198,396	208,799	(10,403)	(5.0%)	Shared Risk Group	1,401,801	1,467,894	(66,093)	(4.5%)
188,119	177,625	10,494	5.9%	Fee for Service	1,260,428	1,226,953	33,475	2.7%
778,412	786,474	(8,062)	(1.0%)	Medi-Cal	5,416,094	5,499,150	(83,056)	(1.5%)
14,989	15,576	(587)	(3.8%)	OneCare Connect	106,559	108,715	(2,156)	(2.0%)
236	246	(10)	(4.1%)	PACE	1,595	1,617	(22)	(1.4%)
1,320	1,372	(52)	(3.8%)	OneCare	9,633	9,406	227	2.4%
794,957	803,668	(8,711)	(1.1%)	CalOptima Total	5,533,881	5,618,888	(85,007)	(1.5%)

January 31, 2018 Unaudited Financial Statements

SUMMARY

MONTHLY RESULTS:

- Change in Net Assets is (\$6.5) million, \$1.1 million unfavorable to budget
- Operating deficit is \$6.7 million with a surplus in non-operating of \$0.3 million

YEAR TO DATE RESULTS:

- Change in Net Assets is \$16.5 million, \$15.9 million favorable to budget
- Operating surplus is \$5.8 million, \$6.9 million favorable to budget

Change in Net Assets by LOB (\$millions)

MONTH-TO-DATE				YEAR-TO-DATE		
<u>Actual</u>	<u>Budget</u>	<u>Variance</u>		<u>Actual</u>	<u>Budget</u>	<u>Variance</u>
(6.4)	(4.3)	(2.1)	Medi-Cal	(0.4)	0.6	(1.0)
0.2	(1.1)	1.3	OCC	5.5	(0.4)	5.9
(0.4)	(0.1)	(0.3)	OneCare	0.0	(0.9)	1.0
<u>(0.1)</u>	<u>0.0</u>	<u>(0.1)</u>	PACE	<u>0.6</u>	<u>(0.3)</u>	<u>0.9</u>
(6.7)	(5.5)	(1.2)	Operating	5.8	(1.0)	6.9
<u>0.3</u>	<u>0.2</u>	<u>0.1</u>	Inv./Rental Inc, MCO tax	<u>10.8</u>	<u>1.7</u>	<u>9.1</u>
0.3	0.2	0.1	Non-Operating	10.8	1.7	9.1
(6.5)	(5.4)	(1.1)	TOTAL	16.5	0.6	15.9

CalOptima
Enrollment Trend by Network Type
Fiscal Year 2018

Network Type	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	MMs
HMO													
Aged	4,058	4,045	4,051	3,864	4,020	3,980	3,982	-	-	-	-	-	28,000
BCCTP	1	1	1	5	1	5	1	-	-	-	-	-	15
Disabled	6,749	6,740	6,729	6,703	6,733	6,743	6,743	-	-	-	-	-	47,140
TANF Child	61,492	61,733	61,361	61,023	60,598	60,595	53,730	-	-	-	-	-	420,532
TANF Adult	30,429	30,420	30,313	30,127	29,905	30,059	36,236	-	-	-	-	-	217,489
LTC	3	4	6	4	4	3	2	-	-	-	-	-	26
MCE	68,020	68,792	69,169	68,294	68,764	69,313	68,665	-	-	-	-	-	481,017
	170,752	171,735	171,630	170,020	170,025	170,698	169,359	-	-	-	-	-	1,194,219
PHC													
Aged	1,480	1,493	1,530	1,401	1,561	1,581	1,603	-	-	-	-	-	10,649
BCCTP	-	-	-	-	-	-	-	-	-	-	-	-	-
Disabled	7,318	7,264	7,258	7,236	7,229	7,221	7,264	-	-	-	-	-	50,790
TANF Child	162,801	163,976	163,202	162,046	162,030	162,046	154,874	-	-	-	-	-	1,130,975
TANF Adult	12,604	12,571	12,410	12,356	12,311	12,312	19,241	-	-	-	-	-	93,805
LTC	-	-	1	1	-	-	1	-	-	-	-	-	3
MCE	38,398	38,821	39,088	38,681	39,261	39,620	39,555	-	-	-	-	-	273,424
	222,601	224,125	223,489	221,721	222,392	222,780	222,538	-	-	-	-	-	1,559,646
Shared Risk Group													
Aged	3,809	3,756	3,831	3,029	3,765	3,641	3,706	-	-	-	-	-	25,537
BCCTP	-	-	-	1	-	-	-	-	-	-	-	-	1
Disabled	8,108	8,058	8,035	7,951	7,978	7,887	7,873	-	-	-	-	-	55,890
TANF Child	72,723	72,861	72,102	71,427	71,139	70,753	63,054	-	-	-	-	-	494,059
TANF Adult	32,775	32,737	32,316	31,441	31,785	31,475	39,189	-	-	-	-	-	231,718
LTC	-	1	2	-	-	2	-	-	-	-	-	-	5
MCE	85,799	86,330	86,191	81,677	85,025	84,995	84,574	-	-	-	-	-	594,591
	203,214	203,743	202,477	195,526	199,692	198,753	198,396	-	-	-	-	-	1,401,801
Fee for Service (Dual)													
Aged	48,036	48,599	48,846	48,863	49,108	49,578	53,851	-	-	-	-	-	346,881
BCCTP	25	22	25	23	22	23	21	-	-	-	-	-	161
Disabled	20,343	20,528	20,516	20,448	20,494	20,691	22,065	-	-	-	-	-	145,085
TANF Child	3	3	2	2	1	1	1	-	-	-	-	-	13
TANF Adult	1,205	1,226	1,184	1,156	1,118	1,165	1,160	-	-	-	-	-	8,214
LTC	3,002	3,124	3,126	3,068	3,137	3,112	3,106	-	-	-	-	-	21,675
MCE	2,816	2,848	2,758	2,831	2,113	1,660	1,713	-	-	-	-	-	16,739
	75,430	76,350	76,457	76,391	75,993	76,230	81,917	-	-	-	-	-	538,768
Fee for Service (Non-Dual)													
Aged	3,580	3,855	4,031	3,714	4,250	4,117	4,197	-	-	-	-	-	27,744
BCCTP	601	602	599	523	598	589	588	-	-	-	-	-	4,100
Disabled	4,466	4,559	4,578	4,364	4,703	4,604	4,721	-	-	-	-	-	31,995
TANF Child	27,513	31,414	31,119	30,822	28,520	31,545	27,514	-	-	-	-	-	208,447
TANF Adult	18,753	19,744	20,087	19,517	19,142	20,210	23,898	-	-	-	-	-	141,351
LTC	372	364	379	194	363	353	366	-	-	-	-	-	2,391
MCE	43,457	44,664	44,438	40,986	42,402	44,767	44,918	-	-	-	-	-	305,632
	98,742	105,202	105,231	100,120	99,978	106,185	106,202	-	-	-	-	-	721,660
MEDI-CAL TOTAL													
Aged	60,963	61,748	62,289	60,871	62,704	62,897	67,339	-	-	-	-	-	438,811
BCCTP	627	625	625	552	621	617	610	-	-	-	-	-	4,277
Disabled	46,984	47,149	47,116	46,702	47,137	47,146	48,666	-	-	-	-	-	330,900
TANF Child	324,532	329,987	327,786	325,320	322,288	324,940	299,173	-	-	-	-	-	2,254,026
TANF Adult	95,766	96,698	96,310	94,597	94,261	95,221	119,724	-	-	-	-	-	692,577
LTC	3,377	3,493	3,514	3,267	3,504	3,470	3,475	-	-	-	-	-	24,100
MCE	238,490	241,455	241,644	232,469	237,565	240,355	239,425	-	-	-	-	-	1,671,403
	770,739	781,155	779,284	763,778	768,080	774,646	778,412	-	-	-	-	-	5,416,094
PACE													
	215	221	228	227	233	235	236	-	-	-	-	-	1,595
OneCare													
	1,367	1,366	1,404	1,406	1,378	1,372	1,320	-	-	-	-	-	9,633
OneCare Connect													
	15,365	15,229	15,265	15,234	15,254	15,223	14,989	-	-	-	-	-	106,559
TOTAL	787,686	797,991	796,181	780,645	784,945	791,476	794,957	-	-	-	-	-	5,533,881

ENROLLMENT:

Overall MTD enrollment was 794,957

- Unfavorable to budget by 8,711 or 1.1%
- Increased 3,481 or 0.4% from prior month (December 2017)
- Decreased 395 from prior year (January 2017)

Medi-Cal enrollment was 778,412

- Unfavorable to budget by 8,062
 - TANF unfavorable by 13,925
 - SPD favorable by 3,010
 - Expansion favorable by 2,646
 - LTC favorable by 207
- Increased 3,766 from prior month

OneCare Connect enrollment was 14,989

- Unfavorable to budget by 587
- Decreased 234 from prior month

OneCare enrollment was 1,320

- Unfavorable to budget by 52
- Decreased 52 from prior month

PACE enrollment was 236

- Unfavorable to budget by 10
- Increased 1 from prior month

**CalOptima - Medi-Cal Total
Statement of Revenues and Expenses
For the Seven Months Ended January 31, 2018**

Month				Year - To - Date				
Actual	Budget	\$ Variance	% Variance		Actual	Budget	\$ Variance	% Variance
778,412	786,474	(8,062)	(1.0%)	Member Months	5,416,094	5,499,150	(83,056)	(1.5%)
236,026,954	227,447,405	8,579,549	3.8%	Revenues	1,754,685,147	1,698,028,315	56,656,832	3.3%
236,026,954	227,447,405	8,579,549	3.8%	Capitation revenue	1,754,685,147	1,698,028,315	56,656,832	3.3%
				Total Operating Revenues	1,754,685,147	1,698,028,315	56,656,832	3.3%
				Medical Expenses				
87,299,216	86,903,192	(396,024)	(0.5%)	Provider capitation	621,563,273	609,060,906	(12,502,367)	(2.1%)
42,450,687	44,578,319	2,127,632	4.8%	Facilities	307,935,016	307,519,140	(415,876)	(0.1%)
24,288,912	14,930,071	(9,358,841)	(62.7%)	Professional Claims	119,491,959	99,076,873	(20,415,086)	(20.6%)
41,786,979	37,723,736	(4,063,243)	(10.8%)	Prescription drugs	255,113,293	253,808,316	(1,304,977)	(0.5%)
34,470,304	33,518,588	(951,716)	(2.8%)	MLTSS	371,805,517	332,332,776	(39,472,741)	(11.9%)
2,789,914	3,526,970	737,056	20.9%	Medical Management	18,769,094	22,741,393	3,972,299	17.5%
834,775	315,017	(519,758)	(165.0%)	Reinsurance & other	5,990,706	2,205,119	(3,785,587)	(171.7%)
233,920,787	221,495,893	(12,424,894)	(5.6%)	Total Medical Expenses	1,700,668,857	1,626,744,523	(73,924,334)	(4.5%)
2,106,167	5,951,512	(3,845,345)	(64.6%)	Gross Margin	54,016,290	71,283,792	(17,267,502)	(24.2%)
				Administrative Expenses				
6,149,833	6,620,429	470,596	7.1%	Salaries, wages & employee benefits	38,264,999	42,413,449	4,148,450	9.8%
80,555	322,024	241,469	75.0%	Professional fees	990,845	2,303,662	1,312,817	57.0%
485,053	1,285,316	800,263	62.3%	Purchased services	4,627,962	11,669,753	7,041,791	60.3%
517,810	401,238	(116,572)	(29.1%)	Printing and postage	2,149,290	2,820,660	671,370	23.8%
378,850	461,246	82,396	17.9%	Depreciation & amortization	2,852,820	3,228,722	375,902	11.6%
1,291,354	1,482,486	191,132	12.9%	Other operating expenses	8,039,367	10,218,720	2,179,353	21.3%
(387,354)	(278,785)	108,569	38.9%	Indirect cost allocation	(2,561,256)	(1,951,495)	609,761	31.2%
8,516,100	10,293,954	1,777,854	17.3%	Total Administrative Expenses	54,364,025	70,703,471	16,339,445	23.1%
				Operating Tax				
10,256,734	0	(10,256,734)	0.0%	Tax Revenue	84,768,955	0	(84,768,955)	0.0%
10,256,734	0	(10,256,734)	0.0%	Premium tax expense	71,489,617	0	(71,489,617)	0.0%
0	0	0	0.0%	Sales tax expense	13,279,338	0	(13,279,338)	0.0%
0	0	0	0.0%	Total Net Operating Tax	0	0	0	0.0%
				Grant Income				
71,382	291,249	(219,867)	(75.5%)	Grant Revenue	188,181	2,038,743	(1,850,562)	(90.8%)
62,307	258,276	195,969	75.9%	Grant expense - Service Partner	166,807	1,807,932	1,641,125	90.8%
22,096	32,973	10,877	33.0%	Grant expense - Administrative	105,919	230,811	124,892	54.1%
(13,021)	0	(13,021)	0.0%	Total Net Grant Income	(84,546)	0	(84,546)	0.0%
236	0	236	0.0%	Other income	769	0	769	0.0%
(6,422,719)	(4,342,442)	(2,080,276)	(47.9%)	Change in Net Assets	(431,512)	580,321	(1,011,833)	(174.4%)
99.1%	97.4%	-1.7%	-1.8%	Medical Loss Ratio	96.9%	95.8%	-1.1%	-1.2%
3.6%	4.5%	0.9%	20.3%	Admin Loss Ratio	3.1%	4.2%	1.1%	25.6%

MEDI-CAL INCOME STATEMENT – JANUARY MONTH:

REVENUES of \$236.0 million are favorable to budget by \$8.6 million, driven by:

- Unfavorable volume related variance of \$2.3 million
- Favorable price related variance of \$10.9 million due to:
 - \$6.3 million of fiscal year 2018 Coordinated Care Initiative (CCI) including In-Home Supportive Services (IHSS) Dual and Non-Dual revenue
 - \$1.9 million of fiscal year 2018 revenue for Applied Behavior Analysis (ABA) and prior year Kaiser ABA of \$2.7 million
 - \$0.4 million of Non-Medical Transportation (NMT) revenue

MEDICAL EXPENSES: Overall \$233.9 million, unfavorable to budget by \$12.4 million due to:

- **Professional Claims** expense is unfavorable to budget \$9.4 million due to Behavior Health Treatment (BHT) expenses of \$5.1 million and Crossover expenses of \$4.1 million
- **Prescription Drug** expense is unfavorable to budget \$4.1 million due to increase in Per Member Per Month (PMPM) cost of \$10.00
- **Facility** expense is favorable to budget \$2.1 million due to \$6.8 million release of Shared Risk accrual, offset by unfavorable expenses of \$4.5 million
- **Managed Long-Term Services and Support (MLTSS)** is unfavorable to budget \$1.0 million due to IHSS expense of \$0.6 and Community Based Adult Services (CBAS) expense of \$0.4 million

ADMINISTRATIVE EXPENSES are \$8.5 million, favorable to budget \$1.8 million, driven by:

- Purchased Services: \$0.8 million favorable to budget due to lower outside claims processing fees, mostly from mental health claims processing being brought in-house, along with a reclassification of \$0.3 million to Professional Claims.
- Salary & Benefits: favorable \$0.5 million
- Other Non-Salary: \$0.5 million favorable to budget

CHANGE IN NET ASSETS is (\$6.4) million for the month, unfavorable to budget by \$2.1 million

**CalOptima - OneCare Connect
Statement of Revenues and Expenses
For the Seven Months Ended January 31, 2018**

Month				Year - To - Date			
Actual	Budget	\$ Variance	% Variance	Actual	Budget	\$ Variance	% Variance
14,989	15,576	(587)	(3.8%)	106,559	108,715	(2,156)	(2.0%)
				Member Months			
				Revenues			
3,682,937	4,058,043	(375,106)	(9.2%)	47,193,511	49,079,198	(1,885,687)	(3.8%)
17,134,355	15,989,048	1,145,307	7.2%	113,722,529	103,518,408	10,204,121	9.9%
6,410,704	5,229,026	1,181,678	22.6%	39,133,496	36,959,937	2,173,559	5.9%
27,227,996	25,276,117	1,951,879	7.7%	200,049,536	189,557,543	10,491,993	5.5%
				Total Operating Revenue			
				Medical Expenses			
11,954,289	9,164,650	(2,789,639)	(30.4%)	78,913,739	59,929,516	(18,984,223)	(31.7%)
4,040,859	5,239,575	1,198,716	22.9%	20,999,165	35,668,391	14,669,226	41.1%
653,887	637,490	(16,397)	(2.6%)	4,324,930	4,377,418	52,488	1.2%
1,432,870	2,427,436	994,567	41.0%	33,388,864	27,847,119	(5,541,745)	(19.9%)
5,758,928	5,514,310	(244,618)	(4.4%)	36,329,926	39,253,299	2,923,373	7.4%
1,106,786	1,283,942	177,156	13.8%	7,043,209	8,529,840	1,486,631	17.4%
139,549	130,845	(8,704)	(6.7%)	1,165,197	803,046	(362,151)	(45.1%)
25,087,168	24,398,248	(688,920)	(2.8%)	182,165,030	176,408,629	(5,756,401)	(3.3%)
				Total Medical Expenses			
2,140,827	877,869	1,262,958	143.9%	17,884,506	13,148,914	4,735,592	36.0%
				Gross Margin			
				Administrative Expenses			
851,522	995,493	143,971	14.5%	5,465,588	6,447,755	982,167	15.2%
98,473	38,334	(60,139)	(156.9%)	200,011	268,335	68,323	25.5%
213,030	239,868	26,838	11.2%	1,126,336	1,679,176	552,840	32.9%
68,541	103,800	35,259	34.0%	529,731	726,606	196,875	27.1%
45,636	50,149	4,513	9.0%	287,098	352,584	65,485	18.6%
692,184	584,428	(107,756)	(18.4%)	4,763,132	4,090,996	(672,136)	(16.4%)
1,969,387	2,012,072	42,685	2.1%	12,371,897	13,565,451	1,193,555	8.8%
				Total Administrative Expenses			
				Operating Tax			
0	0	0	0.0%	0	0	0	0.0%
				Total Net Operating Tax			
171,441	(1,134,203)	1,305,644	115.1%	5,512,610	(416,537)	5,929,147	1,423.4%
				Change in Net Assets			
92.1%	96.5%	4.4%	4.5%	91.1%	93.1%	2.0%	2.2%
7.2%	8.0%	0.7%	9.1%	6.2%	7.2%	1.0%	13.6%
				Medical Loss Ratio			
				Admin Loss Ratio			

ONECARE CONNECT INCOME STATEMENT – JANUARY MONTH:

REVENUES of \$27.2 million are favorable to budget by \$2.0 million driven by:

- Unfavorable volume related variance of \$1.0 million due to lower enrollment
- Favorable price related variance of \$2.9 million due to fiscal year 2018 rate adjustment

MEDICAL EXPENSES of \$25.1 million are unfavorable to budget \$0.7 million due to:

- Favorable volume related variance of \$0.9 million due to lower enrollment
- Unfavorable price related variance of \$1.6 million due to \$.7 million from IBNR

ADMINISTRATIVE EXPENSES of \$2.0 million are in line with budget

CHANGE IN NET ASSETS is \$0.2 million, \$1.3 million favorable to budget

CalOptima - OneCare
Statement of Revenues and Expenses
For the Seven Months Ended January 31, 2018

Month				Year - To - Date			
Actual	Budget	\$ Variance	% Variance	Actual	Budget	\$ Variance	% Variance
1,320	1,372	(52)	(3.8%)	9,633	9,406	227	2.4%
				Member Months			
				Revenues			
51,586	47,677	3,909	8.2%	472,473	326,806	145,667	44.6%
992,172	942,360	49,812	5.3%	5,136,239	6,096,699	(960,460)	(15.8%)
505,213	493,679	11,534	2.3%	2,767,879	3,339,301	(571,422)	(17.1%)
1,548,970	1,483,716	65,254	4.4%	8,376,591	9,762,806	(1,386,215)	(14.2%)
				Total Operating Revenue			
				Medical Expenses			
478,424	411,872	(66,552)	(16.2%)	396,342	2,683,177	2,286,835	85.2%
776,667	455,580	(321,087)	(70.5%)	3,269,887	3,116,318	(153,569)	(4.9%)
45,142	49,690	4,548	9.2%	304,373	337,736	33,363	9.9%
2,309	43,343	41,034	94.7%	139,684	292,628	152,944	52.3%
444,825	496,528	51,703	10.4%	3,139,421	3,372,236	232,815	6.9%
60,232	21,820	(38,412)	(176.0%)	374,195	156,422	(217,773)	(139.2%)
6,595	5,905	(690)	(11.7%)	51,285	51,049	(236)	(0.5%)
1,814,193	1,484,738	(329,455)	(22.2%)	7,675,186	10,009,566	2,334,380	23.3%
				Total Medical Expenses			
(265,223)	(1,022)	(264,201)	(25,851.4%)	701,405	(246,760)	948,165	384.2%
				Gross Margin			
				Administrative Expenses			
25,216	22,115	(3,101)	(14.0%)	172,321	144,186	(28,135)	(19.5%)
13,333	13,333	0	0.0%	105,682	93,331	(12,351)	(13.2%)
5,425	11,990	6,565	54.8%	121,461	83,980	(37,481)	(44.6%)
1,696	19,288	17,592	91.2%	58,454	142,516	84,062	59.0%
0	172	172	100.0%	(32)	1,250	1,282	102.5%
40,057	31,910	(8,147)	(25.5%)	200,887	223,370	22,483	10.1%
85,727	98,808	13,081	13.2%	658,773	688,633	29,860	4.3%
				Total Administrative Expenses			
(350,950)	(99,830)	(251,120)	(251.5%)	42,631	(935,393)	978,024	104.6%
				Change in Net Assets			
117.1%	100.1%	-17.1%	-17.0%	91.6%	102.5%	10.9%	10.6%
				Medical Loss Ratio			

**CalOptima - PACE
Statement of Revenues and Expenses
For the Seven Months Ended January 31, 2018**

Month				Year - To - Date				
Actual	Budget	\$ Variance	% Variance	Actual	Budget	\$ Variance	% Variance	
236	246	(10)	(4.1%)	Member Months	1,595	1,617	(22)	(1.4%)
1,316,552	1,283,816	32,736	2.5%	Revenues	8,398,413	8,216,832	181,581	2.2%
314,506	302,148	12,358	4.1%	Medi-Cal capitation revenue	2,337,675	1,944,628	393,047	20.2%
80,664	78,196	2,468	3.2%	Medicare part C revenue	578,738	524,430	54,308	10.4%
-----	-----	-----	-----	Medicare part D revenue	-----	-----	-----	-----
1,711,722	1,664,160	47,562	2.9%	Total Operating Revenues	11,314,826	10,685,890	628,936	5.9%
-----	-----	-----	-----	-----	-----	-----	-----	-----
574,130	629,288	55,158	8.8%	Medical Expenses	3,718,571	4,128,324	409,753	9.9%
508,541	355,253	(153,288)	(43.1%)	Medical Management	2,178,259	2,314,415	136,156	5.9%
404,612	293,130	(111,482)	(38.0%)	Claims payments to hospitals	2,497,081	1,910,225	(586,856)	(30.7%)
151,102	123,236	(27,866)	(22.6%)	Professional Claims	837,972	803,559	(34,413)	(4.3%)
0	11,240	11,240	100.0%	Prescription drugs	17,511	81,324	63,813	78.5%
88,756	101,627	12,871	12.7%	Long-term care facility payments	648,594	661,853	13,259	2.0%
0	0	0	0.0%	Patient Transportation	0	0	0	0.0%
8,000	10,000	2,000	20.0%	Reinsurance	40,000	30,000	(10,000)	(33.3%)
-----	-----	-----	-----	Other Expenses	-----	-----	-----	-----
1,735,141	1,523,774	(211,367)	(13.9%)	Total Medical Expenses	9,937,988	9,929,700	(8,288)	(0.1%)
-----	-----	-----	-----	-----	-----	-----	-----	-----
(23,419)	140,386	(163,805)	(116.7%)	Gross Margin	1,376,838	756,190	620,648	82.1%
-----	-----	-----	-----	-----	-----	-----	-----	-----
88,505	103,944	15,439	14.9%	Administrative Expenses	534,292	668,103	133,811	20.0%
6,360	5,000	(1,360)	(27.2%)	Salaries, wages & employee benefits	23,032	35,000	11,968	34.2%
14,930	21,136	6,206	29.4%	Professional fees	45,343	147,952	102,609	69.4%
2,097	5,547	3,450	62.2%	Purchased services	23,513	38,829	15,316	39.4%
2,168	2,052	(116)	(5.6%)	Printing and postage	15,104	14,364	(740)	(5.2%)
7,351	18,503	11,152	60.3%	Depreciation & amortization	97,062	129,533	32,471	25.1%
3,101	2,864	(237)	(8.3%)	Other operating expenses	47,201	20,048	(27,153)	(135.4%)
-----	-----	-----	-----	Indirect cost allocation, Occupancy Expense	-----	-----	-----	-----
124,512	159,046	34,534	21.7%	Total Administrative Expenses	785,548	1,053,829	268,281	25.5%
-----	-----	-----	-----	-----	-----	-----	-----	-----
3,295	0	3,295	0.0%	Operating Tax	37,954	0	37,954	0.0%
3,295	0	(3,295)	0.0%	Tax Revenue	37,954	0	(37,954)	0.0%
-----	-----	-----	-----	Premium tax expense	-----	-----	-----	-----
0	0	0	0.0%	Total Net Operating Tax	0	0	0	0.0%
-----	-----	-----	-----	-----	-----	-----	-----	-----
(147,931)	(18,660)	(129,271)	(692.8%)	Change in Net Assets	591,290	(297,639)	888,929	298.7%
=====	=====	=====	=====	-----	-----	-----	-----	-----
101.4%	91.6%	-9.8%	-10.7%	Medical Loss Ratio	87.8%	92.9%	5.1%	5.5%
7.3%	9.6%	2.3%	23.9%	Admin Loss Ratio	6.9%	9.9%	2.9%	29.6%

**CalOptima - Building 505 City Parkway
Statement of Revenues and Expenses
For the Seven Months Ended January 31, 2018**

Month				Year - To - Date				
Actual	Budget	\$ Variance	% Variance	Actual	Budget	\$ Variance	% Variance	
0	0	0	0.0%					
0	0	0	0.0%					
				Revenues				
				Rental income	155,426	42,774	112,652	263.4%
				Total Operating Revenue	155,426	42,774	112,652	263.4%
				Administrative Expenses				
34,055	23,186	(10,869)	(46.9%)	Purchase services	225,554	162,301	(63,253)	(39.0%)
159,543	161,474	1,930	1.2%	Depreciation & amortization	1,117,474	1,130,316	12,842	1.1%
14,913	9,117	(5,797)	(63.6%)	Insurance expense	104,393	63,817	(40,576)	(63.6%)
105,307	158,122	52,815	33.4%	Repair and maintenance	793,044	1,106,851	313,807	28.4%
31,021	0	(31,021)	0.0%	Other Operating Expense	316,505	0	(316,505)	0.0%
(344,839)	(333,055)	11,784	3.5%	Indirect allocation, Occupancy Expense	(2,455,647)	(2,331,384)	124,263	5.3%
0	18,843	18,843	100.0%	Total Administrative Expenses	101,324	131,901	30,577	23.2%
(0)	(18,843)	18,843	100.0%					
				Change in Net Assets	54,103	(89,127)	143,230	160.7%

OTHER STATEMENTS – JANUARY MONTH:

ONECARE INCOME STATEMENT

CHANGE IN NET ASSETS is (\$351.0) thousand, \$251.1 thousand unfavorable to budget

PACE INCOME STATEMENT

CHANGE IN NET ASSETS for the month is (\$147.9) thousand, \$129.3 thousand unfavorable to budget

505 CITY PARKWAY BUILDING INCOME STATEMENT

CHANGE IN NET ASSETS for the month is \$0.0 thousand, \$18.8 thousand favorable to budget

**CalOptima
BALANCE SHEET
January 31, 2018**

ASSETS

Current Assets	
Operating Cash	\$329,997,190
Investments	700,482,442
Capitation receivable	401,333,697
Receivables - Other	20,501,060
Prepaid Expenses	5,277,928
	<u>1,457,592,317</u>
Total Current Assets	

Capital Assets	
Furniture and equipment	34,039,048
Building/Leasehold improvements	6,349,733
505 City Parkway West	49,433,337
	<u>89,822,119</u>
Less: accumulated depreciation	(38,789,815)
Capital assets, net	<u>51,032,304</u>

Other Assets	
Restricted deposit & Other	300,000
Board-designated assets	
Cash and cash equivalents	21,541,152
Long term investments	514,116,164
Total Board-designated Assets	<u>535,657,316</u>
Total Other Assets	<u>535,957,316</u>

Deferred outflows of Resources - Pension Contributions	5,234,198
Deferred outflows of Resources - Difference in Experience	1,072,771
Deferred outflows of Resources - Excess Earnings	<u>5,270,171</u>

TOTAL ASSETS & OUTFLOWS	<u><u>2,056,159,077</u></u>
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LIABILITIES & FUND BALANCES

Current Liabilities	
Accounts payable	\$23,451,417
Medical claims liability	917,113,249
Accrued payroll liabilities	10,519,695
Deferred revenue	176,689,086
Deferred lease obligations	152,611
Capitation and withholds	150,487,813
	<u>1,278,413,871</u>
Total Current Liabilities	

Other employment benefits liability	29,790,886
Net Pension Liabilities	16,523,507
Long Term Liabilities	100,000
	<u>1,324,828,265</u>
TOTAL LIABILITIES	

Deferred inflows of Resources - Excess Earnings	-
Deferred inflows of Resources - Changes in Assumptions	1,340,010
Tangible net equity (TNE)	88,253,740
Funds in excess of TNE	641,737,062

Net Assets	<u><u>729,990,802</u></u>
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TOTAL LIABILITIES, INFLOWS & FUND BALANCES	<u><u>2,056,159,077</u></u>
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CalOptima
Board Designated Reserve and TNE Analysis
as of January 31, 2018

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	146,540,425				
	Tier 1 - Logan Circle	146,376,453				
	Tier 1 - Wells Capital	145,950,850				
Board-designated Reserve						
		438,867,727	300,016,071	466,417,418	138,851,656	(27,549,691)
TNE Requirement	Tier 2 - Logan Circle	96,789,588	88,253,740	88,253,740	8,535,848	8,535,848
Consolidated:		535,657,315	388,269,811	554,671,158	147,387,505	(19,013,843)
<i>Current reserve level</i>		1.93	1.40	2.00		

**CalOptima
Statement of Cash Flows
January 31, 2018**

	<u>Month Ended</u>	<u>Year-To-Date</u>
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets	(6,467,032)	16,532,410
Adjustments to reconcile change in net assets to net cash provided by operating activities		
Depreciation and amortization	540,561	3,985,398
Changes in assets and liabilities:		
Prepaid expenses and other	(291,112)	376,719
Catastrophic reserves		
Capitation receivable	(20,977,430)	121,713,978
Medical claims liability	(47,251,728)	(329,312,771)
Deferred revenue	9,627,971	72,715,962
Payable to providers	(232,232,907)	(430,351,897)
Accounts payable	10,821,563	(15,793,264)
Other accrued liabilities	324,375	2,253,119
Net cash provided by/(used in) operating activities	<u>(285,905,739)</u>	<u>(557,880,346)</u>
 GASB 68 CalPERS Adjustments	 -	 -
CASH FLOWS FROM INVESTING ACTIVITIES		
Change in Investments	132,846,944	381,943,310
Change in property and equipment	(69,461)	(716,676)
Change in Board designated reserves	1,239,466	(518,942)
Net cash provided by/(used in) investing activities	<u>134,016,950</u>	<u>380,707,691</u>
 NET INCREASE/(DECREASE) IN CASH & CASH EQUIVALENTS	 (151,888,789)	 (177,172,655)
 CASH AND CASH EQUIVALENTS, beginning of period	 <u>\$481,885,979</u>	 <u>507,169,844</u>
 CASH AND CASH EQUIVALENTS, end of period	 <u>\$ 329,997,190</u>	 <u>\$ 329,997,190</u>

BALANCE SHEET:

ASSETS decreased \$265.2 million from December

- **Cash and Cash Equivalents** decreased by \$151.9 million due to Shared Risk payment offset by a transfer of funds from investment
- **Investments** decreased \$132.8 million due to transfer of funds for shared risk and claim payments
- **Net Capitation Receivables** increased \$17.9 million based upon payment receipt timing and receivables

LIABILITIES decreased \$258.7 million from December

- **Capitation Payable** decreased \$232.2 million due to payment of shared risk group
- **Medical Claims Liability** by line of business decreased \$47.3 million due to DHCS recoupment of Medi-Cal expansion
- **Accrued Expenses** increased \$9.6 million due to timing of payments

NET ASSETS are \$730.0 million, a decrease of \$6.5 million from December

CalOptima Foundation
Statement of Revenues and Expenses
For the Seven Months Ended January 31, 2018
Consolidated

Month				Year - To - Date			
Actual	Budget	\$ Variance	% Variance	Actual	Budget	\$ Variance	% Variance
-----				-----			
0	0	0	0.0%	0	0	0	0.0%
-----				-----			
-----				-----			
0	6,184	6,184	100.0%	0	43,289	43,289	100.0%
0	2,985	2,985	100.0%	0	20,894	20,894	100.0%
0	0	0	0.0%	0	0	0	0.0%
0	0	0	0.0%	0	0	0	0.0%
0	0	0	0.0%	0	0	0	0.0%
2,083	231,923	229,840	99.1%	14,581	1,623,461	1,608,880	99.1%
-----				-----			
2,083	241,092	239,009	99.1%	14,581	1,687,644	1,673,063	99.1%
-----				-----			
0	0	0	0.0%	0	0	0	0.0%
-----				-----			
(2,083)	(241,092)	(239,009)	(99.1%)	(14,581)	(1,687,644)	(1,673,063)	(99.1%)
=====				=====			

**CalOptima Foundation
Balance Sheet
January 31, 2018**

<u>ASSETS</u>		<u>LIABILITIES & NET ASSETS</u>	
Operating cash	2,868,139	Accounts payable-Current	14,581
Grants receivable	0	Deferred Revenue	0
Prepaid expenses	0	Payable to CalOptima	0
Total Current Assets	<u>2,868,139</u>	Grants-Foundation	0
		Total Current Liabilities	<u>14,581</u>
		Total Liabilities	14,581
		Net Assets	<u>2,853,558</u>
 TOTAL ASSETS	 <u>2,868,139</u>	 TOTAL LIABILITIES & NET ASSETS	 <u>2,868,139</u>

CALOPTIMA FOUNDATION JANUARY MONTH

INCOME STATEMENT:

OPERATING REVENUE

- No activity

OPERATING EXPENSES

- Audit Fees \$2.1 thousand

BALANCE SHEET:

ASSETS

- Cash--\$2.9 million remains from the FY14 \$3.0 million transferred by CalOptima for grants and programs in support of providers and community

LIABILITIES

- Accrued Payables--\$14.6 thousand for Audit fees

NET INCOME YTD is (\$14.6) thousand

**Budget Allocation Changes
Reporting Changes for January 2018**

Transfer Month	Line of Business	From	To	Amount	Expense Description	Fiscal Year
July	Medi-Cal	IS - Infrastructure - Professional Fee (Virtualization Architecture Assessment)	IS - Infrastructure - Professional Fee (On-Site Staff for the Phone System)	\$48,600	Re-Purpose \$48,600 from Professional Fees (Virtualization Architecture Assessment) to pay for an on-site staff for the phone system	2018
July	Medi-Cal	Facilities - Purchased Services (Restacking Services)	Facilities - Purchased Services (Reconfiguration Services)	\$15,000	Re-Purpose \$15,000 from Purchased Services (Restacking Services) to reconfiguration and breakdown of furniture for the mail room and the Rover Rock Offices and other related expenses	2018
August	Medi-Cal	Health Education & Disease Mgmt - Purchased Services (Adult Weight Management Vendor)	Health Education & Disease Mgmt - Purchased Services (Ansafone)	\$30,000	Re-Purpose \$30,000 from Purchased Services (Adult Weight Management Vendor) to pay for Ansafone services	2018
August	Medi-Cal	Health Education & Disease Mgmt - Purchased Services (Pediatric Weight Management Vendor)	Health Education & Disease Mgmt - Purchased Services (Captivate contract and other initiatives)	\$25,000	Re-Purpose \$25,000 from Purchased Services (Pediatric Weight Management Vendor) to pay for Captivate contract and other initiatives	2018
August	PACE	PACE Administrative - Purchased Services (Encounter Reporting & Translation Services)	PACE Administrative - Purchased Services (Satisfaction Survey)	\$12,208	Re-Purpose \$12,208 from Purchased Services (Encounter Reporting & Translation Services) to pay for Satisfaction Survey	2018
August	Medi-Cal	Facilities - Capital Project (Upgrade CalOptima and Building Access System)	Facilities - Capital Project (Mail Room/Basement/Property Management Office)	\$15,000	Reallocate \$15,000 from Capital Project (Upgrade CalOptima and Building Access System) to Capital Project (Mail Room/Basement/Property Management Office)	2018
September	Medi-Cal	Other G&A - Other Operating Expenses	Facilities - Building Repair and Maintenance	\$65,000	Reallocate \$65,000 from Other G&A (other operating expenses) to cover cost to conduct a review/study from soil engineer and the necessary repairs of the east entry sinkhole.	2018
September	OCC	Health Education & Disease Management - Member Communications	Health Education & Disease Management - Purchased Services	\$12,000	Reallocate \$12,000 within medical management activities budget for additional funding needed on CareNet in OneCare Connect.	2018
November	Medi-Cal	Human Resources - Purchased Services -Temporary Outsource Service	Human Resources - Purchased Services - General	\$10,000	Re-Purpose \$10,000 from Purchased Services (Temporary Outsource Service) to fund for training module design and other department initiatives in Purchased Services	2018

Board of Directors' Meeting March 1, 2018

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

- **2016 CMS Financial Audit:**

On August 24, 2017, the Centers for Medicare & Medicaid Services (CMS) notified CalOptima that its OneCare program has been selected for a 2016 financial audit. By way of background, at least one-third of Medicare Advantage Organizations (MAOs) are selected for CMS' annual audit of financial records, which will include data relating to Medicare utilization, costs, and computation of the bid. CMS contracted with Bland & Associates to conduct the review of claims data, solvency, enrollment, base year entries on the bids, medical and/or drug expenses, related party transactions, general administrative expenses, and direct and indirect remuneration (DIR). Starting on November 21, 2017 through January 10, 2018, Bland & Associates selected Parts C and D samples for review. All sample submissions have been submitted by the regulatory deadline of February 5, 2018. The onsite audit dates have been confirmed for February 28, 2018 through March 1, 2018.

- **CMS Timeliness Monitoring Project:**

On December 12, 2017, CMS announced its efforts to collect data for organization determinations, appeals and grievances (ODAG) and coverage determinations, appeals and grievances (CDAG) for the requested review period of March 1, 2017 through May 31, 2017. On February 5, 2018, CMS' contractor, Conrad LLP, notified CalOptima of its requirement to submit data, also known as universes, as part of the CMS Timeliness Monitoring Project for its OneCare program. Prior to conducting timeliness tests on the submitted universes, CMS' contractor will schedule a webinar with your organization to verify the accuracy of the data you submitted. CalOptima must submit all of the universe data electronically via the Secure File Transfer Protocol (SFTP) by 2/26/18. On February 8, 2018, CMS' contractor conducted an initial kick off conference call to discuss the review process requirements and to respond to any initial questions about the information requested or the review process. CMS' contractor has not set a date yet for the data integrity webinar.

- Medicare Data Validation Audit (OneCare and OneCare Connect):

In preparation for the annual Medicare Data Validation Audit, CalOptima is in the process of collecting the required Part C and Part D reporting and working with all impacted business areas to ensure the data completed validation prior to regulatory submissions in February 2018. The audit period is from January 1, 2017 through December 31, 2017 and the audit is set to begin on April 1, 2018.

2. Compliance Program Effectiveness (CPE) Audit (applicable to OneCare Connect and OneCare):

- CMS requires all Medicare plan sponsors to conduct an independent audit on the effectiveness of its Compliance Program on an annual basis, and to share the results with its governing body. As such, CalOptima engaged an independent auditor to conduct an audit of its Compliance Program in accordance with the CMS Medicare Parts C and D Program Audit Protocols. The onsite audit took place from November 6 – 9, 2017. CalOptima received the final audit report on January 17, 2018. Overall, the independent auditor determined that CalOptima provided evidence that its current Compliance Program is effectively using the seven (7) elements of an effective Compliance Program to review and address issues of non-compliance and potential fraud and abuse. Two (2) areas for improvement were noted regarding communication to the Compliance Committee and timely development and implementation of corrective action plans (CAPs). Two (2) best practices were also noted regarding annual audits for first tier entities and utilization of a “high touch” approach in corrective action remediation with internal operational areas.

3. Medi-Cal

- 2017 Medi-Cal Audit:

The Department of Health Care Services (DHCS) conducted its annual audit of CalOptima's Medi-Cal program from February 6-14, 2017. The audit covered the period from February 1, 2016 through January 31, 2017. On November 16, 2017, DHCS sent CalOptima a final report regarding the audit, which identified four (4) findings in the areas of utilization management, case management and coordination of care, and member rights. CalOptima submitted a timely corrective action plan (CAP) to DHCS regarding the findings, which DHCS approved and on January 19, 2018, formally closing the audit.

- 2018 Medi-Cal Audit:

On November 29, 2017, the DHCS notified CalOptima of its intent to conduct its annual audit of CalOptima's Medi-Cal program from February 26, 2018 through March 9, 2018. The audit will cover the period from February 1, 2017 through January 31, 2018. The audit will consist of an evaluation of CalOptima’s compliance with its contract and regulations in the areas of utilization management, case management and care coordination, access and availability, member rights and responsibilities, quality improvement system, organization and administration of CalOptima, facility site reviews, and medical records review. The

entrance conference took place on February 26, 2018, and the audit is currently in progress with an anticipated completion date of March 9, 2018.

4. PACE

- 2018 PACE Mock Audit:

Beginning in January 2018, CalOptima’s Office of Compliance initiated its mock audit activities in anticipation of the upcoming CMS and DHCS 2018 PACE audit. CalOptima has not been formally engaged by CMS and DHCS for this audit yet.

B. Regulatory Notices of Non-Compliance

1. CalOptima did not receive any notices of non-compliance from its regulators for the month of January 2018.

C. Updates on Internal and Health Network Audits

1. Internal Audits: Medi-Cal^{a\}

- Medi-Cal Utilization Management (UM): Prior Authorization (PA) Requests

Month	Timeliness for Urgents	Clinical Decision Making (CDM) for Urgents	Letter Score for Urgents	Timeliness for Routine	Timeliness for Denials	CDM for Denials	Letter Score for Denials	Timeliness for Modified	CDM for Modified	Letter Score for Modified	Timeliness for Deferrals	CDM for Deferrals	Letter Score for Deferrals
September 2017	40%	73%	78%	80%	60%	90%	89%	90%	97%	88%	100%	67%	84%
October 2017	0%	100%	90%	10%	30% 30%	77%	84%	40%	100%	87%	0%	60%	51%
November 2017	100%	100%	93%	10%	80%	80%	81%	70%	93%	92%	0%	30%	26%

- The lower scores for timeliness were due to the following reasons:
 - Failure to meet timeframe for decision (Urgent – 72 hours; Routine – 5 business days; Deferral – 14 business days)
 - Failure to meet timeframe for member notification (2 business days)
 - Failure to meet timeframe for provider written notification (2 business days)
 - Failure to meet timeframe for provider initial notification to the requesting provider (24 hours)
 - Failure to meet time frame for member delay notification (5 business days)
 - Failure to meet time frame for provider delay notifications (5 business days)

3 a\ “N/A” indicates that the category is not applicable to that file type. “Nothing to Report” indicates that there were no files submitted for review for that file type.

- The lower scores for clinical decision making were due to the following reasons:
 - Failure to cite criteria for decision
 - Failure to obtain adequate clinical information
 - Failure to have appropriate professional make decision

- The lower letter scores were due to the following reasons:
 - Failure to provide information on how to file a grievance
 - Failure to provide letter in member preferred language
 - 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
 - Failure to provide alternative direction back to PCP on denial
 - Failure to provide name and contact information for health care professional responsible for decision to requesting provider
 - Failure to provide peer-to-peer discussion with medical reviewer

- Medi-Cal Claims: Professional and Hospital Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
September 2017	100%	100%	100%	100%
October 2017	100%	100%	100%	90%
November 2017	100%	100%	100%	100%

➤ No significant trends to report.

- Medi-Cal Claims: Provider Dispute Resolutions (PDRs)

Month	Letter Accuracy	Determination Timeliness	Acknowledgement Timeliness
September 2017	100%	90%	100%
October 2017	100%	80%	100%
November 2017	100%	100%	100%

➤ No significant trends to report.

- 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
September 2017	100%	100%
October 2017	100%	100%
November 2017	100%	100%

➤ No significant trends to report.

2. Internal Audits: OneCare

- OneCare Pharmacy: Formulary Rejected Claims Review

Month	% Claims Rejected in Error (Member Impact)
September 2017	0%
October 2017	0%
November 2017	0%

➤ No claims were rejected in error due to formulary restrictions from September through November 2017.

- OneCare Pharmacy: Coverage determination timeliness is reviewed on a monthly basis to ensure that coverage determinations are processed in the appropriate timeframe.

<u>Month</u>	% Compliant with Timeliness
September 2017	100%
October 2017	100%
November 2017	100%

➤ The compliance rate for coverage determination timeliness remains consistent at 100% from September through November 2017.

- OneCare Utilization Management

Month	Timeliness for Expedited Initial Organization Determination (EIOD)	Clinical Decision Making (CDM) for EIOD	Letter Score for EIOD	Timeliness for Standard Organization Determination (SOD)	Letter Score for SOD	Timeliness for Denials	CDM for Denials	Letter Score for Denials
September 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
October 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
November 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

➤ Due to low membership for the months of September 2017 through November 2017, there were no denials, expedited organization determinations, or standard organization determinations reported for this time period.

- OneCare Claims: Professional and Hospital Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
September 2017	100%	100%	100%	100%
October 2017	70%	100%	100%	100%
November 2017	100%	100%	100%	100%

➤ No significant trends to report.

- OneCare Claims: Provider Dispute Resolutions (PDRs)

Month	Determination Timeliness	Payment Accuracy	Letter Accuracy	Check Lag
September 2017	100%	100%	100%	100%
October 2017	100%	100%	100%	100%
November 2017	100%	100%	100%	100%

➤ No significant trends to report.

6 a\ “N/A” indicates that the category is not applicable to that file type. “Nothing to Report” indicates that there were no files submitted for review for that file type.

- OneCare Customer Service: Call center activity is reviewed for appropriate classification, routing, and privacy handling.

Month	OneCare Customer Service
September 2017	100%
October 2017	100%
November 2017	100%

➤ No significant trends to report.

3. Internal Audits: OneCare Connect^{a\}

- OneCare Connect Pharmacy: Formulary Rejected Claims Review

Month	% Claims Rejected in Error (Member Impact)
September 2017	0%
October 2017	0%
November 2017	0%

➤ No claims were rejected in error due to formulary restrictions from September through November 2017.

- OneCare Connect Pharmacy: Coverage determination timeliness is reviewed on a monthly basis to ensure that coverage determinations are processed in the appropriate timeframe.

Month	% Compliant with Timeliness
September 2017	99%
October 2017	100%
November 2017	100%

➤ No significant trends to report.

7 | a\ “N/A” indicates that the category is not applicable to that file type. “Nothing to Report” indicates that there were no files submitted for review for that file type.

- OneCare Connect Utilization Management: Prior Authorization (PA) Requests

Month	Timeliness for Urgents	Clinical Decision Making (CDM) for Urgents	Letter Score for Urgents	Timeliness for Routine	Letter Score for Routine	Timeliness for Denials	CDM for Denials	Letter Score for Denials	Timeliness for Modified	CDM for Modified	Letter Score for Modified	Timeliness for Deferrals	CDM for Deferrals	Letter Score for Deferrals
September 2017	100%	100%	89%	80%	60%	100%	100%	88%	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report
October 2017	0%	100%	33%	20%	10%	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report
November 2017	90%	N/A	40%	70%	45%	100%	100%	84%	Nothing to Report	Nothing to Report	Nothing to Report	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; Deferral – 14 business days)
 - Failure to meet timeframe for provider written notification (2 business days)
 - Failure to meet timeframe for provider initial notification to the requesting provider (24 hours)
- The lower letter scores were due to the following reasons:
 - Failure to provide letter in member’s preferred language
 - Failure to provide description of services in lay language

- OneCare Connect Claims: Professional and Hospital Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
September 2017	100%	100%	100%	100%
October 2017	100%	100%	100%	100%
November 2017	100%	100%	100%	100%

- No significant trends to report.

- OneCare Connect Claims: Provider Dispute Resolutions (PDRs)

Month	Determination Timeliness	Payment Accuracy	Letter Accuracy	Check Lag
September 2017	100%	92%	100%	100%
October 2017	100%	100%	100%	100%
November 2017	95%	100%	100%	100%

8 a) “N/A” indicates that the category is not applicable to that file type. “Nothing to Report” indicates that there were no files submitted for review for that file type.

- The compliance rate for determination timeliness decreased from 100% in October 2017 to 95% in November 2017 due to the processing timeframe exceeding the thirty (30) days from receipt of claim.
- OneCare Connect Customer Service: Call center activity is reviewed for appropriate classification, routing, and privacy handling.

Month	OneCare Connect Customer Service
September 2017	100%
October 2017	100%
November 2017	100%

➤ No significant trends to report.

4. Internal Audits: PACE

- PACE Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
September 2017	100%	100%	100%	100%
October 2017	100%	100%	100%	100%
November 2017	100%	100%	100%	100%

➤ No significant trends to report.

- PACE Claims: Provider Dispute Resolutions (PDRs)

Month	Determination Accuracy	Letter Accuracy	Acknowledgement Timeliness	Check LAG
September 2017	100%	100%	100%	100%
October 2017	100%	100%	100%	N/A
November 2017	100%	100%	100%	100%

➤ No significant trends to report.

9 a\ “N/A” indicates that the category is not applicable to that file type. “Nothing to Report” indicates that there were no files submitted for review for that file type.

5. Health Network Audits: Medi-Cal, OneCare, OneCare Connect^{a\}

- Utilization Management (UM): Prior Authorization (PA) Requests

For the months of October through November 2017, CalOptima's Audit & Oversight department suspended its monthly file reviews for health networks' UM files due to the 2017 delegation oversight annual audits in progress. As a less resource intensive alternative, CalOptima's Audit & Oversight department conducted webinars for each health network to assess the processing of the networks' UM files from their medical management system. Auditors reviewed UM files for timeliness, clinical decision making, and appropriate use of letter templates.

The common issues identified across the health networks were related to:

- Failure to use of lay language
- Failure to issue letters in member's primary language
- Failure to comply with policies and procedures
- Non-timely clinical decision making

- Claims: Professional and Hospital Claims (Medi-Cal, OneCare, OneCare Connect)

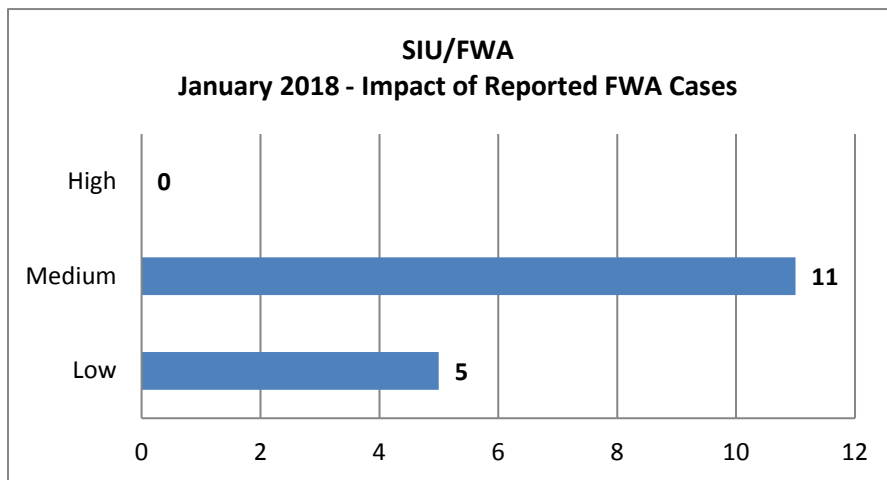
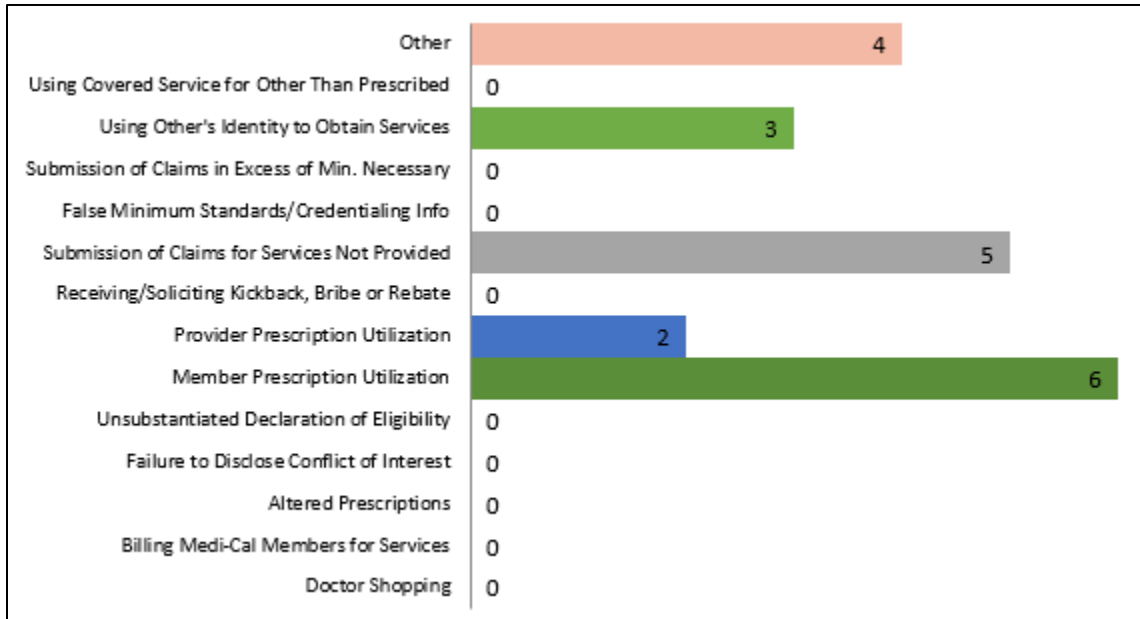
For the months of October through November 2017, CalOptima's Audit & Oversight department suspended its monthly file reviews for health networks' claims files due to the 2017 delegation oversight annual audits in progress. As a less resource intensive alternative, CalOptima's Audit & Oversight department conducted webinars for each health network to assess the processing of the networks' claims files from their claims processing system. Auditors reviewed claims for timeliness, accuracy, and misclassifications.

The common issue identified across the health networks was related to:

- Failure to have a process in place to issue member Integrated Denial Notices (IDNs) in the approved OneCare and OneCare Connect threshold languages.

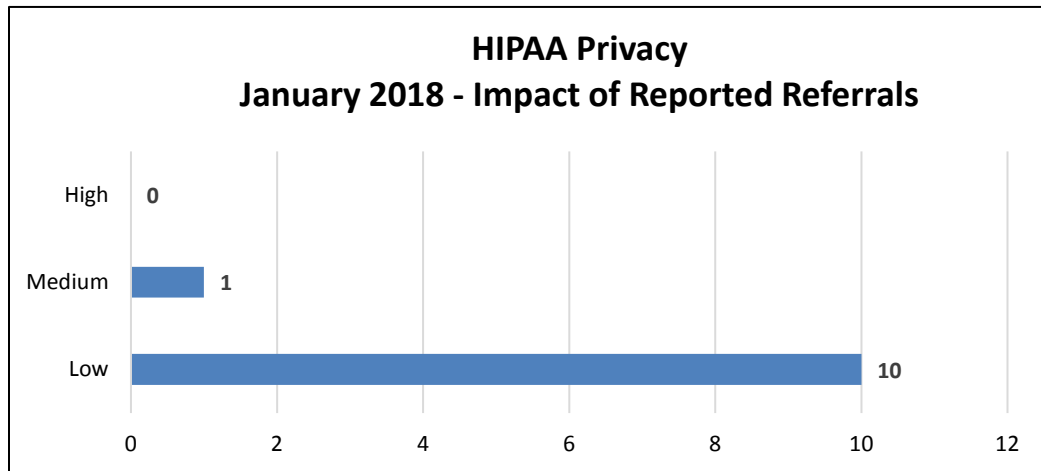
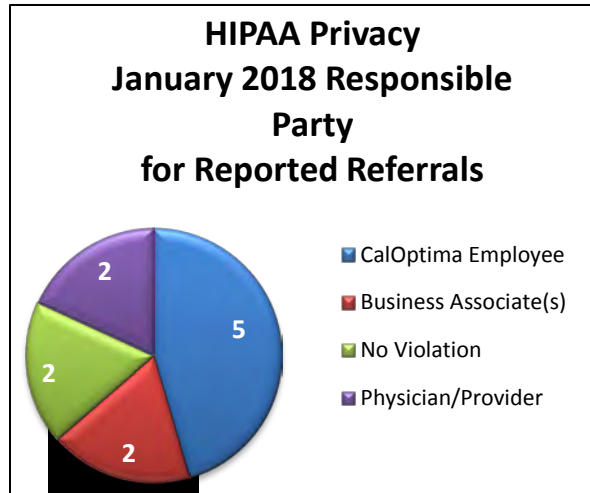
D. Special Investigations Unit (SIU) / Fraud, Waste & Abuse (FWA) Investigations

Types of FWA Cases: (Received in January 2018)



Note: Of the 20 referrals received by CalOptima's SIU, a risk assessment could not be performed for 4 of the referrals due to insufficient information provided in the referral.

E. Privacy Update (January 2018)



PRIVACY STATISTICS

Total Number of Referrals Reported to DHCS (State)	10
Total Number of Referrals / Breaches Reported to DHCS and Office for Civil Rights (OCR)	1
Total Number of Referrals Reported	11



CalOptima
Better. Together.

Federal & State Legislative Advocate Reports

Board of Directors Meeting
March 1, 2018

Akin Gump Strauss Hauer & Feld / Edelstein Gilbert Robson & Smith

M E M O R A N D U M

February 16, 2018

To: CalOptima
From: Akin Gump Strauss Hauer & Feld, LLP
Re: February Board of Directors Report

In a flurry of legislative activity despite two brief government shutdowns, Congress managed to address a host of expired or expiring healthcare provisions that were important priorities for CalOptima including funding for the Children’s Health Insurance Program and community health centers as well as authorization for Medicare Advantage Dually Eligible Special Needs Plans (D-SNPs). To educate Members of Congress about the value CalOptima provides its members and the impact that federal policy has on how CalOptima operates, CalOptima Board of Directors and leadership visited with Members of Congress on Capitol Hill on February 14th, 2018. This report details the legislation passed in the preceding weeks and the CalOptima leadership meetings with the Orange County delegation and their staff.

January 26 Shutdown & Continuing Resolution

Prior to Christmas, Congress passed two pieces of legislation that changed the dynamic for a number of issues that would determine the activity that resulted at the end of January and the middle of February.

On December 22nd, Congress passed a continuing resolution that avoided a government shutdown and extended FY2017 spending levels for another four weeks until January 19th in order to give itself more time to reach an agreement related to the FY2018 budget. The challenge in passing a budget and federal appropriations bills for FY2018 were made more difficult than in previous years because the sequester, which would automatically cut defense and non-defense spending, was set to take effect unless Congress acted to prevent it. Generally, Republicans sought to increase defense spending and Democrats sought to increase non-defense spending. This created a two-step process: first, the overall spending levels needed to be set, and then second, with the new overall spending level in place, the House and Senate Appropriations committees could write a full year spending bill for the remainder of FY2018. The continuing resolution at the end of 2017 gave Congress more time to negotiate the first step – the overall spending levels – while continuing to fund the government at the previous year’s levels and set the deadline for reaching that agreement at January 19th.

The second piece of legislation that set the context for the debate in January and February was Tax Cuts and Jobs Act, which repealed the penalties for the individual mandate beginning in 2019. In an unintended consequence, this changed the dynamic around a then-pending issue: the expiration of funding for CHIP. On January 11, the Congressional Budget Office (CBO)

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Page 2

estimated that extending CHIP funding for 10 years would save \$6 billion in federal expenditures. CBO believed that without CHIP, many children would then be covered under their parents' plans on the Affordable Care Act marketplaces, which is more expensive for the government because of the subsidies offered to individuals and families buying insurance on the marketplace. The repeal of the individual mandate, CBO said, would also increase the premiums and therefore the premium subsidies, making CHIP coverage an even less expensive coverage option for the government by comparison. Prior to the January 11th CBO estimate, Members of Congress could not agree on how to raise revenue or cut spending in other programs to offset the estimated \$8.2 billion cost of 5 years of additional CHIP spending. That disagreement became moot and the prospects for a long-term CHIP extension suddenly looked bright.

However, a third unresolved issue, the immigration status of children brought to the United States as minors known as Dreamers, loomed. Following the President's decision to terminate the Deferred Action for Childhood Arrivals (DACA) program, these children faced a March 5 deadline before their immigration status expired and they became vulnerable to deportation. The Dreamers and their champions in Congress saw the January 19 funding deadline as the only opportunity to pass legislation that would grant them legal status. As a result, they urged the Senate, where a supermajority of 60 votes from both Democrats and Republicans would be needed to pass the next spending bill to avoid a shutdown, to reach a deal. Without a deal to resolve their immigration status, then, they said, their champions in Congress should not vote for a spending bill to keep the government open.

On January 19, following weeks of negotiations on how to resolve the immigration status of those enrolled in the DACA program that ultimately failed, a bill to keep the government open secured only 50 votes – well short of the 60 needed to end debate. Both California Senators, Dianne Feinstein (D-CA) and Kamala Harris (D-CA), voted against this bill, citing its lack of provisions for Dreamers. As a result, the government entered its first shutdown since the fall of 2013.

But, it only lasted until Monday morning when Senate Majority Leader Mitch McConnell (R-KY) and Senate Minority Leader Charles Schumer (D-NY) announced a deal. Senator McConnell promised to open debate on the Senate floor on immigration and Senator Schumer pledged to vote for a continuing resolution keeping the government open through February 8th. The bill also included 6 years of funding for the Children's Health Insurance Program, an important win for Schumer's Democrats. In addition, the funding for these 6 years maintained a bipartisan agreement reached at the end of 2017 regarding the treatment of additional federal support for CHIP. The bill continues the 23 percentage point CHIP enhanced federal match rate

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Page 3

established by the ACA for FY2018 and FY2019, decreases it to 11.5 percentage points in FY2020, and returns to the regular CHIP match rate for FY2021 through FY2023.

On January 22nd, 33 Senate Democrats joined 48 Senate Republicans to end the one workday shutdown. Again, both California Senators voted against the bill, citing its lack of provisions for Dreamers. The House then passed the bill 266-150. Democratic Representatives Correa (CA-46), Lowenthal (CA-47), and Sanchez (CA-38) from Orange County voted against the bill while Republican Representatives Issa (CA-49), Rohrabacher (CA-48), Royce (CA-39), and Walters (CA-45) all voted for it.

February 8 Shutdown & Budget Deal

Despite this breakthrough on CHIP funding, the short-term agreement reached on January 22nd did not yet complete even the first step of the budget process outlined above needed to set funding levels for the remainder of FY2018. It merely gave Congress 3 more weeks to reach such an agreement but without the issue of immigration complicating the debate. With another midnight deadline in sight, Senate leaders announced a massive new spending deal on February 7th.

Among its budget-related provisions, the deal:

- Suspended sequestration cuts;
- Suspended the debt ceiling until March 2019; and
- Raised the spending caps by \$300 billion over two years with an increase in defense of \$80 billion and \$85 billion over the next two years and an increase in non-defense spending of \$63 billion and \$68 billion over the next two years.

Among its health-related provisions, the deal:

- Provided four additional years of funding for CHIP on top of the recently enacted six years of funding;
- Provided \$7 billion and a two year reauthorization for community health centers;
- Permanent authorization for Medicare Advantage Dually Eligible Special Needs Plans (D-SNPs);
- \$6 billion to address the opioid crisis; and
- \$5.8 billion for child care.

While the deal enjoyed broad bipartisan support, several hours remained in the Senate debate before a vote could be held to end debate on move forward with passing the deal. The Senators could agree unanimously to hold that vote before midnight and avoid a shutdown, but one refused: Senator Rand Paul (R-KY). He objected to all requests from other Senators to oppose

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Page 4

the increased spending in the bill ultimately relenting early the following morning. With his speech dragging past midnight, the government again entered into a short shutdown, though this time only several hours long. The Senate passed the Bipartisan Budget Act by a vote of 71-28 with both California Senators again voting against it, citing its lack of protections for Dreamers. The House quickly passed it 240-186 with all three Orange County Democrats again voting against it and Republican Representatives Issa, Walters, and Royce voting for it. Representative Rohrabacher was the lone Orange County Republican to vote against it. The President signed it into law later that day.

CalOptima Visit to Capitol Hill

On February 14th, CalOptima's leadership visited Capitol Hill and met with Members of Congress and their staff to educate them on the value CalOptima provides for its plan members and how federal policy impacts their ability to continue to provide high quality, low cost care. The CalOptima delegation included CEO Michael Schrader, Director of Public Policy Arif Shaikh, and Board of Director members Ria Berger, Ron DiLuigi, and Dr. Nikan Khatibi.

Over the course of the day, the group met with 6 Congressional offices including staff for Senators Dianne Feinstein and Kamala Harris and Representative Ed Royce as well as meeting directly with Representatives Lowenthal, Walters, and Sanchez and their health policy staff. In each meeting, CEO Schrader stressed the accolades that CalOptima has received from the National Committee for Quality Assurance as the top California Medicaid plan for the last 4 consecutive years. He highlighted that this achievement was reached through the consistent application of practices to coordinate the care CalOptima plan members. As an expert in pain management and addiction medicine, Dr. Khatibi discussed CalOptima's efforts to address opioid abuse prevention and treatment. In addition, Ms. Berger drew on her experience with Healthy Smiles for Kids of Orange County to tout CalOptima's benefits for CHIP enrollees and children's health care. Mr. DiLuigi highlighted the community-based care that CalOptima's senior citizen plan members receive through the PACE program. He also cautioned that in past environments of increasing federal deficits and debt Medicaid has been a frequent target for spending cuts and offered CalOptima as a policy resource for new ideas and data on how to ensure the quality of the program in future years. Ultimately, the trip successfully educated Members and their health policy staff about the importance of CalOptima in the lives of its plan members and the broader Orange County community.



**CalOptima Legislative Report
By Don Gilbert and Trent Smith
February 5, 2018**

While the Legislature has returned to Sacramento to begin the second year of its two-year session, it remains relatively quiet for the time being. It can best be described as the calm before the storm. The deadline to introduce new bills is February 16. Newly introduced bills are trickling in, but a vast majority will be introduced between February 12 and 16. In fact, if past years are any indication, close to one thousand bills could be introduced during the deadline week.

While the Legislature waits for the flood of new bills, the Senate and Assembly Health Committees have been holding joint hearings to study the concept of universal health care. The hearings have been very lively, with supporters of universal health care packing the hearing room and providing very colorful testimony. It is unlikely that a universal health care bill will pass this year. However, we expect bills will be introduced in the coming weeks that propose expanding healthcare to unserved populations. For example, SB 974 (Lara) was recently introduced. This bill proposes expanding Medi-Cal eligibility to adult undocumented immigrants.

In addition, we believe a bill will be introduced to allow individuals who do not meet the current financial criteria required for Medi-Cal eligibility to purchase Medi-Cal coverage by paying premiums to Medi-Cal managed care plans. This proposal was debated briefly in one of the joint health committee hearings on universal health care. The debate focused on the good job that public Medi-Cal managed care plans do in providing quality care to their enrollees. Thus, some have advocated for expanding the role of public Medi-Cal managed care plans to include private pay members. Obviously, we will be very involved if a bill such as this is introduced.

Another issue that is generating a lot of interest among legislators is prescription opioid abuse. There have been several informational hearings on the issue and many bills will be introduced in an attempt to combat the over prescribing and abuse of prescription opioids. We expect a bill will be introduced to require physicians to prescribe all drugs electronically to the pharmacy, rather than allowing paper prescriptions. While electronic prescribing is a common practice among many physicians, experts still believe that paper prescriptions are still a source of fraud and abuse.

Bills will also be introduced to limit the initial quantity of prescription opioids. One bill, AB 1998 (Rodriguez), has already been introduced and proposes to limit, to three days, the initial prescription of opioids. However, a physician would be able to use their professional judgement to write a prescription for a greater amount as long as justification is included in the patient's medical file. We also understand a similar bill will be introduced to establish the initial prescription limit to seven days.

With a \$19 billion state budget surplus, we are also expecting the introduction of bills that will increase Medi-Cal benefits or expand Medi-Cal eligibility in some manner. For example, AB 1785 (Nazarian) has already been introduced to exclude 529 college savings accounts from being considered as part of the income and asset test used to determine Medi-Cal eligibility.

A bill focused on addressing both opioid abuse and Medi-Cal reimbursement is AB 1963 (Waldron). This measure would increase Medi-Cal reimbursement for medications and treatments used to address opioid addiction.

Again, there are only a handful of bills of interest to CalOptima that have been introduced so far. However, next month's report will surely include a summary of many more.

2017–18 Legislative Tracking Matrix

FEDERAL BILLS

Bill Number (Author)	Bill Summary	Bill Status	CalOptima Action/Position
H.R. 1892 Larson	Continuing Resolution (CR): <ul style="list-style-type: none"> Establishes a two-year budget framework and continues current federal spending levels until March 23, 2018 Permanently reauthorizes Dual Eligible Special Needs Plans (OneCare) Extends reauthorization for the Children's Health Insurance Program (CHIP) until 2027, authorizing the program for ten years. Extends the Community Health Center Fund (CHCF) for two years 	02/09/2018 Signed into law	Sent letter of support for CHIP, D-SNP and CHCF
H.R. 4957 Sanchez	Alzheimer's Care: Among other actions, would establish Alzheimer's models of care based on a comprehensive continuum of care, similar to care delivery in the Program of All-Inclusive Care for the Elderly (PACE).	02/09/2018 Introduced in House	Watch
H.R. 195 Russell	Continuing Resolution (CR): Extended current federal discretionary spending until February 8, 2018. Also, authorizes CHIP funding for six years, until 2023, and gradually phases down the enhanced federal matching rate – 88/12 federal/state, to the regular CHIP rate – 65/35 federal/state in FY 2021.	01/22/2018 Signed into law	Sent letter of support for CHIP
H.R. 1 Brady	Tax Cuts and Jobs Act: Amends portions of the Internal Revenue Code that address corporate and individual tax rates and deductions. It also eliminates the Affordable Care Act's individual mandate, effective December 31, 2018.	12/22/2017 Signed into law	Watch
H.R. 3922 Walden	Five Year CHIP Re-authorization: Would extend federal CHIP funding, which expired on September 30, 2017, for five years. Retains the current ACA mandated state/federal CHIP matching rate (88/12 for California) for two years, reduces it by 11.5 percent for one year (76.5/23.5), and reverts to pre-ACA levels for two years (65/35). Also includes spending offsets such as increasing Medicare premiums for beneficiaries who make more than \$500,000 annually, requires Medicaid beneficiaries to report lottery winnings as income, and decreases funding for the ACA-enacted Prevention and Public Health Fund.	11/03/2017 Passed House, referred to Senate	Sent letter of support for CHIP re-authorization
H. Concurrent Resolution 71 Black	FY 18 Budget Resolution: The annual budget resolution sets the budgetary framework for the upcoming fiscal year, and allows the majority party to pass reconciliation legislation by 51 votes in the Senate rather than the 60-vote threshold. While the budget resolution is non-binding and does not appropriate federal dollars, it does outline spending priorities for the remainder of the unfunded fiscal year (December 9, 2017 - September 30, 2018).	10/26/2017 Passed House and Senate (Budget resolutions do not require a Presidential signature)	Watch

2017–18 Legislative Tracking Matrix (continued)

Bill Number (Author)	Bill Summary	Bill Status	CalOptima Action/Position
Bipartisan Health Care Stabilization Act of 2017 Alexander/ Murray	Marketplace Stabilization: Would fund cost-sharing reductions (CSRs) – federal payments to marketplace insurers to reduce deductibles and co-pays for consumers earning between 139-250 percent of the FPL who have a “silver” level plan – through 2019. Also, increases flexibility and streamlines the state waiver approval process, allows all individuals to purchase “copper” (or catastrophic) plans, and requires HHS to allow plans to be sold across state lines. While this bill does not impact Medicaid directly, it is of interest to CalOptima because of its impact on the health care system, and, because it is common for Medicaid members to “churn” between Medicaid and the individual market.	10/19/2017 Draft bill text released	Watch
S. 1827 Hatch	Five Year CHIP Re-authorization: Extends CHIP funding for five years. The CHIP enhanced FMAP (E-FMAP), which accounts for 88 percent of California’s CHIP budget, would be extended for two years. States would receive an 11.5 percent reduction in CHIP funding in federal FY (FFY) 2020 and 2021, which would result in reverting back to the pre-ACA CHIP funding formula of 65 percent federal dollars and 35 percent state dollars.	10/04/2017 Passed Senate Committee on Finance	Support
H.R. 3921 Burgess	Five Year CHIP Re-authorization: Extends CHIP funding for the Children’s Health Insurance Program (CHIP) for five years. The CHIP enhanced FMAP (E-FMAP), which accounts for 88 percent of California’s CHIP budget, would be extended for two years. States would receive an 11.5 percent reduction in CHIP funding in federal FY (FFY) 2020 and 2021, which would result in reverting back to the pre-ACA CHIP funding formula of 65 percent federal dollars and 35 percent state dollars.	10/04/2017 Passed Senate, referred to the House	Sent letter of support
S. 870 Hatch	Permanent D-SNP Re-authorization: Among other provisions, permanently re-authorizes 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.	09/26/2017 Passed House Committee on Energy and Commerce	Sent letter of support
S. 1804 Sanders	Medicare for All: This bill would replace the current U.S. health care system with a single-payer system, known as Medicare for All. This system would provide comprehensive health care services for all U.S. residents, sunset the current Medicare and Medicaid programs, and enroll all eligible individuals into the new universal plan. No official financial analysis or CBO score is currently available.	09/13/2017 Referred to Senate Committee on Finance	Watch
H.R. 601 Lowey	Continuing Resolution (CR): Extends current federal discretionary spending (\$1.24 trillion overall) and raises the debt ceiling through December 8, 2017. The bill ensures funding for federal agencies such as the U.S. Department of Health and Human Services (HHS) continues at approximately \$65 billion per year. Mandatory spending (\$2.54 trillion overall) for program such as Medicare (\$646 billion/year) and Medicaid (\$545 billion/year) is not impacted by the CR.	09/08/2017 Signed into law	Watch

2017–18 Legislative Tracking Matrix (continued)

Bill Number (Author)	Bill Summary	Bill Status	CalOptima Action/Position
H.R. 1628 Black	<p>ACA Repeal/Replace: “Graham-Cassidy” would have replaced the Medicaid FMAP with per capita caps, repealed the Medicaid expansion by 2020, and combined state exchange and state Medicaid expansion dollars into a block grant.</p> <p><i>Senate Amendment 271:</i> “Repeal Now, Replace Later” would have repealed the Medicaid expansion beginning in 2020.</p> <p><i>Senate Amendment 270:</i> “The Better Care Reconciliation Act” would have replaced the Medicaid FMAP with per capita caps and phase-down federal funding for the Medicaid expansion beginning in 2021.</p> <p>The American Health Care Act would have made sweeping changes to the national health care system. For CalOptima, the most significant changes would have been 1) Changes to the Medicaid financing structure from the 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 benefits” for Medicaid plans, and 4) Potentially decreased funding and additional restrictions for CMS waivers.</p>	<p>09/26/2017 Senate leaders announce no vote</p> <p>07/26/2017 Failed Senate</p> <p>07/25/2017 Failed Senate</p> <p>05/04/2017 Passed House, referred to Senate</p>	<p>Sent letter of opposition</p> <p>Sent letter of concern</p> <p>Sent letter of concern</p>
S. 191 Cassidy	<p>ACA Repeal/Replace: The Patient Freedom Act would repeal several mandates in the Affordable Care Act (ACA), such as the individual and employer mandates, and the essential health benefit requirements. The bill retains most of the ACA consumer protections, such as prohibiting discrimination and pre-existing conditions exclusions. 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, 2) A state-based health care system with no federal financial assistance, or 3) Continue under current system at funding no more than option one.</p>	<p>01/23/2017 Referred to Senate Committee on Finance</p>	<p>Watch</p>

2017–18 Legislative Tracking Matrix (continued)

STATE BILLS

Bill Number (Author)	Bill Summary	Bill Status	CalOptima Action/Position
AB 2275 Arambula	Medi-Cal Oversight: Would create new quality requirements for Medi-Cal plans. It would be a significant departure from the state's current quality assurance and performance improvement program and could potentially require CalOptima to extensively modify to its reporting processes.	02/13/2018 Introduced	Watch Provided technical feedback to the bill's author
SB 974 Lara	Medi-Cal Eligibility: Extends full scope Medi-Cal coverage to all eligible adults, regardless of immigration status.	02/01/2018 Introduced	Watch
Trailer Bill - 340b Drug Program	340b Drug Purchasing Program: This trailer bill language would prohibit the use of 340B discounted drugs in Medi-Cal starting July 1, 2019, pending approval from the Centers for Medicare & Medicaid Services (CMS). Section 340B of the Public Health Service Act allows certain hospitals and clinics to purchase pharmaceuticals at discounted prices. The federal and state governments have found inconsistencies with the program's implementation. According to the state Department of Health Care Services (DHCS), these inconsistencies create a substantial administrative burden on the state. As such, DHCS' proposed trailer bill language seeks to prohibit the use of 340B drugs in Medi-Cal. In the event that CMS does not grant state permission to entirely exclude 340b drugs from Medi-Cal, the state will seek CMS approval for limiting the use of 340b drugs in Medi-Cal.	01/16/2018 Trailer bill language published on the Department of Finance Website	Watch
AB 2203 Gray	Medi-Cal Rates: Beginning July 1, 2019, would align Medi-Cal primary care provider rates to the applicable rate for those services under the federal Medicare Program.	02/14/2018 Introduced	Watch
AB 2331 Weber	Special Needs Redetermination: Would require a county to perform a redetermination only every 36 months for a Medi-Cal beneficiary who has a developmental disability and receives services through a regional center. Current law requires the redetermination of a Medi-Cal beneficiary's eligibility to receive Medi-Cal benefits every 12 months.	02/13/2018 Introduced	Watch
SB 945 Atkins	Breast and Cervical Cancer Treatment Program (BCCTP): Current law requires the Department of Health Care Services (DHCS) to provide breast and cervical cancer treatment for Medi-Cal beneficiaries for a period of 18 to 24 months, beginning when a person is first diagnosed. SB 945 would eliminate the 18 to 24 month period of treatment requirement, which would require DHCS to provide services for the duration of the illness, as long as an individual continues to meet all other eligibility requirements. CalOptima has more than 600 members currently receiving BCCTP services.	01/29/2018 Introduced	Watch
SB 399 Portantino	Behavioral Health: Makes changes to current law related to the treatment of Autism Spectrum Disorder, such that managed care plans would be required to cover certain treatment protocols that are not currently covered.	01/29/2018 Passed Senate, referred to Assembly	Watch Provided technical feedback to the bill's author
AB 1963 Waldron	Opioid Treatment: Requires DHCS to increase provider rates for certain opioid treatments, including buprenorphine/naloxone combination treatment.	02/08/2018 Referred to Assembly Health Committee	Watch

2017–18 Legislative Tracking Matrix (continued)

Bill Number (Author)	Bill Summary	Bill Status	CalOptima Action/Position
AB 1998 Rodriguez	Opioid Treatment: Would institute stricter prescription controls related to opioids, generally limiting opioid prescriptions to amounts sufficient for not more than three days.	02/02/2018 Introduced	Watch
AB 205 Wood	Mega-Reg: Implements certain provisions of the CMS Medicaid managed care rules (Mega-Reg) by making changes at the state level regarding Medi-Cal managed care plans. Specifically, this bill would change the grievance and appeals process for plans by lengthening the amount of time members have to request a state fair hearing from 90 days to 120 days. It would also establish new time and distance standards for members to access primary and specialty care services.	10/13/2017 Signed into law	Watch
SB 608 Hernandez	Hospital QAF: Modifies the hospital quality assurance fee to bring it into compliance with Mega-Reg requirements. The current language of the bill only reflects a portion of the California Hospital Association's proposal to reform the QAF. The bill's language is likely to be substantially amended.	09/01/2017 Held under submission	Watch
SB 152 Hernandez	California Children's Services: 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. This bill would also allow DHCS to make this report available to the public with 90 days instead of the original 30 days.	07/17/2017 Ordered to inactive file	Watch

The CalOptima Legislative Tracking Matrix includes information regarding legislation that directly impacts CalOptima and our members. These bills are closely followed 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.

2017–18 Legislative Tracking Matrix (continued)

2018 Federal Legislative Dates

January 3	Congress convenes 2nd session
March 26–April 9	Spring recess
July 27–September 3	Summer recess
November 6	General Election

2018 State Legislative Dates

January 3	Legislature reconvenes
February 16	Last day for legislation to be introduced
April 27	Last day for policy committees to hear and report bills to fiscal committees
May 11	Last day for policy committees to hear and report non-fiscal bills to the floor
May 25	Last day for fiscal committees to report fiscal bills to the floor
May 29–June 1	Floor session only
June 1	Last day to pass bills out of their house of origin
June 5	Statewide Primary Election
June 15	Budget bill must be passed by midnight
June 28	Last day for a legislative measure to qualify for the Nov. 6 General Election ballot
July 6–August 5	Summer recess
August 17	Last day for fiscal committees to report bills to the floor
August 20 – 31	Floor session only
August 31	Last day for bills to be passed. Final recess begins upon adjournment
September 30	Last day for Governor to sign or veto bills passed by the Legislature
November 6	General Election
November 30	Adjournment <i>Sine Die</i> at midnight
December 3	Convening of the 2019-20 session

Sources: 2018 State Legislative Deadlines, California State Assembly: <http://assembly.ca.gov/legislativedeadlines>

Board of Directors Meeting March 1, 2018

CalOptima Community Outreach Summary — February 2018

Background

CalOptima is committed to serving our community by sharing information with current and potential members and strengthening relationships with our community partners. One of the ways CalOptima accomplishes this is through our participation in public events. CalOptima participates in public activities that meet at least one of the following criteria:

- Member interaction/enrollment: The event/activity attracts a significant number of CalOptima members and/or potential members who could enroll in a CalOptima program.
- Branding: The event/activity promotes awareness of CalOptima in the community.
- Partnerships: The event/activity has the potential to create positive visibility for CalOptima and create a long-term collaborative partnership between CalOptima and the requesting entity.

We consider requests for sponsorship based on several factors as indicated pursuant to Policy AA. 1223: Participation in Community Events Involving External Entities, including, but not limited to: the number of people the activity/event will reach; the marketing benefits for CalOptima; the strength of the partnership or level of involvement with the requesting entity; past participation; staff availability; and budget availability.

In addition to participating in community events, CalOptima staff actively participates in several community meetings including coalitions/collaboratives, committees and advisory groups focused on community health issues related to improving access to health care, reducing health disparities, strengthening the safety net system and promoting a healthier Orange County.

CalOptima Community Resource Fair

In collaboration with Case Management, Community Relations will host a Community Resource Fair on Thursday, March 29, 2018, from 9 a.m. to 12 p.m. at CalOptima. The purpose of the resource fair is to increase the knowledge of CalOptima staff and our delegated health network partners of resources available in the community to better assist our members.

The resource fair is an excellent educational and networking opportunity. All CalOptima staff and the delegated health networks' case managers, personal care coordinators, social workers, referral specialists, and others who help members connect to community resources are invited to attend. Attendees will also have an opportunity to win several gift baskets.

Approximately 35 community partners will be available at the event to provide information on a wide variety of services and programs that could benefit our families and children member population. Community partners invited include non-profit community-based organizations, county agencies and other service providers.

For additional information or questions, please contact Tiffany Kaaiakamanu, manager of Community Relations, at **657-235-6872** or email tkaaiakamanu@caloptima.org.

Summary of Public Activities

During February 2018, CalOptima participated in 37 community events, coalitions and committee meetings:

TARGET AUDIENCE: HEALTH AND HUMAN SERVICES PROVIDERS

Date	Events/Meetings
2/02/18	<ul style="list-style-type: none">• Covered Orange County General Meeting• Help Me Grow Advisory Meeting
2/05/18	<ul style="list-style-type: none">• Orange County Health Care Agency Mental Health Services Act Steering Committee Meeting
2/06/18	<ul style="list-style-type: none">• Collaborative to Assist Motel Families Meeting
2/07/18	<ul style="list-style-type: none">• Orange County Aging Services Collaborative Meeting• Anaheim Human Services Network Meeting• Orange County Healthy Aging Initiative Meeting
2/08/18	<ul style="list-style-type: none">• FOCUS Collaborative Meeting
2/09/18	<ul style="list-style-type: none">• Senior Citizen Advisory Committee Meeting
2/10/18	<ul style="list-style-type: none">• Heart to Heart Conference — Orange County, hosted by Orange County Strategic Plan for Aging
2/12/18	<ul style="list-style-type: none">• Fullerton Collaborative Meeting
2/13/18	<ul style="list-style-type: none">• Orange County Strategic Plan for Aging — Social Engagement Committee Meeting• Buena Clinton Neighborhood Coalition Meeting• Susan G. Komen Orange County — Unidos Contra el Cancer del Seno Coalition Meeting
2/14/18	<ul style="list-style-type: none">• Buena Park Collaborative Meeting• Anaheim Homeless Collaborative Meeting
2/15/18	<ul style="list-style-type: none">• Orange County Children’s Partnership Committee• Surf City Senior Providers Network Luncheon• Orange County Women’s Health Project Advisory Board Meeting
2/20/18	<ul style="list-style-type: none">• Placentia Community Collaborative Meeting• Orange County Cancer Coalition
2/21/18	<ul style="list-style-type: none">• Covered Orange County Steering Committee Meeting

- Minnie Street Family Resource Center Professional Roundtable
 - Orange County Promotoras Meeting
 - La Habra Collaborative — Move More, Eat Healthy Campaign Meeting
 - Orange County Communication Workgroup
- 2/22/18
- Disability Coalition of Orange County
 - Orange County Care Coordination for Kids
- 2/26/18
- Stanton Collaborative Meeting
 - Community Health Research and Exchange Meeting
- 2/27/18
- Orange County Senior Roundtable
 - Santa Ana Building Healthy Community
- 2/28/18
- Orange County Human Trafficking Task Force General Meeting

TARGET AUDIENCE: MEMBERS/POTENTIAL MEMBERS

Date	# Staff to Attend	Events/Meetings
2/03/18	1	<ul style="list-style-type: none"> • 2018 Orange County Black History Cultural Faire hosted by Orange County Heritage Council (Registration Fee: \$175 included one table for outreach at event)
2/17– 2/18/18	16	<ul style="list-style-type: none"> • Annual Tet Festival hosted by the Union of Vietnamese Students Association (Sponsorship Fee: \$5,000 included booth in prime location at the festival, one banner display on front gate, listing in program booklet, logo on all promotional posters and flyers, host website for one year, 40 admission tickets, 4 VIP admission badges, 4 VIP parking permits)
	16	<ul style="list-style-type: none"> • Lunar New Year 2018 Tet Festival hosted by CEAVA Foundation Inc, Orange County Parks, and the Office of Supervisor Andrew Do (Sponsorship Fee: \$5,000 included one booth for outreach, banners display at event, recognition on stage and radio, and full-size ad on flyers)
2/24/18	1	<ul style="list-style-type: none"> • 2018 ActNOW Conference hosted by The G.R.E.E.N. Foundation (Sponsorship Fee: \$1,000 included one table for outreach and recognition at event)

CalOptima organized or convened the following five community stakeholder events, meetings and presentations:

TARGET AUDIENCE: MEMBERS/POTENTIAL MEMBERS

Date	Events/Meetings/Presentations
2/02/18	<ul style="list-style-type: none"> • County Community Service Center Health Seminar — Topic: Introduction to Hoarding (Vietnamese)
2/07/18	<ul style="list-style-type: none"> • CalOptima New Member Orientation for Medi-Cal Members (Korean and Farsi)

- 2/22/18
 - CalOptima New Member Orientation for Medi-Cal Members (Vietnamese)
 - CalOptima New Member Orientation for Medi-Cal Members (Chinese and Arabic)

- 2/27/18
 - CalOptima Info Series — Topic: Behavioral Health (English)

CalOptima provided zero endorsements for events during this reporting period (e.g., letters of support, program/public activity event with support, or use of name/logo).

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.

<h1>March</h1>				
Date and Time	Event Title	Event Type/Audience	Staff/Financial Participation	Location
Friday, 3/2 9-10:30am	++Covered OC General Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	The Village 1505 E. 17 th St. Santa Ana
Saturday, 3/4 10:30am-2:30pm	+UCLA Vietnamese Community 2018 Winter Health Fair	Health/Resource Fair Open to the Public	2 Staff	Westminster Civic Center 8200 Westminster Blvd. Westminster
Monday, 3/5 1-4pm	++OCHCA Mental Health Services Act Steering Committee	Steering Committee Meeting: Open to Collaborative Members	N/A	Delhi Center 505 E. Central Ave. Santa Ana
Tuesday, 3/6 9:30-11am	++Collaborative to Assist Motel Families	Steering Committee Meeting: Open to Collaborative Members	N/A	Anaheim Downtown Community Center 250 E. Center St. Anaheim
Wednesday, 3/6 10-11am	*New Member Orientation <i>Presentations in English and Spanish</i>	Community Presentation Open to Members	N/A	CalOptima
Thursday, 3/8 11:30am-12:30pm	++FOCUS Collaborative Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	Magnolia Park Family Resource Center 11402 Magnolia St. Garden Grove

* CalOptima Hosted

1 – Updated 2018-02-05

+ Exhibitor/Attendee
++ Meeting Attendee

Thursday, 3/8 3:30-5:30pm	++State Council on Developmental Disability Regional Advisory Committee	Steering Committee Meeting: Open to Advisory Members	N/A	State Council on Developmental Disabilities 2000 E. Fourth St. Santa Ana
Friday, 3/9 8am-12pm	+Office of Senator Bates and Assemblyman Brough South Orange County Senior Day	Health/Resource Fair Open to the Public	Sponsorship \$1,000 1 Staff	Norman P. Murray Community Senior Center 24932 Veterans Way Mission Viejo
Friday, 3/9 9:30am-11am	+Senior Citizen Advisory Council Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	Location varies
Monday, 3/12 2:30-3:30pm	++Fullerton Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Fullerton Library 353 W. Commonwealth Ave. Fullerton
Tuesday, 3/13 9-10:30am	++OC Strategic Plan for Aging	Steering Committee Meeting: Open to Collaborative Members	N/A	Alzheimer's OC 2515 McCabe Way Irvine
Tuesday, 3/13 11:30am-12:30pm	++Buena Clinton Neighborhood Coalition	Steering Committee Meeting: Open to Collaborative Members	N/A	Buena Clinton Youth and Family Center 12661 Sunswept Ave. Garden Grove
Tuesday, 3/13 2-4pm	++Susan G. Komen OC- Unidos Contra el Cancer del Seno Coalition	Steering Committee Meeting: Open to Collaborative Members	N/A	Susan G. Komen OC 2817 McGaw Ave. Irvine
Wednesday, 3/14 10-11:30am	++Buena Park Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Buena Park Library 7150 La Palma Ave. Buena Park
Wednesday, 3/14 12-1:30pm	++Anaheim Homeless Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Anaheim Central Library 500 W. Broadway Anaheim
Thursday, 3/15 8am-4pm	+Faith Community Nurses at Hoag, Alzheimer's Family Center and Family Caregiver Resource Center	Conference Community Presentation <i>RSVP required</i> Health/Resource Fair	Sponsorship \$750 2 Staff	UCI Pacific Ballroom 311 Peltason Dr. Irvine

* CalOptima Hosted

2 – Updated 2018-02-05

+ Exhibitor/Attendee
++ Meeting Attendee

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	Spirituality Conference			
Thursday, 3/15 8:30-10am	++Orange County Children's Partnership Committee	Steering Committee Meeting: Open to Collaborative Members	N/A	OC Hall of Administration 10 Civic Center Plaza Santa Ana
Thursday, 3/15 2:30-4:30pm	++Orange County Women's Health Project Advisory Board Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	The Village 1505 E. 17th St. Santa Ana
Tuesday, 3/20 8:30-10am	++North Orange County Senior Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	St. Jude Community Services 130 W. Bastanchury Rd. Fullerton
Tuesday, 3/20 10-11:30am	++Placentia Community Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Trinity Center Placentia Presbyterian Church 849 Bradford Ave. Placentia
Wednesday, 3/21 9:15-11am	++Covered Orange County Steering Committee	Steering Committee Meeting: Open to Collaborative Members	N/A	The Village 1505 E. 17th St. Santa Ana
Wednesday, 3/21 10am-1pm	+City of Costa Mesa Knowledge and Health Fair	Health/Resource Fair Open to the Public	Registration Fee \$100 2 Staff	City of Costa Mesa Senior Center 695 W. 19th St. Costa Mesa
Wednesday, 3/21 11am-1pm	++Minnie Street Family Resource Center Professional Roundtable	Steering Committee Meeting: Open to Collaborative Members	N/A	Minnie Street Family Resource Center 1300 McFadden Ave. Santa Ana
Wednesday, 3/21 1-4pm	++Orange County Promotoras	Steering Committee Meeting: Open to Collaborative Members	N/A	Location Varies
Wednesday, 3/21 1:30-3pm	++La Habra Move More, Eat Health Campaign	Steering Committee Meeting: Open to Collaborative Members	N/A	Friends of Family Community Clinic 501 S. Idaho St. La Habra

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++ Meeting Attendee

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Wednesday, 3/21 3:30-4:30pm	++Orange County Communications Workgroup	Steering Committee Meeting: Open to Collaborative Members	N/A	Location Varies
Thursday, 3/22 8:30-10am	++Disability Coalition of Orange County	Steering Committee Meeting: Open to Collaborative Members	N/A	Dayle McIntosh Center 501 N. Brookhurst St. Anaheim
Thursday, 3/22 9:30-10:30am	*New Member Orientation <i>Presentation in Vietnamese</i>	Community Presentation Open to Members	N/A	County Community Service Center 15496 Westminster Ave. Westminster
Thursday, 3/22 8:30-10am	++OC Care Coordination for Kids	Steering Committee Meeting: Open to Collaborative Members	N/A	Help Me Grow 2500 Redhill Ave. Santa Ana
Saturday, 3/24 8:30am-12pm	+Magnolia School District Wellness Fair	Health/Resource Fair Open to the Public	1 Staff	Dr. Jonas Salk Elementary School 1411 S. Gilbert St. Anaheim
Saturday, 3/24 9am-3pm	+City of Westminster Spring Festival	Health/Resource Fair Open to the Public	2 Staff	Westminster Civic Center 8200 Westminster Blvd. Westminster
Saturday, 3/24 11am-1pm	+Santa Ana Unified School District and Active Learning 5 th Annual Fair in the Park	Health/Resource Fair Open to the Public	2 Staff	Memorial Park 2102 S. Flower St. Santa Ana
Monday, 3/26 12:30-1:10pm	++Stanton Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Stanton Civic Center 7800 Katella Ave. Stanton
Tuesday, 3/27 7:30-9am	++OC Senior Roundtable	Steering Committee Meeting: Open to Collaborative Members	N/A	Orange Senior Center 170 S. Olive Orange
Tuesday, 3/27 3:30-4:30pm	++Santa Ana Building Healthy Communities	Steering Committee Meeting: Open to Collaborative Members	N/A	KidWorks 1902 W. Chestnut Ave. Santa Ana

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Wednesday, 3/28 10:30-11:30am	++OC Human Trafficking Task Force	Steering Committee Meeting: Open to Collaborative Members	N/A	Community Service Program 1221 E. Dyer Rd. Santa Ana
Saturday, 3/31 9-11am	+City of Stanton Easter Egg Hunt and Resource Fair	Health/Resource Fair Open to the Public	3 Staff	Stanton Central Park 10660 Western Ave. Stanton

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+ *Exhibitor/Attendee*
++ *Meeting Attendee*

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