NOTICE OF A
REGULAR MEETING OF THE
CALOPTIMA BOARD OF DIRECTORS

THURSDAY, MARCH 5, 2020
2:00 P.M.

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

BOARD OF DIRECTORS

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

Supervisor Doug Chaffee, Alternate

REVISED

CHIEF EXECUTIVE OFFICER	CHIEF COUNSEL	CLERK OF THE BOARD
Michael Schrader	Gary Crockett	Sharon Dwiers

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

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

The Board Meeting Agenda and supporting documentation is available for review at CalOptima, 505 City Parkway West, Orange, CA 92868, Monday-Friday, 8:00 a.m. – 5:00 p.m. The Board Meeting Agenda and supporting materials are also available online at www.caloptima.org. Board meeting audio is streamed live at https://caloptima.org/en/AboutUs/BoardMeetingsLive.aspx

CALL TO ORDER
Pledge of Allegiance
Establish Quorum

PRESENTATIONS/INTRODUCTIONS

MANAGEMENT REPORTS

1. Chief Executive Officer Report
   a. Appointment of Supervisors to CalOptima Board
   b. Preventive Care Outreach Campaign
   c. Health Networks' Medical Loss Ratio
   d. Behavioral Health Integration Incentive Program
   e. Medicaid Fiscal Accountability Rule
   f. Managed Care Organization Tax
   g. Draft Federal Budget Cuts to Medicaid
   h. Key Meetings

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 6, 2020 ~~19~~ Regular Meeting of the CalOptima Board of Directors | *Rev. 3/5/2020*
   b. Receive and File Minutes of the November 15, 2019 Special Meeting of the CalOptima Board of Directors' Finance and Audit Committee, the December 13, 2019 Special Meeting of the CalOptima Board of Directors' Quality Assurance Committee; the December 12, 2019 Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee

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

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

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

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

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

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

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

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

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

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

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

REPORTS

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

15. Consider Actions Related to Homeless Health Care Pilot Initiatives

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

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

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

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

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

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

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

ADVISORY COMMITTEE UPDATES

23. Provider Advisory Committee Update

INFORMATION ITEMS

24. January 2020 Financial Summary

25. Compliance Report

26. Federal and State Legislative Advocates Reports

27. CalOptima Community Outreach and Program Summary

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

CLOSED SESSION

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

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

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

ADJOURNMENT

MEMORANDUM

DATE:	February 25, 2020
TO:	CalOptima Board of Directors
FROM:	Michael Schrader, CEO
SUBJECT:	CEO Report — March 5, 2020, Board of Directors Meeting
COPY:	Sharon Dwiers, Clerk of the Board; Member Advisory Committee; Provider Advisory Committee; OneCare Connect Member Advisory Committee; and Whole-Child Model Family Advisory Committee

Orange County Board of Supervisors Reappoints Steel and Do to CalOptima Board
In January, Supervisor Michelle Steel was elected chairwoman of the Orange County Board of Supervisors, and Supervisor Andrew Do was elected vice chair. On February 11, Chairwoman Steel made her selections for the CalOptima Board of Directors, reappointing herself and Supervisor Do, for a term from January 1, 2020, to December 31, 2020. Supervisor Chafee was also reappointed as the alternate member for the same term. CalOptima looks forward to continuing to work with the supervisors to fulfill our mission to serve CalOptima members.

CalOptima Considering Impact of Coronavirus in Orange County
On February 25, Centers for Disease Control and Prevention leaders announced that the spread of coronavirus in the United States appears inevitable. Given this news, CalOptima will begin collaborating with the Orange County Health Care Agency and other local agencies to ensure the implementation of all necessary protections to safeguard the health of our members and employees. In a related event, state and federal officials were seeking to use the Fairview Developmental Center in Costa Mesa to quarantine individuals who have tested positive, but Costa Mesa filed suit and won a temporary restraining order until March 2, pending a meeting between local officials and state and federal agencies.

Outreach Campaign Aimed at Boosting Children's Use of Preventive Care
To address state audit findings showing gaps in preventive care for children, the Department of Health Care Services (DHCS) is launching a statewide effort to raise awareness and utilization of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services. Locally, DHCS will mail a notice to approximately 180,000 CalOptima households with Medi-Cal members under age 21 who have underutilized or not used preventive services to encourage them to access care. The state is also requiring managed care plans to follow up with an outreach call campaign to members within 10 days of the mailing. CalOptima will use an interactive voice response telephone system to reach the identified families. We also informed the health networks regarding this effort, as the intent is to increase requests for primary care services.

Health Networks Meet Medical Loss Ratio (MLR) Requirement for 2018
CalOptima completed the annual MLR audit of our contracted health networks for Calendar Year 2018. Under contract, health networks are required to spend 85 percent or more of their capitation revenue on member health-related expenses. CalOptima aggregates results for OneCare Connect and Medi-Cal Classic and Expansion members to assess compliance. The

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results show that all health networks are meeting the MLR requirements for this review period. CalOptima thanks the health networks for their cooperation during the audit and for their commitment to providing quality care to members.

Behavioral Health Integration (BHI) Incentive Program Applications Forwarded to DHCS
DHCS created a Proposition 56-funded BHI Incentive Program and is requiring Medi-Cal managed care plans, including CalOptima, to complete administrative, review and oversight tasks on its behalf. In January, CalOptima received 30 applications for the program and convened a committee of seven internal and four external reviewers to score the applicants based on DHCS selection criteria. The committee completed its work, resulting in 17 applications scoring above DHCS' 70% requirement and 13 applications receiving insufficient scores or being found ineligible. CalOptima notified all respondents and submitted the 17 successful applications to the state on February 18. The state asked CalOptima to aggregate applicant information in a template document, which is due February 26. The state will make funding decisions by March 18. The 17 applications have requested a total of approximately $18.9 million, although DHCS has not indicated whether it will provide full funding or make adjustments.

U.S. Senators Voice Concerns About Medicaid Fiscal Accountability Rule (MFAR)
In January, CalOptima sent a comment letter to the Centers for Medicare & Medicaid Services (CMS) about MFAR, joining many other California stakeholders in taking issue with the proposal's financial impact. This month, two U.S. senators added their voices, when Sens. John Cornyn (R-TX) and Mark Warner (D-VA) expressed concerns about MFAR during a hearing on the Department of Health and Human Services (HHS) budget. They urged HHS Secretary Alex Azar to work with states to limit the negative impacts of the proposed rule. Lawmakers and other stakeholders are pressing HHS to modify the rule by delaying or withdrawing the state financing provisions while allowing the transparency requirements to take effect. One significant financial area that the current MFAR proposal would affect is the Managed Care Organization (MCO) tax. Sources say that some lawmakers are exploring a legislative response if the Administration is unwilling to compromise.

State Revises MCO Tax Structure and Resubmits Request for Federal Approval
In late January, CMS denied DHCS' request to implement the MCO tax for the period of July 1, 2019, to December 31, 2022, which spans multiple state fiscal years. Earlier this month, DHCS submitted an updated request to CMS that included modifications to the MCO tax structure. The MCO tax is considered an important source of revenue for the Medi-Cal program.

Draft Federal Budget Calls for Cuts to Medicare, Medicaid
On February 10, the White House released President Donald Trump's FY 2021 federal budget request. The proposed budget is $4.8 trillion, with $94.5 billion in funding for HHS, which is a 10% decrease from the current year. Specific to health policy, the Administration is proposing various policies that aim to save approximately $465 billion over 10 years in Medicare and $52 billion in Medicaid. Note that the budget requests are proposals; the initiatives must be considered and approved by Congress. Below are five proposals impacting Medicaid:

- Curtail improper Medicaid payments, including overpayments for ineligible beneficiaries.
- Expand authority through financial penalties to address noncompliance with provider screening, enrollment and revalidation requirements.

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- Streamline review of Medicaid Section 1115 and 1915(b) waivers and provide states flexibility in designing new programs.
- Tighten eligibility requirements to require that Medicaid beneficiaries who are "able-bodied, working-age individuals" find employment, train for work or perform community services as a condition of receiving Medicaid benefits.
- Make the nonemergency transportation benefit optional for states.

Key Meetings Ensure CalOptima Remains Engaged, Collaborative in the Community
Below are summaries of selected meetings that reflect CalOptima's commitment to engage with a wide variety of stakeholders and collaborate on timely health care and policy issues.

- *Legislators—Assemblywomen Quirk-Silva and Petrie-Norris:* Assemblywomen Sharon Quirk-Silva, chair of the Assembly Select Committee on Orange County Chronic Homelessness, and Cottie Petrie-Norris, who is also a member of the Select Committee, are convening a small group on February 28 to discuss options to house severely mentally ill, and I was invited to attend. The invitation letter stated that they would like to create a plan to address the needs of this population as soon as possible.
- *Hospital Leaders—Hospital Association of Southern California (HASC):* At the request of HASC, I spoke on February 18 to a group of about 20 hospital leaders regarding Medi-Cal Healthier California for All (formerly known as CalAIM). I shared the background regarding the state proposal and several of the likely impacts on CalOptima's Medi-Cal and OneCare Connect/OneCare programs in Orange County.
- *Health Network Partners—CEO Meeting:* On February 11, CalOptima held our quarterly meeting with health network CEOs. Most of the topics were financial. In the quality area, Chief Medical Officer David Ramirez, M.D., addressed the opportunity to earn incentives for Adverse Childhood Experience screenings as well as our Pay for Value program. Chief Financial Officer Nancy Huang covered Medi-Cal updates, including the overpayment adjustment due to statewide errors in eligibility related to deceased members and CalOptima's FY 2020–21 budget, which may have changes in Whole-Child Model capitation and Medi-Cal Expansion risk adjustment. Medicare topics were the Risk Adjustment Payment System over-submission and the upcoming budget.
- *State Officials—Enhanced Care Management (ECM) and In Lieu of Services (ILOS):* Five CalOptima leaders and I attended the February 10 DHCS meeting addressing ECM and ILOS, which are part of the Medi-Cal Healthier California for All proposal. DHCS officials presented an overview of the feedback on ECM and ILOS from the state workgroup and shared templates for the ECM model of care and the transition plan from Whole-Person Care (WPC) and Health Homes Program to ECM and ILOS. There was also a forum specific to Orange County's situation, whereby the county and plan must navigate a transition from county-run WPC to plan-run ECM. Further, a panel presentation covered lessons learned relevant to ILOS options, such as recuperative care and supportive housing. Overall, the meeting was instructive, but attendees raised concerns about the anticipated rates and the difficulty of creating a transition plan without adequate financial information.
- *Association Leaders—California Association of Health Plans (CAHP) State Programs Committee (SPC):* CalOptima hosted the quarterly meeting of CAHP SPC at our offices on February 13. As chair of the committee, I welcomed Charles Bacchi, CEO of CAHP, and the group of about 60 plan representatives from across the state. The agenda included discussions about the draft state budget, legislative activity and Medi-Cal Healthier

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California for All. CAHP also shared updates about the Medi-Cal Rx transition, delegated network adequacy certification and the BHI Incentive Program.

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MINUTES

REGULAR MEETING
OF THE
CALOPTIMA BOARD OF DIRECTORS

February 6, 2020

A Regular Meeting of the CalOptima Board of Directors was held on February 6, 2020 at CalOptima, 505 City Parkway West, Orange, California. Chair Paul Yost, M.D., called the meeting to order at 2.01 p.m. Director Schoeffel led the Pledge of Allegiance.

ROLL CALL

Members Present: Paul Yost, M.D., Chair; Dr. Nikan Khatibi, Vice Chair; Ron DiLuigi; Supervisor Andrew Do; Lee Penrose; (at 2:11 p.m.) Richard Sanchez (non-voting); Scott Schoeffel; Supervisor Michelle Steel (at 2:11 p.m.)

Members Absent: Ria Berger; Alexander Nguyen, M.D.

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

Chair Yost announced that he was reordering the agenda to hear Agenda Item 29., Federal and State Legislative Advocates Reports: presentation from Edelstein Gilbert Robson & Smith, immediately following Agenda Item 1., Chief Executive Officer Report.

Chair Yost also noted that he was reordering the agenda to hear Agenda Item 21., IGT 9 and 10 Update to just before Agenda Item 15., Consider Pursuit of Proposals with Qualifying Funding Partners to Secure Medi-Cal funds Through the Voluntary Rate Range Intergovernmental Transfer Program for Rating Period 2019-20 (IGT 10)

PRESENTATION

On behalf of the Board of Directors', Chair Yost recognized Len Rosignoli, Chief Information Officer, who is retiring, in honor of his 6 years of dedicated service to CalOptima, the Board of Directors, and the members we serve.

MANAGEMENT REPORTS

1. Chief Executive Officer Report

Chief Executive Officer (CEO) Michael Schrader highlighted several items from his CEO Report, including the CalOptima 2020 Report to the Community, the launch of the Health Homes Program Phase 1, and the Behavioral Health benefit transition from Magellan Health to CalOptima.

INFORMATION ITEM

29. Federal and State Legislative Advocates Reports

Trent Smith, Partner at Edelstein Gilbert Robson & Smith, provided an overview of the state legislative

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environment, changes underway with Governor Newsom's administration specific to health care and the Orange County delegation, and upcoming state elections.

PUBLIC COMMENTS

1. Ilia Rolon, First 5 Orange County – Oral re: Agenda Item 4, Consider Approval of Unbudgeted Expenditures to Support Community Education Efforts to Increase Medi-Cal Provider Awareness of Trauma-Informed Care and Adverse Childhood Experiences (ACE) Screening.

CONSENT CALENDAR

2. Minutes

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

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

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

Supervisor Do pulled Consent Calendar Item 4 for discussion.

Action: ***On motion of Supervisor Do, seconded and carried, the Board of Directors approved the balance of the Consent Calendar as presented. (Motion carried 7-0-0; Director Berger, Director Nguyen absent)***

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

Supervisor Do indicated his full support of this item and noted that additional funding may be needed to continue educational efforts.

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Action: ***On motion of Chair Yost, seconded and carried, the Board of Directors authorized unbudgeted expenditures of up to $80,000 from existing reserves for outreach and education efforts to increase Medi-Cal provider awareness of evidence-based ACE screening and Trauma-Informed Care. (Motion carried; 7-0-0; Director Berger; Director Nguyen absent)***

REPORTS

5. Consider Ratification of Amendments to the Medi-Cal Health Network Contracts, Except AltaMed Health Services Corporation, and Expenditures for Whole-Child Model Program Implementation
This item was continued due to lack of a quorum.

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

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 amend the Vision Service Plan (VSP) HMO Services Contract to reflect: 1) Reinstated Adult Routine Vision benefits for the Medi-Cal Line of Business Effective January 1, 2020, and 2) An Increase to VSP's Administrative Capitation rate in accordance with reinstated benefits. (Motion carried 7-0-0; Director Berger, Director Nguyen absent)***

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

Action: ***On motion of Director Penrose, seconded and carried, the Board of Directors Ratified Revised Amendment 40 of the Primary Agreement between CalOptima and the California Department of Health Care Services. (Motion carried 7-0-0; Director Berger, Director Nguyen absent)***

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

Action: ***On motion of Director DiLuigi, seconded and carried, the Board of Directors authorized and directed the Chairman of the Board of Directors to execute an Amendment(s) to the Primary Agreement between the Department of Health Care Services (DHCS) and CalOptima related to the Adult Expansion (AE) Risk Corridor. (Motion carried 7-0-0; Director Berger, Director Nguyen absent)***

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

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 exercise the option to extend the contract of Akin Gump Straus Hauer & Feld LLP for federal legislative advocacy services for one year, per the terms of the current contract, commencing February 21, 2020. (Motion carried 7-0-0; Director Berger, Director Nguyen absent)

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

Vice Chair Khatibi suggested that CalOptima conduct an RFP process in 2021 for pharmacy benefit management services.

Action: ***On motion of Director Penrose, seconded and carried, the Board of Directors Ratified Amendment to CalOptima's contract with MedImpact for Pharmacy Benefit Manager (PBM) Services, to revise prescription drug rebate provisions for CalOptima's Medi-Cal line of business. (Motion carried 7-0-0; Director Berger, Director Nguyen absent)***

11. Receive and File Delivery System Evaluation and Recommendations

Tim Reilly, Partner, Pacific Health Consulting Group, and Barbara Culley, Healthcare Management Consultant at Milliman, presented their delivery system evaluation and recommendations. Their five overarching recommendations include: 1) Begin with a clear network vision of CalOptima Board objectives for network access, adequacy, and cost and quality performance; 2) Create a comprehensive network strategy document that supports the CalOptima mission and vision with prioritized activities to meet network cost and performance goals; 3) Add networks/IPAs to the network if needed to fill health plan needs (e.g. access, services, and specialties, and add any physician meeting criteria to the direct network); 4) Remove barriers to contracting that add administrative costs (e.g. RFP process previously used); and 5) Increase transparency and accountability in network performance by reporting outcomes in relation to other networks with assistance to reach performance goals, particularly for essential service providers.

After considerable discussion and review of the consultants' 14 pages of recommendations, the Chair formed an Ad Hoc committee to work with PHCG consultants and return to the Board with recommendations at a future Board meeting. The Chair appointed the following Board members to serve on the Delivery System Ad Hoc: Supervisor Do, Vice Chair Khatibi, Director Schoeffel and Director DiLuigi. It was also noted that, in the interest of transparency, CalOptima's provider partners should be included in the discussions.

Mr. Schrader noted that, with the formation of the ad hoc and the expectation of additional work from the PHCG consultants, staff will bring a recommendation to the Board to authorize additional expenditures and amendment of the PHCG contract to expand the scope of work to include additional hours related to supporting the Delivery System Ad Hoc and making further recommendations to the Board.

Action: ***On motion of Director Penrose, seconded and carried, the Board of Directors Received and Filed the Delivery System Evaluation and Recommendations (Motion carried 7-0-0; Director Berger, Director Nguyen absent)***

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

Action: ***On motion of Director Penrose, seconded and carried, the Board of Directors authorized the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to enter into an agreement with Newmark Knight Frank for real estate related services pursuant to the attached Scope of Work (SOW). (Motion carried 7-0-0; Director Berger, Director Nguyen absent)***

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

Action: ***On motion of Vice Chair Khatibi, seconded and carried, the Board of Directors approved modification of the following Medical Policies and Procedures: A.) GG.1304: Continuity of Care During Health Network or Provider Termination or Health Network Non-Participation in the Whole-Child Model Program [Medi-Cal]; B.) GG.1325: Continuity of Care for Members Transitioning into CalOptima Services [Medi-Cal]; and C.) GG.1425: Prescriber Restriction Program [Medi-Cal]. (Mot ion carried 7-0-0; Director Berger, Director Nguyen absent)***

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

Action: ***On motion of Supervisor Steel, seconded and carried, the Board of Directors authorized the Chief Executive Officer, with the assistance of Legal Counsel, to execute Memorandums of Understanding (MOUs) with Behavioral Health Integration (BHI) Incentive Program grantee(s) upon selection and approval by the Department of Health Care Services (DHCS). (Mot ion carried 7-0-0; Director Berger, Director Nguyen absent)***

As noted at the top of the meeting, Chair Yost reordered the agenda to hear Agenda Item 21., IGT 9 and 10 Update prior to Agenda Item 15.

INFORMATION ITEM

21. IGT 9 and 10 Update
Ms. Gomez presented an update on the activities related to IGT 9 and 10.

REPORTS

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

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(IGT 10)

Action: ***On motion of Director DiLuigi, seconded and carried, the Board of Directors authorized the following activities to secure Medi-Cal funds through the Voluntary Intergovernmental Transfer (IGT) Rate Range Program: 1.) Submission of a proposal to the California Department of Health Care Services (DHCS) to participate in the Voluntary Rate Range IGT Program for Rating Period 2019-20 (IGT 10); 2.) Pursuit of IGT funding partnerships with the University of California-Irvine, the Children and Families Commission, the County of Orange, the City of Orange, and the City of Newport Beach to participate in the upcoming Voluntary Rate Range IGT Program for Rating Period 2019-20 (IGT 10); and 3.) Authorized the Chief Executive Officer to execute agreements with these entities and their designated providers as necessary to seek IGT 10 funds. (Mot ion carried 7-0-0; Director Berger, Director Nguyen absent)***

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

Eric Gonzaga, Principal of Grant Thornton LLP, presented an overview of its analysis of CalOptima's compensation and benefits benchmarking and analysis.

After considerable discussion, the Board asked that Grant Thornton provide additional comparable information on peer groups and return to the March Board meeting for further consideration.

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

Action: ***On motion of Vice Chair Khatibi, seconded and carried, the Board of Directors: 1.) approved new appointment of Monica Maier to fill a vacant Family Member seat for a term ending June 30, 2021; and 2.) approved new appointment of Jacqui Knudsen to fill a Consumer Advocate seat for a term ending June 30, 2022. (Mot ion carried 7-0-0; Director Berger, Director Nguyen absent)***

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

Action: ***On motion of Director DiLuigi, seconded and carried, the Board of Directors: 1.) Authorized expenditure for CalOptima's participation in the following community event: a.) Up to $2,000 and staff participation at the Iranian American Community Group's 7th Annual Persian Nowruz Festival in Irvine on March 22, 2020; 2.) 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 event and expenditures. (Motion carried; 7-0-0; Director Berger, Director Nguyen absent)***

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ADVISORY COMMITTEE UPDATES

19. Provider Advisory Committee Update
John Nishimoto, O.D., PAC Chair, provided a brief update, noting that the PAC's report is in the Board packet. Dr. Nishimoto noted that the PAC is recommending reclassification of two PAC seats to better reflect provider representation.

20. Whole-Child Model Family Advisory Committee Update
Maura Byron, WCM FAC Chair, provided a brief update on recent committee activities. Ms. Byron also thanked the Board for making the new appointments to the Committee. Ms. Byron also reported that parents of children with special needs are concerned about possible upcoming changes related to continuity of care. She stressed the importance of strong relationships between the parents of children with special needs and their providers.

Director Penrose asked that Mr. Schrader provide an update and keep the Board apprised on the concerns raised by Ms. Byron.

INFORMATION ITEMS

Chair Yost noted that staff has done a thorough job on the remaining Information Items and that the Board Members had reviewed the materials in the Board packets. Chair Yost asked his fellow Board Members if they had any specific questions on any of the information items. Hearing none, the following agenda items were accepted as presented.

22. Governor's State Budget Update
23. Medi-Cal Healthier California for All
24. Health Homes Program Update
25. Update on Hospital Data Sharing
26. Program of All-Inclusive Care for the Elderly Update
27. November and December 2019 Financial Summaries
28. Compliance Report
30. CalOptima Community Outreach and Program Summary

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

Director Sanchez announced that recruitment for positions on the CalOptima Board of Directors is now open, and encouraged interested parties to apply, including current Board Members.

Vice Chair Khatibi welcomed the City of Hope to Orange County and encouraged the CEO to reach out to this new community partner and make them feel welcome.

CLOSED SESSION

The Board of Directors adjourned to closed session at 4:25 p.m. pursuant to: 1) Government Code section 54957, PUBLIC EMPLOYEE PERFORMANCE EVALUATION (Chief Executive Officer) and 2) Government Code section 54957.6, CONFERENCE WITH LABOR NEGOTIATORS: Agency Designated Representatives: (Dr. Nikan Khatibi, Richard Sanchez and Scott Schoeffel) Unrepresented Employee: (Chief Executive Officer).

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The Board reconvened to open session at 4:45 p.m. with no reportable action.

ADJOURNMENT
Hearing no further business, Chair Yost adjourned at 4:46 p.m.

/s/ Sharon Dwiers
Sharon Dwiers
Clerk of the Board

Approved: March 5, 2020

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MINUTES

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

CALOPTIMA
505 CITY PARKWAY WEST
ORANGE, CALIFORNIA

November 15, 2019

CALL TO ORDER
Chair Lee Penrose called the meeting to order at 2:31 p.m. Director Berger led the Pledge of Allegiance.

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

Members Absent: None

Others Present: Michael Schrader, Chief Executive Officer; Gary Crockett, Chief Counsel; Nancy Huang, Chief Financial Officer; Sharon Dwiers, Interim Clerk of the Board

PUBLIC COMMENT
There were no requests for public comment.

MANAGEMENT REPORTS

1. Chief Financial Officer Report

Nancy Huang, Chief Financial Officer, provided an update on the real estate services Request for Proposal (RFP), which was released on October 17, 2019. CalOptima received three proposals in response to the RFP. Staff is following the process in CalOptima's Board-approved purchasing policy and plans to bring the final vendor selection recommendation and funding request to the February Board meeting for approval.

Ms. Huang reported that CalOptima recently identified a potential overreporting of diagnoses for the OneCare and OneCare Connect programs, which could affect the Medicare Risk Adjustment/RAF scores, and CalOptima's rates for prior years. Staff reported the potential overreporting to the Centers for Medicare & Medicaid Services (CMS) and notified the health networks at the November 8, 2019 Health Network CEO meeting and at the November 12, 2019 Health Network Risk Adjustment Teams meeting. Ms. Huang noted that staff has corrected the programming logic that led to the overreporting and has engaged an outside vendor to manage this process for CalOptima going forward. Staff is reconciling the data and will submit the correction file to CMS in January 2020. CMS revenue adjustments are expected at the end of the first quarter or beginning of the second quarter of calendar 2020.

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Chair Penrose and the other committee members indicated that they were comfortable with the results of the RFP going directly to the Board for review and approval, due to timing. Chair Penrose also mentioned that he planned on reaching out to Ms. Huang prior to the February Board for an update and encouraged the other committee members to do so as well.

With regard to the overreporting of diagnoses for the OneCare and OneCare Connect programs, Chair Penrose directed staff to provide regular updates on the data reconciliation, including between FAC meetings.

INVESTMENT ADVISORY COMMITTEE UPDATE

2. Treasurer's Report

Ms. Huang presented an overview of the Treasurer's Report for the period July 1, 2019 through September 30, 2019. As reported to 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 during that period.

During this quarter, CalOptima received a Department of Health Care Services' (DHCS') Private Hospital Directed Payment Program (PHDP) payment of $1.04 million, covering dates of service during the first six months of FY 2017-18. CalOptima distributed PHDP payments to all eligible local hospitals in early October. Due to immediate distribution requirements and to avoid unnecessary transactions fees, staff did not rebalance this funding between the three investment managers at quarter's end.

CONSENT CALENDAR

3. Approve the Minutes of the September 19, 2019 Regular Meeting of the CalOptima Board of Directors' Finance and Audit Committee; Receive and File Minutes of the July 22, 2019 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

4. Consider Recommending Board of Directors' Approval of Proposed Changes to CalOptima Policy GA.3400: Annual Investments

Mr. Huang introduced the recommended action that the Board of Directors approve proposed changes to Policy GA.3400: Annual Investments, for Calendar Year 2020. Ms. Huang also highlighted changes in revised policy, noting that the Investment Advisory Committee (IAC) reviewed and recommended FAC approval.

Action: ***On motion of Director Schoeffel, seconded and carried, the Committee recommended Board of Directors' approve the proposed changes to CalOptima Policy GA.3400: Annual Investments (Motion carried 3-0-0)***

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5. Consider Recommending Board of Directors' Approval of CalOptima's Health Homes Program Policies

Ms. Huang introduced the recommend actions and provided a brief overview. It was noted that payments to delegated health networks acting as Community Based Care Management Entities (CB-CMEs) may need to be adjusted because the Health Homes Program (HHP) is a new program, and there is a possibility that rate development assumptions used by DHCS to calculate CalOptima's capitation rates may be materially different from actual utilization and expenses. Staff will continue working closely with DHCS on appropriate funding levels and will communicate any discrepancies to health networks as needed.

Action: ***On motion of Director Berger, seconded and carried, the Committee recommended that the Board of Directors' approve the CalOptima Policies and Procedures listed below to address Health Homes Program (HHP) implementation and requirements: 1) GG.1331: Health Homes Program Services and Care Management [Medi-Cal]; 2) GG.1350: Health Homes Program Member Eligibility [Medi-Cal]; 3) FF.4001: Special Payments: Health Homes Program Supplemental Payment for Capitated Health Networks [Medi-Cal]; which includes: a) Payment of a HHP Core Services Capitation Payment HHP eligible and enrolled members and a separate Engagement Activities Supplemental Capitation Payment for HHP eligible members regardless of HHP enrollment. (Motion carried 3-0-0)***

Chair Penrose thanked staff for the new QBAR-like process which has helped the Committee to more easily review important information about CalOptima's finances and expenditures. He also reminded staff that the Committee is looking forward to regular Whole-Child Model (WCM) updates.

INFORMATION ITEMS

The following Information Items were accepted as presented:

6. September 2019 Financials
7. CalOptima Information Security Update
8. Quarterly Operating and Capital Budget Update
9. Quarterly Reports to the Finance and Audit Committee
    a. Shared Risk Pool Performance
    b. Reinsurance Report
    c. Health Network Financial Report
    d. Contingency Contract Report

COMMITTEE MEMBER COMMENTS

Committee members thanked staff for their work in preparing the meeting materials and for moving the meeting forward on the calendar to accommodate Committee member schedules.

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ADJOURNMENT
Hearing no further business, Chair Penrose adjourned the meeting at 2:57 p.m.

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

Approved: February 20, 2020

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MINUTES

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

CALOPTIMA
505 CITY PARKWAY WEST
ORANGE, CALIFORNIA

December 13, 2019

A Special Meeting of the CalOptima Board of Directors' Quality Assurance Committee was held on December 13, 2019, at CalOptima, 505 City Parkway West, Orange, California.

CALL TO ORDER
Chair Paul Yost called the meeting to order at 3:38 p.m. and led the Pledge of Allegiance.

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

Members Absent: Dr. Nikan Khatibi

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

PUBLIC COMMENTS
There were no requests for public comment.

CONSENT CALENDAR

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

Action: ***On motion of Director Nguyen, seconded and carried, the Committee approved the Minutes of the October 17, 2019 Special Meeting of the CalOptima Board of Directors' Quality Assurance Committee as presented. (Motion carried 2-0-0; Director Khatibi absent)***

REPORTS

2. Consider Recommending Board of Directors; Approval of Calendar Year 2020 Health Network Medi-Cal Pay for Value Performance Program Incorporating the Quality Rating Methodology

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Betsy Ha, Executive Director, Quality and Population Health Management, presented a brief overview of the item noting that staff is recommending that we align with industry standards and the National Committee for Quality Assurance (NCQA).

Chair Yost noted that many of CalOptima's Board Members have expressed an interest in seeing more homogeneity among the health networks in their ratings, wanting to consistently see performance at a higher level across all health networks.

Action: ***On motion of Chair Yost, seconded and carried, the Committee recommended Board of Directors' approval of the Calendar Year 2020 Health Network Medi-Cal Pay for Value Performance Program incorporating the Quality Rating Methodology, for Measurement Period effective January 1, 2020 through December 31, 2020. (Motion carried 2-0-0; Director Khatibi absent)***

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

Ms. Ha presented a brief overview of this item and reviewed the statistics of the effects of trauma on children and adults.

Director Nguyen commented that better results might be achieved if providers receive incentives to conduct the ACE screenings.

Action: ***On motion of Director Nguyen, seconded and carried, the Committee recommended Board of Directors' authorize unbudgeted expenditures of up to $80,000 from existing reserves for outreach and education efforts to increase Medi-Cal provider awareness of evidence-based ACE screening and Trauma-Informed Care. (Motion carried 2-0-0; Director Khatibi absent)***

INFORMATION ITEMS

4. Member Experience Initiative: Improving Access and Availability

Marsha Choo, Manager, Quality Analytics, presented an overview of CalOptima's member experience performance. Ms. Choo reviewed some of the methods CalOptima uses to measure member experience, including the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, which is conducted in English and Spanish. In addition, Ms. Choo reviewed the key measures that the Department of Health Care Services (DHCS) monitors. Ms. Choo noted that there are opportunities for improvement, and staff has identified several strategies to improve member experience. These include expanding access to specialty care, coaching provider offices on customer service, and extending hours of provider offices.

Director Nguyen mentioned that there are organizations that provide specialty care that could supplement CalOptima's provider network, such as Rubicon M.D., which may be an effective strategy to minimize low ratings in accessing care by members. Director Nguyen also suggested that CalOptima consider conducting the CAHPS surveys in other threshold languages for a clearer picture of CalOptima's member experience performance.

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5. Intergovernmental Transfer (IGT) 9 Update

Candice Gomez, Executive Director, Program Implementation, and David Ramirez, M.D., Chief Medical Officer, presented an update on IGT 9. Ms. Gomez provided general background on IGTs 1 through 7, noting that the funds received from these IGTs must be used to deliver enhanced services for the Medi-Cal population, and that these funds are accounted for outside of operating income and expenses. However, with IGTs 8 and 9, the funds must be used for Medi-Cal covered services for the Medi-Cal population, and are part of operating income and expenses. Ms. Gomez also mentioned that there is no guarantee of future availability of IGT funds, which is why the IGT funds are better suited to one-time investments or as start-up funding for new services or initiatives for the benefit of Medi-Cal beneficiaries. To date, CalOptima's share of funding from IGTs 1 through 8 is $121.31 million.

Dr. Ramirez added that $45 million is CalOptima's estimated share of IGT 9 funding and staff will provide recommendations on possible usage of funds for Medi-Cal members.

Ms. Gomez noted that the next steps include meetings with the Board's advisory committees and stakeholders to solicit feedback. Staff plans to present initial recommendations for the Board to consider at its February meeting. Final recommendations will be presented for approval at the March or April CalOptima Board meeting.

6. Quality Measures and Health Condition Attestation Program for OneCare Connect and CalOptima Community Network Members

Dr. Ramirez presented an overview the Medicare Attestation Program staff will be proposing noting that this information item focuses on members that are in the CalOptima Community Network (CCN) and the OneCare Connect (OCC) program. Dr. Ramirez stated that Medicare Attestation Programs are a common industry practice for Medicare plans and are intended to facilitate proper coding, accurate data reporting, and correct payments. Dr. Ramirez noted that CCN does not currently have a Medicare Attestation Program. Dr. Ramirez provided background on how CalOptima monitors diagnosis codes and utilization data submitted by providers and submits regular diagnosis data to the Centers for Medicare & Medicaid Services (CMS). CMS uses the diagnosis data to assess program quality and calculate expected health care costs, which ties into risk adjustment factors (RAF) scores and affects the revenue CalOptima receives from CMS. In reviewing the RAF scores, CCN's average score is 18% below the health network average. Dr. Ramirez mentioned that the lower score may be due to diagnosis codes being reported incorrectly. Staff recommends developing a policy for review and approval at the policy review committee and if approved, bringing a recommendation to the Board that would authorize including CCN members in a Medicare Attestation Program to ensure accurate data reporting and RAF scores, which will ensure that CalOptima receives appropriate payments for CCN OCC members.

7. OneCare and OneCare Connect Behavioral Health Implementation Update

Edwin Poon, Ph.D., Director, Behavioral Health Services, presented an update on the OneCare (OC) and OneCare Connect (OCC) behavioral health (BH) transition activities. Dr. Poon noted that currently, the BH services benefit is administered by Magellan, CalOptima's Managed Behavioral Health Organization for OC and OCC members. On May 2, 2019, the CalOptima Board approved the integration of OC and OCC covered BH services within CalOptima internal operations effective January 1, 2020. Since the Board's May 2, 2019 action, staff has been working on credentialing and contracting with as many Magellan OC/OCC BH providers as possible to ensure that network

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adequacy levels continue to be met. CalOptima has identified approximately 320 members who have received services from non-contracted providers and staff is reaching out to work with those members on transitioning to contracted providers. Dr. Poon added that CalOptima has recruited additional staff and is working to continue to contract with additional BH providers.

8. PACE Member Advisory Committee Update

Elizabeth Lee, Director of PACE, provided an update on the CalOptima PACE Member Advisory Committee meeting held on September 11, 2019, highlighting discussions on program enhancements, including: 1.) Activities: special entertainment and BINGO for morning and afternoon shifts; 2.) Nursing: diabetes education class for participants; 3.) Social Work: reminiscence group; and 4.) Rehabilitation Therapy: 'Boxing Champs' group, life skills education, and therapeutic dance. Ms. Lee also reported that feedback is being sought from participants about potentially extending PACE center hours and adding Saturday hours. Ms. Lee noted that most participants do not want pickups before 7:00 a.m. and do not want to be dropped off at home later than 6:00 p.m. in the evening. Ms. Lee added that Saturday hours elicited mixed reactions, with most participants conceptually supportive of the idea of Saturday hours, but not for themselves.

9. Quarterly Reports to the Quality Assurance Committee

The following Quarterly Report was accepted as presented:

a. Quality Improvement Report

COMMITTEE MEMBER COMMENTS

Committee members thanked staff for their work and wished everyone a happy holiday.

ADJOURNMENT

Hearing no further business, Chair Yost adjourned the meeting at 4:51 p.m.

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

Approved: February 19, 2020

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MINUTES

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

December 12, 2019

A Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee (PAC) was held on Thursday, December 12, 2019, at the CalOptima offices located at 505 City Parkway West, Orange, California.

CALL TO ORDER

John Nishimoto, O.D., PAC Chair, called the meeting to order at 8:06 a.m. Teri Miranti led the Pledge of Allegiance.

ESTABLISH QUORUM

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

Members Absent: All Members present

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

MINUTES

Approve the Minutes of the October 10, 2019 Special Joint Meeting of the CalOptima Board of Directors' Member Advisory Committee, OneCare Connect Member Advisory Committee, Provider Advisory Committee, and the Whole-Child Model Family Advisory Committee

Action: ***On motion of Member Sweidan, seconded and carried, the Committee approved the minutes of the October 10, 2019 Special Joint meeting. (Motion carried 12-0-0)***

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Approve the Minutes of the November 14, 2019 Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee

Action: ***On motion of Member Sweidan, seconded and carried, the Committee approved the minutes of the November 14, 2019 Regular meeting. (Motion carried 12-0-0)***

PUBLIC COMMENTS

There were no requests for public comment.

REPORTS

Consider Recommendation to Reclassify Provider Advisory Committee Seats

The PAC Recruitment Ad Hoc Committee comprised of Chair Nishimoto, Vice Chair Miranti and Member Lazo-Pearson recommended that the vacant Long-Term Services and Supports Representative seat be reclassified as an additional Allied Health Services seat. The Committee also recommended renaming the Traditional/Safety Net seat to Safety Net Representative seat.

Action: ***On motion of Member Sweidan, seconded and carried, the Committee approved the recommendation to reclassify the PAC Committee seats. (Motion carried 12-0-0)***

Consider Recommendation to Revise Provider Advisory Committee Chair and Vice Chair Term Lengths

The Joint Advisory Recruitment Ad Hoc Committee which consists of the Chairs and Vice Chairs of the Member Advisory Committee (MAC), OneCare Connect Member Advisory Committee (OCC MAC) and PAC, recommended that the Chair and Vice Chair term lengths be changed from a one year term to a two-year term for all committees.

Action: ***On motion of Member Sweidan, seconded and carried, the Committee approved the recommendation to revise the PAC Chair and Vice Chair Term Lengths (Motion carried 12-0-0)***

Chair Nishimoto reordered the agenda to hear item V1.A Delivery System Update before continuing with the Chief Executive Officer Report.

Delivery System Update

Tim Reilly, Partner, Pacific Health Consulting Group (PHCG) presented an update on the progress of PHCG's review of CalOptima's Delivery System. Mr. Reilly noted that the final report will be presented at the February 6, 2020 CalOptima Board meeting.

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CEO AND MANAGEMENT REPORTS

Chief Executive Officer Update

Michael Schrader, Chief Executive Officer (CEO), provided an update on the CalAIM Program. Mr. Schrader also updated the members on the Department of Health Care Services (DHCS) Managed Care Plans (MCP) state waiver proposal for FY 2021-2025.

Chief Operating Officer Update

Ladan Khamseh, Chief Operating Officer (COO), provided an update on the Behavioral Health Integration between CalOptima and Magellan effective January 1, 2020. Ms. Khamseh also reported that phase one of the Health Homes Program (HHP) would also become effective January 1, 2020.

Chief Medical Officer Update

David Ramirez, M.D., Chief Medical Officer (CMO), discussed CalOptima's incentives for Skilled Nursing Facilities (SNFs). Dr. Ramirez also provided an update to the Medication Assisted Therapy program's (MAT) pharmacy waiver.

INFORMATION ITEMS

Homeless Health Update

Mary Botts, Manager, Enterprise Analytics provided a presentation on the Homeless Health Clinical Analysis. Ms. Botts discussed the homeless identification methods and provided a comprehensive analysis of the homeless population trend and identified disparities. Ms. Botts also noted that CalOptima has partnered with the Orange County Health Care Agency and several other healthcare entities.

Proposition 56 Tobacco Tax Update

Candice Gomez, Executive Director, Program Implementation, discussed the Proposition 56 (Tobacco Tax) initiatives. Ms. Gomez mentioned the Adverse Childhood Event (Trauma) Screening Services that will become effective July 1, 2020. She also noted the Behavioral Health Integration Incentive Program's application reviewing deadlines conducted by DHCS. The first application for the BHI Incentive Program for Managed Care Plans will be due January 21, 2020.

Federal & State Budget Update

Shamiq Hussain, Sr. Policy Advisor, Government Affairs, provided a brief update on the California state budget. Mr. Hussain noted that the DHCS policy discussion is centered around the CalAIM proposals, which may evolve as DHCS receives stakeholder feedback and input from the Centers for Medicare & Medicaid Services (CMS),

PAC Member Updates

Dr. Nishimoto noted he would be presenting at the next PAC Meeting which is scheduled for February 13, 2020 at 8:00 a.m.

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ADJOURNMENT
There being no further business, Chair Nishimoto adjourned the meeting at 10:01 a.m.

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

Approved: February 13, 2020

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 5, 2020
Regular Meeting of the CalOptima Board of Directors

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

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

Recommended Action
Recommend the reappointment of Susan Munson to the Board of Directors' Investment Advisory Committee (IAC) for a two-year term beginning March 5. 2020.

Background
At a Special Meeting of the CalOptima Board of Directors held on September 10, 1996, the Board authorized the creation of the CalOptima IAC, established qualifications for committee members, and directed staff to proceed with the recruitment of the volunteer members of the Committee.

When creating the IAC, the Board stipulated that the Committee would consist of five (5) members; one (1) member would automatically serve by virtue of his or her position as CalOptima's Chief Financial Officer. The remaining four (4) members would be Orange County residents who possess experience in one (1) or more of the following areas: investment banking, investment brokerage and sales, investment management, financial management and planning, commercial banking, or financial accounting.

At the September 5, 2000, meeting, the Board approved expanding the composition of the IAC from five (5) members to seven (7) members in order to have more diverse opinions and backgrounds to advise CalOptima on its investment activities.

Discussion
The candidate recommended for reappointment, Susan Munson has consistently provided leadership and service to CalOptima's investment strategies through their participation as IAC member.

Susan Munson is a Managing Director in the Middle Market Sales Group for Cantor Fitzgerald and Company. She has 30 years of experience in the fixed income markets serving institutional accounts, with an emphasis on public agency investment practices and California Government Code. She has held positions with both registered investment advisory firms and sell side firms, including 13 years with Merrill Lynch's Institutional Advisory Division where she covered state and local governments, financial institutions, investment managers, and publicly traded corporations. Susan is the founder and Advisory Board Chair of Fixed Income Academy, an educational platform where financial professionals learn about the bond markets and develop investment management skills. She frequently speaks and teaches at national and regional conferences on the topic of investment strategy and policy development. Susan maintains her Certified Financial Planner designation, is a Certified Fixed Income Practitioner, and serves on the Education and Conference Committee for the California Municipal Treasurers Association.

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Fiscal Impact
There is no fiscal impact. Individuals appointed to the IAC are responsible for assisting CalOptima in meeting the objectives of CalOptima's annual investment policy, including preservation of capital, meeting the agency's liquidity needs, and obtaining an acceptable return on investment of available funds.

Rationale for Recommendation
The individual recommended for CalOptima's IAC have extensive experience that meets or exceeds the specified qualifications for membership on the IAC. In addition, the candidate has already provided outstanding service as a member of the IAC.

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

Attachment
None

/s/ Michael Schrader *02/26/2020*
Authorized Signature **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 5, 2020
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

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

Contact

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

Recommended Action

Consider Recommending Board of Directors' Approval of the CY 2020 and 2021 Health Network Medi-Cal Pay for Value (P4V) Program Payment Methodology incorporating the Health Network Quality Rating (HNQR) methodology for the Measurement Years effective January 1, 2020 through December 31, 2021.

Background

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

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

Discussion

For the Medi-Cal program, staff recommends adopting and incorporating a new "Quality Rating Methodology" consistent with NCQA validated methodology. Having a standard Quality Rating Methodology will provide CalOptima with one reliable methodology to establish an overall quality rating score for each Health Network. The quality rating score will be used to establish P4V payment methodology, or other future programs to improve quality health care for CalOptima members.

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Measures

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

Data and Frequency

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

Benchmarks

All measure results (clinical and Member Experience) will be benchmarked against the National Committee for Quality Assurance Quality Compass National Medicaid percentiles.

Score Calculation

- The CY2020 Health Network Medi-Cal P4V Program has a Measurement Period of January 1, 2020 through December 31, 2020.
- Overall Rating
  - The overall rating is the weighted average of a Health Network's HEDIS and CAHPS measure ratings, plus Accreditation bonus points (if the plan is Accredited by NCQA), rounded to the nearest half point displayed as stars (see below for rounding rules).
  - The overall rating is based on performance on dozens of measures of care and is calculated on a 0–5 (5 is highest) scale in half points.
- Measure point calculation
  - A measure result in the top decile (>= 90th percentile) receives 5 points
  - A measure result in the top 3rd but not in the ~~tip~~ top 10th (>= 66th but < 90th percentile) receives 4 points *Rev. 2/19/20*
  - A measure result in the middle 3rd (>= 33rd but < 66th percentile) receives 3 points
  - A measure result in the bottom 3rd but not in the bottom 10th (>= 10th but < 33rd percentile) receives 2 points
  - A measure result in the bottom 10th (< 10th percentile) receives 1 point
- Health Network's score = Σ (measure rating * measure weight) / Σ weights + Accreditation Bonus Points

- Health Network's Rating = round the score to the nearest half point
- Final scoring will result in an overall Health Network Quality Rating for each Health Network. Based on the final overall score, Health Networks will be assigned a score from 1-5 with 5.0 representing the best possible performance.
- NCQA Rounding Rules: The overall rating is calculated and truncated to 3 decimal places and round according to the rules below.

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

Payment Methodology

- Health Network allocation for P4V payments will be increased from $2.00 PMPM to $5.00 PMPM maximum.

Health Network Quality Rating	**Percent of $5 PMPM Health Network Payment Received**
≥ 4.5	100%
≥ 4.0	80%
≥ 3.5	60%
≥ 3.0	40%
≥ 2.5	20%
< 2.5	0%

- A health network must achieve a minimum score of 2.5 to be eligible to receive P4V incentive dollars.
- Health Networks with a rating less than 2.5 will not be eligible to receive any P4V incentive award and may be asked to complete a Corrective Action Plan (CAP).
- MY 2020 (January 1 through December 31, 2020) Health Network Quality Rating will be used for the MY 2020 P4V program.

- MY 2021 (January 1 through December 31, 2021) Health Network Quality Rating will be used for the MY 2021 P4V program
- All P4V incentive payments will be performance based.
- No separate improvement incentive money is available during these periods (MY2020 and MY2021); however, a higher payment could be received in 2021 if a health network moves up a tier in the HNQR tiers (for example movement from 3.0 rating to 3.5 rating increases percent of payment earned from 40 to 60 percent.
- Health Networks must be "in good standing" at the time of payment as determined by the Audit and Oversight Committee.

Distribution of Incentive Dollars

- Performance allocations will be distributed upon final calculation and validation of each Health Network Quality Rating, based on NCQA final HEDIS and CAHPS scores for the health networks.
- A health network must be "in good standing" and achieve a minimum score of 2.5 to be eligible to receive P4V incentive dollars.

Fiscal Impact

The recommended action to approve the CY 2020 and 2021 Health Network Medi-Cal P4V Program Payment Methodology to incorporate the new Health Network Quality Rating Methodology has no additional fiscal impact to the CalOptima Fiscal Year 2019-20 Operating Budget approved by the Board on June 6, 2019. The current budget, which was based on CY 2019 Quality Rating Methodology, included Health Network Medi-Cal P4V program funding in an amount not to exceed $2.00 per member per month (PMPM) through June 30, 2020.

Management will include expenses in an amount not to exceed $5.00 PMPM related to the Health Network Medi-Cal P4V program for the period beginning July 1, 2020, and after in future operating budgets.

Rationale for Recommendation

CalOptima must pivot from stagnant performance trend to demonstrate breakthrough improvement in all measures in order to maintain its standing as one of the highest performing Medi-Cal Managed Care Plans. Having a consistent Health Network Quality Rating Methodology using NCQA methodology will provide CalOptima with one consistent quality measurement system to establish an overall quality rating score for each Health Network to reward performance and achieve CalOptima's strategic quality goals, which include member experience and clinical excellence.

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

Attachments
1. Medi-Cal Health Network Payment Methodology (presentation)

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

02/26/2020 — **Date**

CalOptima
A Public Agency
Better. Together.

Proposed Health Network Quality Rating and Payment Methodology for MY2020

Board of Directors' Quality Assurance Committee Meeting
February 19, 2020

David Ramirez, M.D., Chief Medical Officer

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Guiding Principles for Proposed Changes

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

MCAS

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

HN Rating Methodology

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

Proposed New Scoring

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

Proposed Measures for MY 2020

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

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

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

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Proposed Measures for MY 2020 (cont.)

- Behavioral Health
  - **Antidepressant Medication Management (AMM Acute phase)**
  - **Antidepressant Medication Management (AMM Continuation phase)**
  - **Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using Antipsychotic Medications (SSD)**
  - **Metabolic Monitoring for Children and Adolescents (APC)**

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

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

Proposed Measures for MY 2020 (cont.)

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

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

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

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Member Satisfaction Measures

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

Health Network Quality Rating Tiers Overall Rating

Based on 2018 Performance and Proposed Measures

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

Health Network Quality Rating

Based on 2018 Performance and Proposed Measures

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

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Payment Methodology for MY2020

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P4V Payments to HNs

- Tier-based payment based upon Health Network Quality Rating Score
- Rating ≥ 2.5 to be eligible to receive P4V incentive money.
- Health networks with a rating less than 2.5 will not be eligible to receive any P4V money and may be asked to complete a Corrective Action Plan (CAP).

P4V 2020 Program Payment Methodology

- $5 PMPM per HN allocated for MY 2020 and MY2021.
- Performance based $5 PMPM payment will be calculated at the end of each measurement period, based on the final HN quality rating achieved for the measurement period.

Rating	Percent of $5 PMPM Payment
≥ 4.5	100%
≥ 4.0	80%
≥ 3.5	60%
≥ 3.0	40%
≥ 2.5	20%
< 2.5	0%

P4V Changes to MY2020

- Change to a new “Health Network Quality Rating Methodology” consistent with NCQA validated methodology for the Medi-Cal program.
- Performance based incentive dollars only — higher Health Network Quality Rating (HNQR) earns higher payment.
- Member Satisfaction (CAHPS) survey results will now use National NCQA Medicaid benchmarks.

Next Steps

- Present the final recommendations for QAC approval in February 2020 and CalOptima Board of Directors' approval in March 2020.
- OneCare Connect measures and methodology are proposed to remain unchanged.

CalOptima's Mission

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

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 5, 2020
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

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

Contact

David Ramirez, M.D., Chief Medical Officer (714) 246-8400
Betsy Ha, R.N. Executive Director, Quality & Population Health Management (714) 246-8400

Recommended Action

Consider approval of the Calendar Years 2020 and 2021 Pay for Value Program for OneCare Connect line of business, which defines measures and allocations for performance and improvement for the Measurement Years (MY) effective January 1, 2020 through December 31, 2021.

Background

On February 7, 2019 CalOptima Board of Directors approved a Pay for Value (P4V) COBAR for MY2019 for Medi-Cal and OneCare Connect (OCC) lines of businesses. CalOptima has implemented a comprehensive Health Network P4V Performance Measurement Program consisting of recognizing outstanding performance and supporting on-going improvement that will strengthen CalOptima's mission of providing quality health care. Annually, the CalOptima staff conducts a review of the current measures and their performance over time. A part of this analysis included evaluating both the overall performance of the measure and the level of improvement left to achieve. In addition, the staff analyzed the difficulty of improving a measure due to the size of the eligible population or difficulty in data gathering. Finally, the staff evaluated any changes to the measures that are important to CalOptima's NCQA Accreditation status, CMS Star Rating Status and/or overall NCQA Health Plan Rating.

The purpose of CalOptima's P4V program for the Health Networks OCC line of business, including CalOptima Community Network (CCN) is consistent with the P4V programs of the prior years, which remains:

1. To recognize and reward Health Networks and their physicians for demonstrating quality performance;
2. To provide comparative information for members, providers, and the public on CalOptima's performance; and
3. To provide industry benchmarks and data-driven feedback to Health Networks and physicians on their quality improvement efforts.

Discussion

For the OneCare Connect line of business, staff recommends no changes to the previously Board approved measures and scoring methodology for the OCC pay for value program. A separate COBAR has been submitted to the Quality Assurance Committee regarding the recommendation for proposed changes to the Medi-Cal Pay for Value Program for measurement years 2020 and 2021.

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Distribution of Incentive Dollars

There is no proposed change to the previously Board approved distribution strategy for earned pay for value dollars. The following P4V program requirements will remain:

- All health networks will continue to have clinical performance measures and member satisfaction measures.
- Performance and improvement allocations are distributed upon final calculation and validation of each measurement rate. Weighting of performance and improvement may be adjusted based on overall CalOptima performance.
- To qualify for payment for each of the Clinical and member satisfaction measures, the Health Network must have a minimum denominator in accordance with statistical principles.
- To qualify for payments, a health network or physician group must be contracted with CalOptima during the entire measurement period, period of pay for value accrual, and must be in good standing with CalOptima at the time of disbursement of payment.
- Any separate OCC Quality Withhold incentive dollars earned will be distributed based upon Board of Directors previously approved methodology.
- Payments can be made annually or more frequently, at CalOptima's discretion.
- Distribution methodology to CCN providers for measurement year 2020 and 2021 payout will remain the same as approved by Board of Directors.

Fiscal Impact

The fiscal impact of the OCC P4V program will not exceed $20.00 per member per month for MY 2020 (January 1, 2020, to December 31, 2020) and MY 2021 (January 1, 2021, to December 31, 2021). Management will include these expenses in the CalOptima Fiscal Year (FY) 2020-21 and FY 2021-22 Operating Budgets.

Rationale for Recommendation

This alignment leverages improvement efforts and efficiencies that the Health Networks implement for other health plans. CalOptima has modified each program for applicability to the membership, measurement methodology, and strategic priorities.

Concurrence

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

Attachments

1. Attachment 1: MY2020 - 2021 OCC P4V Program Measurement Set
2. Attachment 2: February 2, 2019 Board Approved P4V COBAR for MY2019 for Medi-Cal and OneCare Connect lines of businesses

/s/ Michael Schrader — *02/26/2020*
Authorized Signature — **Date**

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Attachment 1: MY2020 - 2021 OCC P4V Program Measurement Set

OneCare Connect Measures	**2020 Measurement Year / HEDIS 2021 Specifications Anticipated Payment Date: Q4 2021**	**Measurement Assessment Methodology**
Clinical Domain – HEDIS Weight: 60.00% Each measure weighted equally	Measures: • Breast Cancer Screening (BCS) • Comprehensive Diabetes Care (CDC) – HbA1c poor control (> 9.0) • Plan All Cause Readmissions (PCR) • Part D Medication Adherence for Diabetes • Colorectal Cancer Screening	A relative point system by measure based on: • CMS STAR thresholds • Cut Point Level Improvement
Member Satisfaction Domain - CAHPS Weight: 40%	Adult Satisfaction Survey (Adult CAHPS): • Annual Flu Vaccine • Getting Appointments and Care Quickly • Getting Needed Care • Rating of Healthcare Quality	A relative point system by measure based on: • CMS CAHPS Cut Points • Cut Point Level Improvement
Display Measure	Comprehensive Diabetes Care (CDC) Nephropathy Monitoring	CMS Technical Specifications and Benchmarks for STAR measures

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OneCare Connect Measures	**2021 Measurement Year / HEDIS 2022 Specifications Anticipated Payment Date: Q4 2022**	**Measurement Assessment Methodology**
Clinical Domain – HEDIS Weight: 60.00% Each measure weighted equally	<u>Measures:</u> • Breast Cancer Screening (BCS) • Comprehensive Diabetes Care (CDC) – HbA1c poor control (> 9.0) • Plan All Cause Readmissions (PCR) • Part D Medication Adherence for Diabetes • Colorectal Cancer Screening	A relative point system by measure based on: • CMS STAR thresholds • Cut Point Level Improvement
Member Satisfaction Domain - CAHPS Weight: 40%	<u>Adult Satisfaction Survey (Adult CAHPS):</u> • Annual Flu Vaccine • Getting Appointments and Care Quickly • Getting Needed Care • Rating of Healthcare Quality	A relative point system by measure based on: • CMS CAHPS Cut Points • Cut Point Level Improvement
Display Measure	Comprehensive Diabetes Care (CDC) Nephropathy Monitoring	CMS Technical Specifications and Benchmarks for STAR measures

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to Be Taken March 5, 2020
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

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

Contact

Belinda Abeyta, Executive Director, Operations, (714) 246-8400

Recommended Actions

Recommend authorizing reallocation of budgeted, but unused funds in the amount of $200,000 within Cultural & Linguistic Services from Printing and Postage to Translation Expense through June 30, 2020.

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's Cultural & Linguistic Services Department utilization of transitional and interpreter services has increased by 22% which will deplete the budgeted Purchased Services funding allocation by April 2020. The primary drivers for the increase in utilization is related to Behavioral Health Services and the translating of member materials.

To address this anticipated shortfall, management proposes a reallocation of $200,000 in budgeted, but unused funds within Cultural & Linguistic Services under the Medi-Cal line of business from Printing and Postage to Translation Expense. Customer Service will be sending fewer member notifications related to the Health Homes Program (HHP) than originally required by the Department of Health Care Services (DHCS). DHCS required MCPs to send an Errata and three (3) member notifications of the HHP program to all Medi-Cal membership. DHCS later determined the MCPs would mail only the Errata and member notifications to the members who would qualify for the HHP program, thereby making these funds available for reallocation.

Fiscal Impact

The fiscal impact for the recommended action to reallocate funds within Cultural & Linguistic Services to fund Translation Expense is budget neutral. As proposed, unused funds of $200,000 for Printing and Postage that were approved as part of the CalOptima FY 2019-20 Operating Budget on June 6, 2019, will fund additional expenses in Translation Expense through June 30, 2020.

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Rationale for Recommendation

CalOptima is obligated to provide appropriate and timely translation of member materials in all threshold languages, and face-to-face and telephonic interpretive services in any language upon request. The recommendation will ensure CalOptima remains compliant with contractual and statutory requirements.

Concurrence

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

Attachments

1. February 20, 2020 Board Finance and Audit Committee Presentation

/s/ Michael Schrader *02/26/2020*
Authorized Signature **Date**

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Cultural & Linguistics Budget Reallocation

Board of Directors' Finance and Audit Committee Meeting
February 20, 2020

Belinda Abeyta
Executive Director, Operations

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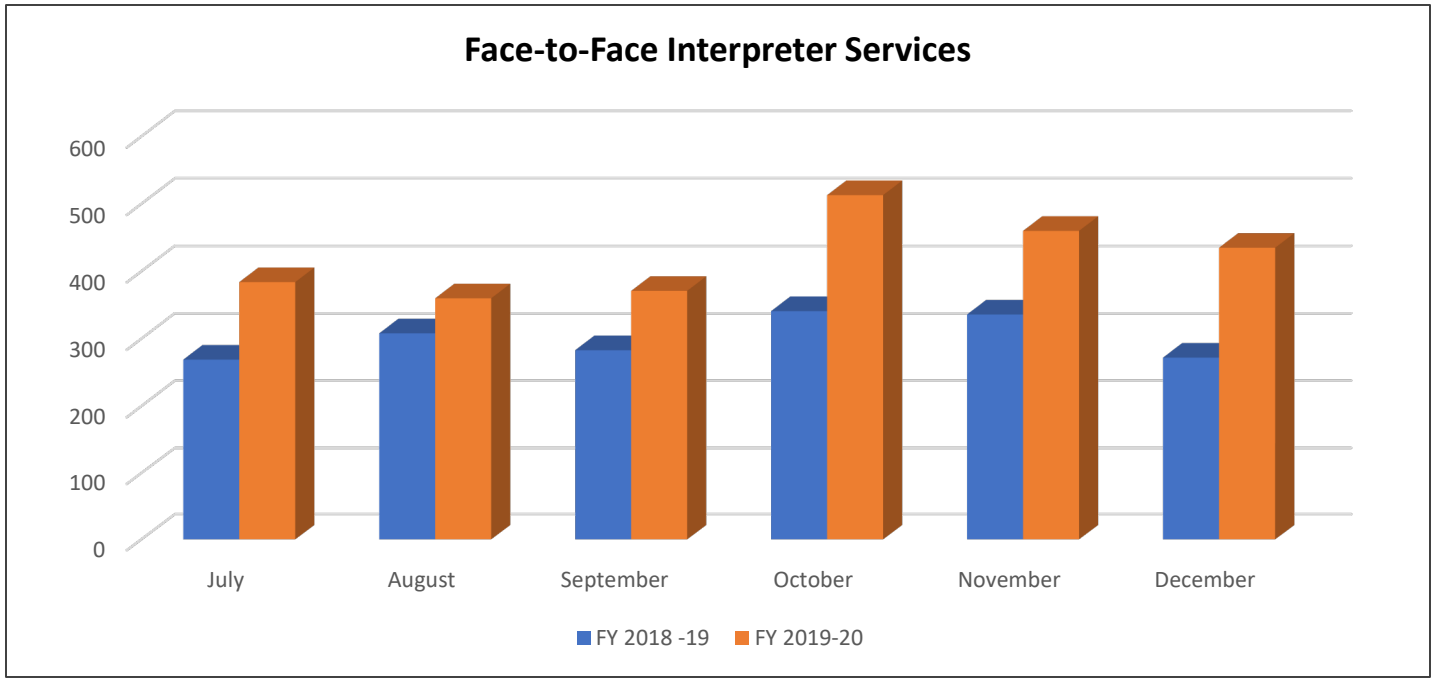
Background

- Increased utilization of translations and interpreter services will deplete FY 2019–20 allocated budget by April 2020
  - Face-to-face interpreter services
    - External vendor
  - Telephonic interpreter services
    - Internal staff
    - External vendor
  - Translation of member materials
    - Internal staff
    - External vendor

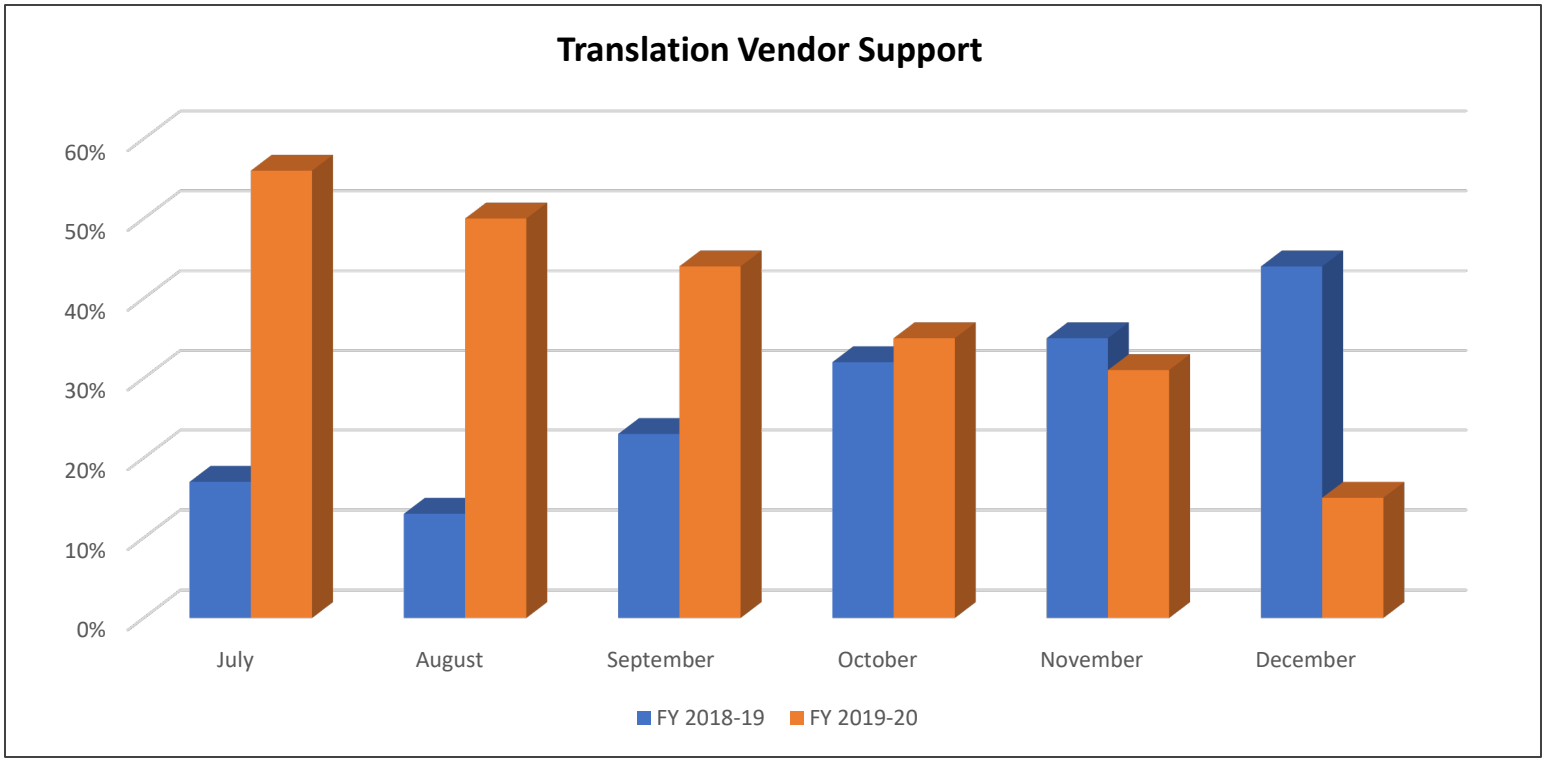
Drivers for Increased Utilization

- Face-to-face interpreter services requests have increased from FY 2018–19
  - Increased member awareness
  - Behavioral Health transition



Drivers for Increased Utilization (cont.)

- Translation of member materials
  - ➢ Increased utilization of vendor support



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Funding Source

- Unused funds in the printing and postage budgeted allocations
  - ➢ Decreased member notifications
    - ▪ Health Homes Program
      - Eliminated three notifications to all Medi-Cal members
        - ➢ Only one notice
        - ➢ Monthly member notifications to only qualified members

Recommended Action

- Recommend that the CalOptima Board of Directors authorize reallocation of budgeted, but unused funds in the amount of $200,000 within Cultural & Linguistic Services from Printing and Postage to Translation Expense through June 30, 2020

CalOptima's Mission

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

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to Be Taken March 5, 2020
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

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

Contact

Belinda Abeyta, Executive Director, Operations, (714) 246-8400

Recommended Actions

Recommend authorizing unbudgeted operating expenditures within the Medi-Cal program purchased services expense category in an amount not to exceed $1,395,000 from existing reserves for the following:

1. An increase of up to $645,000 to fund contingency fees for pre-payment claims editing solutions of professional services claims;
2. An increase of up to $750,000 to fund contingency fees for overpayment recoveries related to inpatient DRG and outpatient APC paid claims and non-pursuit fees.

Background/Discussion

The recommended budget adjustments for clinical editing solutions and recovery solutions are included within the Claims Administration Fiscal Year (FY) 2019-20 Operating budget as summarized below.

1. Cotiviti. Cotiviti is CalOptima's claims editing solution that identifies claim coding accuracy for providers rendering professional services. Cotiviti is a contingency contract based on a fee of 19.5% per claim based on the acceptance of the coding edit prior to the final claim payment. Cotiviti's claims editing software utilizes National Correct Coding Initiative Edits (NCCI), Medicare and Medi-Cal guidelines to determine the claim coding accuracy of professional services claims.

   CalOptima's Claims Administration Department provides guidance to Cotiviti as to which claims coding edits can be utilized for professional service claims submitted to CalOptima for payment consideration. Savings for the first six months of FY 2019-20 total $4,382,247 with contingency fees of $832,646 paid to Cotiviti. Claims Administration increased the number of claims coding edits in FY 2019-20 Q3, generating $1,110,917 in avoided overpayments from FY 2019-20 Q2.

   Claims Administration has identified four additional claims coding edits that Claims Administration will request Cotiviti to implement for professional service claims within the next 120 days increasing savings to CalOptima. Claims Administration budgeted $958,000 for contingency fees with $125,354 remaining for FY 2019-20 budget. This requested addition to budget is to cover the additional contingency fees up to $645,000.

2. Varis. Varis is CalOptima's clinical editing solutions for post-payment recoveries of overpayments of inpatient DRG and outpatient APC paid claims. Varis is a contingency contract

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based on a per claim fee of 25% for inpatient and 26% for outpatient contingent upon the successful recovery of overpayments. Claims Administration budgeted $727,000 for contingency fees in the FY 2019-20 budget with $6,384 for the remaining FY 2019-20 budget.

Current trending from FY 2018- 19 to FY 2019 -20 shows a 10% year-over-year growth in recovered overpayments that would generate increased contingency fees to Varis that are not budgeted. Management recommends authorization of additional funding of up to $750,000 in contingency fees.

Fiscal Impact

The recommended actions to authorize administrative expenditures within the Medi-Cal program for contingency fees for claims editing solution and recovery services is unbudgeted. An allocation in an amount not to exceed $1,395,000 from existing reserves will fund this action. Staff anticipates that the changes to the contingency contracts will result in higher avoided and recovered overpayments in medical expenses with the level of recoveries fully offsetting the additional contingency fees.

Rationale for Recommendation

Staff recommends approval of the recommended action to ensure CalOptima continual utilization of claim editing solutions and recovery services to ensure appropriate and accurate claims payments and recoveries through June 30, 2020.

Concurrence

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

Attachment

1. Claims Administration Budget Request Presentation

/s/ Michael Schrader *2/26/2020*
Authorized Signature **Date**

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Claims Administration Budget Request

Board of Directors' Finance and Audit Committee Meeting
February 20, 2020

Belinda Abeyta
Executive Director, Operations

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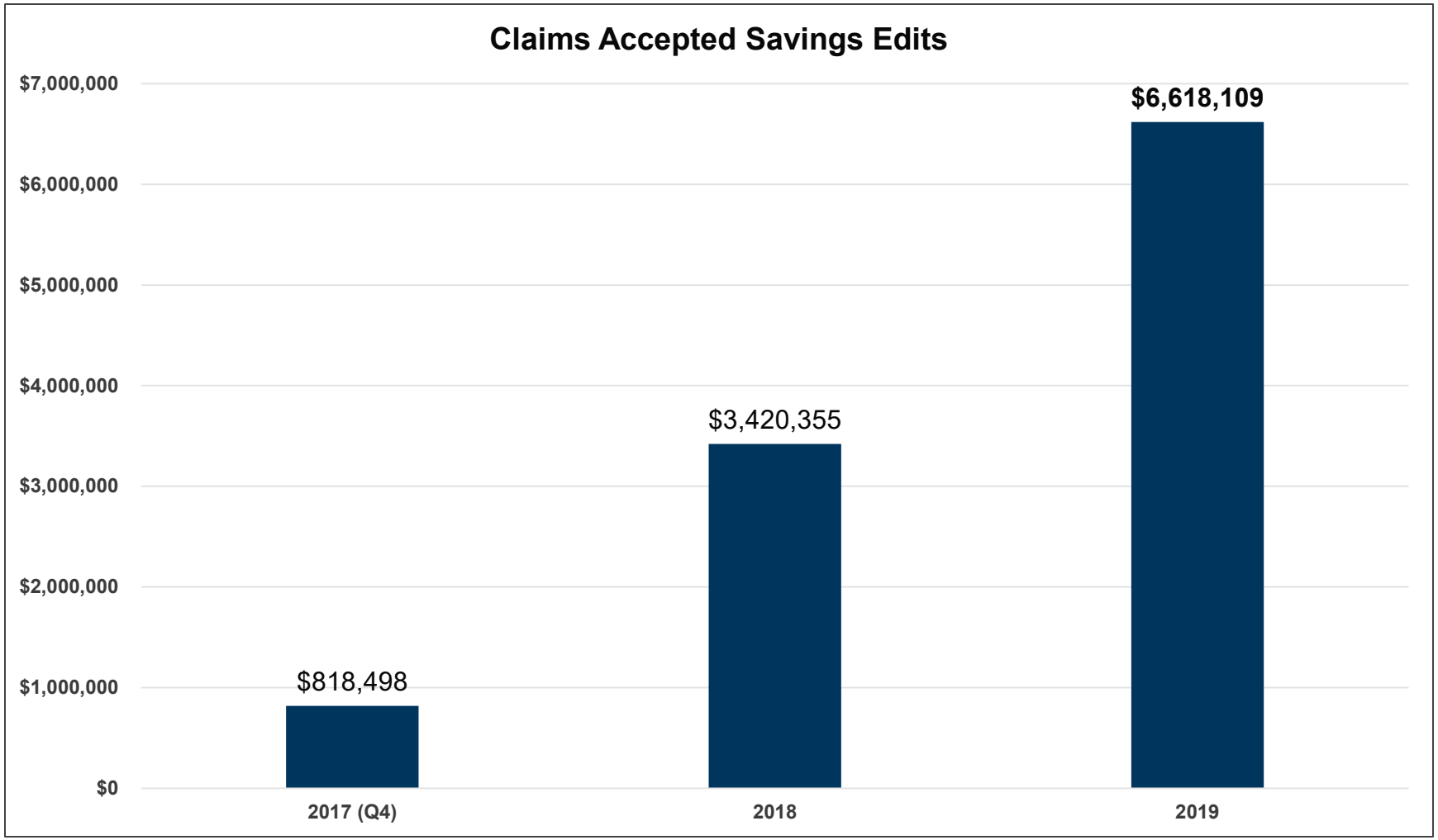
Cotiviti Background

- Cotiviti is a claims coding solution
- Provides prepayment review of professional services to identify claims coding accuracy
  - Uses National Correct Coding Initiative (NCCI) edits
  - Follows Medi-Cal and Centers for Medicare & Medicaid Services guidelines
- Charges a contingency fee for acceptance of coding recommendations

Year-Over-Year Growth



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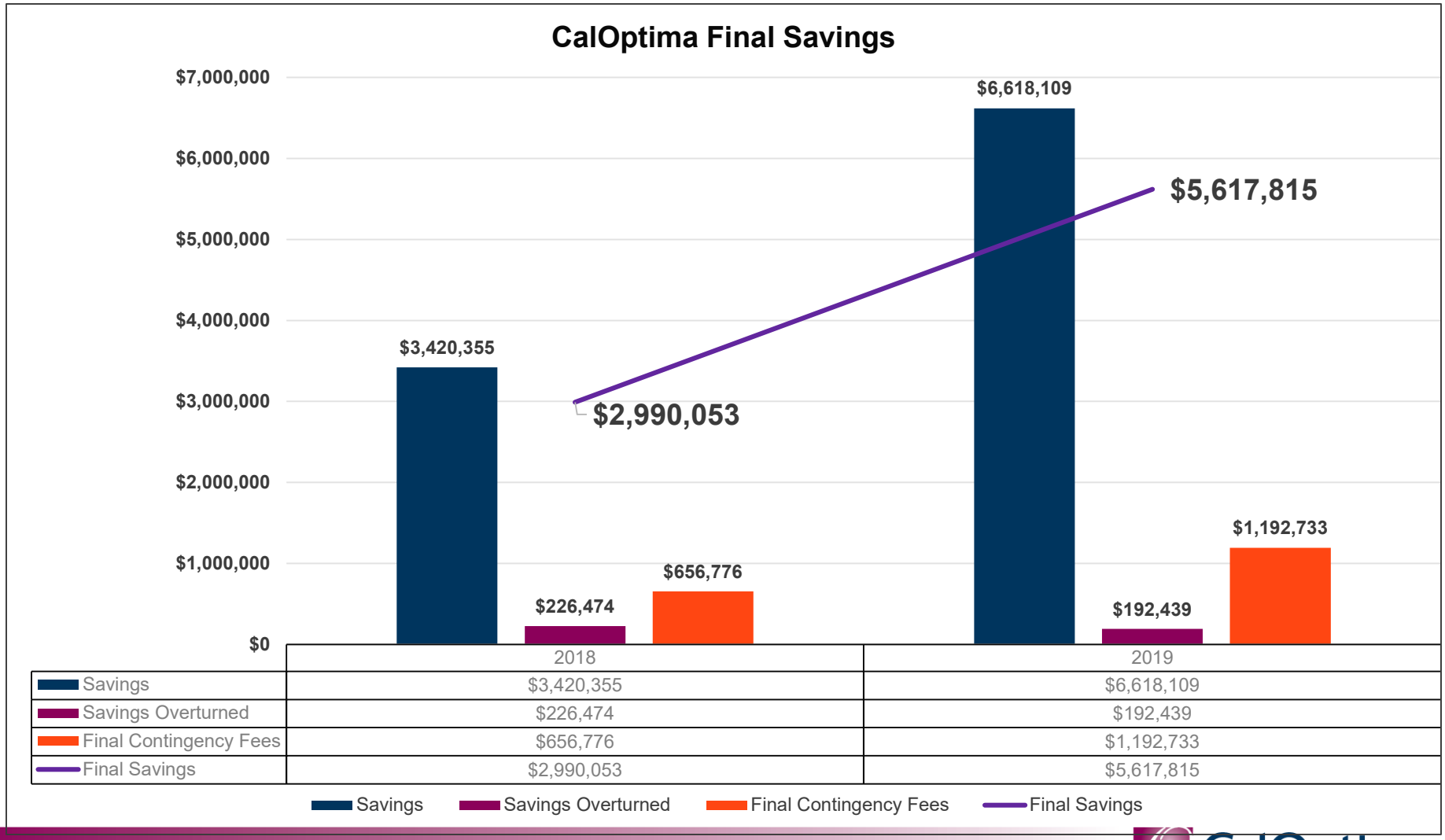
Final Savings



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Top Five Coding Edits Accepted

- Unbundling
- Frequency
- Same provider
- Mutually exclusive
- Unlisted procedure code

Top Five Provider Types

- Pathology
- Hospital
- Ambulance, medical transportation
- Obstetrics/Gynecology
- Internal medicine

Next Steps

- Implement additional coding edits by June 30, 2020

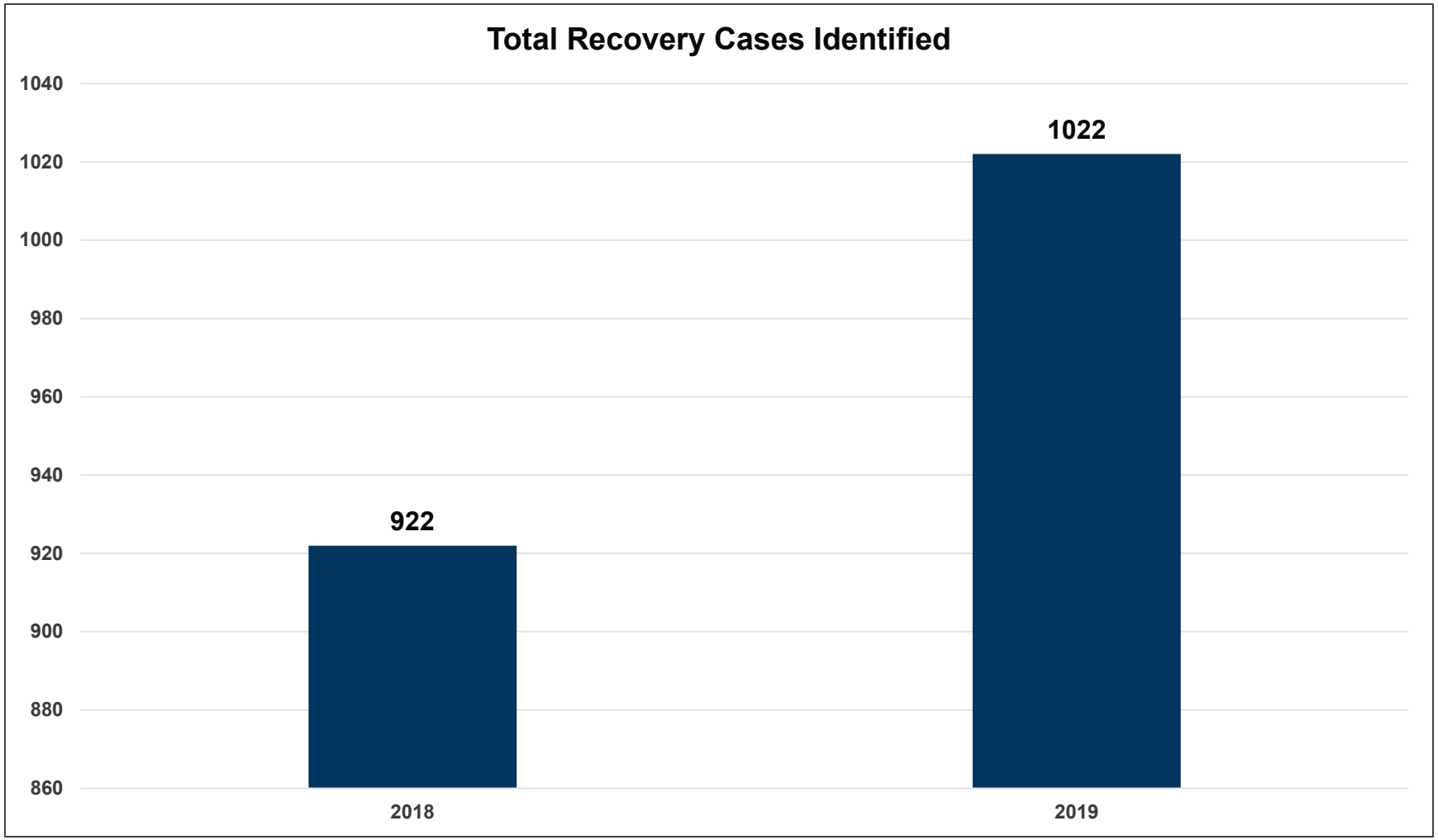
Coding Edits	Projected Savings
Multiple Treatment Reduction	$936,000
Imaging Family Reduction	$513,000
Surgical Edits	$156,000
Age	$163,000

- Identify coding edits that can be implemented within Facets

Varis Background

- Varis provides recovery identification services for overpayment of claims
  - Inpatient facility claims reimbursed at Diagnosis Related Group (DRG)
  - Outpatient facility claims reimbursed at Ambulatory Payment Classification (APC)
- Both contracted and noncontracted providers are subject to recovery identification, using medical records review
- Varis uses a fee structure
  - Contingency fee based on the overpayment recovery received
  - Recoveries can take up to a year to receive
    - Resulting contingency fees cross budget years
    - CalOptima can also incur non-pursuit fees

Year-Over-Year Growth



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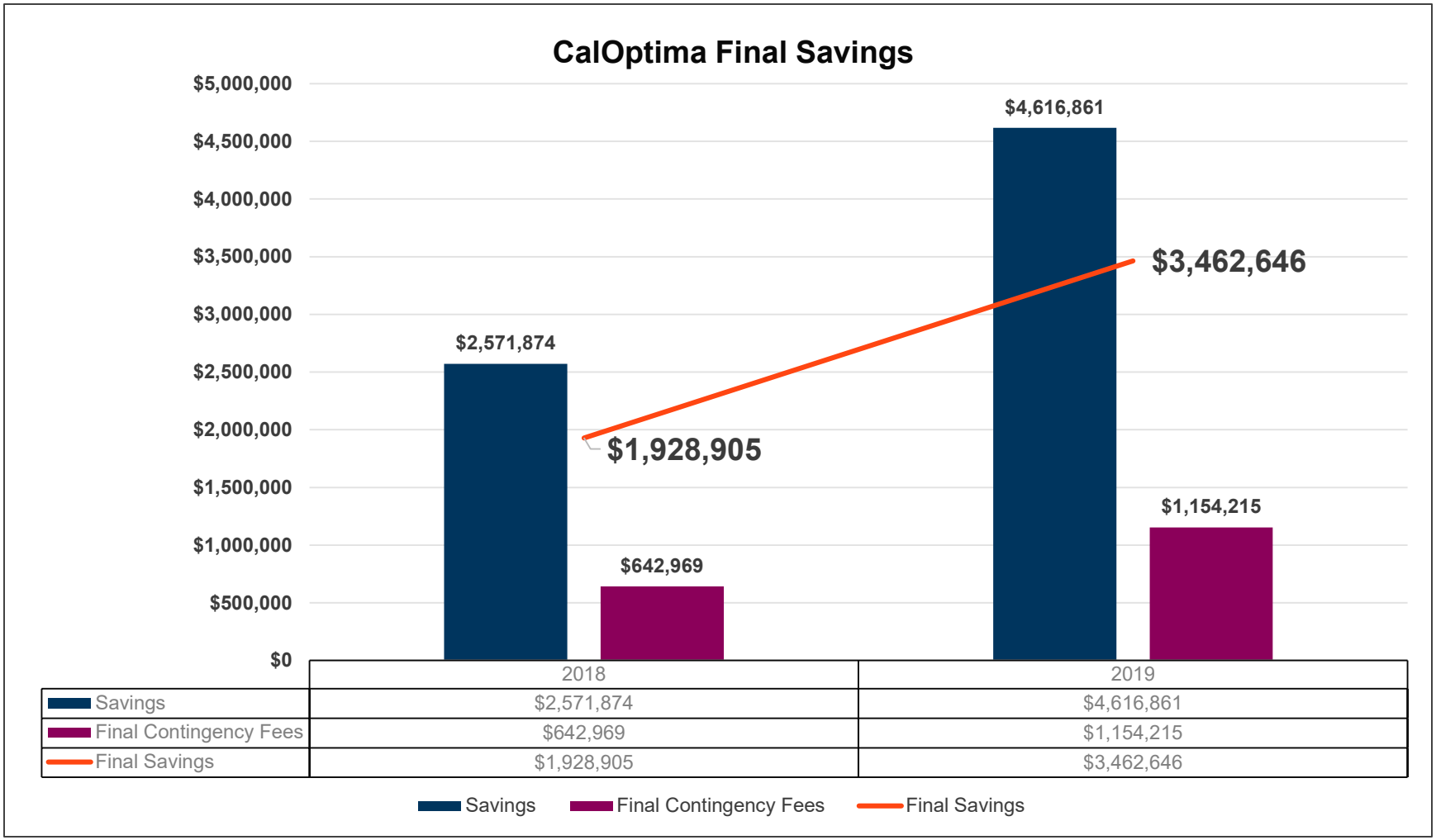
Final Savings



Top Five DRG Codes by Recovery

DRG Code	Description
871	Septicemia or Severe Sepsis without Mechanical Ventilation >96 Hours with Major Complications or Comorbidity
682	Renal Failure with Major Complications or Comorbidity
246	Percutaneous Cardiovascular Procedures with Drug-Eluting Stent with Major Complications or Comorbidity or 4+ Arteries or Stents
329	Major Small and Large Bowel Procedures with Major Complications or Comorbidity
207	Respiratory System Diagnosis with Ventilator Support >96 Hours or Peripheral Extracorporeal Membrane OX

Next Steps

- Continue seeking recoveries
  - 599 cases open
    - Subject to non-pursuit fees

Recommended Action

- Authorize unbudgeted expenditures within the Medi-Cal purchased services expense category in an amount not to exceed ~~$1.4~~ $1,395,000 million from existing reserves | *Rev.* 2/20/20

  for the following:

  - An increase of up to $645,000 to fund contingency fees for prepayment claims editing solutions of professional services claims
  - An increase of up to $750,000 to fund contingency fees for overpayment recoveries related to inpatient DRG and outpatient APC paid claims and non-pursuit fees

CalOptima's Mission

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

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Continued to the April Board Meeting

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 5, 2020
Regular Meeting of the CalOptima Board of Directors

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

Contact
David Ramirez, Chief Medical Officer (714) 246-8400
Nancy Huang, Chief Financial Officer (714) 246-8400
Candice Gomez, Executive Director Program Implementation (714) 246-8400

Recommended Actions
1. Approve the recommended allocation of IGT 9 funds in the amount of $45 million for initiatives for quality performance, access to care, data exchange and support and other priority areas; and
2. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to take actions necessary to implement the proposed initiatives, subject to staff first returning to the Board for approval of:
    a. Additional initiative(s) related to member access and engagement; and
    b. New and/or modified policies and procedures, and contracts/contract amendments, as applicable.

Background
Intergovernmental Transfers (IGT) are transfers of public funds between eligible government entities which are used to draw down federal funds for the Medi-Cal program. To date, CalOptima has participated in eight Rate Range IGT transactions. Funds from IGTs 1 through 8 have been received and IGT 9 funds are expected from the state in the first quarter of 2020. IGTs 1 through 9 covered the applicable twelve-month state fiscal year (FY) periods (i.e., FY 2020-2011 through FY 2018-19). IGT 1 through 7 funds were retrospective payments for prior rate range years and were designated to be used to provide enhanced/additional benefits to existing Medi-Cal beneficiaries, as represented to CMS.

The IGT funds received under IGT 1 through 7 have supported special projects that address unmet healthcare needs of CalOptima members, such as vision and dental services for children, obesity prevention and intervention services, provider incentives for adolescent depression screenings, recuperative care for homeless members, and support for members through the Personal Care Coordinator (PCC) program. These funds have been best suited for one-time investments or as seed capital for enhanced health care services for the benefit of Medi-Cal beneficiaries.

Beginning with IGT 8, the IGT program covers the current fiscal year and funds are incorporated into the contract between the California Department of Health Care Services (DHCS) and CalOptima for the current fiscal year. Funds must be used for CalOptima covered Medi-Cal services per DHCS requirements. Upon Board approval, funds may be allocated and used over multiple years. IGT 8 funds have been allocated to the Homeless Health Initiative. In July 2018, CalOptima received notice from DHCS regarding the fiscal year 2018-19 Voluntary Rate Range IGT 9. While supporting documents were submitted to DHCS in August 2018, IGT 9 funds have not yet been received or allocated. Submission of documentation to participate in IGT 9 was ratified at the September 9, 2018

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Board of Directors meeting. CalOptima is expected to receive funding from DHCS in calendar year 2020. CalOptima's estimated share is expected to be approximately $45 million.

Discussion

While IGT 1-7 funds were available to provide enhanced services to existing CalOptima Medi-Cal beneficiaries, beginning with IGT 8, the requirement is that IGT funds are to be used for Medi-Cal program covered services and operations. IGT 8 (and subsequent IGT) funds are subject to all applicable requirements set forth in the CalOptima Medi-Cal contract with DHCS and are considered part of the capitation payments CalOptima receives from DHCS and are accounted for as either medical or administrative expenses, and factor into CalOptima's Medical Loss Ratio (MLR) and Administrative Loss Ratio (ALR). As indicated, per DHCS, the use of these funds is limited to covered Medi-Cal benefits for existing CalOptima members.

While IGT 9 funds have not yet been received, CalOptima staff has begun planning to support use of the funds. CalOptima staff has considered the DHCS requirements for use of IGT 9 funds and Board approved strategic priorities and objectives in identifying the following focus areas:

- Member access and engagement
- Quality performance
- Data exchange and support
- Other priority areas

CalOptima staff has and will continue to share information about the proposed focus areas with various stakeholders.

CalOptima staff anticipates receiving approximately $45 million in IGT 9 funding and proposes allocation of funds towards the following focus areas:

Focus Area	Amount Requested
Member access and engagement	$6.5 million
Quality performance	$3.4 million
Data exchange and support	$2.0 million
Other priority areas	$33.1 million

Within the IGT 9 focus areas, staff has identified initiatives targeted for $40.5 million of the anticipated $45 million. These initiatives include:

Proposals	Focus Area	Term	Amount Requested
1. Expanded Office Hours	Member access and engagement	Two–years	$2.0 million
2. Post-Acute Infection Prevention (PIPQI)	Quality performance	Three–years	$3.4 million
3. Hospital Data Exchange Incentive	Data exchange and support	One–year	$2.0 million
4. IGT Program	Other priority areas	Five–years	$2.0 million

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Administration			
5. Whole Child Model (WCM) Program	Other priority areas	One–year	Up to $31.1 million

Prior to implementation, CalOptima staff will return to the Board with recommendations related the remaining estimated $4.5 million towards member access and engagement, as well as regarding new and/or modified policies and procedures, and contracts, as applicable.

Fiscal Impact

The recommended action has no net fiscal impact to CalOptima's operating budget over the proposed project terms. Staff estimates that IGT 9 revenue from DHCS will be sufficient to cover the allocated expenditures and initiatives recommended in this COBAR.

Rationale for Recommendation

CalOptima staff is recommending the use of IGT funds in a manner consistent with state parameters for IGT funds, identified focus areas.

Concurrence

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

Attachments

1. Power Point Presentation: Intergovernmental Transfer (IGT) 9 Update
2. CalOptima Board Action dated September 6, 2018, Consider and Authorize Activities to Secure Medi-Cal Funds through IGT 9
3. CalOptima Board Action dated June 6, 2019, Approve Post-Acute Infection Prevention Quality Initiative and Authorize Quality Incentive Payments
4. IGT Funding Proposals

/s/ Michael Schrader — *02/26/2020*
Authorized Signature — **Date**

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A Public Agency

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Intergovernmental Transfer (IGT) 9 Update

Board of Directors Meeting

March 5, 2020

David Ramirez, M.D., Chief Medical Officer

Nancy Huang, Chief Financial Officer

Candice Gomez, Executive Director, Program Implementation

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IGT Background

- IGT process enables CalOptima to secure additional federal revenue to increase California's low Medi-Cal managed care capitation rates
  - IGT 1–7: Funds must be used to deliver enhanced services for the Medi-Cal population
    - Funds are outside of operating income and expenses
  - IGT 8–10: Funds must be used for Medi-Cal covered services for the Medi-Cal population
    - Funds are part of operating income and expenses

IGT Funding Process

High-Level Overview
1. CalOptima receives DHCS notice announcing IGT opportunity
2. CalOptima secures funding partnership commitments (e.g., UCI, Children and Families Commission, et al.)
3. CalOptima submits Letter of Interest to DHCS listing funding partners and their respective contribution amounts
4. Funding partners wire their contributions and an additional 20% fee to DHCS
5. CMS provides matching funds to DHCS
6. DHCS sends total amount to CalOptima
7. From the total amount, CalOptima returns each funding partner's original contribution
8. From the total amount, CalOptima also reimburses each funding partner's 20% fee and where applicable, retained amount for MCO tax (IGT 1–6 only)
9. Remaining balance of the total amount is split 50/50 between CalOptima and the funding partners or their designees

CalOptima Share Totals to Date

IGTs	CalOptima Share	Date Received
IGT 1	$12.43 million	September 2012
IGT 2	$8.70 million	June 2013
IGT 3	$4.88 million	September 2014
IGT 4	$6.97 million	October 2015 (Classic)/ March 2016 (MCE)
IGT 5	$14.42 million	December 2016
IGT 6	$15.24 million	September 2017
IGT 7	$15.91 million	May 2018
IGT 8	$42.76 million	April 2019
IGT 9*	TBD	TBD (Spring 2020)
IGT 10*	TBD	TBD
Total Received	**$121.31 million**	

** Pending DHCS guidance*

IGT 9 Status

- CalOptima's estimated share is approximately $45 million
  - Expect receipt of funding in calendar year 2020
  - Funds used for Medi-Cal programs, services and operations
  - Funds are part of operating income and expenses
    - Medical Loss Ratio (MLR) and Administrative Loss Ratio (ALR) apply
    - Managed through the fiscal year budget

- Stakeholder vetting on the following focus areas
  - Member access and engagement
  - Quality performance
  - Data exchange and support
  - Other priority areas

Proposed Allocation

Focus Area	Amount Requested
Member access and engagement	$6.5 million
Quality performance	$3.4 million
Data exchange and support	$2.0 million
Other priority areas	$33.1 million

- Staff has identified initiatives targeted $40.5 million of the anticipated $45 million
- Additional initiatives in development will be presented before the end of the fiscal year

1. Member Access and Engagement: Expanded Office Hours

- Description
  - Offer additional incentives to providers and/or clinics
    - Expand office hours in the evening and weekends
    - Expand primary care services to ensure timely access
- Guidelines
  - Primary care providers in community clinics serving members in high-demand/impacted areas are eligible
  - Per-visit access incentive awarded to providers and/or clinics for members seen during expanded hours
- Key Components
  - Two-year initiative
  - Budget request of $2.0 million ($500,000 in FY 2019–20)

2. Quality Performance: Post-Acute Infection Prevention Initiative (PIPQI)

- Description
  - Expand CalOptima's PIPQI to suppress multidrug-resistant organisms in contracted skilled nursing facilities (SNFs) and decrease inpatient admissions for infection
- Guidelines
  - Phase 1: Training for 41 CalOptima-contracted SNFs not currently participating in initiative
  - Phase 2: Compliance, quality measures and performance incentives for all participating facilities
  - Two FTE to support adoption, training and monitoring
- Key Components
  - Three-year initiative
  - Budget request of $3.4 million ($1 million in FY 2019–20)

3. Data Exchange: Hospital Data Exchange Incentive

- Description
  - Support data sharing among contracted and participating hospitals via use of CalOptima selected vendors
    - Other organizations within the delivery system may also be added
  - Enhance monitoring of hospital activities for CalOptima's members, aiming to improve care management and lower costs
- Guidelines
  - Participating organizations will:
    - Work with CalOptima and vendor to facilitate sharing of ADT (Admit, Discharge, Transfer) and Electronic Health Record data
    - Be eligible for an incentive once each file exchange is in place
- Key Components
  - One-year initiative
  - Budget request of $2.0 million (CY 2020)

4. Other Priorities: IGT Program Administration

- Definition
  - Administrative support for prior, current and future IGTs
    - Continue support for two existing staff positions to manage IGT transaction process, project and expenditure oversight
    - Fund Grant Management System license, public activities and other administrative costs
- Guidelines
  - Will be consistent with CalOptima policies and procedures
  - Will provide oversight of the entire IGT process and ensure funding investments are aligned with CalOptima strategic priorities and member needs
- Key Components
  - Five years of support
  - Budget request of $2.0 million

5. Other Priorities: Whole-Child Model (WCM) Program

- Definition
  - CalOptima launched WCM on July 1, 2019
  - Based on the initial analysis, CalOptima is projecting an overall loss of up to $31.1 million in FY 2019–20
- Challenges
  - Insufficient revenue from DHCS to cover WCM services
  - Complex operations and financial reconciliation
- Key Components
  - One year
  - Budget request of up to $31.1 million to fund the deficit from WCM program in FY 2019–20

Recommended Actions

1. Approve the recommended allocation of IGT 9 funds in the amount of $45 million for initiatives for quality performance, access to care, data exchange and support and other priority areas; and
2. Authorize the Chief Executive Office, with the assistance of Legal Counsel, to take actions necessary to implement the proposed initiatives, subject to staff first returning to the Board for approval of:
   a) Additional initiative(s) related to member access and engagement; and
   b) New and/or modified policies and procedures, and contracts/contract amendments, as applicable.

CalOptima's Mission

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

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

14. Consider Ratification of the Pursuit of Proposals with Qualifying Funding Partners to Secure Medi-Cal Funds Through the Voluntary Rate Range Intergovernmental Transfer Program for Rate Year 2018-19 (IGT 9)

Contact

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

Recommended Actions

Ratify and authorize the following activities to secure Medi-Cal funds through the Voluntary Intergovernmental Transfer (IGT) Rate Range Program:

1. Submission of a proposal to the California Department of Health Care Services (DHCS) to participate in the Voluntary Rate Range Intergovernmental Transfer Program for Rate Year 2018-19 (IGT 9);
2. Pursuit of IGT funding partnerships with the University of California-Irvine, the Children and Families Commission, the County of Orange, the City of Orange, and the City of Newport Beach to participate in the upcoming Voluntary Rate Range Intergovernmental Transfer Program for Rate Year 2018-19 (IGT 9), and;
3. Authorize the Chief Executive Officer to execute agreements with these entities and their designated providers as necessary to seek IGT 9 funds.

Background

Intergovernmental Transfers (IGT) are transfers of public funds between eligible government entities which are used to draw down federal funds for the Medi-Cal program. To date, CalOptima has participated in seven Rate Range IGT transactions. Funds from IGTs 1 – 7 have been received and IGT 8 funds are expected in the first quarter of 2019. IGT 1 – 7 funds were retrospective payments for prior rate range years and have been used to provide enhanced/additional benefits to existing Medi-Cal beneficiaries. These funds have been best suited for one-time investments or as seed capital for new services or initiatives for the benefit of Medi-Cal beneficiaries.

The IGT funds that have been received to date have supported special projects that address unmet needs for CalOptima members, such as vision and dental services for children, obesity prevention and intervention services, provider incentives for adolescent depression screenings, recuperative care for homeless members, and support for members through the Personal Care Coordinator (PCC) program. For the approved and funded IGT transactions to date, the net proceeds have been evenly divided between CalOptima and the respective funding partners, and funds retained by CalOptima have been invested in addressing unmet needs.

Discussion

Beginning with IGT 8, the IGT program covers the current fiscal year and funds will be incorporated into the contract between DHCS and CalOptima for the current fiscal year. Unlike previous IGTs (1-7), IGT funds must now be used in the current rate year for CalOptima covered

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services per DHCS instructions. CalOptima may determine how to spend the IGT funds (net proceeds) as long as they are for CalOptima covered services for Medi-Cal beneficiaries.

On July 31, 2018, CalOptima received notification from DHCS regarding the State Fiscal Year (SFY) 2018-19 Voluntary Rate Range Intergovernmental Transfer Program (IGT 9). CalOptima's proposal, along with the funding entities' supporting documents were due to DHCS on August 31, 2018.

The five eligible funding entities from the previous IGT transactions were contacted regarding their interest in participation. All five funding entities have submitted letters of interest regarding participation in the IGT program this year. These entities are:

1. University of California, Irvine,
2. Children and Families Commission of Orange County,
3. County of Orange,
4. City of Orange, and
5. City of Newport Beach.

Board approval is requested to ratify the submission of the proposal letter to DHCS for participation in the 2018-19 Voluntary IGT Rate Range Program and to authorize the Chief Executive Officer to enter into agreements with the five proposed funding entities or their designated providers for the purpose of securing available IGT funds. Consistent with the eight prior IGT transactions, it is anticipated that the net proceeds will be split evenly between the respective funding entities and CalOptima.

Staff will return to your Board with more information regarding the IGT 9 transaction and an expenditure plan for CalOptima's share of the net proceeds at a later date. .

Fiscal Impact
The recommended action to ratify and authorize activities to secure Medi-Cal funds through IGT 9 will generate one-time IGT revenue that will be invested in Board-approved programs/initiatives. Expenditure of IGT funds is for restricted, one-time purposes and does not commit CalOptima to future budget allocations. As such, there is no net fiscal impact on CalOptima's current or future operating budgets as IGT funds have been accounted for separately.

Rationale for Recommendation
Consistent with the previous eight IGT transactions, ratification of the proposal and authorization of funding agreements will allow the ability to maximize Orange County's available IGT funds for Rate Year 2018-19 (IGT 9).

Concurrence
Gary Crockett, Chief Counsel

Attachment
Department of Health Care Services Voluntary IGT Rate Range Program Notification Letter

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

8/29/2018 — **Date**

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

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

July 31, 2018

Greg Hamblin
Chief Financial Officer
CalOptima
505 City Parkway West
Orange, CA 92868

SUBJECT: State Fiscal Year (SFY) 2018-19 Voluntary Rate Range Program – Request for Medi-Cal Managed Care Plan's (MCP) Proposal

Dear Mr. Hamblin:

The 2018-19 Voluntary Rate Range Program, authorized by Welfare and Institutions (W&I) Code sections 14164, 14301.4, and 14301.5, provides a mechanism for funding the non-federal share of the difference between the lower and upper bounds of a MCP's actuarially sound rate range, as determined by the Department of Health Care Services (DHCS). Governmental funding entities eligible to transfer the non-federal share are defined as counties, cities, special purpose districts, state university teaching hospitals, and other political subdivisions of the state, pursuant to W&I Code section 14164(a). These governmental funding entities may voluntarily transfer funds to DHCS via intergovernmental transfer (IGT). These voluntary IGTs, together with the applicable Federal Financial Participation (FFP), will be used to fund payments by DHCS to MCPs as part of the capitation rates paid for the service period of July 1, 2018 through June 30, 2019 (SFY 2018-19).

DHCS shall not direct the MCP's expenditure of payments received under the 2018-19 Voluntary Rate Range Program. These payments are subject to all applicable requirements set forth in the MCP's contract with DHCS. These payments must also be tied to covered Medi-Cal services provided on behalf of Medi-Cal beneficiaries enrolled within the MCP's rating region.

The funds transferred by an eligible governmental funding entity must qualify for FFP pursuant to Title 42 Code of Federal Regulations (CFR) Part 433, Subpart B, including the requirements that the funding source(s) shall not be derived: from impermissible sources such as recycled Medicaid payments, Federal money excluded from use as state match, impermissible taxes, and non-bona fide provider-related donations. Impermissible sources do not include patient care or other revenue received from programs such as Medicare or Medicaid to the extent that the program revenue is not obligated to the state as the source of funding.

DHCS shall continue to administer all aspects of the IGT related to the 2018-2019 Voluntary Rate Range Program, including determinations related to fees.

PROCESS FOR SFY 2018-19:

MCPs should refer to the estimated SFY 2018-19 county/region-specific non-federal share required to fund available rate range amounts for the MCP (see Attachment C). As a reminder, participation in the 2018-19 Voluntary Rate Range Program is voluntary on the part of the transferring entity and the MCP. If an MCP elect to participate in the 2018-19 Voluntary Rate Range Program, the MCP must adhere to the process for participation outlined below:

Soliciting Interest

The MCP shall contact potential governmental funding entities to determine their interest, ability, and desired level of participation in the 2018-19 Voluntary Rate Range Program. All providers and governmental funding entities who express their interest directly to DHCS will be redirected to the applicable MCP to facilitate negotiations related to participation. If, following the submission of the MCP's proposal, one or more governmental funding entities included in the MCP's proposal are unable or unwilling to participate in the Voluntary Rate Range Program, the MCP shall attempt to find other governmental funding entities able and willing to participate in their place.

The MCP must inform all participating governmental entities that, unless DHCS determines a statutory exemption applies, IGTs submitted in accordance with W&I Code section 14301.4 are subject to an additional 20 percent assessment fee (calculated on the value of their IGT contribution amount) to reimburse DHCS for the administrative costs of operating the Voluntary Rate Range Program and to support the Medi-Cal program. DHCS will determine if a fee waiver is appropriate.

Submission Requirements

Once the MCP has coordinated with the relevant governmental funding entities, the following documents must be submitted to DHCS in accordance with the requirements and procedures set forth below:

- The MCP must submit a **proposal** to DHCS. This proposal must include:

    1. A cover letter signed by the MCP's Chief Executive Officer or Chief Financial Officer on MCP letterhead.

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2. The MCP's primary contact information (name, e-mail address, mailing address, and phone number).
3. County/region-specific summaries of the selected governmental funding entities, related providers, and participation levels specified for SFY 2018-19. The combined amounts or percentages must not exceed 100 percent of the estimated non-federal share of the available rate range amounts provided by DHCS. If the MCP is unable to use the entire available rate range, the MCP must indicate the unfunded amount and percentage.
4. All letters of interest (described below) and supporting documents must be attached to the proposal. If the "supplemental attachment" described below is not collected by the MCP and attached to the proposal at the time of submission, please indicate if the information will be submitted to DHCS directly by each governmental funding entity.

- The MCP must obtain a **letter of interest** (using the format provided in Attachment A) from each governmental funding entity included in the MCP's proposal to DHCS. An individual authorized to sign the certification on behalf of the governmental funding entity must sign the letter of interest. Each letter of interest must specify:

  1. The governmental funding entity's name and Federal Tax Identification Number,
  2. The dollar amount or percentage of the total available rate range the governmental funding entity will contribute for each MCP and county/region, and
  3. The governmental funding entity's primary contact information (name, e-mail address, mailing address, phone number).

- The MCP must distribute to governmental funding entities and ensure submission to DHCS of the **SFY 2018-19 Voluntary Rate Range Program Supplemental Attachment** (see Attachment B) by Friday, August 31, 2018.

- The proposals and letters of interest are due to DHCS ***by 5pm on Friday, August 31, 2018***. Please send a PDF copy of the required documents by e-mail to Sandra.Dixon@dhcs.ca.gov. ***Failure to submit all required documents by the due date may result in exclusion from the SFY 2018-19 Voluntary Rate Range Program.***

Each proposal is subject to review and approval by DHCS. The review will include an evaluation of the proposed provider participation levels in comparison to their

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uncompensated contracted Medi-Cal costs and/or charges. DHCS reserves the right to approve, amend, or deny the proposal at its discretion.

Upon DHCS' approval of the governmental funding entities and non-federal share amounts for the 2018-19 Voluntary Rate Range Program, DHCS will provide the necessary funding agreement templates, forms, and related due dates to the specified governmental funding entities and MCP contacts. The governmental funding entities will be responsible for completing all necessary funding agreement documents, responding to any inquiries necessary for obtaining approval, and obtaining all required signatures.

If you have any questions regarding this letter, please contact Sandra Dixon at (916) 345-8269 or by email at Sandra.Dixon@dhcs.ca.gov.

Sincerely,

Jennifer Lopez
Division Chief
Capitated Rates Development Division

Attachments

cc: Michael Schrader, Chief Executive Officer
CalOptima
505 City Parkway West
Orange, CA 92868

Sandra Dixon
Financial Management Section
Capitated Rates Development Division
Department of Health Care Services
P.O. Box 997413, MS 4413
Sacramento, CA 95899-7413

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ATTACHMENT A – LETTER OF INTEREST TEMPLATE

Jennifer Lopez
Division Chief
Capitated Rates Development Division
Department of Health Care Services
1501 Capitol Avenue, MS 4413
P.O. Box 997413
Sacramento, CA 95899-7413

Dear Ms. Lopez:

This letter confirms the interest of [Insert Participating Funding Entity Name], a governmental entity, federal I.D. Number [Insert Federal Tax I.D. Number], in working with [Managed Care Plan's Name] (hereafter, "the MCP") and the California Department of Health Care Services (DHCS) to participate in the Voluntary Rate Range Program, including providing an Intergovernmental Transfer (IGT) to DHCS to be used as a portion of the non-federal share of actuarially sound Medi-Cal managed care capitation rate payments incorporated into the contract between the MCP and DHCS for the period of July 1, 2018, to June 30, 2019. This is a non-binding letter, stating our interest in helping to finance health improvements for Medi-Cal beneficiaries receiving services in our jurisdiction. The governmental entity's funds are being provided voluntarily, and the State of California is in no way requiring the governmental entity to provide any funding.

[Insert Participating Funding Entity Name] is willing to contribute up to $_____ for the SFY 2018-19 rating period as negotiated with the MCP. We recognize that, unless a waiver is approved by DHCS, there will be an additional 20-percent assessment fee payable to DHCS on the funding amount, for the administrative costs of operating the voluntary rate range program.

The following individual from our organization will serve as the point of communication between our organization, the MCP and DHCS on this issue:

Entity Contact Information:

(Please provide complete information including name, street address, e-mail address and phone number.)

I certify that I am authorized to sign this certification on behalf of the governmental entity and that the statements in this letter are true and correct.

Sincerely,
Signature

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Attachment B

SFY 2018-19 Voluntary Rate Range Program Supplemental Attachment

Provider Name:	
County:	
Health Plan:	

Instructions

Complete all yellow-highlighted fields. **Submit this completed form via e-mail to Sandra Dixon (sandra.dixon@dhcs.ca.gov) at the Department of Health Care Services (DHCS) by Friday, August 31, 2018.**

1. In the table below, report charges/costs and payments received or expected to be received from the Health Plan indicated above for Medi-Cal services (Inpatient, Outpatient, and All Other) provided to Medi-Cal beneficiaries enrolled in the Health Plan and residing in the County indicated above, for dates of service from July 1, 2016 through June 30, 2017.

	Charges	Costs	Payments from Health Plan*	Uncompensated Chares (charges less payments)	Uncompensated Costs (Costs less payments)
Inpatient				$	$
Outpatient				$	$
All Other				$	$
Total	$	$	$	$	$

* Include payments received and anticipated to be received for service dates of July 1, 2016 through June 30, 2017.

2. Are you able to fund 100% of the higher of the uncompensated charges or uncompensated costs (as stated above)? *(Yes / No)*

   If No, please specify the amount of funding available:

3. Describe the scope of services provided to the specified Health Plan's Medi-Cal members, and if these services were provided under a contract arrangement.

4. For any capitation payments to be funded by the IGT, please provide the following:

   (i) The name of the entity transferring funds:

   (ii) The operational nature of the entity (state, county, city, other):

   (iii) The source of the funds:
   (Funds must not be derived from impermissible sources such as recycled Medicaid payments, federal funds excluded from use as State match, impermissible taxes, and non-bona fide provider-related donations.)

   (iv) Does the transferring entity have general taxing authority? *(Yes / No)*

   (v) Does the transferring entity receive appropriations from a state, county, city, or other local government jurisdiction? *(Yes / No)*

5. Comments / Notes

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ATTACHMENT C

TOTAL AVAILABLE RATE RANGE

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Orange County Organized Health System dba Cal Optima - Orange (HCP 506)
IGT - 2018/19 (July 2018 - June 2019)

	Total	50% FMAP (Non-MCHIP and OE)	88% FMAP (MCHIP)	Optional Expansion (93.5%)
Total Funds Available	$ 138,114,451	$ 68,412,249	$ 7,133,302	$ 62,568,900
Federal Match	$ 98,985,353	$ 34,206,125	$ 6,277,306	$ 58,501,922
Governmental Funding Entity's Portion	$ 39,129,098	$ 34,206,124	$ 855,996	$ 4,066,978
	28.3%	50.0%	12.0%	6.5%

Rate Categories[1]	Member Months (per Mercer est.)	Lower Bound (per Mercer Rate Worksheets)	Upper Bound (per Mercer Rate Worksheets)	Difference between Upper and Lower Bound	Other Dept. Usage[2]	Available PMPM (less Other Dept. Usage)	Estimated Available Total Fund
Child - non MCHIP	2,474,781	$ 84.85	$ 89.93	$ 5.08	$ -	$ 5.08	$ 12,571,887
Child - MCHIP	1,273,587	$ 84.85	$ 89.93	$ 5.08	$ -	$ 5.08	$ 6,469,822
Adult - non MCHIP	1,082,406	$ 299.18	$ 316.64	$ 17.46	$ -	$ 17.46	$ 18,898,809
Adult - MCHIP	38,000	$ 299.18	$ 316.64	$ 17.46	$ -	$ 17.46	$ 663,480
SPD	466,754	$ 755.18	$ 798.48	$ 43.30	$ -	$ 43.30	$ 20,210,448
SPD/Full-Dual	22,704	$ 219.25	$ 229.52	$ 10.27	$ -	$ 10.27	$ 233,170
BCCTP	7,156	$ 1,225.69	$ 1,296.82	$ 71.13	$ -	$ 71.13	$ 509,006
LTC	14,686	$ 10,472.34	$ 10,858.28	$ 385.94	$ -	$ 385.94	$ 5,667,915
LTC/Full-Dual	0	$ 6,036.73	$ 6,235.58	$ 198.85	$ -	$ 198.85	$ -
OBRA	0	$ -	$ -	$ -	$ -	$ -	$ -
Whole Child Model	74,642	$ 1,824.65	$ 1,962.92	$ 138.27	$ -	$ 138.27	$ 10,321,014
Optional Expansion	2,853,119	$ 442.21	$ 471.45	$ 29.24	$ 7.31	$ 21.93	$ 62,568,900
	8,307,835	$ 309.49	$ 328.62	$ 19.14	$ 2.51	$ 16.62	$ 138,114,451

[1]The supplemental payments (Maternity, BHT and HEP C) are not included in the rate range calculation.

[2]Other Departmental Usages decreases available rate range funding.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

33. Consider Approval of Quality Initiative Related to Post-Acute Infection Prevention and Authorization of Related Funding for Quality Initiative Payments

Contact

David Ramirez, M.D., Chief Medical Officer, (714) 246-8400
Emily Fonda, M.D., MMM, CHCQM, Medical Director, (714) 246-8400
Ladan Khamseh, Chief Operating Officer, (714) 246-8400

Recommended Actions

1. Authorize establishment of a Multi-Drug-Resistant Organisms (MDRO) suppression quality initiative; and
2. Authorize the distribution of up to $2.3 million in FY 2019-20 CalOptima Medi-Cal funds in payments to providers meeting criteria for payment under this MDRO suppression quality initiative.

Background

The Centers for Disease Control and Prevention (CDC) and the University of California-Irvine (UCI) recently collaborated on an extensive study in 2017 through 2019 to suppress the spread of Multi-Drug-Resistant Organisms (MDRO) in Skilled Nursing Facilities (SNFs) across Orange County. The ambitious study also garnered the support of the California Department of Public Health as well as the Orange County Health Care Agency. This regional collaborative established a structured "…decolonization strategy to reduce the transmission of MDROs both countywide and within healthcare facilities." The name of the collaborative is SHIELD OC.

SHIELD OC is comprised of intervention protocols for both hospitals and nursing homes. There were 16 Orange County SNFs contracted with CalOptima that participated through to the conclusion of the study.

The study was focused on MDRO decolonization through "…the use of topical products to reduce bacteria on the body that can produce harmful infections." In SNFs, the study protocol involved the implementation of two interventions: (1) the consistent use of Chlorhexidine (CHG) antiseptic soap for routine bathing and showering of residents, and (2) the scheduled use of povidone-iodine nasal swabs on residents.

The preliminary study outcomes were very promising and gained the close attention of CDC senior leadership, who have reached out to CalOptima regarding the project on more than one occasion. Long term care (LTC) residents in facilities following the study protocol showed markedly lower rates of MDRO colonization, which translated into lower rates of hospital admissions and lower utilization costs for CalOptima members. The implications of the study, as well as the innovative regional collaboration model, have also garnered the interest of the press. News regarding the collaborative recently aired on National Public Radio and appeared in *USA Today* articles. The lead author in the study, Dr. Susan Huang, was also recently interviewed in a local news radio segment on KNX 1070.

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The study concluded on May 2, 2019. At the SHIELD OC Wrap Up Event, concerns were expressed by facility participants as well as the CDC that the end of the project funding would prevent the SNFs in the study from continuing the study protocol efforts. Without continuation of the interventions, the momentum of the efforts by the participating SNFs would be interrupted, and the considerable gains made in regional decolonization could potentially be unraveled. While the responsibility of infection prevention in post-acute settings is not solely the responsibility of CalOptima, the extensive project has provided significant safety and health benefits to CalOptima members who reside in these facilities. After the conclusion of the study, the collaborative will face an absence of funding and direction. This presents an opportunity for CalOptima to take a leadership role in supporting the care delivery system by offering value-based quality incentives to facilities that follow evidence-based patient safety practices in the institutionalized population segment which are congruent with CalOptima's mission as well as the National Quality Assurance Committee (NCQA) Population Health Management Standards of Delivery System Support.

Discussion

As proposed, the Post-Acute Infection Prevention Quality Initiative will provide an avenue through which CalOptima can incentivize SNFs to provide the study protocol interventions. The study protocols have been recognized to meaningfully suppress the spread of MDROs and will support the safety and health of CalOptima members receiving skilled interventions at or residing in SNFs. Implementation of the quality initiative is in line with CalOptima's commitment to continuous quality improvement.

The initiative would be comprised of two separate phases. Summarily, in Phase I, CalOptima-contracted SNFs in Orange County could initiate a commitment to implementing the study protocol and CalOptima would respond by providing funding to the facility for setup and protocol training. For each participating SNF, Phase I would last for two quarters. In Phase II of the quality initiative, after the SNF has been trained and can demonstrate successful adoption of the protocol, each SNF would be required to demonstrate consistent adherence to the study protocol as well as meet defined quality measures in order to be eligible to continue receiving the quality initiative payments on a retrospective quarterly basis.

Phase I

CalOptima to provide quality initiative funding to SNFs demonstrating a commitment to implementing the SHIELD OC study protocol. The quality initiative is intended to support start up and training for implementation of the protocols not currently in standard use in SNFs but, as per the SHIELD OC study, have been demonstrated to effectively suppress the spread of MDROs.

Contracted SNFs in Orange County must complete an Intent to Implement MDRO Suppression form, signed by both its Administrator and Director of Nursing.

CalOptima will then initiate payment for the first quarter of setting up and training. Payment will be based on an average expected usage cost per resident, to be determined by CalOptima for application across all participating facilities, so the amount of payment for each facility will be dependent on its size. These payments are intended to incentivize the facilities to meet the protocol requirements. The facility must demonstrate use of the supplies and the appropriate

application of the study protocol to the assigned CalOptima staff to qualify for the second quarterly Phase I payment.

The following supplies are required of the facility:

- 4% Chlorohexidine Soap
- 10% Iodine Swab Sticks

The following activities will be required of the facility:

- Proof of appropriate product usage.
- Acceptance of training and monitoring of infection prevention protocol by CalOptima and/or CDC/UCI staff.
- Evidence the decolonization program handouts are in admission packets.
- Monitoring and documentation of compliance with CHG bathing.
- Monitoring and documentation of compliance with iodophor nasal swab.
- Documentation of three peer-to-peer bathing skills assessments per month.

Phase II

CalOptima will provide retrospective quality initiative payments on a quarterly basis for facilities that completed Phase I and meet Phase II criteria outlined below. The amount of each Phase II facility payment will reflect the methodology used in Phase I, accounting for facility size at the average expected usage cost. These payments are intended to support facilities in sustaining the quality practices they adopted during Phase I to suppress MDRO infections.

To qualify for Phase II quality initiative payments, the participating facility must continue demonstrating adherence to the study protocol through the requirements as outlined above for Phase I.

In addition, the facility must also meet minimum quality measures representative of effective decolonization and infection prevention efforts, to be further defined with the guidance of the UCI and CDC project leads. The facilities in Phase II of the initiative must meet these measures each quarter to be eligible for retrospective payment.

The 16 SNFs that participated in SHIELD OC would be eligible for Phase II of the quality initiative at implementation of this quality initiative since they have already been trained in the project and demonstrated adherence to the study protocol. Other contracted SNFs in Orange County not previously in SHILED OC and beginning participation in the quality initiative would be eligible for Phase I.

The proposed implementation of the quality initiative is Q3 2019.

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Fiscal Impact

The recommended action to implement a Post-Acute Infection Prevention Quality Initiative program and make payments to qualifying SMFs, beginning in FY 2019-20 to CalOptima-contracted SNFs in Orange County is projected to cost up to and not to exceed $2.3 million annually. Management plans to include projected expenses associated with the quality initiative in the upcoming CalOptima FY 2019-20 Operating Budget.

Rationale for Recommendation

The quality initiative presents an avenue for CalOptima to actively support an innovative regional collaborative of high visibility that has been widely recognized to support the safety and health of individuals receiving care in SNFs.

Concurrence

Gary Crockett, Chief Counsel

Attachment

1. PowerPoint Presentation
2. SHIELD OC Flyer
3. Letter of Support

/s/ Michael Schrader *5/29/2019*
Authorized Signature **Date**

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Post-Acute Infection Prevention Quality Initiative

Regular Meeting of the Board of Directors

June 6, 2019

Dr. Emily Fonda, MD, MMM, CHCQM

Medical Director

Care Management, Long-Term Services and Supports and Senior Programs

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Background

- Efforts to lower hospitalization rates from long-term care (LTC) placed us in contact with Dr. Huang and her study
  - Through the Long-Term Services and Supports (LTSS) Quality Improvement Subcommittee
- Susan Huang, MD, MPH, Professor, Division of Infectious Diseases at U.C. Irvine — lead investigator for Project SHIELD Orange County (OC)
  - 36 facility decolonization intervention protocol supported by the Center for Disease Control and Prevention (CDC)
  - 16 of those facilities are CalOptima-contracted skilled nursing facilities
- Early results at wrap-up event on 1/30/19 ➔ overall 25 percent lower colonization rate of multidrug resistant organisms in OC skilled nursing facilities

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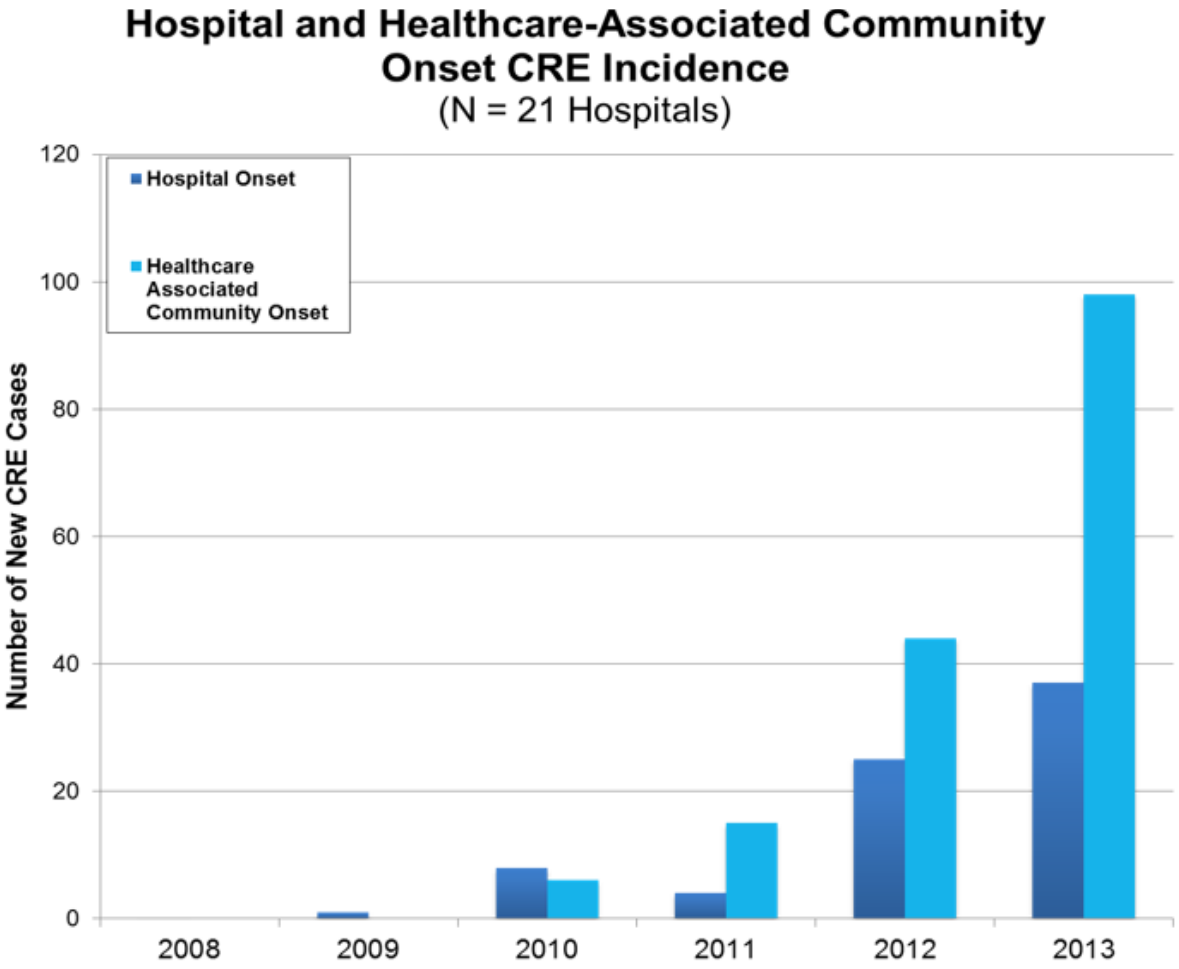
Background

- Rise of Multi-Drug Resistant Organisms (MDROs)
  - Methicillin Resistant *Staphylococcus aureus* (MRSA)
  - Vancomycin Resistant Enterococcus (VRE)
  - Multi-Drug Resistant Pseudomonas
  - Multi-Drug Resistant Acinetobacter
  - Extended Spectrum Beta Lactamase Producers (ESBLs)
  - Carbapenem Resistant Enterobacteriaceae (CRE)
  - Hypervirulent KPC (NDM)
  - *Candida auris*
- **10–15%of hospital patients harbor at least one of the above**
- **65% of nursing home residents harbor at least one of the above**

CRE Trends in Orange County, CA



Gohil S. AJIC 2017; 45:1177-82

CDC Interest

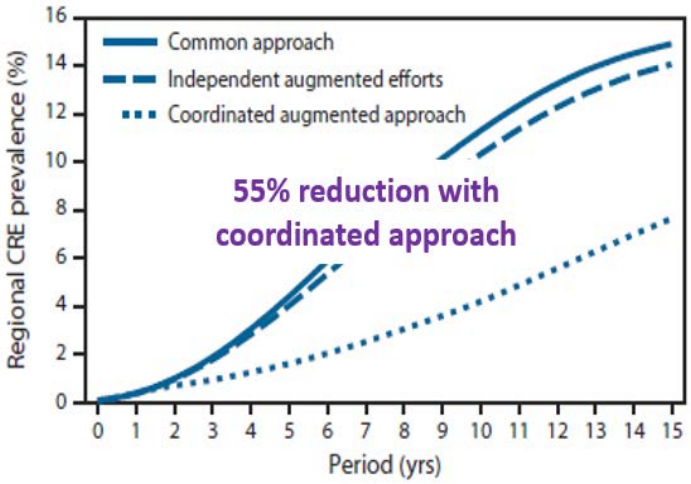
Orange County has historically had one of the highest carbapenem-resistant enterobacteriaceae (CRE) rates in California according to the OC Health Care Agency

Centers for Disease Control and Prevention
MMWR
Morbidity and Mortality Weekly Report
Early Release / Vol. 64
August 4, 2015

Vital Signs: Estimated Effects of a Coordinated Approach for Action to Reduce Antibiotic-Resistant Infections in Health Care Facilities — United States

Rachel B. Slayton, PhD[1]; Damon Toth, PhD[2]; Bruce Y. Lee, MD[3]; Windy Tanner, PhD[2]; Sarah M. Bartsch, MPH[3]; Karim Khader, PhD[2]; Kim Wong, PhD[4]; Kevin Brown, PhD[2]; James A. McKinnell, MD[5]; William Ray[2]; Loren G. Miller, MD[6]; Michael Rubin, MD, PhD[2]; Diane S. Kim[7]; Fred Adler, PhD[8]; Chenghua Cao, MPH[7]; Lacey Avery, MA[1]; Nathan T.B. Stone, PhD[9]; Alexander Kallen, MD[1]; Matthew Samore, MD[2]; Susan S. Huang, MD[7]; Scott Fridkin, MD[1]; John A. Jernigan, MD[1]

FIGURE 3. Projected countywide prevalence of carbapenem-resistant *Enterobacteriaceae* (CRE) over a 15-year period under three different intervention scenarios — 102-facility model, Orange County, California*



* Additional information available at http://www.cdc.gov/drugresistance/resources/publications.html.

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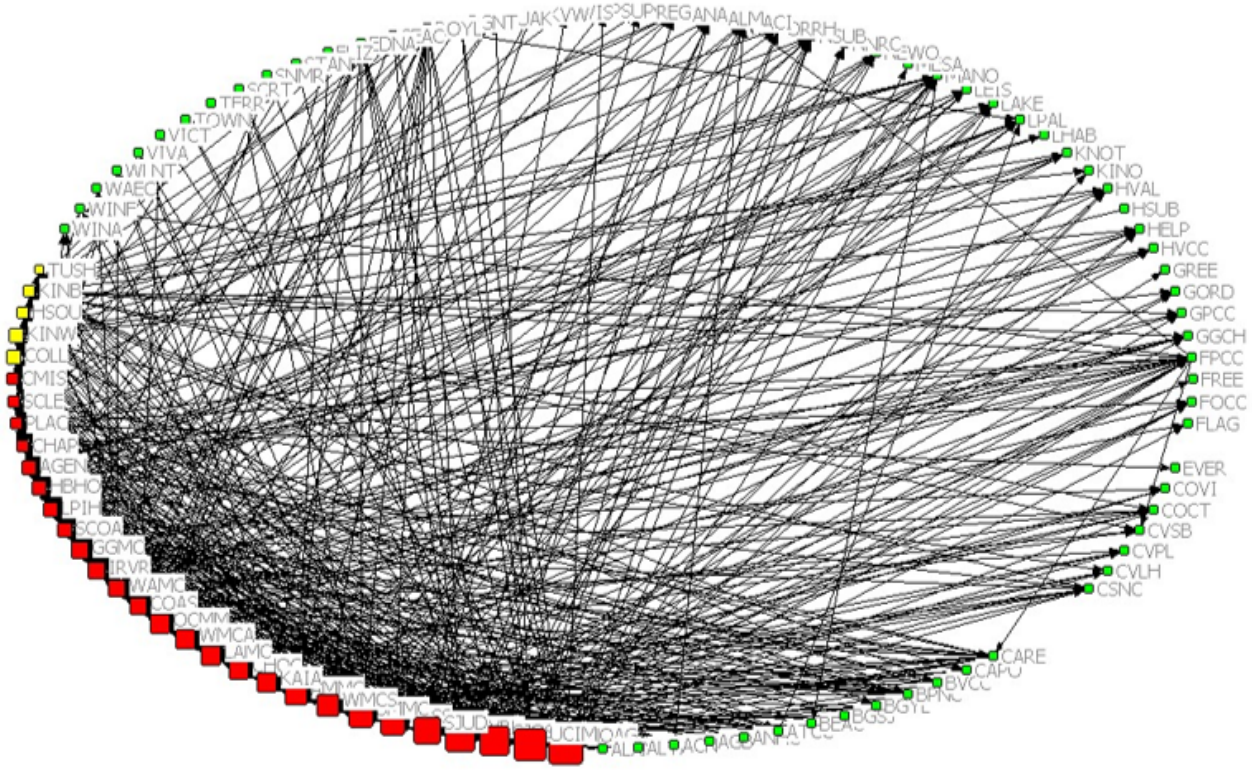
Extent of the Problem

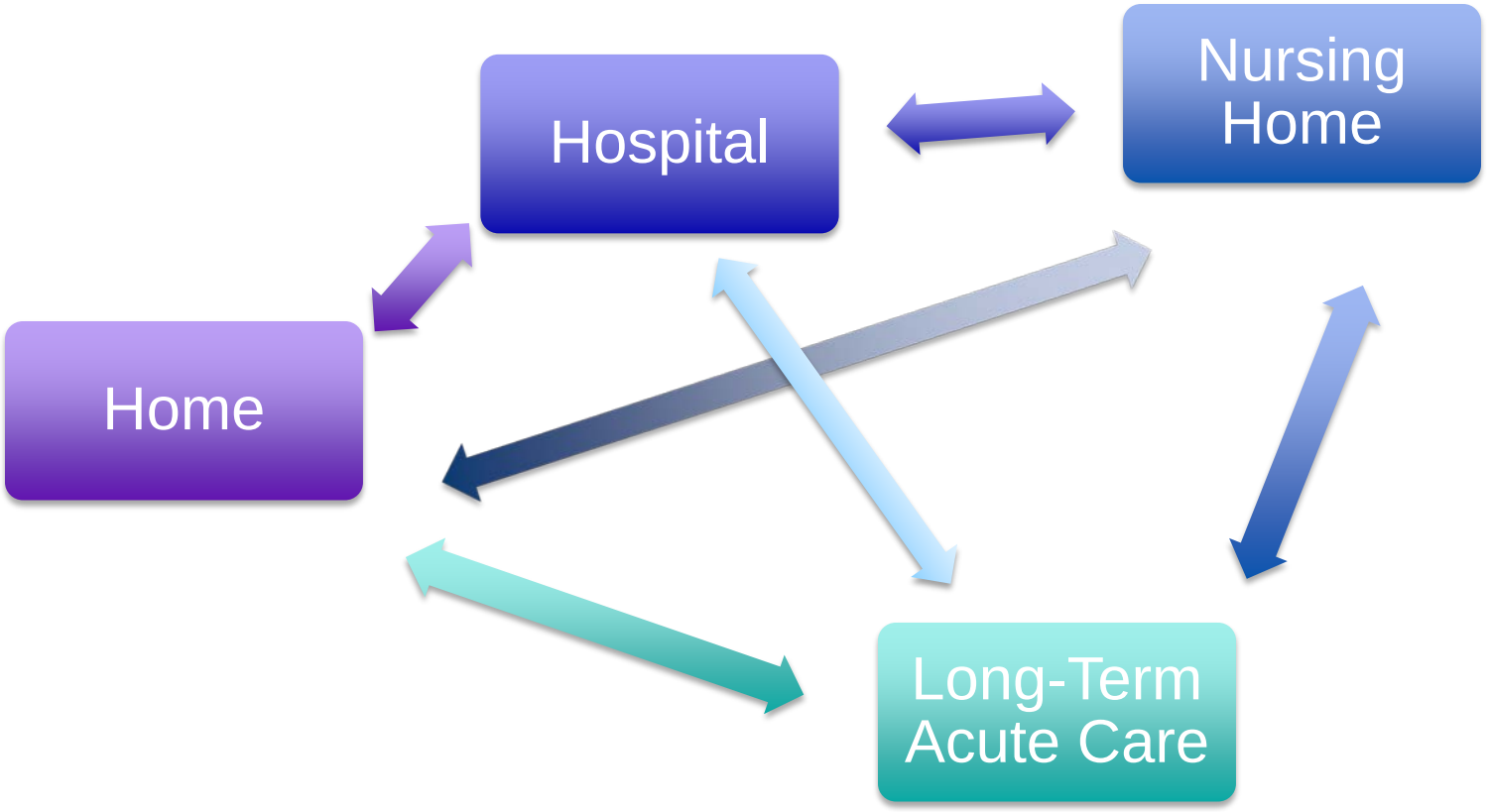
OC Hospitals and Nursing Homes

10 patients shared



Lee BY et al. Plos ONE. 2011;6(12):e29342

Extent of the Problem



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Baseline MDRO Prevalence — 16 Nursing Homes

	N	Any MDRO	MRSA	VRE	ESBL	CRE
Nares	900	28%	28%	-	-	-
Axilla/Groin	900	47%	30%	10%	22%	1%
Peri-Rectal	900	52%	25%	15%	31%	1%
All Body Sites	**900**	**64%**	**42%**	**16%**	**34%**	**2%**

- 64% MDRO carriers, facility range 44–88%
- Among MDRO pathogens detected, only 14% known to facility
- Among all residents, 59% harbored ≥1 MDRO unknown to facility

Participating Health Care Facilities

16 Nursing Homes Contracted with CalOptima

- Alamitos West Health Care Center
- Anaheim Healthcare Center
- Beachside Nursing Center
- Crystal Cove Care Center
- French Park Care Center
- Garden Park Care Center
- Healthcare Center of Orange County
- Laguna Hills Health and Rehab Center
- Lake Forest Nursing Center
- Mesa Verde Post Acute Care Center
- New Orange Hills
- Orange Healthcare & Wellness Centre
- Regents Point – Windcrest
- Seal Beach Health and Rehab Center
- Town and Country Manor
- Victoria Healthcare and Rehab Center

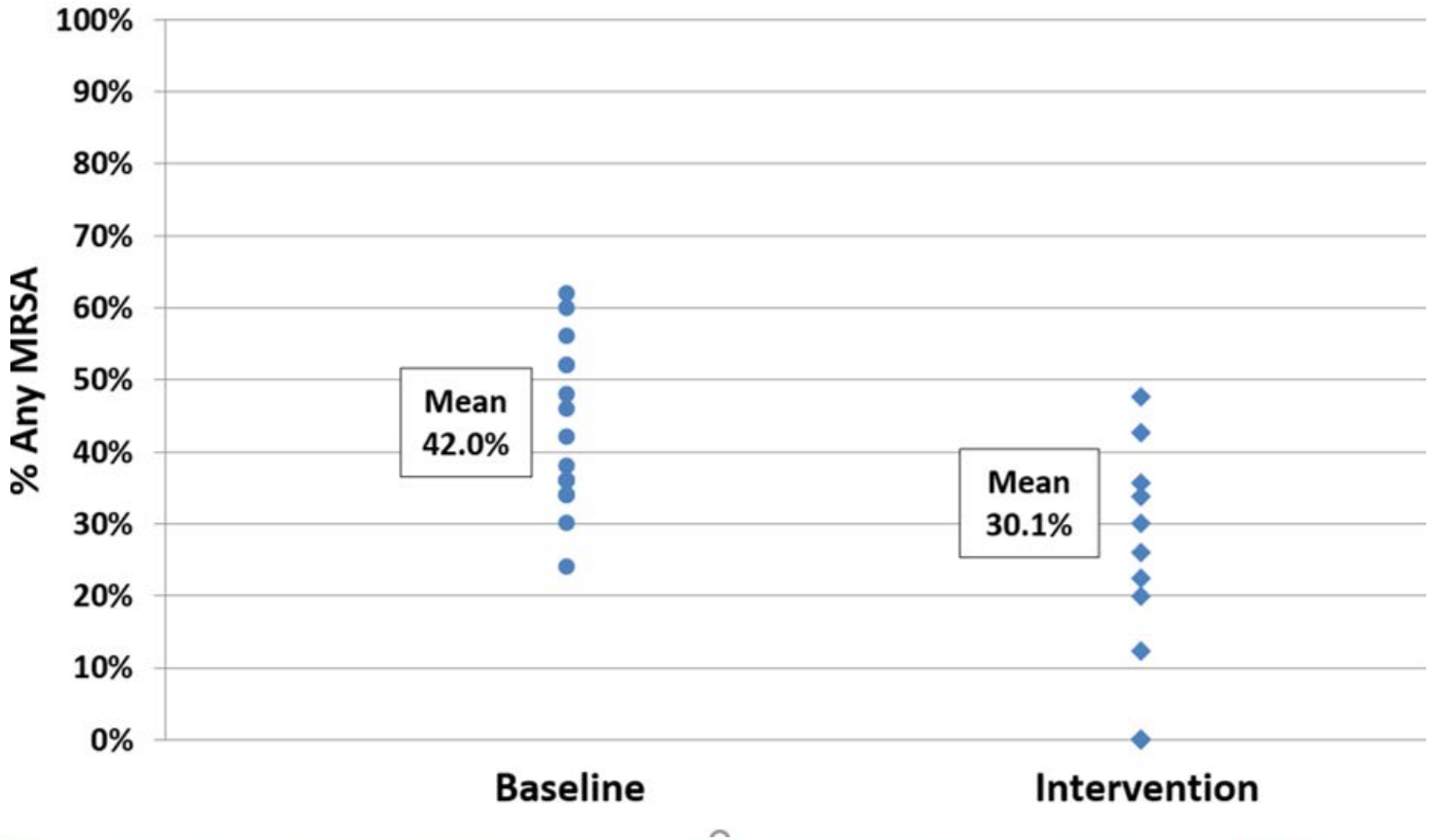
SHIELD OC Decolonization Protocol

- Nursing Homes: Decolonize All Patients
  - Replaced regular soap with chlorhexidine (CHG) antiseptic soap
  - CHG on admit and for all routine bathing/showering
  - Nasal iodophor on admit and every other week
    - https://www.cdc.gov/hai/research/cdc-mdro-project.html
- Following initial testing and training
  - Intervention timeline (22 months) July 1, 2017–May 2, 2019
- Outcome: MDRO Prevalence
  - MRSA, VRE, ESBL, CRE and any MDRO
  - By body site
    - Nasal product reduces MRSA
    - CHG bathing reduces skin carriage

SHIELD Outcomes

SHIELD Impact: Nursing Homes

28% reduction in MRSA



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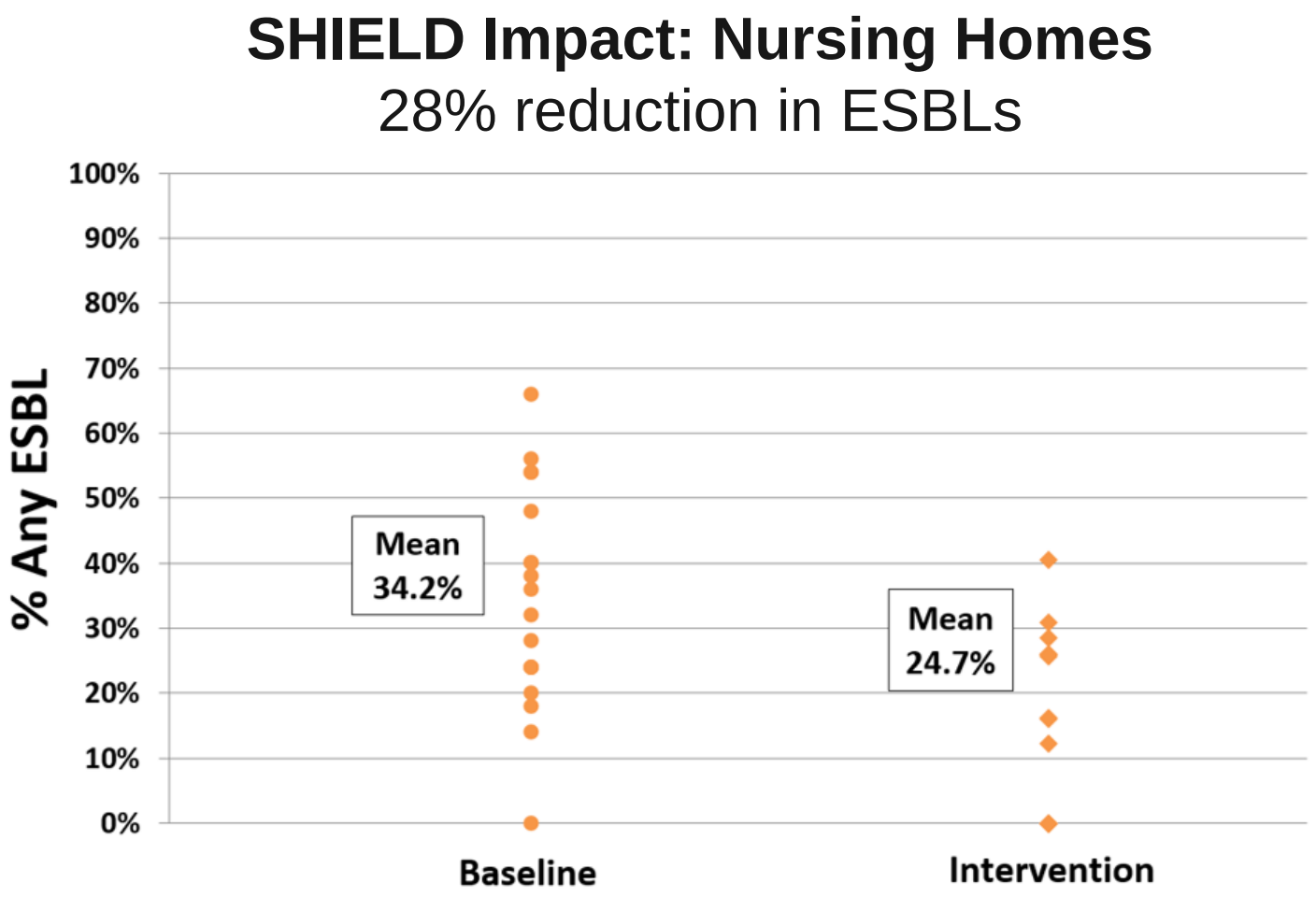
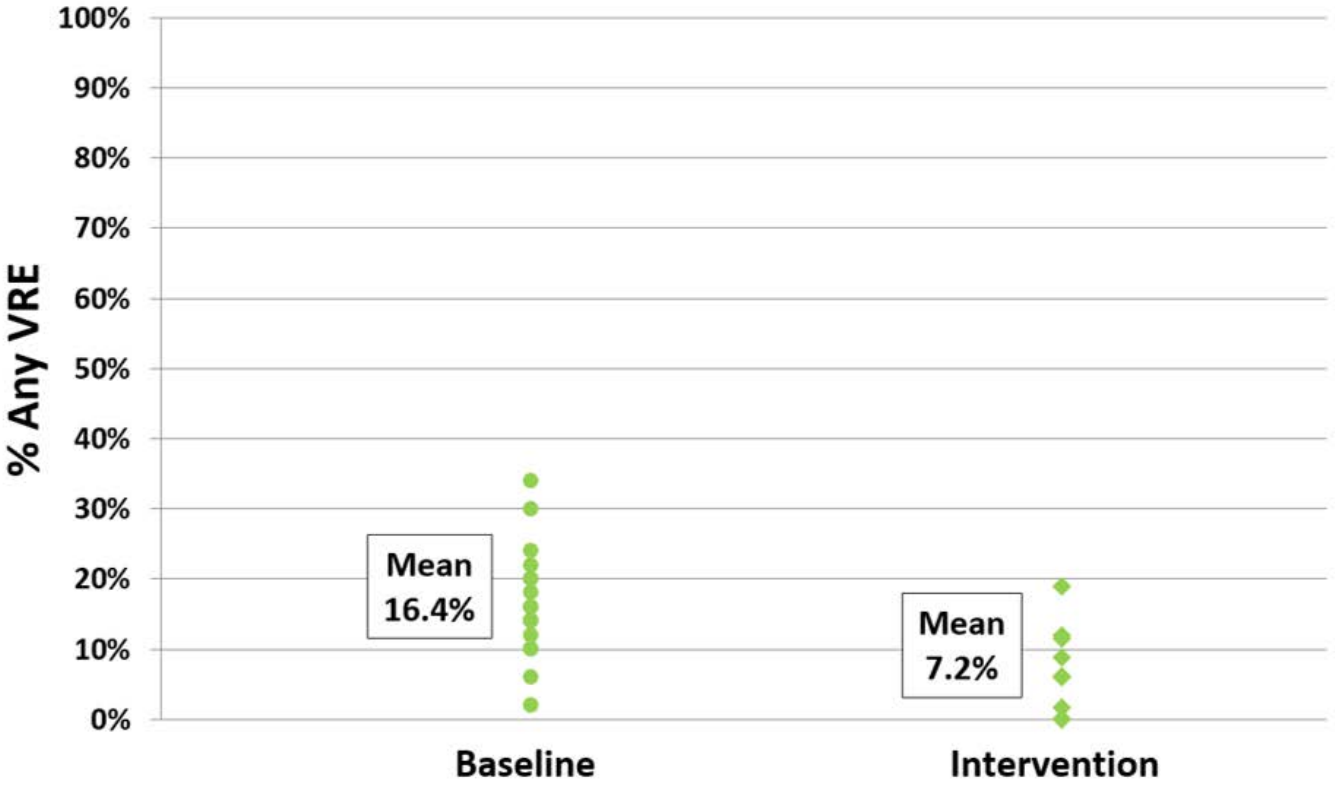
SHIELD Outcomes (cont)



SHIELD Outcomes (cont)

SHIELD Impact: Nursing Homes

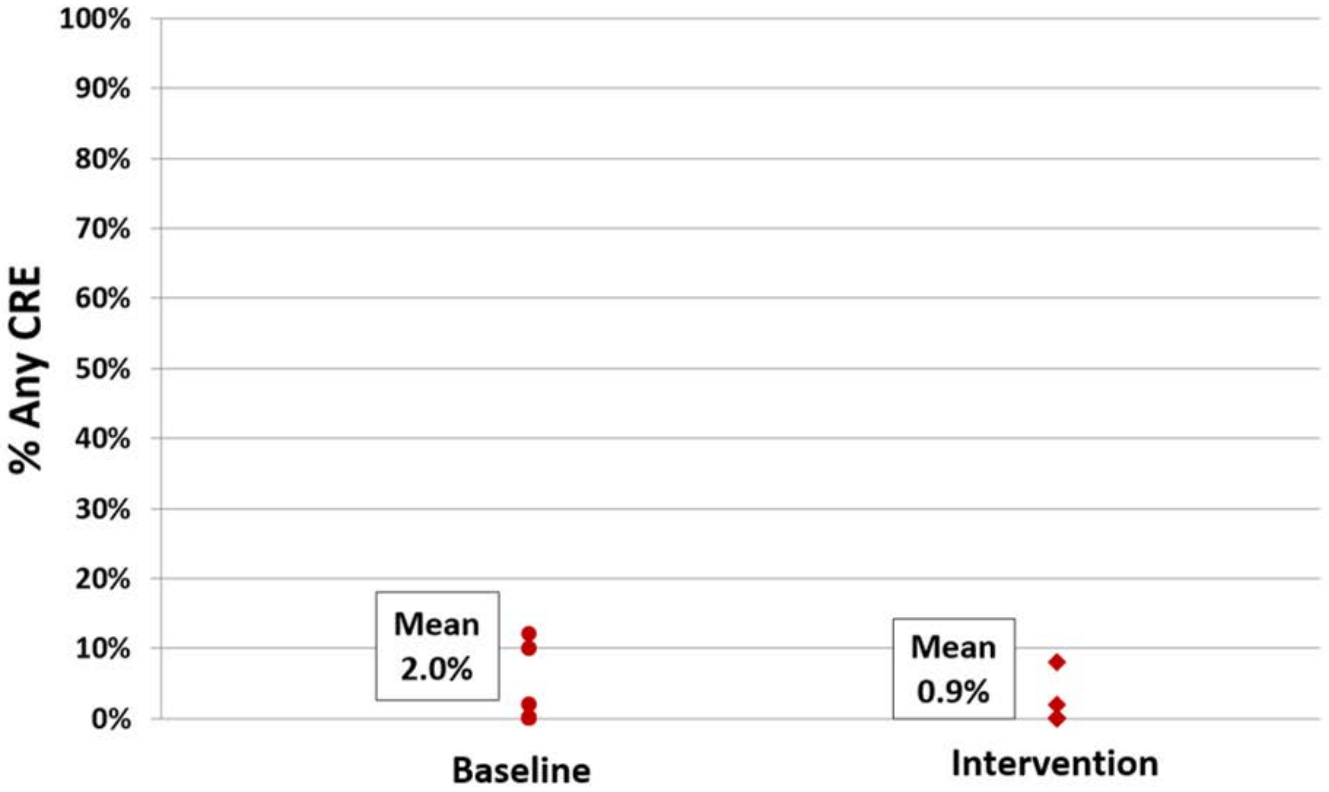
56% reduction in VRE



SHIELD Outcomes (cont)

SHIELD Impact: Nursing Homes

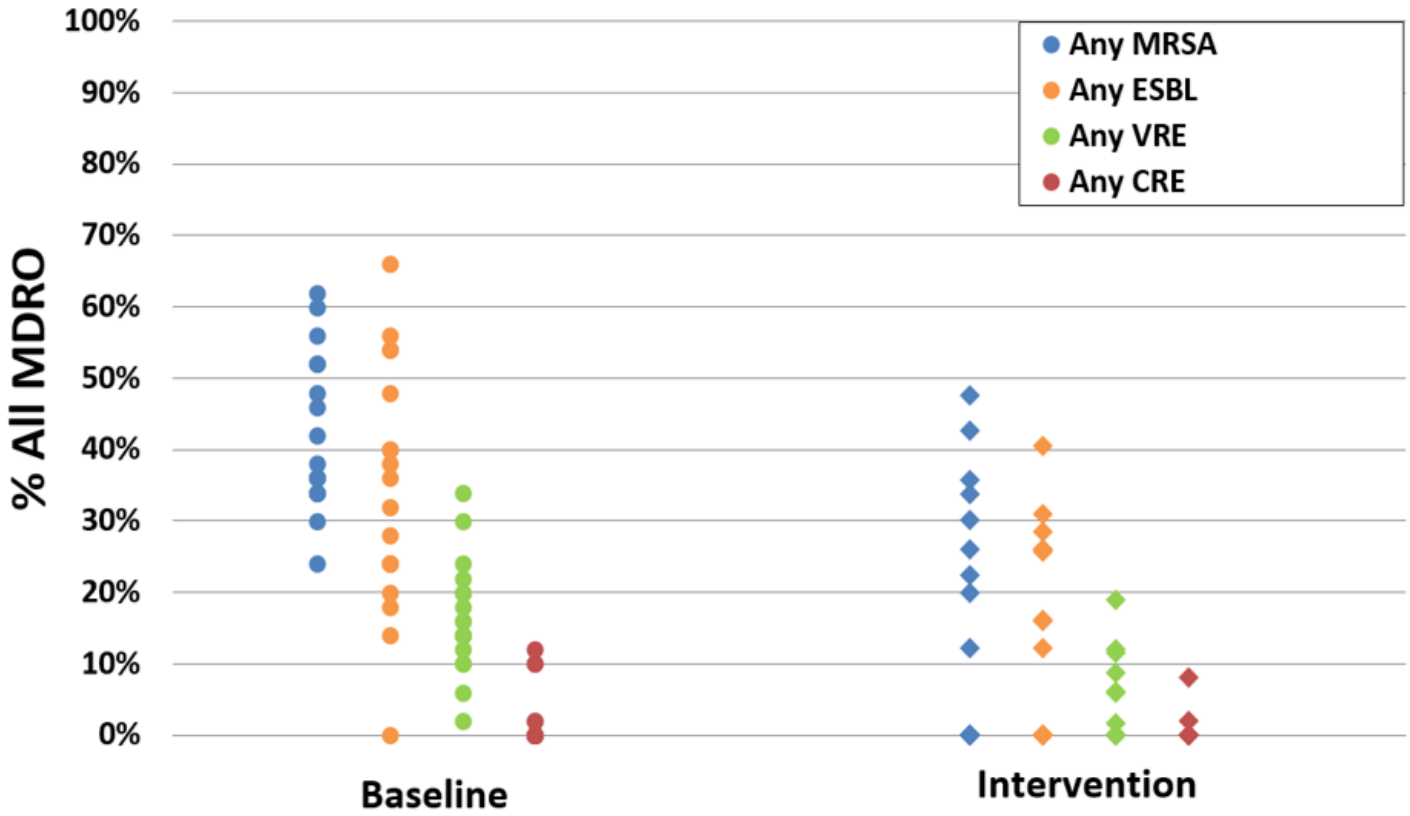
55% reduction in CRE



SHIELD Outcomes (cont)

SHIELD Impact: Nursing Homes

25% reduction in all MDROs



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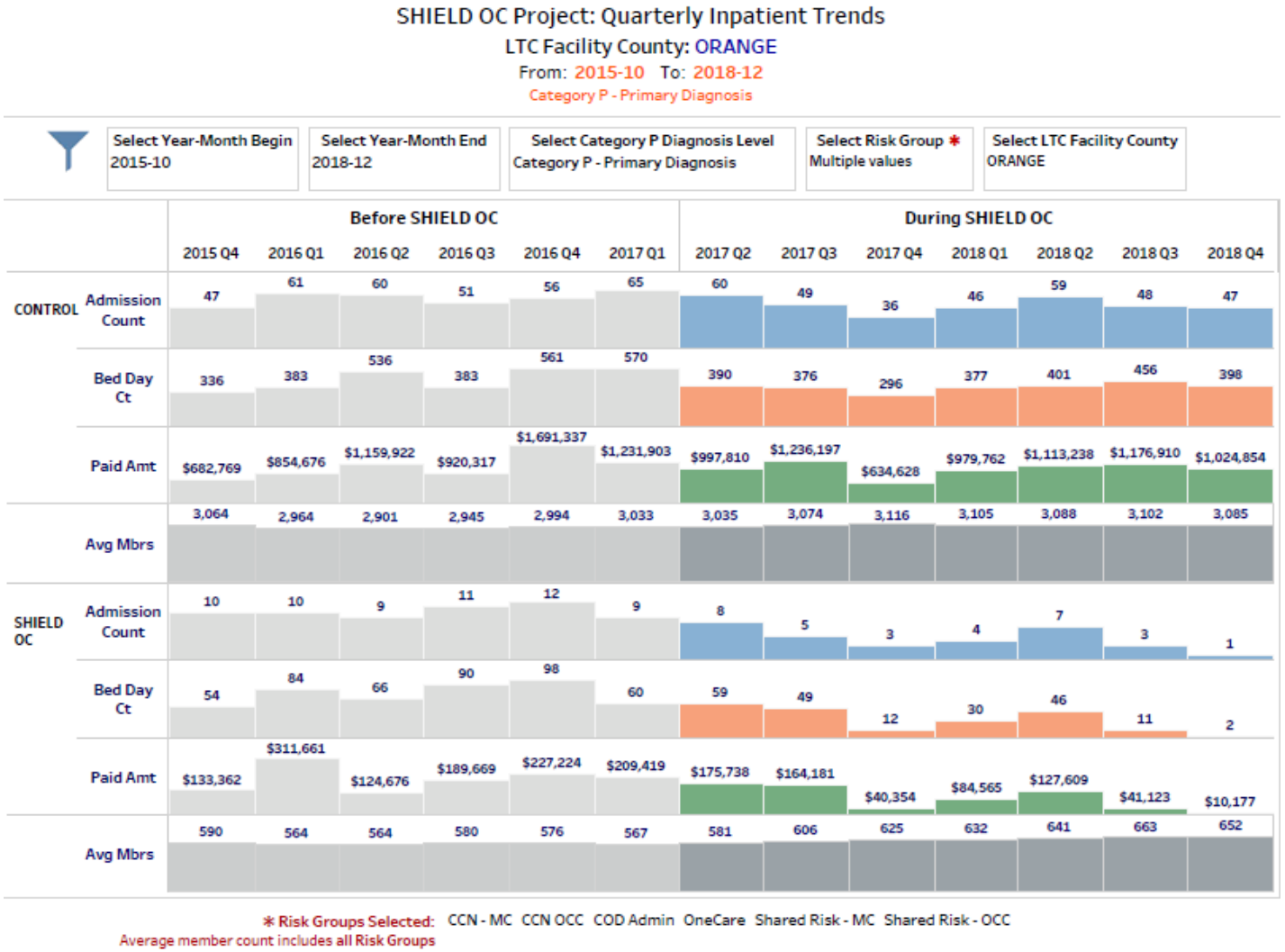
Quarterly Inpatient Trends



SHIELD OC Project: Quarterly Inpatient Trends
LTC Facility County: ORANGE
From: 2015-10 To: 2018-12
Category P - Primary Diagnosis

Select Year-Month Begin	Select Year-Month End	Select Category P Diagnosis Level	Select Risk Group *	Select LTC Facility County
2015-10	2018-12	Category P - Primary Diagnosis	Multiple values	ORANGE

		Before SHIELD OC						During SHIELD OC						
		2015 Q4	2016 Q1	2016 Q2	2016 Q3	2016 Q4	2017 Q1	2017 Q2	2017 Q3	2017 Q4	2018 Q1	2018 Q2	2018 Q3	2018 Q4
CONTROL	Admission Count	47	61	60	51	56	65	60	49	36	46	59	48	47
	Bed Day Ct	336	383	536	383	561	570	390	376	296	377	401	456	398
	Paid Amt	$682,769	$854,676	$1,159,922	$920,317	$1,691,337	$1,231,903	$997,810	$1,236,197	$634,628	$979,762	$1,113,238	$1,176,910	$1,024,854
	Avg Mbrs	3,064	2,964	2,901	2,945	2,994	3,033	3,035	3,074	3,116	3,105	3,088	3,102	3,085
SHIELD OC	Admission Count	10	10	9	11	12	9	8	5	3	4	7	3	1
	Bed Day Ct	54	84	66	90	98	60	59	49	12	30	46	11	2
	Paid Amt	$133,362	$311,661	$124,676	$189,669	$227,224	$209,419	$175,738	$164,181	$40,354	$84,565	$127,609	$41,123	$10,177
	Avg Mbrs	590	564	564	580	576	567	581	606	625	632	641	663	652

* Risk Groups Selected: CCN - MC CCN OCC COD Admin OneCare Shared Risk - MC Shared Risk - OCC
Average member count includes all Risk Groups

Admission counts and costs significantly lower in the SHIELD OC group

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Quarterly Inpatient Trends

- 16 contracted facilities utilizing the CHG program:
  - Inpatient costs for infection for 6 quarters prior to the Chlorhexidine protocol = $1,196,011
  - Inpatient costs for the last 6 quarters following training and use of CHG protocol = $468,009
    - $728,002 lowered inpatient expenditure (61%) for infection in the participating facilities

- 51 contracted facilities not utilizing the CHG program:
  - Inpatient costs for the last 6 quarters =$6,165,589
  - Potential 61% lowered inpatient expenditure for infection = $3,761,009 if the CHG protocol had been expanded

SHIELD Impact on CalOptima

- Adoption of the SHIELD protocol is well-supported by the Center for Disease Control
  - Plan for extended use of an existing trainer in OC for one year
  - Plan for extended monitoring of Orange County MDROs for one year
- 25% decrease in MDRO prevalence translates to the following for CalOptima's LTC population of 3,800 members as of December 2018:
  - Decreased infection-related hospitalizations
  - An opportunity for a significant advancement in population health management
  - Practice transformation for skilled nursing facilities in fulfillment of National Committee for Quality Assurance (NCQA) requirements
  - Continuation of cost savings

CalOptima Post-Acute Infection Prevention Quality Initiative

- Adoption of the SHIELD protocol in all 67 CalOptima post-acute contracted facilities (long-term care and subacute facilities) will:
  - Support the continuation of care in the 16 participating facilities as Phase 2 without loss of momentum
  - Initiate the chlorhexidine bathing protocol in the remaining facilities as Phase 1 utilizing the CDC-supported trainer
  - Require quarterly reporting and fulfillment of quality measures with payments proportional to compliance
  - Include a trainer provided by the CDC for one year
  - Train current CalOptima LTSS nurses to quantify best practices and oversee compliance
  - Provide consideration around adding this patient safety initiative as a Pay 4 Value (P4V) opportunity to the next quality plan

Recommended Actions

- Authorize establishment of a Multi-Drug-Resistant Organisms (MDRO) suppression quality initiative; and
- Authorize the distribution of up to $2.3 million in FY 2019-20 CalOptima Medi-Cal funds in payments to providers meeting criteria for payment under this MDRO suppression quality initiative.

CalOptima's Mission

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

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Shared
Healthcare
Intervention to
Eliminate
Life-threatening
Dissemination of MDROs in
Orange County

SHIELD Orange County – *Together We Can Make a Difference!*

What is SHIELD Orange County?

SHIELD OC is a public health collaborative initiated by the Centers for Disease Control and Prevention (CDC) to combat the spread of endemic and emerging multi-drug resistant organisms (MDROs) across healthcare facilities in Orange County. This effort is supported by the California Department of Public Health (CDPH) and the Orange County Health Care Agency (OCHCA). This regional collaborative will implement a decolonization strategy to reduce transmission of MDROs both countywide and within healthcare facilities.

Visit our CDC webpage here!
https://www.cdc.gov/hai/research/cdc-mdro-project.html

SHIELD OC Goals:

- Reduce MDRO carriage
- Reduce countywide MDRO clinical cultures
- Assess impact in participants and non-participants

SHIELD OC is coordinated by the University of California Irvine and LA BioMed at Harbor-UCLA.

Who is participating?

38 healthcare facilities are participating in SHIELD OC. These facilities were invited to participate based on their inter-connectedness by patient sharing statistics. In total, participants include 17 hospitals, 3 long-term acute care hospitals (LTACHs), and 18 nursing homes.

What is the decolonization intervention?

In the SHIELD OC collaborative, decolonization refers to the use of topical products to reduce bacteria on the body that can produce harmful infections.

- **Hospitals (for adult patients on contact precautions)**
  - Chlorhexidine (CHG) antiseptic soap for daily bathing or showering
  - Nasal decolonization with 10% povidone-iodine
  - Continue CHG bathing for adult patients in ICU units
- **Nursing homes and LTACHs**
  - Chlorhexidine (CHG) antiseptic soap for routine bathing and showering
  - Nasal decolonization with 10% povidone-iodine on admission and every other week

All treatments used for decolonization are topical and their safety profile is excellent.

With questions, please contact the SHIELD OC Coordinating Team

(949) 824-7806 or SHIELDOrangeCounty@gmail.com

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CalOptima Checklist

Nursing Home Name: _____

Month Audited (Month/year): _____/_____

Today's Date: _____/_____/_____

Completed by: _____

- ☐ Proof of product purchase
- ☐ Evidence the decolonization program handout is in admission packet
- ☐ Monitor and document compliance with bathing one day each week
- ☐ Monitor and document compliance with iodophor one day each week iodophor is used
- ☐ Conduct three peer-to-peer bathing skills assessments per month

Product Usage

PRODUCT DESCRIPTION	RECEIPT PROVIDED	QUANTITY DELIVERED	ESTIMATED MONTHLY USAGE
4% CHG Gallons	☐	_____ gallons	_____ gallons
10% Iodine Swabsticks	☐	_____ boxes	_____ boxes
		_____ swabs per box	

INTERNAL USE ONLY –APPROVAL:

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Facility Name: _____Unit: _____ Date: _____

STAFF Skills Assessment:
CHG Bed Bath Observation Checklist

Individual Giving CHG Bath

Please indicate who performed the CHG bath.

☐ **Nursing Assistant (CNA)** ☐ **Nurse** ☐ **LVN** ☐ **Other: _____**

Observed CHG Bathing Practices

Please check the appropriate response for each observation.

☐ **Y** ☐ **N** **Resident received CHG bathing handout**
☐ **Y** ☐ **N** **Resident told that no rinse bath provides protection from germs**
☐ **Y** ☐ **N** **Provided rationale to the resident for not using soap at any time while in unit**
☐ **Y** ☐ **N** **Massaged skin *firmly* with CHG cloth to ensure adequate cleansing**
☐ **Y** ☐ **N** **Cleaned face and neck well**
☐ **Y** ☐ **N** **Cleaned between fingers and toes**
☐ **Y** ☐ **N** **Cleaned between all folds**
☐ **Y** ☐ **N** ☐ **N/A** **Cleaned occlusive and semi-permeable dressings with CHG cloth**
☐ **Y** ☐ **N** ☐ **N/A** **Cleaned 6 inches of all tubes, central lines, and drains closest to body**
☐ **Y** ☐ **N** ☐ **N/A** **Used CHG on superficial wounds, rash, and stage 1 & 2 decubitus ulcers**
☐ **Y** ☐ **N** ☐ **N/A** **Used CHG on surgical wounds (unless primary dressing or packed)**
☐ **Y** ☐ **N** **Allowed CHG to air-dry / does not wipe off CHG**
☐ **Y** ☐ **N** **Disposed of used cloths in trash /does not flush**

Query to Bathing Assistant/Nurse

1. How many cloths were used for the bath?

_____

2. If more than 6 cloths was used, provide reason.

_____

3. Are you comfortable applying CHG to superficial wounds, including surgical wounds?

_____

4. Are you comfortable applying CHG to lines, tubes, drains and non-gauze dressings?

_____

5. Do you ever wipe off the CHG after bathing?

_____

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ORIGINAL ARTICLE

Decolonization to Reduce Postdischarge Infection Risk among MRSA Carriers

S.S. Huang, R. Singh, J.A. McKinnell, S. Park, A. Gombosev, S.J. Eells, D.L. Gillen, D. Kim, S. Rashid, R. Macias-Gil, M.A. Bolaris, T. Tjoa, C. Cao, S.S. Hong, J. Lequieu, E. Cui, J. Chang, J. He, K. Evans, E. Peterson, G. Simpson, P. Robinson, C. Choi, C.C. Bailey, Jr., J.D. Leo, A. Amin, D. Goldmann, J.A. Jernigan, R. Platt, E. Septimus, R.A. Weinstein, M.K. Hayden, and L.G. Miller, for the Project CLEAR Trial

ABSTRACT

BACKGROUND

Hospitalized patients who are colonized with methicillin-resistant *Staphylococcus aureus* (MRSA) are at high risk for infection after discharge.

METHODS

We conducted a multicenter, randomized, controlled trial of postdischarge hygiene education, as compared with education plus decolonization, in patients colonized with MRSA (carriers). Decolonization involved chlorhexidine mouthwash, baths or showers with chlorhexidine, and nasal mupirocin for 5 days twice per month for 6 months. Participants were followed for 1 year. The primary outcome was MRSA infection as defined according to Centers for Disease Control and Prevention (CDC) criteria. Secondary outcomes included MRSA infection determined on the basis of clinical judgment, infection from any cause, and infection-related hospitalization. All analyses were performed with the use of proportional-hazards models in the per-protocol population (all participants who underwent randomization, met the inclusion criteria, and survived beyond the recruitment hospitalization) and as-treated population (participants stratified according to adherence).

RESULTS

In the per-protocol population, MRSA infection occurred in 98 of 1063 participants (9.2%) in the education group and in 67 of 1058 (6.3%) in the decolonization group; 84.8% of the MRSA infections led to hospitalization. Infection from any cause occurred in 23.7% of the participants in the education group and 19.6% of those in the decolonization group; 85.8% of the infections led to hospitalization. The hazard of MRSA infection was significantly lower in the decolonization group than in the education group (hazard ratio, 0.70; 95% confidence interval [CI], 0.52 to 0.96; P=0.03; number needed to treat to prevent one infection, 30; 95% CI, 18 to 230); this lower hazard led to a lower risk of hospitalization due to MRSA infection (hazard ratio, 0.71; 95% CI, 0.51 to 0.99). The decolonization group had lower likelihoods of clinically judged infection from any cause (hazard ratio, 0.83; 95% CI, 0.70 to 0.99) and infection-related hospitalization (hazard ratio, 0.76; 95% CI, 0.62 to 0.93); treatment effects for secondary outcomes should be interpreted with caution owing to a lack of prespecified adjustment for multiple comparisons. In as-treated analyses, participants in the decolonization group who adhered fully to the regimen had 44% fewer MRSA infections than the education group (hazard ratio, 0.56; 95% CI, 0.36 to 0.86) and had 40% fewer infections from any cause (hazard ratio, 0.60; 95% CI, 0.46 to 0.78). Side effects (all mild) occurred in 4.2% of the participants.

CONCLUSIONS

Postdischarge MRSA decolonization with chlorhexidine and mupirocin led to a 30% lower risk of MRSA infection than education alone. (Funded by the AHRQ Healthcare-Associated Infections Program and others; ClinicalTrials.gov number, NCT01209234.)

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Methicillin-resistant *Staphylococcus aureus* (MRSA) causes more than 80,000 invasive infections in the United States annually.[1] It is the most common cause of skin, soft-tissue, and procedure-related infections.[2] Rates of invasive MRSA infection are highest within 6 months after hospital discharge and do not normalize for 1 year.[1,3,4]

Approaches to MRSA have included education about both hygiene and environmental cleaning as well as decolonization with nasal mupirocin and chlorhexidine antiseptic baths to reduce carriage and prevent infection.[5,6] Decolonization has reduced the risks of surgical-site infection, recurrent skin infection, and infection in the intensive care unit (ICU).[7-10] Our goal was to evaluate whether, after hospital discharge, decolonization plus hygiene education was superior to education alone in reducing the likelihood of MRSA infection among patients colonized with MRSA (carriers).

Methods

Trial Design and Intervention

We conducted the Project CLEAR (Changing Lives by Eradicating Antibiotic Resistance) Trial as a multicenter, two-group, unblinded, randomized, controlled trial to compare the effect of hygiene education with that of education plus decolonization on the likelihood of postdischarge infection among MRSA carriers. This trial was approved by the institutional review board of the University of California Irvine. The authors vouch for the accuracy and completeness of the data and for the fidelity of the trial to the protocol, available with the full text of this article at NEJM.org.

Participants were randomly assigned, in a 1:1 ratio, to the education group or the decolonization group. Randomization was performed with a randomized block design stratified according to Hispanic ethnic group and nursing home residence. In the education group, participants received and reviewed an educational binder (provided in English and Spanish) about MRSA and how it is spread and about recommendations for personal hygiene, laundry, and household cleaning (Appendix A in the Supplementary Appendix, available at NEJM.org). In the decolonization group, participants received and reviewed the identical educational binder and also underwent decolonization for 5 days twice monthly for a period of 6 months after hospital discharge (Appendix B in the Supplementary Appendix). The decolonization intervention involved the use of 4% rinse-off chlorhexidine for daily bathing or showering, 0.12% chlorhexidine mouthwash twice daily, and 2% nasal mupirocin twice daily. All products were purchased with grant funds and were provided free of charge to the participants.

Recruitment and Eligibility Criteria

Recruitment involved written informed consent provided between January 10, 2011, and January 2, 2014, during inpatient admissions in 17 hospitals and 7 nursing homes in Southern California (Table S1 in the Supplementary Appendix). Eligibility requirements included an age of 18 years or older, hospitalization within the previous 30 days, positive testing for MRSA during the enrollment hospitalization or within the 30 days before or afterward, and the ability to bathe or shower (alone or assisted by a caregiver). Key exclusion criteria were hospice care and allergy to the decolonization products at recruitment. California mandates MRSA screening at hospital admission in high-risk patients: those undergoing hemodialysis, those who had a recent hospitalization (within the preceding 30 days), those who were undergoing imminent surgery, those who were admitted to the ICU, and those who were transferred from a nursing home.

Follow-up

Participants were followed for 12 months after discharge. In-person visits at home or in a research clinic occurred at recruitment and at months 1, 3, 6, and 9. An exit interview was conducted at 12 months. The trial had a fixed end date of June 30, 2014. Participants who were enrolled after July 1, 2013, had a truncated follow-up and had their data administratively censored at that time. Loss to follow-up was defined as the inability of trial staff to contact participants for 3 months, at which point the participant was removed from the trial as of the date of last contact. Participants received escalating compensation for completing follow-up visits ($25, $30, $35, and $50).

All participants were contacted monthly and requested to report any hospitalizations or clinic visits for infection. After trial closure, medical records from reported visits were requested, double-redacted for protected health information and trial-group assignment, and reviewed for trial outcomes. Records from enrollment hospi-

talizations were requested and reviewed for characteristics of the participants and the presence or absence of MRSA infection at the enrollment hospitalization. Records were requested up to five times, with five additional attempts to address incomplete records.

TRIAL OUTCOMES

Redacted medical records from enrollment hospitalizations and all reported subsequent medical visits were reviewed in a blinded fashion, with the use of standardized forms, by two physicians with expertise in infectious diseases (five of the authors) for coexisting conditions, antibiotic agents, and infection outcomes. If consensus was not reached, discordant outcomes were adjudicated by a third physician with expertise in infectious diseases.

The primary outcome was MRSA infection according to medical-record documentation of disease-specific infection criteria (according to 2013 guidelines) from the Centers for Disease Control and Prevention (CDC) in a time-to-event analysis.[11] A priori secondary outcomes included MRSA infection defined in a time-to-event analysis according to the clinical judgment of two reviewers with expertise in infectious diseases who were unaware of the trial-group assignments, infection from any cause according to disease-specific CDC criteria in a time-to-event analysis, infection from any cause according to infectious disease clinical judgment in a time-to-event analysis, hospitalization due to infection, and new carriage of a MRSA strain that was resistant to mupirocin (evaluated by Etest, bioMérieux)[12] or that had an elevated minimum inhibitory concentration (MIC) of chlorhexidine (≥8 μg per milliliter) on microbroth dilution.[13,14] All outcomes were assessed on the basis of the first event per participant.

DATA COLLECTION

Surveys of health conditions, health care utilization, and household cleaning and bathing habits were administered during recruitment and all follow-up visits. Swabs of both nares, the throat, skin (axilla and groin), and any wounds were taken, but the results are not reported here. At each visit, participants in the decolonization group reported adherence to the intervention, and staff assessed the remaining product. Potential discrepancies were broached with the participant to obtain affirmation of actual adherence. Adherence was assessed as full (no missed doses), partial (some missed doses), and nonadherence (no doses used).

STATISTICAL ANALYSIS

The characteristics of the participants and outcomes were described by frequency and type according to trial group. Outcomes were summarized with the use of Kaplan–Meier estimates of infection-free distributions across the follow-up period and analyzed with the use of unadjusted Cox proportional-hazard models (per-protocol primary analysis) for the postdischarge trial population (all the participants who underwent randomization, met inclusion criteria, and survived beyond the recruitment hospitalization); outcomes were also analyzed according to the as-treated adherence strata (fully adherent, partially adherent, and nonadherent participant-time). In the as-treated analyses, information about participant adherence during at-risk periods before each visit was updated with the use of the adherence assessment at that visit.

The assumption of proportional hazards was assessed by means of residual diagnostic tests and formal hypothesis tests. P values are provided only for the primary outcome. Because the statistical analysis plan did not include a provision for correction for multiple comparisons when tests for prespecified secondary outcomes or post hoc exploratory outcomes were conducted, those results are reported as point estimates with 95% confidence intervals. The widths of the confidence intervals were not adjusted for multiple comparisons, so intervals should not be used to infer definitive treatment effects within subgroups or for secondary outcomes.

In post hoc exploratory analyses, we used adjusted Cox proportional-hazard models to address potential residual imbalances in the characteristics of the participants between the two groups after randomization. The characteristics of the participants were entered into the model if they were associated with outcomes at a P value of less than 0.20 in bivariate analyses. Characteristics included demographic data; educational level; insurance type; presence of coexisting conditions, devices, or wounds at enrollment; hospitalization or residence in a nursing home in the year before enrollment; ICU admission or surgery during enrollment hospitalization; need

for assistance with bathing; frequency of bathing; and randomization strata. Adjusted models also accounted for two time-dependent covariates: receipt of anti-MRSA antibiotics and adherence to the intervention. The number needed to treat was calculated with the use of rates that accounted for participant-time that incorporated censoring due to loss to follow-up, withdrawal from the trial, or the end of the trial.[15] Full details of the trial design and analytic approach are provided in the protocol and in the Supplementary Appendix.

RESULTS

PARTICIPANTS

Figure 1 shows the randomization and follow-up of 2140 participants, of whom 19 were excluded after randomization because they did not meet inclusion criteria (6 participants did not have a positive MRSA test, and 13 died during the enrollment hospitalization). The characteristics of the final 2121 enrolled participants (per-protocol population) are provided in Table 1, and in Tables S2 through S4 in the Supplementary Appendix.

According to the randomization strata, Hispanic participants made up 31.9% of the education group (339 participants) and 32.0% of the decolonization group (339), and nursing home residents made up 11.3% of the education group (120) and 11.0% of the decolonization group (116). In a comparison of the education group with the decolonization group across the 1-year follow-up, early exit from the trial occurred in 34.9% of the participants (371 participants) and 37.0% (391), respectively ($P=0.32$); withdrawal from the trial in 6.8% (72) and 11.6% (123), respectively ($P<0.001$); loss to follow-up in 17.4% (185) and 16.1% (170), respectively ($P=0.41$); and death in 10.7% (114) and 9.3% (98), respectively ($P=0.26$). The characteristics of the participants who withdrew from the trial or were lost to follow-up and of the participants in the decolonization group according to adherence category are shown in Table S5 in the Supplementary Appendix.

OUTCOMES

A total of 8395 full-text medical records were requested, and 8067 (96.1%) were received and redacted. Charts underwent duplicate blinded review (16,134 reviews) by physicians with expertise in infectious diseases at a rate of approximately 800 charts per month for 20 months. Of the 2121 enrollment admission records, 2100 (99.0%) were received. Of the 6271 subsequent inpatient and outpatient records, 5967 (95.2%) were received for outcome assessment. The overall rate of reported hospitalizations per 365 days of follow-up was 1.97 in the education group and 1.75 in the decolonization group.

Regarding the primary outcome in the per-protocol analysis, 98 participants (9.2%) in the education group had a MRSA infection, as compared with 67 (6.3%) in the decolonization group (Table 2). This corresponded to an estimated MRSA infection rate in the education group of 0.139 infections per participant-year, as compared with 0.098 infections per participant-year in the decolonization group. Among first MRSA infections per participant, skin and soft-tissue infections and pneumonia were common. Across both groups, 84.8% (140 of 165) of the MRSA infections resulted in hospitalization, at a rate of 0.117 hospitalizations per participant-year in the education group and 0.083 per participant-year in the decolonization group. Bacteremia occurred in 28.5% (47 of 165) of all MRSA infections; the MRSA bacteremia rate was 0.040 events per participant-year in the education group and 0.028 per participant-year in the decolonization group. Findings were similar when MRSA infection was determined according to the clinical judgment of physicians with expertise in infectious diseases and according to CDC criteria (Table 2). All the MRSA infections were treated with an antibiotic, but the receipt of an antibiotic was not sufficient to render a decision of a MRSA infection.

In the analysis of infection from any cause according to CDC criteria, 23.7% of the participants in the education group (252 participants) had an infection, as compared with 19.6% of those in the decolonization group (207), which corresponded to an estimated rate of 0.407 infections per participant-year in the education group and 0.338 per participant-year in the decolonization group (Table 2). Skin and soft-tissue infections and pneumonia remained the most common infection types.

Pathogens were identified in 67.7% of the infections (Table S6 in the Supplementary Appendix). Participants in the decolonization intervention had a lower rate of infections due to gram-positive pathogens or without cultured pathogens than those in the education group. There was a

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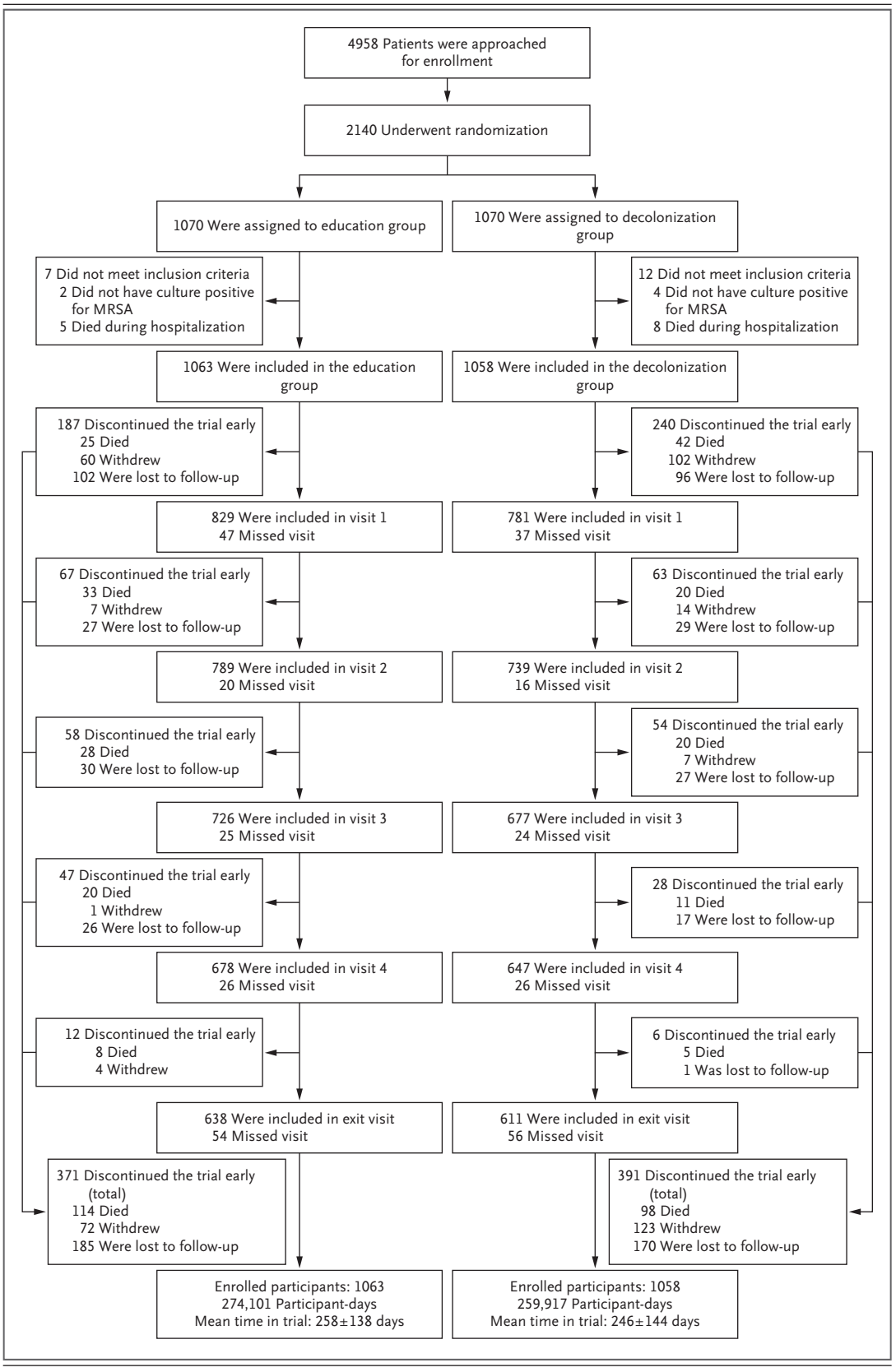

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Figure 1 (facing page). Randomization and Follow-up of the Participants.

This flow chart describes the recruitment and the four follow-up visits (at 1, 3, 6, and 9 months) for the 1-year period after hospital discharge. Recruitment occurred during hospitalization, and 19 participants were excluded from the postdischarge trial population because they did not meet inclusion criteria, leaving 2121 participants in the per-protocol population (1063 participants in the education group and 1058 in the decolonization group). Early exit from the trial was provided between each visit and included active withdrawal from the trial, loss to follow-up, and death. Active withdrawal represented situations in which participants indicated their desire to withdraw from the trial. Loss to follow-up was defined as the inability to contact the participant for 3 months, at which point the participant was removed from the trial at the time of last contact. Visits indicate both participants who successfully completed the visit and those who remained in the trial but missed that visit. The mean (±SD) time in the trial (in days) is shown for each group. All deaths were considered by the investigators to be unrelated to side effects from decolonization products. Summary boxes are provided at the bottom of the figure. MRSA denotes methicillin-resistant *Staphylococcus aureus*.

higher rate of gram-negative infection among the CDC-defined all-cause infections when participants in the decolonization intervention were compared with those in the education group, but this was not seen among clinically defined infections.

Across the two trial groups, infection from any cause led to hospitalization in 85.8% of the participants (394 of 459), and bacteremia occurred in 18.1% (83 of 459). The observed rate of hospitalization due to infection from any cause was 0.356 events per participant-year in the education group and 0.269 per participant-year in the decolonization group. The rate of bacteremia among participants with infection from any cause was 0.074 events per participant-year in the education group and 0.060 per participant-year in the decolonization group. Findings were similar when infection from any cause was determined according to clinical judgment (Table 2).

Estimates of the per-protocol treatment effects are shown in Table 3. No significant departures from proportional hazards were observed. In the main unadjusted analysis, the hazard of MRSA infection according to the CDC criteria (the primary outcome) was significantly lower in the decolonization group than in the education group (hazard ratio, 0.70; 95% confidence interval [CI], 0.52 to 0.96; P=0.03). This lower hazard of MRSA infection led to a 29% lower risk of hospitalization due to CDC-defined MRSA infection in the decolonization group than in the education group (hazard ratio, 0.71; 95% CI, 0.51 to 0.99). The effect was nearly identical for cases and hospitalizations involving clinically defined MRSA infection. Kaplan–Meier curves showing the infection-free time for the primary outcome of CDC-defined MRSA infection and the secondary outcome of infection from any cause show that the curves remained separated even after the intervention ended in month 6 (Fig. 2, and Table S7 in the Supplementary Appendix). Adjusted models showed greater MRSA infection effects that were significant (Table 3). A total of 10 participants (0.9%) in the education group and in 3 (0.3%) in the decolonization group died from MRSA infection. Results of sensitivity analyses conducted regarding death and early withdrawal from the trial are provided in Table S8 in the Supplementary Appendix.

The hazard of infection from any cause according to clinical judgment was lower in the decolonization group than in the education group (hazard ratio, 0.83; 95% CI, 0.70 to 0.99); similarly, the hazard of infection from any cause according to CDC criteria was lower in the decolonization group (hazard ratio, 0.84; 95% CI, 0.70 to 1.01) (Fig. 2B and Table 3). The risk of hospitalization due to infection from any cause was lower in the decolonization group than in the education group (hazard ratio, 0.76; 95% CI, 0.62 to 0.93). The results of the adjusted analyses were similar to those of the unadjusted analyses (Table 3). Deaths due to any infection occurred in 25 participants (2.3%) in the education group and 17 (1.6%) in the decolonization group.

EFFECT OF ADHERENCE

In as-treated analyses, 65.6% of the participant-time in the decolonization group involved full adherence; 19.6%, partial adherence; and 14.8%, nonadherence. Participants were highly consistent in adherence across the follow-up time. Increasing adherence was associated with increasingly lower rates of infection in both the adjusted and unadjusted models (Table 3). In comparisons of the adherence-category subgroups in the decolonization group with the education group overall, the likelihood of CDC-defined MRSA infection decreased 36% and 44%, respectively, as adher-

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Table 1. Characteristics of the Participants at Recruitment Hospitalization.*

Characteristic	Education Group (N=1063)	Decolonization Group (N=1058)	P Value†
Age — yr	56±17	56±17	0.78
Male sex — no. (%)	583 (54.8)	565 (53.4)	0.51
Coexisting conditions‡			
Diabetes — no./total no. (%)	424/1062 (39.9)	462/1056 (43.8)	0.08
Chronic obstructive pulmonary disease — no./total no. (%)	212/1055 (20.1)	203/1045 (19.4)	0.70
Congestive heart failure — no./total no. (%)	145/1055 (13.7)	149/1045 (14.3)	0.73
Cancer — no./total no. (%)	153/1055 (14.5)	161/1045 (15.4)	0.56
Renal disease — no./total no. (%)	140/1062 (13.2)	134/1056 (12.7)	0.74
Charlson Comorbidity Index score§	1.7±1.6	1.7±1.6	0.49
Bathe daily or every other day — no./total no. (%)¶	926/1037 (89.3)	927/1034 (89.7)	0.73
Bathing assistance needed — no./total no. (%)¶	200/1025 (19.5)	224/1013 (22.1)	0.15
MRSA source at enrollment — no. (%)			0.79
Nares‖	580 (54.6)	602 (56.9)	
Wound	320 (30.1)	305 (28.8)	
Respiratory	44 (4.1)	45 (4.3)	
Blood	43 (4.0)	31 (2.9)	
Other	76 (7.1)	75 (7.1)	
Recruitment hospitalization**			
Hospitalized in previous yr — no./total no. (%)‡	595/1046 (56.9)	598/1041 (57.4)	0.80
Nursing home stay in previous yr — no./total no. (%)‡	165/1043 (15.8)	168/1040 (16.2)	0.84
ICU stay — no./total no. (%)	188/1055 (17.8)	206/1045 (19.7)	0.27
Surgery — no./total no. (%)	392/1055 (37.2)	399/1045 (38.2)	0.63
MRSA infection — no./total no. (%)††	447/1055 (42.4)	438/1045 (41.9)	0.83
Wound at hospital discharge — no./total no. (%)	587/1055 (55.6)	588/1045 (56.3)	0.77
Medical device at hospital discharge — no./total no. (%)‡‡	320/1055 (30.3)	307/1045 (29.4)	0.63
Discharged to nursing home — no. (%)	120 (11.3)	116 (11.0)	0.81

* Plus–minus values are means ±SD. There were no significant differences between the two groups. Selected descriptive data are shown. For a full descriptive list of characteristics, see Table S2 in the Supplementary Appendix. ICU denotes intensive care unit.
† Student's t-test was performed for continuous variables, chi-square test for proportions, and Fisher's exact test for proportions if the numerator was 5 or less.
‡ Data reflect a positive response to either a survey question or chart review. Not all participants responded to every question, and not all enrollment charts were received from recruiting hospitals despite a signed release request, so data were missing for 21 participants.
§ Scores on the Charlson Comorbidity Index range from 0 to 10, with higher scores indicating more coexisting illness.
¶ Data reflect respondents to the survey question among all the participants. Not all the participants responded to every question.
‖ By law, California requires hospitals to screen five groups of patients for MRSA on hospital admission (patients who are transferred from a nursing home, who have been hospitalized in the past 30 days, who are undergoing hemodialysis, who are undergoing imminent surgery, and who are admitted to an ICU).
** Data reflect chart review from the received medical records. Not all recruiting hospitals released participants' medical records to the trial despite a signed release request, so records were missing for 21 participants.
†† Assessment of infection was based on criteria of the Centers for Disease Control and Prevention (CDC). Information regarding infection types is provided in Table S3 in the Supplementary Appendix.
‡‡ Information about medical device types is provided in Table S4 in the Supplementary Appendix.

ence increased from partial adherence (hazard ratio, 0.64; 95% CI, 0.40 to 1.00) to full adherence (hazard ratio, 0.56; 95% CI, 0.36 to 0.86). Similar effects were seen with regard to CDC-defined infection from any cause, which was 40% lower among fully adherent participants than among the participants in the education group (hazard ratio, 0.60; 95% CI, 0.46 to 0.78).

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Table 2. MRSA Infection Outcomes (First Infection per Person) per 365 Days of Follow-up, According to Trial Group.*

Variable	MRSA Infection, According to CDC Criteria†		MRSA Infection, According to Clinical Criteria		Any Infection, According to CDC Criteria		Any Infection, According to Clinical Criteria	
	Education	Decolonization	Education	Decolonization	Education	Decolonization	Education	Decolonization
All Participants								
Infection — no. of participants (no. of events/participant-yr)								
Any infection	98 (0.139)	67 (0.098)	98 (0.139)	68 (0.100)	252 (0.407)	207 (0.338)	298 (0.498)	246 (0.414)
Skin or soft-tissue infection	34 (0.048)	32 (0.047)	35 (0.050)	32 (0.047)	80 (0.129)	59 (0.096)	97 (0.162)	82 (0.138)
Pneumonia	18 (0.026)	9 (0.013)	20 (0.028)	10 (0.015)	39 (0.063)	25 (0.041)	45 (0.075)	34 (0.057)
Primary bloodstream or vascular infection	11 (0.016)	10 (0.015)	12 (0.017)	11 (0.016)	20 (0.032)	14 (0.023)	20 (0.033)	14 (0.024)
Bone or joint infection	13 (0.019)	9 (0.013)	12 (0.017)	8 (0.012)	20 (0.032)	22 (0.036)	0.18 (0.030)	17 (0.029)
Surgical-site infection	13 (0.019)	2 (0.003)	13 (0.018)	2 (0.003)	20 (0.032)	8 (0.013)	22 (0.037)	9 (0.015)
Urinary tract infection	3 (0.004)	2 (0.003)	1 (0.001)	1 (0.002)	38 (0.061)	46 (0.075)	52 (0.087)	56 (0.094)
Abdominal infection	1 (0.001)	2 (0.003)	1 (0.001)	2 (0.003)	20 (0.032)	21 (0.034)	26 (0.044)	18 (0.030)
Other infection	5 (0.007)	1 (0.002)	4 (0.006)	2 (0.003)	15 (0.024)	12 (0.020)	18 (0.030)	16 (0.027)
Infection involving bacteremia	28 (0.040)	19 (0.028)	27 (0.038)	18 (0.026)	46 (0.074)	37 (0.060)	46 (0.077)	33 (0.056)
Infection leading in hospitalization	83 (0.117)	57 (0.083)	82 (0.115)	56 (0.082)	225 (0.356)	169 (0.269)	259 (0.420)	199 (0.325)
Time to infection — days	111±91	117±93	116±94	117±95	103±87	110±91	107±91	113±94
Adherent Participants in Decolonization Group‡								
Infection — no. of participants (no. of events/participant-yr)								
Any infection		42 (0.085)		42 (0.088)		118 (0.272)		142 (0.338)
Skin or soft-tissue infection		22 (0.045)		22 (0.046)		40 (0.092)		54 (0.129)
Pneumonia		5 (0.010)		5 (0.011)		11 (0.025)		16 (0.038)
Primary bloodstream or vascular infection		5 (0.010)		6 (0.013)		8 (0.019)		8 (0.019)
Bone or joint infection		5 (0.010)		4 (0.008)		14 (0.032)		11 (0.026)
Surgical-site infection		2 (0.004)		2 (0.004)		6 (0.014)		7 (0.017)
Urinary tract infection		0		0		22 (0.051)		27 (0.064)
Abdominal infection		2 (0.004)		2 (0.004)		12 (0.028)		11 (0.026)
Other infection		1 (0.002)		1 (0.002)		5 (0.012)		8 (0.019)
Infection involving bacteremia		9 (0.019)		8 (0.017)		19 (0.045)		16 (0.039)
Infection leading to hospitalization		36 (0.075)		34 (0.071)		98 (0.226)		115 (0.274)
Time to infection — days		122±93		125±96		119±89		123±94

* Participant-day denominators were censored by the specified outcome. Dates of infection onset based on CDC criteria may differ from those based on clinical judgment.
† This was the primary outcome.
‡ A total of 546 participants were considered to have adhered fully to the decolonization intervention.

Table 3. Effect of Decolonization Plus Education, as Compared with Education Alone, According to Cox Proportional-Hazard Models.*

Variable	MRSA Infection, According to CDC Criteria	MRSA Infection, According to Clinical Criteria	Any Infection, According to CDC Criteria	Any Infection, According to Clinical Criteria
Per-protocol analysis				
Unadjusted hazard ratio (95% CI)	0.70 (0.52–0.96)†	0.71 (0.52–0.97)	0.84 (0.70–1.01)	0.83 (0.70–0.99)
Adjusted hazard ratio (95% CI)‡	0.61 (0.44–0.85)	0.61 (0.43–0.84)	0.80 (0.66–0.98)	0.81 (0.68–0.97)
As-treated analysis§				
Unadjusted hazard ratio (95% CI)				
Nonadherent	1.31 (0.72–2.38)	1.09 (0.57–2.10)	1.68 (1.19–2.36)	1.53 (1.11–2.13)
Partially adherent	0.64 (0.40–1.00)	0.72 (0.47–1.11)	0.86 (0.67–1.11)	0.92 (0.74–1.16)
Fully adherent	0.56 (0.36–0.86)	0.53 (0.34–0.83)	0.60 (0.46–0.78)	0.58 (0.45–0.74)
Adjusted hazard ratio (95% CI)¶				
Nonadherent	0.78 (0.36–1.71)	0.72 (0.37–1.41)	0.780 (0.51–1.26)	0.76 (0.40–1.45)
Partially adherent	0.75 (0.59–0.95)	0.69 (0.54–0.88)	0.78 (0.64–0.97)	0.76 (0.63–0.92)
Fully adherent	0.72 (0.57–0.92)	0.66 (0.51–0.84)	0.75 (0.60–0.94)	0.72 (0.58–0.88)

* The per-protocol population included all the participants (2121) who underwent randomization, met the inclusion criteria, and survived beyond the recruitment hospitalization. The unadjusted analyses included all these participants. The adjusted models included the 1901 participants who provided data for all the baseline characteristics shown in Table S2 in the Supplementary Appendix.

† A P value is provided only for the primary outcome (P=0.03). Because the statistical analysis plan did not include a provision for correcting for multiple comparisons when tests for prespecified secondary outcomes or post hoc exploratory outcomes were conducted, these results are reported as point estimates with 95% confidence intervals. The widths of these confidence intervals were not adjusted for multiple comparisons, so intervals should not be used to infer definitive treatment effects within subgroups or for secondary outcomes.

‡ Models evaluating the outcomes of MRSA infection according to CDC criteria and any infection according to clinical criteria were adjusted for randomization strata, sex, primary insurance type, diabetes, renal disease, liver disease, cancer, cerebrovascular disease, hospitalization within 12 months before enrollment hospitalization, medical device on discharge from enrollment hospitalization, bathing frequency, need for bathing assistance, and anti-MRSA antibiotics as time-varying covariates on the basis of variables associated with outcomes at a P value of less than 0.20 in bivariate analyses. Models evaluating the outcome of MRSA infection according to clinical criteria and any infection according to CDC criteria were adjusted for the same variables with the addition of age. Resistance to mupirocin did not significantly modify the effect of the trial group.

§ The as-treated analysis assessed the effect on trial outcomes on the basis of the participant's level of adherence to the use of decolonization products as compared with the education group. Among the participants in the decolonization group, 65.6% of the participant-time involved full adherence (no missed doses); 19.6%, partial adherence (some missed doses); and 14.8%, nonadherence (no doses used). The comparator for each adherence subgroup was the overall education group.

¶ As-treated models for all outcomes were adjusted for randomization strata, sex, primary insurance type, diabetes, renal disease, liver disease, hospitalization within 12 months before enrollment hospitalization, medical device on discharge from enrollment hospitalization, bathing frequency, and need for bathing assistance on the basis of variables associated with outcomes at a P value of less than 0.20 in bivariate analyses.

Nonadherence was associated with a higher likelihood of infection from any cause than was observed among participants in the education group.

NUMBER NEEDED TO TREAT

Overall, the estimated number needed to treat to prevent a MRSA infection was 30 (95% CI, 18 to 230) and to prevent an associated hospitalization, 34 (95% CI, 20 to 336). The number needed to treat to prevent any infection was 26 (95% CI, 13 to 212) and to prevent an associated hospitalization, 28 (95% CI, 21 to 270). Among the participants who adhered fully to the intervention (all of whom were in the decolonization group), the number needed to treat to prevent a MRSA infection was 26 (95% CI, 18 to 83) and to prevent an associated hospitalization, 27 (95% CI, 20 to 46). The number needed to treat to prevent any infection was 11 (95% CI, 8 to 21) and to prevent an associated hospitalization, 12 (95% CI, 8 to 23).

ADVERSE EVENTS

Adverse events that were associated with the topical decolonization intervention were mild and uncommon, occurring in 44 participants (4.2%) (Table S9 in the Supplementary Appendix). Local irritation occurred with mupirocin in 1.1% of the participants (12 of 1058), with chlorhexidine bathing in 2.3% (24), and with chlorhexidine mouthwash in 1.1% (12). In those respective

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categories, 33% (4 of 12), 29% (7 of 24), and 50% (6 of 12) of the participants chose to continue using the product (overall, 39% of the participants with side effects).

A total of 12.6% of the 1591 participants with postrecruitment MRSA strains had high-level resistance to mupirocin (9.4% [150 participants]) or low-level resistance to mupirocin (3.1% [50]). A total of 1.9% of the participants were newly found to have a mupirocin-resistant strain at subsequent visits (1.9% [16 of 826 participants] in the education group and 2.0% [15 of 765] in the decolonization group, P=0.97). A total of 1.5% of the participants in each group were newly found to have high-level mupirocin-resistant strains (1.6% [13 of 826 participants] in the education group and 1.4% [11 of 765] in the decolonization group, P=0.82) when only sensitive strains were detected at recruitment. Chlorhexidine MICs of 8 μg or more per milliliter were rare (occurring in 2 participants overall [0.1%]). Both patients were in the intervention group, and both isolates had an MIC of 8 μg per milliliter and were negative for the *qac A/B* gene).

DISCUSSION

Infection-prevention campaigns have reduced the risks of health care–associated infections in hospitals, leaving the majority of preventable infections to the postdischarge setting.[16] MRSA carriers are an appealing population target because of their higher risks of infection and postdischarge rehospitalization and the common practice of screening selected inpatients for MRSA colonization.[1,17-19] In the CLEAR trial, topical decolonization led to lower risks of infections and readmissions than hygiene education alone among patients after the transition from hospital to home and other care settings. With a number needed to treat between 25 and 30 to prevent infection and hospitalization, this intervention is relevant to 1.8 million MRSA carriers (5% of inpatients) who are discharged from hospitals each year.[16]

Although decolonization has successfully prevented disease during temporary high-risk circumstances (e.g., recurrent skin infections, ICU care, and arthroplasty and cardiac surgery),[6-10,19-22] a single 5-day decolonization regimen produced short-lived MRSA clearance in half the carriers.[23-26] In contrast, twice-monthly decolonization provided protection for many months after discharge. The protective benefit continued after decolonization. In addition, this regimen was effective despite the greater variability in application with home bathing and showering than has occurred in previous inpatient trials that evaluated nursing-assisted chlorhexidine bath-

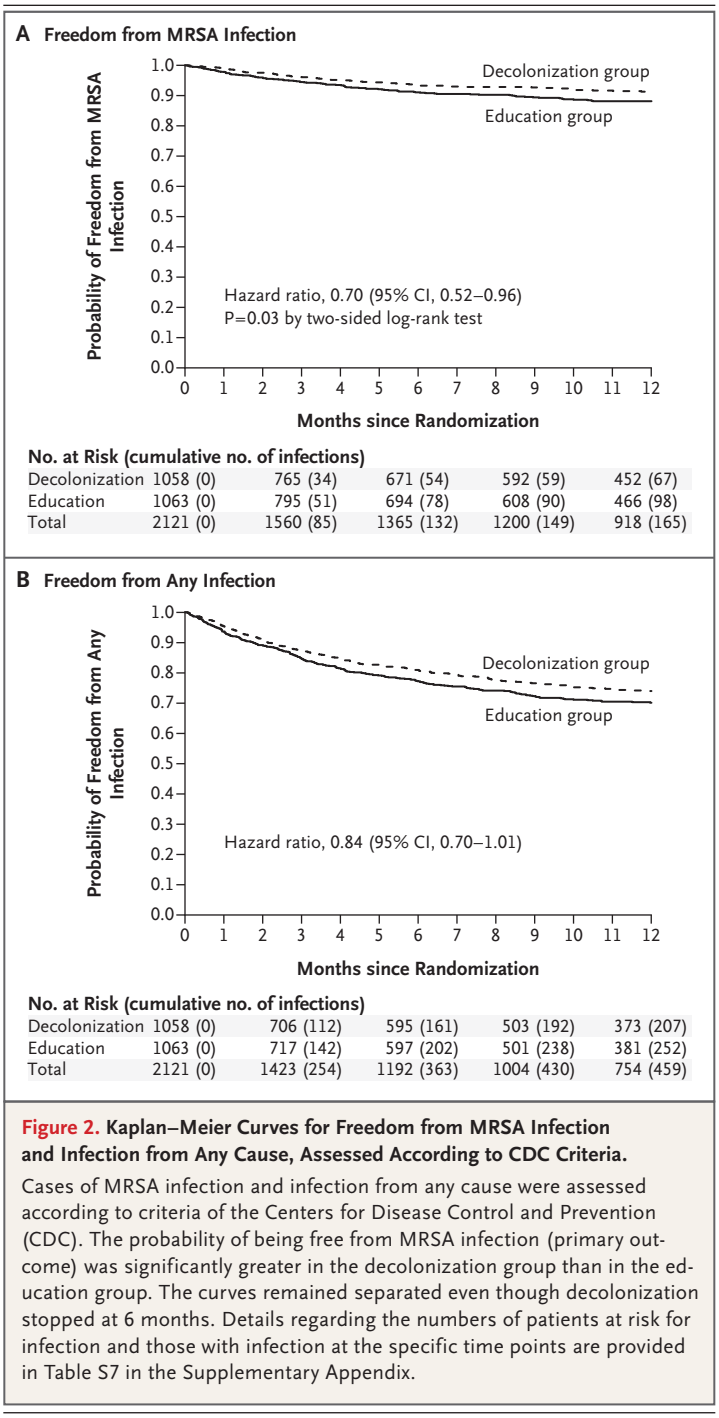

Figure 2. Kaplan–Meier Curves for Freedom from MRSA Infection and Infection from Any Cause, Assessed According to CDC Criteria.

Cases of MRSA infection and infection from any cause were assessed according to criteria of the Centers for Disease Control and Prevention (CDC). The probability of being free from MRSA infection (primary outcome) was significantly greater in the decolonization group than in the education group. The curves remained separated even though decolonization stopped at 6 months. Details regarding the numbers of patients at risk for infection and those with infection at the specific time points are provided in Table S7 in the Supplementary Appendix.

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ing and mupirocin application.[8,9,22] This trial also showed that 4% rinse-off chlorhexidine was effective in a postdischarge population that typically takes showers or baths and is unlikely to use a 2% leave-on chlorhexidine product.[8,9,22]

Not surprisingly, participants who adhered fully to the decolonization intervention had rates of MRSA infection and infection from any cause that were at least 40% lower than the rates among participants in the education group, with a number needed to treat of 12 to prevent infection-related hospitalization. This finding probably is attributable to both the decolonization effect and the likelihood that these participants were more adherent to other prescribed treatments and health-promotion behavior than participants in the education group. Participants who fully adhered to the intervention had fewer coexisting conditions, had fewer devices, required less bathing assistance, and were more likely to have MRSA infection (rather than asymptomatic colonization) at the time of enrollment than either participants in the education group or participants in the decolonization group who had lower levels of adherence. These differences represent an important practical distinction. To the extent that physicians can identify patients who are able to adhere to an intervention, those patients would derive greater benefit from the recommendation to decolonize. Nonadherence was common among nursing home residents, which raises questions about research barriers in that care setting.

Decolonization appeared to affect the risks of skin and soft-tissue infections, surgical-site infections, pneumonia, and bacteremia, although sample-size constraints necessitate cautious speculation. Decolonization also appeared to reduce the rate of gram-positive pathogens and infections without a cultured pathogen. The higher rate of gram-negative pathogens in the decolonization group than in the education group was seen among the CDC-defined all-cause infections but not among the clinically defined infections and requires further substantiation. These observations are based on relatively small numbers; larger studies have shown that chlorhexidine can reduce the incidence of gram-negative infections and bacteriuria.[27-30]

The design of this trial did not permit us to determine the effect of hygiene education alone. Both trial groups received in-person visits and reminders about the importance of MRSA-prevention activities. In addition, the free product overcame financial disparities that could become evident with post-trial adoption of the decolonization intervention.

Some participants (<5%) in the decolonization group had mild side effects; among those participants, nearly 40% opted to continue using the agent. Resistance to chlorhexidine and mupirocin was not differentially engendered in the two groups. We defined an elevated chlorhexidine MIC as at least 8 μg per milliliter, although 4% chlorhexidine applies 40,000 μg per milliliter to the skin.

This trial is likely to be generalizable because it was inclusive. For example, the enrollment of participants with late-stage cancer contributed to the 10% anticipated mortality and the approximate 25% rate of withdrawal and loss to follow-up. These rates are similar to other postdischarge trials with shorter durations of follow-up than the durations in our trial.[31-33] It is unknown whether the participants who withdrew or were lost to follow-up had different infection rates or intervention benefits. They were more educated and less likely to be Hispanic than those who did not withdraw or were not lost to follow-up, but the percentages of participants with coexisting conditions were similar.

Limitations of this trial include the unblinded intervention, although outcomes were assessed in a blinded fashion. The trial also had substantial attrition over the 1-year follow-up, and adherence was based on reports by the participants, with spot checks of remaining product, both of which may not reflect actual use. In addition, nearly all infections led to hospitalization, which suggests that milder infections escaped detection. Most outpatient and nursing home records had insufficient documentation for the event to be deemed infection according to the CDC or clinical criteria. Thus, it remains unknown whether the observed 30% lower risk of MRSA infection or the observed 17% lower risk of infection from any cause with decolonization than with education alone would apply to less severe infections that did not lead to hospitalization. Finally, although resistance to chlorhexidine and mupirocin did not emerge during the trial, the development of resistance may take time, beyond the follow-up period of this trial.

In conclusion, inpatients with MRSA-positive

cultures who had been randomly assigned to undergo decolonization with topical chlorhexidine and mupirocin for 6 months after discharge had lower risks of MRSA infection, infection from any cause, and hospitalization over the 1 year after discharge than those who had been randomly assigned to receive hygiene education only.

The findings and conclusions in this article are those of the authors and do not necessarily represent the views of the Centers for Disease Control and Prevention (CDC), the National Institutes of Health (NIH), or the Agency for Healthcare Research and Quality (AHRQ).

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APPENDIX

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PUBLIC HEALTH

Hospitals Look To Nursing Homes To Help Stop Drug-Resistant Infections

April 2, 20195:00 AM ET

ANNA GORMAN

A certified nursing assistant wipes Neva Shinkle's face with chlorhexidine, an antimicrobial wash. Shinkle is a patient at Coventry Court Health Center, a nursing home in Anaheim, Calif., that is part of a multicenter research project aimed at stopping the spread of MRSA and CRE — two types of bacteria resistant to most antibiotics. *Heidi de Marco/KHN*

Hospitals and nursing homes in California and Illinois are testing a surprisingly simple strategy to stop the dangerous, antibiotic-resistant superbugs that kill thousands of people each year: washing patients with a special soap.

The efforts — funded with roughly $8 million from the federal government's Centers for Disease Control and Prevention — are taking place at 50 facilities in those two states.

This novel collaboration recognizes that superbugs don't remain isolated in one hospital or nursing home but move quickly through a community, said Dr. John Jernigan, who directs the CDC's office on health care-acquired infection research.

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"No health care facility is an island," Jernigan says. "We all are in this complicated network."

At least 2 million people in the U.S. become infected with some type of antibiotic-resistant bacteria each year, and about 23,000 die from those infections, according to the CDC.

People in hospitals are vulnerable to these bugs, and people in nursing homes are particularly vulnerable. Up to 15 percent of hospital patients and 65 percent of nursing home residents harbor drug-resistant organisms, though not all of them will develop an infection, says Dr. Susan Huang, who specializes in infectious diseases at the University of California, Irvine.
"Superbugs are scary and they are unabated," Huang says. "They don't go away."

Some of the most common bacteria in health care facilities are methicillin-resistant *Staphylococcus aureus*, or MRSA, and carbapenem-resistant *Enterobacteriaceae*, or CRE, often called "nightmare bacteria." *E.Coli* and *Klebsiella pneumoniae* are two common germs that can fall into this category when they become resistant to last-resort antibiotics known as carbapenems. CRE bacteria cause an estimated 600 deaths each year, according to the CDC.

CRE have "basically spread widely" among health care facilities in the Chicago region, says Dr. Michael Lin, an infectious-diseases specialist at Rush University Medical Center, who is heading the CDC-funded effort there. "If MRSA is a superbug, this is the extreme — the super superbug."
Containing the dangerous bacteria has been a challenge for hospitals and nursing homes. As part of the CDC effort, doctors and health care workers in Chicago and Southern California are using the antimicrobial soap chlorhexidine, which has been shown to reduce infections when patients bathe with it.

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The Centers for Disease Control and Prevention funds the project in California, based in Orange County, in which 36 hospitals and nursing homes are using an antiseptic wash, along with an iodine-based nose swab, on patients to stop the spread of deadly superbugs.
Heidi de Marco/KHN

Though hospital intensive care units frequently rely on chlorhexidine in preventing infections, it is used less commonly for bathing in nursing homes. Chlorhexidine also is sold over the counter; the FDA noted in 2017 it has caused rare but severe allergic reactions.
In Chicago, researchers are working with 14 nursing homes and long-term acute care hospitals, where staff are screening people for the CRE bacteria at admission and bathing them daily with chlorhexidine.

The Chicago project, which started in 2017 and ends in September, includes a campaign to promote hand-washing and increased communication among hospitals about which patients carry the drug-resistant organisms.

The infection-control protocol was new to many nursing homes, which don't have the same resources as hospitals, Lin says.

In fact, three-quarters of nursing homes in the U.S. received citations for infection-control problems over a four-year period, according to a Kaiser Health News analysis, and the facilities with repeat citations almost never were fined. Nursing home residents often are sent back to hospitals because of infections.
In California, health officials are closely watching the CRE bacteria, which are less prevalent there than elsewhere in the country, and they are trying to prevent CRE from taking hold, says Dr. Matthew Zahn, medical director of epidemiology at the Orange County Health Care Agency
"We don't have an infinite amount of time," Zahn says. "Taking a chance to try to make a difference in CRE's trajectory now is really important."

The CDC-funded project in California is based in Orange County, where 36 hospitals and nursing homes are using the antiseptic wash along with an iodine-based nose swab. The goal is to prevent new people from getting drug-resistant bacteria and keep the ones who already have the bacteria on their skin or elsewhere from developing infections, says Huang, who is leading the project.

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Licensed vocational nurse Joana Bartolome swabs Shinkle's nose with an antibacterial, iodine-based solution at Anaheim's Coventry Court Health Center. Studies find patients can harbor drug-resistant strains in the nose that haven't yet made them sick.
Heidi de Marco/KHN

Huang kicked off the project by studying how patients move among different hospitals and nursing homes in Orange County — she discovered they do so far more than previously thought. That prompted a key question, she says: "What can we do to not just protect our patients but to protect them when they start to move all over the place?"

Her previous research showed that patients who were carriers of MRSA bacteria on their skin or in their nose, for example, who, for six months, used chlorhexidine for bathing and as a mouthwash, and swabbed their noses with a nasal antibiotic were able to reduce their risk of developing a MRSA infection by 30 percent. But all the patients in that study, published in February in the *New England Journal of Medicine*, already had been discharged from hospitals.

Now the goal is to target patients still in hospitals or nursing homes and extend the work to CRE. The traditional hospitals participating in the new project are focusing on patients in intensive care units and those who already carry drug-resistant bacteria, while the nursing homes and the long-term acute care hospitals perform the cleaning — also called "decolonizing" — on every resident.

One recent morning at Coventry Court Health Center, a nursing home in Anaheim, Calif., 94-year-old Neva Shinkle sat patiently in her wheelchair. Licensed vocational nurse Joana Bartolome swabbed her nose and asked if she remembered what it did.

"It kills germs," Shinkle responded.

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"That's right. It protects you from infection."

In a nearby room, senior project coordinator Raveena Singh from UCI talked with Caridad Coca, 71, who had recently arrived at the facility. She explained that Coca would bathe with the chlorhexidine rather than regular soap. "If you have some kind of open wound or cut, it helps protect you from getting an infection," Singh said. "And we are not just protecting you, one person. We protect everybody in the nursing home."

Coca said she had a cousin who had spent months in the hospital after getting MRSA. "Luckily, I've never had it," she said.

Coventry Court administrator Shaun Dahl says he was eager to participate because people were arriving at the nursing home carrying MRSA or other bugs. "They were sick there and they are sick here," Dahl says.
Results from the Chicago project are pending. Preliminary results of the Orange County project, which ends in May, show that it seems to be working, Huang says. After 18 months, researchers saw a 25 percent decline in drug-resistant organisms in nursing home residents, 34 percent in patients of long-term acute care hospitals and 9 percent in traditional hospital patients. The most dramatic drops were in CRE, though the number of patients with that type of bacteria was smaller.

The preliminary data also show a promising ripple effect in facilities that aren't part of the effort, a sign that the project may be starting to make a difference in the county, says Zahn of the Orange County Health Care Agency.

"In our community, we have seen an increase in antimicrobial-resistant infections," he says. "This offers an opportunity to intervene and bend the curve in the right direction."

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USA TODAY

How to fight ‘scary’ superbugs that kill thousands each year? Cooperation — and a special soap

Anna Gorman, Kaiser Health News Published 9:27 a.m. ET April 12, 2019 | **Updated 1:47 p.m. ET April 12, 201**

Hospitals and nursing homes in California and Illinois are testing a surprisingly simple strategy against the dangerous, antibiotic-resistant superbugs that kill thousands of people each year: washing patients with a special soap.

The efforts — funded with roughly $8 million from the federal government’s Centers for Disease Control and Prevention — are taking place at 50 facilities in those two states.

This novel approach recognizes that superbugs don’t remain isolated in one hospital or nursing home but move quickly through a community, said Dr. John Jernigan, who directs the CDC’s office on health care-acquired infection research.

“No health care facility is an island,” Jernigan said. “We all are in this complicated network.”

At least 2 million people in the U.S. become infected with an antibiotic-resistant bacterium each year, and about 23,000 die from those infections, according to the CDC.

People in hospitals are vulnerable to these bugs, and people in nursing homes are particularly vulnerable. Up to 15% of hospital patients and 65% of nursing home residents harbor drug-resistant organisms, though not all of them will develop an infection, said Dr. Susan Huang, who specializes in infectious diseases at the University of California-Irvine.

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USA TODAY

Certified nursing assistant Cristina Zainos prepares a special wash using antimicrobial soap. *(Photo: Heidi de Marco, Kaiser Health News)*

“Superbugs are scary and they are unabated,” Huang said. “They don’t go away.”

Some of the most common bacteria in health care facilities are methicillin-resistant Staphylococcus aureus, or MRSA, and carbapenem-resistant Enterobacteriaceae, or CRE, often called “nightmare bacteria.” E. coli and Klebsiella pneumoniae are two common germs that can fall into this category when they become resistant to last-resort antibiotics known as carbapenems. CRE bacteria cause an estimated 600 deaths each year, according to the CDC.

CREs have “basically spread widely” among health care facilities in the Chicago region, said Dr. Michael Lin, an infectious-diseases specialist at Rush University Medical Center, who is heading the CDC-funded effort there. “If MRSA is a superbug, this is the extreme — the super superbug.”

Containing the dangerous bacteria has been a challenge for hospitals and nursing homes. As part of the CDC effort, doctors and health care workers in Chicago and Southern California are using the antimicrobial soap chlorhexidine, which has been shown to reduce infections when patients bathe with it. Though chlorhexidine is frequently used for bathing in hospital intensive care units and as a mouthwash for dental infections, it is used less commonly for bathing in nursing homes.

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In Chicago, researchers are working with 14 nursing homes and long-term acute care hospitals, where staff are screening people for the CRE bacteria at admission and bathing them daily with chlorhexidine.

The Chicago project, which started in 2017 and ends in September, includes a campaign to promote handwashing and increased communication among hospitals about which patients carry the drug-resistant organisms.

The infection-control work was new to many nursing homes, which don't have the same resources as hospitals, Lin said.

In fact, three-quarters of nursing homes in the U.S. received citations for infection-control problems over a four-year period, according to a Kaiser Health News analysis, and the facilities with repeat citations almost never were fined. Nursing home residents often are sent back to hospitals because of infections.

In California, health officials are closely watching the CRE bacteria, which are less prevalent there than elsewhere in the country, and they are trying to prevent CRE from taking hold, said Dr. Matthew Zahn, medical director of epidemiology at the Orange County Health Care Agency. "We don't have an infinite amount of time," he said. "Taking a chance to try to make a difference in CRE's trajectory now is really important."

The CDC-funded project in California is based in Orange County, where 36 hospitals and nursing homes are using the antiseptic wash along with an iodine-based nose swab. The goal is to prevent new people from getting drug-resistant bacteria and keep the ones who already have the bacteria on their skin or elsewhere from developing infections, said Huang, who is leading the project.

Huang kicked off the project by studying how patients move among different hospitals and nursing homes in Orange County, and discovered they do so far more than imagined. That prompted a key question: "What can we do to not just protect our patients but to protect them when they start to move all over the place?" she recalled.

Her previous research showed that patients with the MRSA bacteria who used chlorhexidine for bathing and as a mouthwash, and swabbed their noses with a nasal antibiotic, could reduce their risk of developing a MRSA infection by 30%. But all the patients in that study, published in February in the New England Journal of Medicine, already had been discharged from hospitals.

Now the goal is to target patients still in hospitals or nursing homes and extend the work to CRE. The traditional hospitals participating in the new project are focusing on patients in intensive care units and those who already carried drug-resistant bacteria, while the nursing homes and the

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long-term acute care hospitals perform the cleaning — also called “decolonizing” — on every resident.

One recent morning at Coventry Court Health Center, a nursing home in Anaheim, Calif., 94-year-old Neva Shinkle sat patiently in her wheelchair. Licensed vocational nurse Joana Bartolome swabbed her nose and asked if she remembered what it did.

“It kills germs,” Shinkle responded.

“That’s right — it protects you from infection.”

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Kaiser Health News is a national health policy news service that is part of the nonpartisan Henry J. Kaiser Family Foundation.

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DEPARTMENT OF HEALTH & HUMAN SERVICES **Public Health Service**

Centers for Disease Control
and Prevention (CDC)
Atlanta GA 30341-3724

May 14, 2019

CalOptima Board of Directors
505 City Parkway West
Orange, CA 92868

Dear CalOptima Board of Directors:

As the Director of the Division of Healthcare Quality Promotion at the Centers for Disease Control and Prevention (CDC), I want to relay that CDC is very encouraged by your proposed Post-Acute Infection Prevention Quality Initiative (PIPQI). We hope that this type of insurer initiative will help protect nursing home residents from infections and hospitalization.

To combat antibiotic resistant – an important global threat – CDC has activities to prevent infections, improve antibiotic use, and detect and contain the spread of new and emerging resistant bacteria. The nursing home population is at particular risk for acquiring these bacteria and developing infections that require antibiotics and hospital admission because of their age, complex health status, frequency of wounds, and need for medical devices. Surveillance data have shown that the majority of nursing home residents currently have one of these highly antibiotic resistant bacteria on their body, and often these bacteria are spread between residents, within the nursing home, and to other healthcare facilities.

There is a need for public health agencies, insurers, and healthcare providers to forge coordinated efforts to promote evidence-based infection prevention strategies to prevent infections and save lives. We see great synergy in linking CDC's role in providing surveillance and infection prevention guidance to CalOptima's ability to protect its members by supporting patient safety initiatives to reduce infections and the hospitalizations they cause.

CDC funded the Orange County regional decolonization collaborative (SHIELD) as a demonstration project to inform broader national infection prevention guidance. The ability to maintain its resounding success in reducing antibiotic resistant bacteria and infections is critical and Orange County will benefit on initiatives such as PIPQI that provide incentives to enable its adoption into operational best practices.

CDC plans to continue transitional support for this initiative, including training support for the 16 nursing homes currently in the SHIELD collaborative for at least one year. We hope that this training effort can complement and synergize the efforts of CalOptima's education and liaison nurses. In addition, we are providing transitional support to the Orange County Health Department to continue their ongoing surveillance efforts in order that the ongoing benefits of the intervention can be captured.

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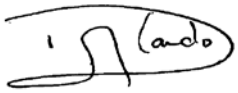
We look forward to collaborating with you. We believe this partnership is a valuable opportunity to protect highly vulnerable patients and to set an example of how insurers and public health can work together to improve healthcare quality.

Sincerely,



Denise Cardo, MD
Director, Division of Healthcare Quality Promotion
Centers for Disease Control and Prevention

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Attachment 4: IGT Funding Proposals

Proposal 1: Expanded Office Hours

Initiative Description: The Member Access and Engagement: Expanded Office Hours (Expanded Office Hours) is a two-year program to incentivize primary care providers and/or clinics for providing after-hour primary care services to CalOptima members in highly demanded and highly impacted areas. The Expanded Office Hours aims to improve member experience, timely access to needed care, and achieve positive population health outcomes.

Target Population(s): Primary care providers serving CalOptima's Medi-Cal members in highly demanded/impacted areas

Plan of Action/Key Milestones:
High level actions of how CalOptima will invest financial and staff resources to support the Expanded Office Hours initiative, such as:

1. Provider Data Gathering and Internal System Configuration
    - Identify primary care providers in community clinics who serve members in highly demanded and impacted areas
    - Configure the internal system (using codes 99050 and 99051) so claims can be adjudicated, and providers can receive expanded office hour incentives.
        - CPT code descriptions:
            - 99050: Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (e.g., holidays, Saturday or Sunday), in addition to basic service
            - 99051: Service(s) provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service
2. Provider Outreach
    - Collaborate with Provider Relations and Health Network Relations to promote the opportunity and encourage providers to provide these services.
    - $125 per member per visit incentive
3. Announce the Expanded Office Hours initiative to impacted Members
    - Call Center and frontline staff training
4. Monitor utilization of the expanded office hour services
    - Monitor and report claims and encounter for identification and linkage to primary care providers providing expanded office hour services

5. Evaluation
    - Conduct evaluation after pilot to see if member access has improved and depending on the outcome, consider expanding the initiative.

Estimated Budget: Total $2 million (up to $500,000 for FY2019/20, remaining amounts from FY2019/20 and $750,000 for FY2020/21, $750,000 FY2021/22)

Project Timeframe: April 2020 – March 2022

IGT 9 Focus Area: Member access and engagement

Strategic Plan Priority/Objectives: Expand CalOptima's Member-Centric Focus

- Focus on Population Health
- Strengthen Provider Network and Access to Care
- Enhance Member Experience and Customer Service

Participating/Collaborating Partners/Vendors/Covered Entities: Participating providers

Proposal 2: Post-Acute Infection Prevention Initiative (PIPQI)

Initiative Description: Expand CalOptima's program to suppress Multi Drug Resistant Organisms (MDROs) in CalOptima's contracted nursing facilities and decrease inpatient admissions due to infection. The pilot program was approved by CalOptima's Board of Directors on June 6, 2019.

Benefits of the Initiative:

- Member-centric focus: avoid MDRO colonization and inpatient admissions
- Potential cost savings from decreased antibiotic utilization
- Decreased demand for antibiotic-related c. difficile isolation beds
- Decreased Healthcare Acquired Infection rates (HAI):
    - Potential improved Star ratings
    - Strengthens community and national partnerships:
        - UCI (Professor Susan Huang -Department of Infectious Diseases)
        - Matthew Zahn, MD, Orange County Health Care Agency-Division of Epidemiology, CDC
        - (John A. Jernigan, MD, MS, Director, Office of Prevention Research and Evaluation Division of Healthcare Quality Promotion Centers for Disease Control and Prevention)
        - contracted nursing facilities
        - members/families
- Increased value and improved care delivery
- Enhanced operational excellence and efficiency

*Please note that there is currently an outbreak of a fungal infection called C. auris in Orange County LTACHs and NFs. It's a costly and virulent infection and the Public Health Department is involved. There are currently 160 cases in OC (need updated numbers). Chlorhexidine eradicates and protects against this fungus as well as Multi Drug Resistant Organisms (MDROs)

Target Member Population(s): CalOptima Members receiving services at contracted nursing facilities

Plan of Action/Key Milestones:

A. Teleconference requested by the CDC scheduled for April 2, 2020, as CalOptima is the only County in the U.S. that is an early adopter of CHG/Iodophor in NFs to lower MDRO colonization rates

B. Dedicate two Long Term Support Services Nurses to:

1) Provide training for newly participating facilities,
2) Provide ongoing support and compliance monitoring* at all participating facilities,
3) Develop additional informing, training and monitoring materials.

C. Promote the expansion of the Post-Acute of Infection Prevention Program and engage nursing facility administration and staff at the March 20, 202 LTSS Workshop.

*Monitoring includes monthly random testing (five patients per facility confirming presence of Chlorhexidine, invoices /delivery receipt for Chlorhexidine and Iodophor). Additional metrics: acute inpatient admission rates due to infection, Hospital Acquired Infection (HAI) rates.

Estimated Budget: Total budgeted amount $3.4 million over 3 fiscal years ($1 million for FY2019/20, $1.2 million for FY 2020/21 and $1.2 million for FY 2021/22)

Project Timeframe: Three years FY 2019/20– 2021/22

IGT 9 Focus Area: Quality performance and data exchange and support

Strategic Plan Priority/Objectives: Innovate and Be Proactive, Expand CalOptima's Member-Centric Focus, Strengthen Community Partnerships, Increase Value and Improve Care Delivery, Enhance Operational Excellence and Efficiency.

Participating/Collaborating Partners/Vendors/Covered Entities: University of California Irvine Medical Center, Department of Infectious Disease, Dr. Susan Huang; Orange County Health Care Agency-Division of Epidemiology, Centers for Disease Control (CDC); John A. Jernigan, MD, MS, Director, Office of Prevention Research and Evaluation Division of Healthcare Quality Promotion Centers for Disease Control and Prevention; CalOptima contracted nursing facilities.

Proposal 3: Hospital Data Sharing Initiative

Initiative Description: Establish incentives for implementation of a data sharing solution for Admit, Discharge, Transfer (ADT) and Electronic Health Record data to support alerting of hospital activities for CalOptima members for the purposes of improving care management. Participating entity will be eligible for incentive once each file exchange is in place. The overall goal is to improve costs, quality, care, and satisfaction.

Target Population(s): Contracted and participating Orange County hospitals serving CalOptima members and, potentially, other Community Based Organizations within the delivery system

Plan of Action/Key Milestones: Staff will obtain Board of Directors approval, contract with selected vendors, implement the solutions, establish an incentive plan and details, and work with the vendors and the hospitals to establish the means of sharing data.

Estimated Budget: $2 million to be exhausted by end of FY 2020-2021

Project Timeframe: Until end of FY 2020-2021

IGT 9 Focus Area: Data exchange and support

Strategic Plan Priority/Objectives: Expand CalOptima's Member-Centric Focus and Increase Value and Improve Care Delivery

Participating/Collaborating Partners/Vendors/Covered Entities: Hospitals providing the requested data

Proposal 4: Intergovernmental Transfer (IGT) Program Administration

Initiative Description: Administrative support activities related to prior, current and future IGTs opportunities, grants, internal initiatives. This will continue support for management of the IGT transaction process, project and expenditure oversight related to prior IGTs (outstanding grants and internal projects), as well as current IGTs in progress (i.e., IGTs 9 and 10) and oversight. Administration will be consistent with CalOptima standard policies, procedures and practices and will ensure funding investments are aligned with CalOptima's strategic priorities and member needs. Two staff positions, the Grant Management System license, public activities and other administrative costs are included.

Target Member Population(s): NA

Plan of Action/Key Milestones: NA

Estimated Budget: $2,000,000

Project Timeframe: Five–years

IGT 9 Focus Area: Other priority areas

Strategic Plan Priority/Objectives: Innovate and Be Proactive, Strengthen Community Partnerships, Increase Value and Improve Care Delivery

Participating/Collaborating Partners/Vendors/Covered Entities: NA

Proposal 5: Whole Child Model (WCM) Program

Initiative Description: To fund WCM program deficit in year one

Target Member Population(s): WCM eligible members (12,000 to 13,000)

Plan of Action/Key Milestones: N/A

Estimated Budget: Total $31.1 million for FY 2019-20

Project Timeframe: FY 2019-20 (July 1, 2019 to June 30, 2020)

IGT 9 Focus Area: Other priority areas

Strategic Plan Priority/Objectives:
To Support care delivery for WCM population in FY 2019-20

1) Insufficient revenue from DHCS
2) Complexity in operation and financial reconciliation

Participating/Collaborating Partners/Vendors/Covered Entities: N/A

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 5, 2020
Regular Meeting of the CalOptima Board of Directors

Consent Calendar
9. Consider Extension of Altruista Health Contract for Comprehensive Medical Management System

Contact
Nora Onishi, Director Information Services, (714) 246-8400

Recommended Action(s)
Authorize the Chief Executive Officer (CEO) to:

1. Extend the Altruista contract through April 6, 2024, with the existing terms and conditions; and
2. Authorize payment of maintenance and support fees to Altruista through the contract end-date at currently contracted rates., contingent on a successful and enhanced upgrade being completed as early as possible.

Rev. 2/20/20

Background
Altruista Health is the vendor that supplies CalOptima with its comprehensive medical management solution known as Guiding Care.

At the December 5, 2013 Regular Meeting of the CalOptima Board of Directors, the CEO was authorized to (1) select a vendor through an RFP process for a new comprehensive care management system and (2) contract with the selected vendor for an initial term of three years with five one-year extension options, each extension subject to Board approval.

Through the CalOptima competitive bidding process, the Guiding Care system, from Altruista Health, was ultimately selected as the solution of choice. The contract effective and execution date was April 7, 2014. Implementation began in May of 2014 and CalOptima was live with this new solution on Monday, March 30, 2015.

On March 2, 2017, the CalOptima Board of Directors authorized a one-year extension to April 6, 2018 along with delegating authority to the CEO to execute the four remaining one-year extensions. On December 6, 2018, the Board approved execution of the remaining extension options through April 6, 2021.

Discussion
The medical management system, Guiding Care, is one of the two primary systems used to operate the business of CalOptima. The other is Facets, from Cognizant/TriZetto. These two systems are not only tightly embedded into CalOptima business operations, but tightly integrated from a technology perspective with many other ancillary software solutions. Guiding Care has over thirty technology interfaces that have been custom developed to support the operations.

During calendar year 2020, the Guiding Care system is undergoing a significant upgrade, scheduled to be completed during third quarter. This upgrade is intended to improve existing functionality and enable the use of new functionality.

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Typically, it may be time to conduct a Request for Proposal (RFP) process to evaluate the marketplace for comparable solutions. Although the existing contract expires in 2021, the upcoming upgrade is significant enough that an RFP process would be premature at this time. It will be important to stabilize the upgrade before deciding if the Guiding Care system will be sustainable for a longer term or if a replacement should be considered.

For these reasons, staff is requesting approval to extend the contract with Altruista for an additional three years with the same terms, conditions, and rates. This will provide enough time to adopt and stabilize the upgrade and to evaluate whether an RFP should be issued. If so, the three-year extension will also provide the necessary time to complete an RFP process if warranted.

Fiscal Impact
Management will include expenses for the recommended action to extend the Altruista Health contract for comprehensive medical management from April 6, 2021, through April 6, 2024, in future CalOptima operating budgets.

Rationale for Recommendation
The extension will enable operations to continue in a seamless manner.

Concurrence
Gary Crockett, Chief Counsel
David Ramirez, MD, Chief Medical Officer
Board of Directors' Finance and Audit Committee

Attachments
1. Board Action: December 5, 2013, Authorize CEO to Select and Contract with a Vendor for a Medical Management System
2. Board Action: March 2, 2017, Consider Authorizing Extension of Contract with Altruista Health for Comprehensive Medical Management System and Delegating Authority to Exercise Remaining Contract Extension Options
3. Board Action: December 6, 2018, Consider Extension of Contracts Related to CalOptima's Key Operational and Human Resource Systems

/s/ Michael Schrader *02/26/2020*
Authorized Signature **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 5, 2013
Regular Meeting of the CalOptima Board of Directors

Report Item

VI. F. Authorize the Chief Executive Officer (CEO) to Select and Contract with a Vendor for a Medical Management System

Contact

Bill Jones, Chief Operating Officer, (714) 246-8400

Recommended Actions

Authorize the CEO to:

1. Select a vendor through a Request for Proposal (RFP) process for a comprehensive medical management system that will meet current and anticipated business requirements; and
2. With the assistance of legal counsel, contract with the selected vendor for an initial term not to exceed three years, with five one-year extension options~~, with each option year~~ exercisable at CalOptima's sole discretion, with each extension option subject to prior Board approval.

Amended 12/5/13

Background

On March 4, 2010, following an RFP process, the CalOptima Board of Directors authorized management to engage in negotiations with McKesson, our current medical management system vendor, to enter into a new agreement provided the parties could come to terms agreeable to CalOptima. Staff ultimately closed the RFP and extended the existing contract because it was determined that the industry was moving toward more integrated systems that would combine medical management with CalOptima's core claims processing system. The contract with the current vendor was extended for a three year period through May 18, 2013. On April 4, 2013, the Board authorized staff to further extend the McKesson contract through December 31, 2016. The extension was deemed critical at the time to allow CalOptima to maintain the current medical management system and achieve ICD-10 compliance by the October 1, 2014. Several short term extensions of the McKesson agreement have been implemented as contract negotiations have progressed. The agreement currently expires on December 31, 2013, and negotiations are continuing.

In addition, the Board authorized staff to conduct an overall systems assessment and make recommendations to upgrade current systems or implement new systems as part of the three year strategic plan approved in September 2013.

Discussion

Both the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) are pursuing aggressive, and constantly evolving, program requirements and timelines for implementation of the Cal Medi-Connect program. As noted previously, an additional delay in implementation was announced by DHCS on August 13, 2013, and the key milestone dates have shifted from the prior dates shared with the Board. At present, the expected start date for Cal MediConnect is April 1, 2014. In preparation, CalOptima participated in an on-site readiness review July 25-26, 2013 and a subsequent systems readiness review on October 21, 2013.

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As a result of the feedback from the on-site and systems readiness reviews, consistent with Board direction to conduct an overall systems assessment, staff has conducted an evaluation and discussion relative to the capabilities of the current medical management system and whether those capabilities support CalOptima's need for Cal MediConnect and to scale for other products.

In the discussion of the April 4, 2013 Board action authorizing the extension of the McKesson agreement, it was recognized that, with the addition of new programs and member populations, there may clinical needs for additional modules for the existing medical management system. While extending and upgrading the current system is an option, management believes that it is in the best interest of CalOptima to evaluate other alternatives to ensure that we are getting the best value from the medical management solution that is chosen as part of our long term solution set.

In order to minimize member and provider disruption, management proposes to complete the RFP process and select a vendor and initiate implementation as soon as January, 2014. Regardless of the outcome of the RFP process, this timeline should minimize the number of members that would need to be moved from one platform to another, should a different system be selected than the current medical management system. With the impending start date for Cal MediConnect currently set at April 1, 2014, this timing is critical. The length of time it takes to get the system replaced or upgraded will directly correlate with the number of members that have to be potentially converted. Conversions of this nature are complex and best if kept to a minimum.

Fiscal Impact
The financial impact is included in the proposed budget for Cal MediConnect, which will be presented in a separate action.

Rationale for Recommendation
The Cal MediConnect program requires tighter integration between all services that are included in the program. Building a system that fully integrates the administrative and clinical responsibilities for Medi-Cal and Medicare covered services is critical in supporting a reduced opt out rate and achieving better outcomes for our members.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *11/27/2013*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

9. Consider Authorizing Extension of Contract with Altruista Health for Comprehensive Medical Management System and Delegating Authority to Exercise Remaining Contract Extension Options

Contact

Len Rosignoli, Chief Information Officer, (714) 246-8400

Recommended Actions

1. Authorize the Chief Executive Officer (CEO) to exercise a one year extension option to extend the Altruista contract through April 6, 2018;
2. Authorize payment of maintenance and support fees to Altruista through this extension period; and
3. Delegate authority to the CEO to exercise the remaining four individual one year contract extension options and to include related maintenance and support fees in future CalOptima operating budgets as applicable.

Background

Altruista Health is the vendor that supplies CalOptima with its comprehensive medical management solution known as Guiding Care.

At the December 5, 2013 Regular Meeting of the CalOptima Board of Directors, the CEO was authorized to (1) select a vendor through a Request for Proposal (RFP) process for a new comprehensive care management system and (2) contract with the selected vendor for an initial term of three years with five one-year extension options, each extension subject to Board approval (see attached).

Through the CalOptima RFP process, the Guiding Care system from Altruista Health was selected as the solution of choice. The contract effective and execution date was April 7, 2014. Implementation began in May of 2014 and CalOptima was ultimately live with this new solution on March 30, 2015. The initial three-year term expires on April 6, 2017.

Discussion

The medical management system, Guiding Care, is one of the two primary systems used to operate the business of CalOptima. The other is Facets, from Cognizant/TriZetto, used for membership enrollment/eligibility, customer service, benefits administration, provider data management, provider reimbursement, and claims processing. These two systems are not only tightly embedded into CalOptima business operations, but tightly integrated from a technology perspective with many other ancillary software solutions. Guiding Care has 29 technology interfaces that have been custom developed to support the operations. Replacing the most tightly integrated solutions is possible, but requires a substantial investment and can be disruptive to operations.

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With two years of usage, staff does not believe that it would be prudent at this time to consider evaluation of possible replacements for this still new solution.

For these reasons, staff is requesting that the Board delegate the authority to exercise the remaining one-year extension options to the CEO. If each one is exercised, the five one-year extension options would run through April 6, 2022. Based on this timeline, staff will likely evaluate the market with a request for information (RFI) or request for proposal (RFP) process in the first quarter of 2020. This will provide sufficient time to complete solution evaluation, selection, and implementation, should it be determined that a new solution is warranted.

Fiscal Impact
The fiscal impact of this extension is budget neutral. The CalOptima Fiscal Year 2016-17 Operating Budget includes the annual fees for the Altruista solution. Management plans to include anticipated expenses for the recommended contract extension periods on or after July 1, 2017 in future CalOptima Operating Budgets.

Rationale for Recommendation
The extension will enable operations to continue in a seamless manner.

Concurrence
Gary Crockett, Chief Counsel

Attachment
Board Action dated December 5, 2013, Authorize the Chief Executive Officer (CEO) to Select and Contract with a Vendor for a Medical Management System

/s/ Michael Schrader — *2/23/2017*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 5, 2013
Regular Meeting of the CalOptima Board of Directors

Report Item
VI. F. Authorize the Chief Executive Officer (CEO) to Select and Contract with a Vendor for a Medical Management System

Contact
Bill Jones, Chief Operating Officer (714) 246-8400

Recommended Actions
Authorize the CEO to:
1. Select a vendor through a Request for Proposal (RFP) process for a comprehensive medical management system that will meet current and anticipated business requirements; and
2. With the assistance of legal counsel, contract with the selected vendor for an initial term not to exceed three years with five one-year extension options, with each option year exercisable at CalOptima's discretion.

Background
On March 4, 2010, following an RFP process, the CalOptima Board of Directors authorized management to engage in negotiations with McKesson, our current medical management system vendor, to enter into a new agreement provided the parties could come to terms agreeable to CalOptima. Staff ultimately closed the RFP and extended the existing contract because it was determined that the industry was moving toward more integrated systems that would combine medical management with CalOptima's core claims processing system. The contract with the current vendor was extended for a three year period through May 18, 2013. On April 4, 2013, the Board authorized staff to further extend the McKesson contract through December 31, 2016. The extension was deemed critical at the time to allow CalOptima to maintain the current medical management system and achieve ICD-10 compliance by the October 1, 2014. Several short term extensions of the McKesson agreement have been implemented as contract negotiations have progressed. The agreement currently expires on December 31, 2013, and negotiations are continuing.

In addition, the Board authorized staff to conduct an overall systems assessment and make recommendations to upgrade current systems or implement new systems as part of the three year strategic plan approved in September 2013.

Discussion
Both the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) are pursuing aggressive, and constantly evolving, program requirements and timelines for implementation of the Cal Medi-Connect program. As noted previously, an additional delay in implementation was announced by DHCS on August 13, 2013, and the key milestone dates have shifted from the prior dates shared with the Board. At present, the expected start date for Cal MediConnect is April 1, 2014. In preparation, CalOptima participated in an on-site readiness review July 25-26, 2013 and a subsequent systems readiness review on October 21, 2013.

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As a result of the feedback from the on-site and systems readiness reviews, consistent with Board direction to conduct an overall systems assessment, staff has conducted an evaluation and discussion relative to the capabilities of the current medical management system and whether those capabilities support CalOptima's need for Cal MediConnect and to scale for other products.

In the discussion of the April 4, 2013 Board action authorizing the extension of the McKesson agreement, it was recognized that, with the addition of new programs and member populations, there may clinical needs for additional modules for the existing medical management system. While extending and upgrading the current system is an option, management believes that it is in the best interest of CalOptima to evaluate other alternatives to ensure that we are getting the best value from the medical management solution that is chosen as part of our long term solution set.

In order to minimize member and provider disruption, management proposes to complete the RFP process and select a vendor and initiate implementation as soon as January, 2014. Regardless of the outcome of the RFP process, this timeline should minimize the number of members that would need to be moved from one platform to another, should a different system be selected than the current medical management system. With the impending start date for Cal MediConnect currently set at April 1, 2014, this timing is critical. The length of time it takes to get the system replaced or upgraded will directly correlate with the number of members that have to be potentially converted. Conversions of this nature are complex and best if kept to a minimum.

Fiscal Impact
The financial impact is included in the proposed budget for Cal MediConnect, which will be presented in a separate action.

Rationale for Recommendation
The Cal MediConnect program requires tighter integration between all services that are included in the program. Building a system that fully integrates the administrative and clinical responsibilities for Medi-Cal and Medicare covered services is critical in supporting a reduced opt out rate and achieving better outcomes for our members.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *11/27/2013*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

11. Consider Extension of Contracts Related to CalOptima's Key Operational and Human Resource Systems

Contact

Len Rosignoli, Chief Information Officer, (714) 246-8400
Ladan Khamseh, Chief Operating Officer, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO) to:

1. Extend the contracts with the following vendors as listed below through the dates indicated in the attachment:
    a. Altruista Guiding Care
    b. Burgess Reimbursement System
    c. Edifecs XEngine
    d. Catalyst Solutions
    e. Medecision
    f. Star MTM
    g. Ansafone
    h. Ceridian Dayforce
    i. Silk Road Open Hire and Wingspan

2. Authorize payment of maintenance and support fees to these vendors through the dates and up to the amounts indicated in the attachment, Table 1.

Background

CalOptima contracts with many vendors that provide a variety of software solutions to support the overall business model. Two core systems are central to this infrastructure while many other supporting solutions surround the core.

Within the managed care industry, this is standard practice, as no commercially-available single solution meets the demands of the industry for all functions, especially when considering the varying lines of business, government regulations, and the uniqueness of each health plan. The trend over the past ten years or more has been to utilize this approach by using a core administrative processing system surrounded by specialty solutions. CalOptima, as well as the other 15 Local Health Plans of California, and virtually all health plans, use this approach.

The two core systems for CalOptima are:

1. Cognizant Facets – This solution handles the key functions of enrollment of members, health benefit configuration, claims processing and adjudication, provider contract reimbursement, and customer service.

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2. Altruista Guiding Care – This solution handles the key functions of Care Management, including Case Management, Utilization Management, Authorizations/Referrals, Disease Management, as well as Appeals & Grievances.

The systems included in this staff recommendation are:

a. Altruista Guiding Care – As mentioned above, this is one of CalOptima's two core systems. CalOptima originally contracted with Altruista in April of 2014 for a term of seven total years, including an initial term and five one-year optional renewal terms extending to 4/6/2021. The system was live as of April 2015. There are two years remaining on the current contract, supporting the decision to recommend approval to extend for those two years, to 4/6/2021. Replacement of this core system was a substantial investment in money and time. It can take years for a core system of this type to fully stabilize. There are additional features yet to be explored, including the Population Health modules. No later than during Fiscal Year (FY) 2019-2020, a Request for Information (RFI) will be issued, primarily to remain informed and evaluate the marketplace for systems of this type, to help determine how long this system will remain or when it may be considered for replacement through a Request for Proposal (RFP) process.

b. Burgess Reimbursement System – This solution provides two key function. One - it enables continuous monitoring of the hundreds of claims reimbursement Medicare fee schedules maintained by the Federal Centers for Medicare and Medicaid Services (CMS) ensuring that CalOptima's Medicare fee schedules are up-to-date as soon as Medicare makes a change. Two - it uses sophisticated algorithms to calculate the reimbursement pricing for all CalOptima Medicare related claims. In the future, this solution will be expanded to perform the same functions for the Medi-Cal fee schedules and claims pricing. This system is very tightly integrated within the Facets core system software.

c. Edifecs – XEngine – This tool supports quality for the CalOptima Facets Claims process. XEngine is a tool that validates and ensures compliance with regulatory transaction standards and streamlines operational efficiency.

d. Catalyst Solutions – This vendor provides essential supplemental maintenance services and support of the Facets system based on their depth of knowledge of Facets and the inner workings of the software.

e. Medecision - Aerial Care Coordination - This solution is the current CalOptima provider portal – more commonly known to the CalOptima provider partners as CalOptima Link. This portal enables thousands of provider office users to verify eligibility, review claims status, view patient rosters, and submit service authorization requests. This will ultimately be replaced by the new CalOptima Provider Portal.

f. Star MTM – This vendor provides the system and services to support the Pharmacy Medication Therapy Management process required by The Centers for Medicare and Medicaid Services (CMS) for both the OneCare and OneCare Connect lines of business. This process is tightly integrated within the overall administration of CalOptima's pharmacy benefit. An RFP will be issued during FY 2020-2021 to re-evaluate this service.

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g. Ansafone – This vendor provides critical services supporting both CalOptima's Customer Service function and the Medical Affairs function. Ansafone provides after-hours call center support for both general customer service calls as well as more specific medical affairs calls. Ansafone also periodically conducts designed member outreach calls, as needed. An RFP for this service will be issued during FY 2018-2019 to evaluate the marketplace and to determine if CalOptima will retain the existing vendor or consider other alternatives.

h. Ceridian Dayforce – This is the primary Human Resources (HR) system handling employee benefits and payroll.

i. Silk Road Open Hire and Wingspan – Open Hire is the current HR applicant tracking and recruitment system. Wingspan is the current performance management system where all CalOptima employee performance evaluations are stored.

   These three HR systems are tightly woven into the support and management of the CalOptima employees and are mission-critical for ongoing smooth operations. CalOptima has been on these systems for nearly ten years. During FY2019-20, CalOptima will issue an RFP for these functions to evaluate the marketplace to determine if a replacement is warranted, and if a single comprehensive HR solution can be procured rather than separate systems.

Discussion
The vendors listed in the attached table represent the solutions described above with contracts expiring in 2019 or sooner.

Many of these solutions are tightly embedded/integrated into either Facets and/or Guiding Care or are mission critical to the Human Resources function. Replacing any of these solutions would require a substantial additional investment, time commitment, and significant disruption to operations.

Fiscal Impact
The CalOptima FY 2018-19 Operating Budget includes the annual fees for the listed contracted vendors related to CalOptima's core and HR systems through June 30, 2019. Management will include expenses for the recommended contract extension periods on or after July 1, 2019, in future CalOptima Operating Budgets.

Rationale for Recommendation
Extension of the contracts for these systems will ensure there is no disruption to the services provided by each of the solutions and allow continuity of operations throughout the organization and with CalOptima's member and provider community, and its employees.

Concurrence
Gary Crockett, Chief Counsel

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Attachments

1. Proposed Contract Extensions – Table 1
2. Contracted Entities Covered by this Recommended Board Action

/s/ Michael Schrader — *11/28/2018*

Authorized Signature — **Date**

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Attachment – Table 1 - Proposed Contract Extensions

Vendor – Solution Name	Description of Service	Original Contract Start Date	Current Contract Expires	Recommend Contract Extension Through	Comments	Annual Cost Based on Fiscal Year 2018-19 Fees
Altruista Health – Guiding Care	Core Care Management Solution	4/6/2014	4/6/2019	4/6/2021	2 years remaining on the original contract	$1,485,000
Burgess – Burgess Reimbursement System	Medicare/Medi-Cal Fee Schedules and Claims Pricing	1/1/2008	12/31/2019	6/30/2022	Tightly Integrated with Facets	$442,162
Edifecs – XEngine	Electronic transaction standardization tool	3/9/2011	12/31/2019	12/31/2021	Tightly Integrated with Facets	$90,000
Catalyst Solutions	Facets Support Services	4/21/2014	12/31/18	6/30/2022	Integral supplemental maintenance services for Facets	$35,000
Medecision – Aerial Care Coordination	Provider Portal (CalOptima Link)	3/23/2011	12/31/2019	12/31/2020	Eventually to be replaced with Provider Portal	$1,560,000
Star MTM	Pharmacy Medication Therapy Management Services	11/1/2014	3/21/2020	3/21/2022	Tightly Integrated into the Pharmacy process. Expect to issue RFP during Fiscal Year 2020-2021.	$156,000
Ephonamation.com, Inc., DBA Ansafone	After hours customer service call center; after hours medical affairs call center; member outreach.	9/1/2016	8/31/2019	8/31/2020	Tightly integrated within Customer Service and Medical Affairs. RFP to be issued during Fiscal Year 2018-2019.	$213,000
Ceridian - Dayforce	The main Human Resources System for Benefits and Payroll	6/29/2008	6/30/2019	12/31/2021	Plan to issue RFP during Fiscal Year 2019-2020	$254,000

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Vendor – Solution Name	Description of Service	Original Contract Start Date	Current Contract Expires	Recommend Contract Extension Through	Comments	Annual Cost Based on Fiscal Year 2018-19 Fees
Silk Road – Open Hire and Wingspan	Human Resources Support Systems – Performance Management, Applicant Tracking	6/19/2009	6/30/2019	12/31/2021	Plan to issue RFP during Fiscal Year 2019-2020	$58,500

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Altruista Health, Inc.	11800 Sunrise Valley Dr Suite 1000	Reston	VA	20191
Burgess Group, LLC	1701 Duke St	Alexandria	VA	22314
Edifecs, Inc.	1756 114th Ave SE	Bellevue	WA	98004
Catalyst Solutions, LLC	2353 S Broadway	Denver	CO	80210
Medecision, Inc.	550 E Swedesford Rd Building D, Suite 220	Wayne	PA	19087
Star MTM, LLC DBA Clinical Support Services	701 Seneca St	Buffalo	NY	14210
Ephonamation.com, Inc., DBA Ansafone Communications	145 E Columbine Ave	Santa Ana	CA	92707
Ceridian Corporation	3311 E Old Shakopee Rd	Minneapolis	MN	55425
SilkRoad Technology, Inc.	100 S Wacker Dr Suite 425	Chicago	IL	60606

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2019

QUALITY IMPROVEMENT EVALUATION

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2019 QUALITY IMPROVEMENT EVALUATION

SIGNATURE PAGE

Quality Improvement Committee Chair:

_____ _____

David Ramirez, M.D. **Date**

Chief Medical Officer

Board of Directors' Quality Assurance Committee Chair:

_____ _____

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

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2019 Quality Improvement Evaluation of Overall Program Effectiveness

EXECUTIVE SUMMARY

The 2019 Annual Quality Improvement (QI) Program Evaluation analyzes the core clinical and service indicators to determine if the QI Program has achieved its key performance goals during the year. This evaluation focuses on quality activities undertaken during the first three quarters of the 2019 calendar year to improve health care and services available to CalOptima members.

The final 2019 QI Work Plan with the full calendar year results will be presented as a separate document in Q1 2020 to the Quality Improvement Committee (QIC). The 2019 QI Evaluation also identifies key areas that offer opportunities for improvement to be implemented or continued as part of the 2020 QI Program and its Work Plan.

CalOptima achieved many of its organizational objectives in 2019:

- Continued to be one of the highest ranked Medicaid plans in the state.
- All Department of Health Care Services (DHCS) measures required to achieve a Minimum Performance Level (MPL) were met in 2019 (based on the latest plan level HEDIS results for measurement year 2018).
- Performed well on several HEDIS measures in comparison to the national thresholds. Out of the 62 reportable measures, CalOptima performed better on 42 measures in 2019, compared to 2018. And 69% of measures are at the National Medicaid 50th percentile or higher.
- Performed successful incentive outreach to members to obtain preventive care. In 2019, there were outreach programs for W15 well child visits, postpartum care, breast and cervical cancer screening.
- Expanded and continued initiatives to address access to care and member satisfaction, such as:
  - Provider Coaching to evaluate and improve services provided at point of care.
  - CalOptima Days to improve access and promote preventive health screenings were conducted and 27 were completed in 2019
  - Active recruitment of new providers (both primary and specialty care).
- Implemented CalOptima's comprehensive health network (HN) Pay for Value (P4V) Performance Measurement Program to recognize outstanding performance and support ongoing improvement that aimed to strengthen CalOptima's mission of providing quality health care.
  - In 2019, the program proved to be a success as CalOptima was able to improve rates for several P4V measures.
- Implemented a quality incentive for Community Health Centers that participate in the Homeless Clinical Access Program (HCAP). CalOptima coordinates with Community Health Centers through our HCAP to bring primary care services via mobile clinics at designated shelters and hot spots. This program started in late 2019 and will continue in 2020.
- Post-acute Infection Prevention Quality Incentive (PIPQI) was implemented on 10/1/2019 to reduce post-acute infections at 25 nursing facilities of which 12 were already participating with University California Irvine (UCI) since Q2 2017 in the SHIELD study.
- Implementation of opioid cumulative MME point-of-sale (POS) pharmacy edits such that members with claims exceeding a cumulative MME threshold of 90mg will trigger a soft rejection and exceeding 400mg will trigger a hard rejection. POS soft drug utilization review (DUR) rejections for concomitant opioids and benzodiazepines.

- Pharmacy Home Program Policy: Members filling prescriptions at four (4) or more pharmacies in a two-month period are restricted to a single pharmacy for a period of one year.
- Prescriber Restriction Program Policy: Pharmacy claims utilization reports indicate the Members filling controlled substance prescriptions from four (4) or more Prescribers in a two (2) month period are restricted to designated prescribers.
- In 2019, CalOptima facilitated weekly Be Safe rounds to identify members at risk of opioid misuse and provide personalized outreach and assistance to members with high Morphine Milligram Equivalent (MME).

For 2019, CalOptima had adequate staffing, resources, and a well-defined quality committee structure in place to meet the required needs of the QI program. This included the new Whole-Child Model Clinical Quality Committee which provided clinical guidance for the Whole-Child Model program that went live on July 1, 2019. There was exceptional participation from external and internal practitioners as well as staff. CalOptima also adopted a very strong "Plan-Do-Study-Act" (PDSA) cycle approach to develop initiatives in 2019 that will continue into 2020. These initiatives are focused on long-term improvement efforts for selected high priority measures. In 2020, CalOptima will continue to evaluate the needs of the program through the QI Work Plan on a quarterly basis and add staffing, as needed, to supplement the QI department.

In 2020, CalOptima will also implement a robust population-based health management program that will focus on different conditions ranging from cancer screening to managing patients with multiple complex conditions. This program will have strong member and provider engagement components and will be monitored on a quarterly basis. Activities will include providing practitioners with lists of members who showed gaps in care, along with incentives to encourage provider offices to contact those members to obtain the needed screenings or other assessments. In conjunction with provider incentives, CalOptima will also have member incentives to encourage the members to see their providers for care.

SECTION 1: QI PROGRAM STRUCTURE

Activities in the 2019 QI Program and associated Work Plan activities focused on refining the structure and process of care delivery, with the emphasis on member centric activity and consistency with regulatory and accreditation standards. All activities were undertaken in direct support of the Mission, Vision, Values and Strategic Initiatives of CalOptima's Board of Directors.

Components of the QI Program and Structure

The components of the QI Program are closely aligned to meet the goal of continuously improving the quality of care for our members.

QI Program Documents:

- **Annual Evaluation** — Completed a comprehensive evaluation of the QI program at the end of the fiscal year that assesses the performance of measures/indicators that are part of the QI program.
- **Program Description** — Developed and implemented a robust written QI program description that focuses on improving standards of care and addressing gaps in care identified in prior year's evaluation. The organization will enhance the QI program by

including “new initiatives” in the QI program description that will outline measurable goals and objectives that the organization is going to focus on in subsequent years.

- **Work Plan** — Created a work plan to monitor and evaluate performance of QI measures and interventions on an ongoing basis. This is a dynamic document that may change throughout the year dependent on priorities and opportunities.
- **Policies and Procedures** — Ensure that the organization has developed and implemented appropriate policies and procedures that are needed to provide care to the members.

Reviews of QI Documents:

- CalOptima successfully completed review of all the above documents with the QI committees during 2019. The documents were reviewed and approved by the CalOptima Board of Directors.
- Feedback from the practitioners that participated in the QI committee meetings were included in program documents (i.e. Program Description, Work Olan and Annual Evaluation).

Quality Improvement Committee (QIC) — Provides critical feedback and guidance to the QI department on key initiatives. The QIC also reviewed and approved all the key documents in a timely manner.

- The QIC is the primary committee that is responsible for the QI Program and reports to the Quality Assurance Committee (QAC) of the Board. The committee also recommends policy decisions.
- The committee provided oversight and direction to the QI Program, Work Plan and Evaluation in the first quarter of 2019. This gave the QI department a framework on how to start implementing the QI program throughout 2019. For the remainder of the year, the QI staff updated the committee on the progress of the program through regular reports. In addition to reviewing and approving the reports, the QIC (which included participating practitioners) provided valuable insight on barriers and potential interventions. These recommendations focused on improving performance improvement activities directed towards clinical quality, quality of service, patient safety, as well as quality cultural and ethnic accessible services. Upon evaluation of the QI activities, the QIC recommended needed actions or improvements to the activities and ensured follow-up, as appropriate.
- In 2019, the QIC reviewed and provided feedback on key clinical and other coordination of care initiatives like member outreach, provider education and outreach, incentives, educational materials, etc.
- The committee also reviewed and approved the policies and procedures as they were presented to the committee throughout 2019.
- The committee reviewed and provided feedback on key reports: annual analysis of Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS); access to care; complaints and appeals; etc. Part of the feedback included specific actions that CalOptima could take to improve performance.
- The committee also received quarterly reports from the Credentialing Peer Review, Utilization Management Committee, Member Experience Committee, Grievance and Appeal Committee, Behavioral Health QIC and LTSS-QISC. At the end of 2019, to fully integrate BHI and LTSS into the existing QIC, it was recommended to sunset the BHQIC and LTSS-QISC in 2020 and incorporate reporting directly to QIC.
- The QIC established the Whole-Child Model Clinical Advisory Committee (WCM CAC) at the end of 2018 and met eight times in 2019. The committee’s purpose is to provide

clinical guidance to the Whole-Child Model program which services children with CCS eligible conditions. The WCM program at CalOptima operates in collaboration with the County CCS, Family Advisory Committee, and Health Network CCS providers and had a successful launch on 7/1/2019. The committee has initiated review of quality measures related to the WCM program and will monitor performance measures in 2020.

Assessment of QI Staff and Resources:
CalOptima continues to dedicate significant resources and staffing to meet the needs of the QI program. The QI department also has support from other key departments within the organization including, but not limited to, the following:

- Quality Analytics
- Population Health Management
- Behavioral Health Integration
- Case Management
- Member Services (including outreach and engagement)
- Provider Relations and Contracting
- Credentialing and Facility Site Review

Review of System Resources:
CalOptima has dedicated significant resources to ensuring they have adequate systems in place to monitor and evaluate performance of QI programs on an ongoing basis. The resources include HEDIS Analysts for reporting plus extensive analytic staff support. Additional support and collaboration were provided by Provider Relations, Network Management, Grievance and Appeals, and Customer Service departments.

CalOptima has the capability to generate quality reports, gaps in care reports, physician feedback reports, and other relevant reports needed in the QI program. There is a robust data integration flow in place that allows the organization to utilize data from different sources and identify improvement opportunities. The team also has an adequate number of business analysts that can support the reporting needs of the organization.

Overall Assessment of Program Structure:

At the current time, CalOptima has adequate staffing and resources required to meet the needs of the QI program in addition to organizational program requirements. CalOptima will continue to evaluate the needs of the program through the work plan on a quarterly basis and add staffing and additional resources, as needed to supplement the QI department. The organization receives adequate feedback from its community practitioners in the development and implementation of the QI initiatives and programs through the different committees.

SECTION 2: QUALITY & SAFETY OF CLINICAL CARE

HEDIS Overview

CalOptima monitors several external and internally developed clinical quality measures measure and track the quality of health care services provided by the Plan and its network of contracted providers. In order to calculate these rates for these measures, CalOptima collects data for a number of different sources that include, but are not limited, to the following:

- Annual HEDIS submission
- Claims and encounter data from contracted primary and specialty care providers

- Claims and encounters from ancillary care providers (e.g. hospitals, labs, radiology centers, etc.)

Measuring and reporting these measures helps CalOptima assess the effectiveness of the care members are receiving. These clinical quality measures are used to evaluate multiple aspects of patient care including preventive care, coordination of care, patient safety, and management of chronic conditions.

Overall Performance Highlights:

- Medi-Cal
  - All DHCS measures required to achieve a MPL were met in 2019 (based on the latest plan level HEDIS results for measurement year 2018)
  - 42 out of 62 (68%) measures performed better than the prior year.
  - 69% of measures are at the National Medicaid 50th percentile or higher.
  - However, the goal is to improve all the State required measures to above the 50th percentile as it is the new requirement by the State.
  - Pay for Value program measures showed improvement but several still below the 50th percentile.
  - Based on the review of rates, several measures were identified as an opportunity for improvement. The following measures performed at a lower percentile in comparison to prior year. CalOptima is going to monitor these measures in the 2020 QI Work Plan.

Key Measures for Medi-Cal:

Focus on new MCAS measure set required by DHCS

Measures in red indicate a decrease from HEDIS 2018 performance

easure	Quality Compass Percentiles Met	
	HEDIS 2018	HEDIS 2019
Comprehensive Diabetes Care (HbA1c Testing)*	75th	50th
Comprehensive Diabetes Care (Eye Exam)* (not a MCAS measure)	75th	50th
Cervical Cancer Screening	50th	50th
Breast Cancer Screening	50th	50th
Prenatal and Postpartum Care (Prenatal Care)	50th	50th
Prenatal and Postpartum Care (Postpartum Care)	75th	50th
Well Child Visits in the First 15 Months of Life	<10th	<10th
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life	75th	50th

* Drop in rate may be due to change in specification from prior year. NCQA issued guidance to trend this measure with caution.

Key Measures for OneCare (OCC) Connect LOB:

Measure	Quality Compass Percentiles Met	
	HEDIS 2018	HEDIS 2019
Breast Cancer Screening	3 Star	2 Star
Plan All-Cause Readmissions (OCC Quality Withhold)	1 Star	2 Star
Antidepressant Medications Management (Acute Phase Treatment)	<=10th	25th
Follow-up After Hospitalization for Mental Illness (OCC Quality Withhold)	<10th	25th
Adults' Access to Preventive/Ambulatory Health Services (age 20–44) +C	<=10th	25th

Key Measures for OneCare LOB:

Measure	Quality Compass Percentiles Met	
	HEDIS 2018	HEDIS 2019
Breast Cancer Screening (C01)	2 Star	3 Star
Colorectal Cancer Screening (C02) +C	3 Star	3 Star
Plan All-Cause readmissions	3 Star	2 Star
Adults' Access to Preventive/Ambulatory Health Services (Total) +C	50th	25th

Evaluation of 2019 Priority Initiatives

CalOptima Homeless Health Initiative

The CalOptima Homeless Health Initiative (HHI) was launched on April 1, 2019, to bridge the gap for the homeless population between existing care delivery systems and the needs of a transient and transitioning membership.

The program objectives were to provide care to homeless CalOptima members in more nontraditional settings through Clinical Field Teams (CFTs), mobile clinics and clinics in shelters. In addition, preventive services for the homeless were established through a quality incentive-based Homeless Clinical Access Program (HCAP). Attention for putting recuperative care and a medical respite program for homeless CalOptima members are in progress.

Next steps include helping transition members back to their primary care provider (PCP). Evaluation of this initiative will be ongoing in 2020, and strategy will be adjusted accordingly.

CalOptima Days

In 2019 CalOptima collaborated with our health network partners and community clinics to co-host 27 health and wellness events called “CalOptima Day.” Our provider partners designated a day to prioritize appointments for CalOptima members. Of the 27 CalOptima Day events there were five piloted to target the adult population. These events were to outreach to CalOptima members who were due for either a well-care visit and/or immunizations. CalOptima successfully provided well-care checkups and immunizations to more than 1,250 Medi-Cal

members through these CalOptima Day events. The aim was to increase the HEDIS rates for pediatric measures and to achieve the performance goals as defined by the 2019 QI Work Plan.

Member Participation:

- 1250 members attended CalOptima Day events in 2019
- The average attendance rate per event was 68.72%

Targeted Pediatric HEDIS Measures:

1. Childhood Immunization Status (CIS)
2. Immunizations for Adolescents (IMA)
3. Well-Child Visits in the First 15 Months of Life (W15)
4. Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)
5. Adolescent Well-Care Visits (AWC)

Potential Impact (based on dates of service through June 2019):

- Based on the July 2019 Prospective Rates:
  - The following are potential HEDIS numerator hits: (based on member attendance at CalOptima Day)
    - 34 W15, 21 CIS, 39 IMA, 158 W34 and 373 AWC hits
    - The 18 pediatric events yielded a total potential of 625 HEDIS hits across the 5 measures
    - These are "potential" HEDIS hits because CIS-Combo 10, IMA-Combo 2 and W15 requires the completion of a combination of vaccinations or a series of well-care visits.

Discussion: Although evaluation of CalOptima Days (based on July Prospective Rates for pediatric measures) shows no significant impact to plan or HN level HEDIS rates, it was due to the low volume of members seen versus the overall denominator. The five CalOptima Days targeting the adult population showed similar impact as the pediatric populations.

- Many Benefits:
  - Improved data sharing and collaboration with provider offices
  - Increased interest from provider offices due to provider incentive
  - Positive member experience
- Challenges for CalOptima Days:
  - Resource intensive
  - Little impact on plan and HN HEDIS measures
  - Due to data lag, identification of those members needing services was challenging

Next Steps:

- Based on the review of results, CalOptima Days will focus on more targeted measures with smaller denominators.
- CalOptima Days will focus partnership will those providers willing to take on more responsibility to mine their own practice data to mitigate the issues related to data lag and to reduce the CalOptima resources needed. This will allow for the expansion of CalOptima Days and subsequent increased member participation without an increase in CalOptima staff resources.

P4V Program

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

This trend is very consistent with California Health Care Foundation's recently published quality report entitled: *A Close Look at Medi-Cal Managed Care: Statewide Quality Trends from the Last Decade.* From 2009–2018, quality of care in Medi-Cal managed care was stagnant at best on most measures. Among 41 quality measures collected in two or more years, 59 percent remained unchanged or declined. CalOptima's HNs provided feedback including, concerns with difficulty of improving selected measure due to the size of the eligible population and/or difficulty in gathering data. Based on the feedback, a proposed new methodology aims for greater transparency, consistency and administrative simplification. Finally, the proposed methodology aligns with changes to the measures that are important to CalOptima's National Committee for Quality Assurance (NCQA) Accreditation status, Centers for Medicare and Medicaid Services (CMS) Star Rating Status, newly required DHCS managed care accountability set (MCAS) and/or overall NCQA Health Plan Rating. This new methodology will be presented to our QAC in February 2020.

Provider Incentive Programs:

In addition to our comprehensive P4V Program, CalOptima also extended provider incentives for several Performance Improvement Plans (PIPs), and quality initiatives. Areas of focus included, Improving Adult Access to Primary Care Services, Screening for Clinical Depression, Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents, and Well-Child Measures. Preliminary data suggest the provider incentives added value for all initiatives except for Improving Adult Access to Primary Care Services.

Member Incentive Programs

CalOptima Days were targeted events, where identified child, adolescent and adult members were given a $25 gift card to come in for a well-care or immunization visit. The total member incentives distributed for CalOptima Day events was approximately $25,000 for 2019. CalOptima also had other Medi-Cal member incentive programs in 2018 that were continued in 2019. These include: diabetic eye exam, diabetic A1C test, Shape your Life (weight control), breast and cervical cancer screening.

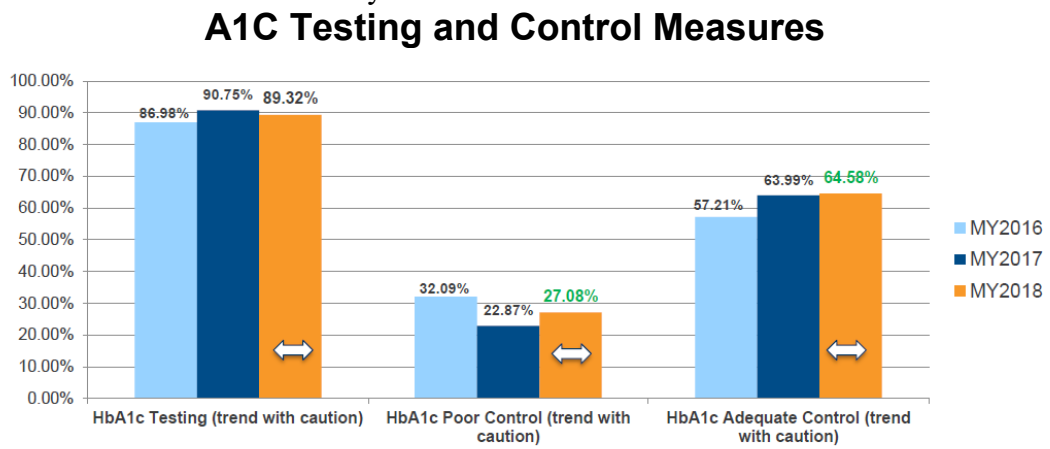
In 2019, new Medi-Cal member incentives were launched, including those for the postpartum care and W15 measures. CalOptima will continue existing member incentives in 2020, but will be adding member incentives for adolescent well-care visits for Medi-Cal, colorectal cancer screening for OC and OCC, and expand the current breast cancer screening incentive to OC and OCC.

Evaluation of Interventions for Specific HEDIS Measures

Comprehensive Diabetes Care (CDC)

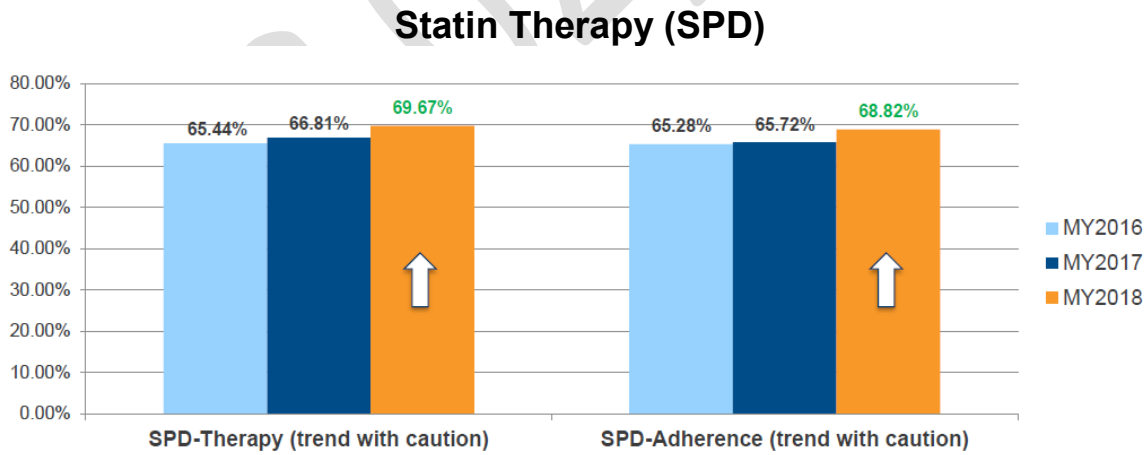
Eye Exam and A1C Testing and Statin Therapy for Patients with Diabetes (SPD)

The tables below show the trend analysis for Medi-Cal CDC and SPD measures for the last 3 years.



HEDIS Measure	QC 50th Percentile	QC 75th Percentile	QC 90th Percentile	Goal	Reporting Requirements*
HbA1c Testing	87.83%	90.45%	92.7%	91.58%	MPL
HbA1c Poor Control (>9.0%) (Lower is better)	38.2%	33.09%	29.68%	29.68%	MPL
HbA1c Adequate Control (<8.0%) ++	51.34%	55.47%	59.49%	59.49%	ACC, P4V, MPL, RS

*Red = less 50th percentile, Green= met goal, MPL met, ++ measure triple weighted for Health Plan Ratings
↑ ↓ statistically higher or lower ↔ statistically no difference
*RS=Health Plan Rating, MPL=DHCS Minimum Performance Level, ACC=NCQA Accreditation, P4V=Pay for Value



HEDIS Measure	QC 50th Percentile	QC 75th Percentile	QC 90th Percentile	Goal	Reporting Requirements**
Statin Therapy for Patients with Diabetes (SPD) - therapy	62.7%	65.6%	68.78%	67.19%	ACC, RS
Statin Therapy for Patients with Diabetes (SPD) - adherence	59.11%	64.62%	72.03%	68.33%	ACC, RS

*Red = less than 50th percentile, Green= met goal, MPL met
↑ ↓ statistically higher or lower ↔ statistically no difference
**RS=Health plan rating, MPL=DHCS Minimum Performance Level, ACC=NCQA Accreditation, P4V=Pay for Value

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Completed Activities in 2019:

- IVR campaign with A1C testing and statin medicine messaging for diabetics ran in November 2019 in conjunction with Diabetes Awareness month.
- Direct mail of separate diabetic eye exam and A1C testing member incentive to members who were still outstanding for an annual exam or test.
- Incentivize Diabetic Eye Exams through P4V program.
- Member newsletter article on the importance of Diabetic yearly eye exams, and statin use after a heart attack.
- Collaboration with various HNs on promoting incentive via their call campaign outreach efforts.
- Targeted round-robin identification of high-risk members with diabetes for telephonic health coaching on outstanding exams and tests needed.
- Targeted call campaign intervention launched in Oct./Nov. identified emerging risk population of diabetics who were well controlled, but now have an A1C between ≥8.0% and ≤9.0%.
- Provider fax reports of diabetic members NOT on a statin.
- Complementary member quarterly mailings to educate members with diabetes NOT on a statin on the benefits of statin-use in preventing cardiovascular risk and the importance of having the discussion with their provider.
- Social media message in November 2019 emphasizing the increased for heart disease with diabetes, encouraging members to talk to their doctor about whether a statin may be right for them.

Existing Barriers:

- Members were confused about their benefits related to eye exams. Members who are diabetic are covered to see a vision specialist once every 12 months, but this may not have been communicated clearly to members. CalOptima obtained approval for members to get the service every 12 months with one vendor but this was not translated into the vendor's daily operations for identifying eligible members with diabetes.
- Sharing information between specialists and PCPs sometimes does not occur, thus the PCP may not be aware of previous diabetic eye exam results or the need for an annual diabetic eye exam.
- Limitations in obtaining lab and test data from electronic health records as well as from non-contracted lab vendors.
- Reconciliation of provider data with CalOptima, as some providers use point of care and are not submitting through normal channels.
- Members are not aware of the increased risk of cardiovascular complications with diabetes.

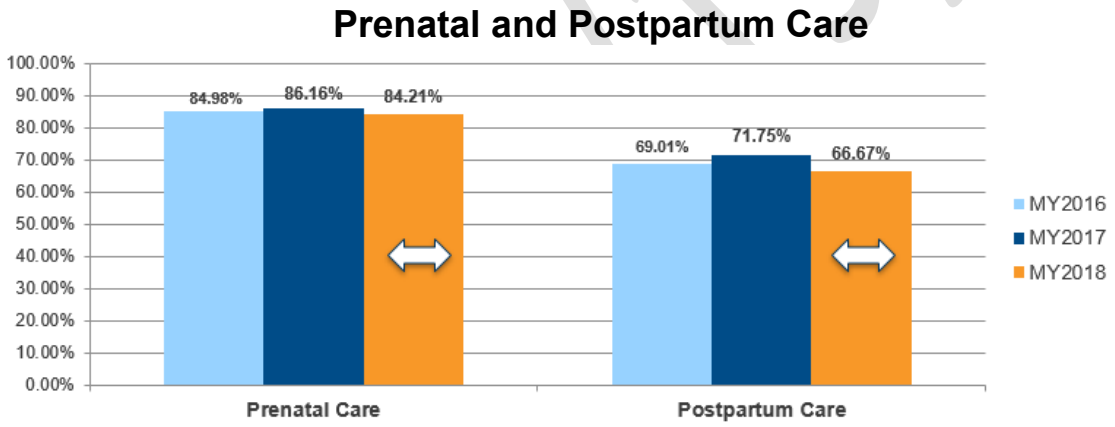
Next Steps for 2020:

- Add A1C testing and good control of A1C levels to 2020 P4V program.
- Promote more widely the $25 member incentive program for completion of diabetic eye exams and A1C testing to providers through various provider communication modes such as fax blasts, provider portal, HN and provider meetings and through provider relations representatives.
- Offer member incentives to all diabetic members, instead of targeted mailing to only those who are non-compliant.
- Promote the member incentive on the CalOptima updated website as well as through social media and various health guides and newsletters.

- Strategize promotion of member incentives through website, newsletters and other avenues.
- Collaborate with Office Ally and other electronic health records to improve lab data
- CalOptima website and social media platforms will have educational message banner rotating with diabetes awareness messaging in November.
- Continue targeted call campaign and health coaching intervention for CDC identified members at risk.
- Update VSP contract to ensure barrier is removed for annual eye exam for members with diabetes.
- Implement integration of EMR data from Office Ally.
- Continue quarterly faxes to providers of their diabetic members who are not compliant or not on a statin.
- Continue quarterly member mailings to newly identified diabetic members who are not currently on a statin.
- Newsletter articles on the importance of diabetic labs and exams, and diabetes and heart health on statin-use.

Prenatal/Postpartum Screenings (PPC)

The table below shows the trend analysis for Medi-Cal PPC measures for the last 3 years.



HEDIS Measure	QC 50th Percentile	QC 75th Percentile	QC 90th Percentile	Goal	Reporting Requirements**
Prenatal Care	83.21%	87.06%	90.75%	87.06%	ACC, MPL, RS
Postpartum Care	65.21%	69.34%	73.97%	73.97%	ACC, MPL, RS

*Red = less than 50th percentile, Green= met goal, MPL met
↑ ↓ statistically higher or lower ↔ statistically no difference
**RS=Health plan ratings, MPL=DHCS Minimum Performance Level, ACC=NCQA Accreditation, P4V=Pay for Value

Completed Activities in 2019:

- The postpartum care member incentive dollar amount increased Sept. 1, 2019 from $25 to $50.
- Collaborated with engaged HNs with their call campaign outreach efforts.
- Strategized promotion of member incentives through website and monthly quality meetings with HNs.

- Member newsletter Spring and Fall 2019 promoted Health Management Programs, including Bright Steps Maternity Health Program and emphasized the importance of the postpartum visit.

Existing Barriers:

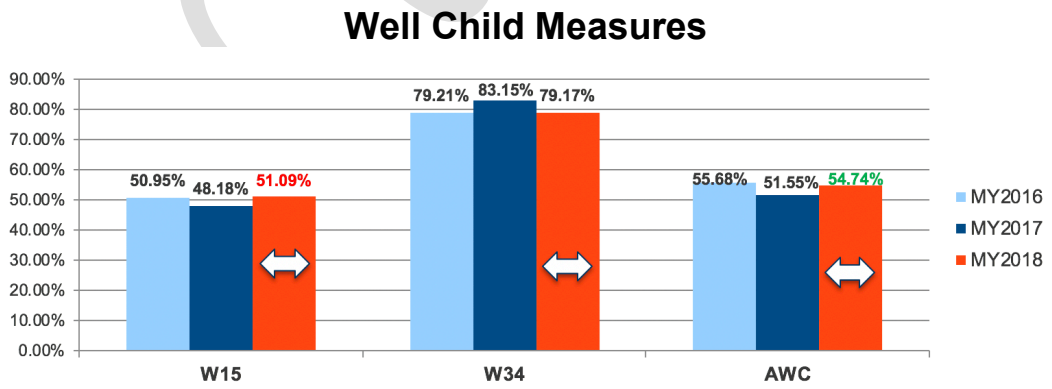
- A significant number of members have been going in for the wound check visit within the first two weeks and not returning for a postpartum visit between days 21–56 days of delivery.

Next Steps for 2020:

- Promote the $50 member incentive program for completing a postpartum visit within the required timeframes.
- CalOptima website and social media platforms will have an educational message banner rotating with women's health and maternal mental health awareness messaging in May 2020.
- HEDIS Postpartum Care technical specifications have been relaxed to promote a visit between 1–12 weeks and will likely have a large impact on compliance.
- Conduct Bright Step postpartum assessment in a timely manner.
- Improve collaboration with HNs and CalOptima's Community Network (CCN) providers to promote prenatal and postpartum visits.
- Prenatal and postpartum care measures will be incentivized in the 2020 P4V program.
- Member newsletter articles in 2020 emphasizing prenatal and postpartum care and the member incentive.

Well-Child Visits 0-15 Months (W15)

The rates for the W15, W34 and AWC measures are presented below. W15 measure performed below the 50th percentile and is at risk for being below the new MPL in 2019.



HEDIS Measure	QC 50th Percentile	QC 75th Percentile	QC 90th Percentile	Goal	Reporting Requirements**
Well-Child Visits in the First 15 Months of Life — 6 Well-Child Visits (W15)	66.23%	71.29%	75.43%	58.54%	P4V
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	73.89%	79.33%	83.7%	83.70%	MPL, P4V
Adolescent Well-Care Visits (AWC)	54.57%	61.99%	66.8%	54.57%	P4V

*Red = less than 50th percentile, Green = met goal, MPL met, ↑ ↓ statistically higher or lower, ↔ statistically no difference
**RS = Health plan rating, MPL = DHCS Minimum Performance Level, ACC = NCQA Accreditation, P4V = Pay for Value

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Completed Activities in 2019:

- W15 member incentive of $50 gift card was sent to targeted members due with missing well-child visits 4–6 with ample time to complete before the 15th month birthday deadline to impact HEDIS MY 2019.
- W15 provider incentive of $50 for each completed incentive form for eligible members.
- Health Guides with immunization and well-child schedules were mailed to all members Ages 0–6 in Q2 of 2019.
- Medi-Cal member newsletter Spring 2019 highlighted articles promoting scheduling first health exam for new members, well child visits and immunizations.
- Targeted W15 call campaign to promote the 5 and/or 6 visits for members in HEDIS 2020 by health educators (Sept–Oct).
- This measure was incentivized in the 2019 P4V program.
- CalOptima Day events for child measures also included targeted W15 at high-volume provider offices.
- Root cause analysis via survey to new mothers asking them where they took their children for their first two well-child visits and when. Final confirmation of survey responses pending cross-check with claims and encounter data.
- Provider fax blast to all PCPS of members with outstanding W15 visits.

Existing Barriers:

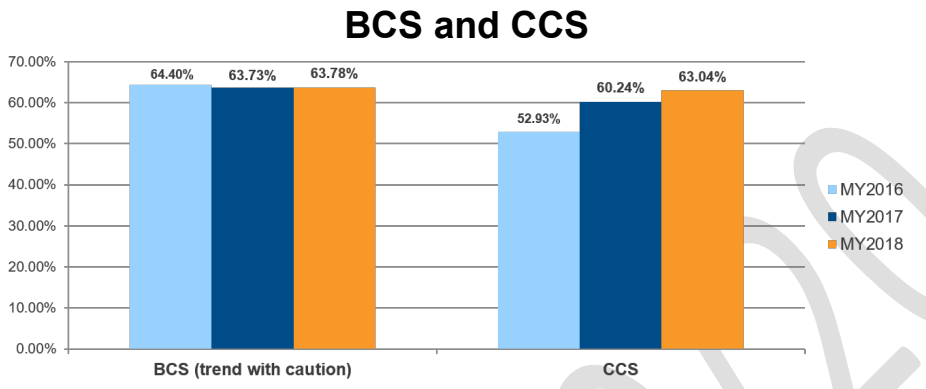
- One of the major barriers is identifying the visits which occur in the first two months of life as they frequently occur under the mother's name and ID/medical record/CIN. It is partly related to the way the baby is covered by Medi-Cal after delivery and this can cause a lot of confusion when the data does come into the plan.
- Also, providers do not always use the right CPT code, so it seems like a regular office visit that occurred for the mother rather than a well-child visit that occurred for a newborn baby.
- Members are not completing the full requirement of 6 visits in a timely manner or are not aware that they need to get 6 visits before the 15 month birthday.

Next Steps in 2020:

- Evaluation shows there are members who have completed well-care visits in the first two months of life for which we have no data. Additional assessment of data gaps in process.
- Implement CalOptima Days targeting the W15 population only at high volume provider offices.
- Promote incentive program for completing 1–3 and 4–6 well-child visits in the first 15 months of life to members and providers alike through various modes of communication, including the website and portals.
- Targeted outreach campaigns (IVR, call campaigns, etc.) throughout the year. At least five to six touch points during the year are necessary for the member to change their behavior.
- Medi-Cal member newsletter Spring 2020 will have articles highlighting immunization schedules for children returning to school, well-care visits and scheduling first health exam for new members.
- Promotion of W15 member incentive through Bright Steps prenatal and postpartum calls with PCCs.
- Well child visits for 15 month, 3-6 years and adolescents, will be incentivized in the 2020 P4V program.

Breast Cancer Screening (BCS) and Cervical Cancer Screening (CCS)

In 2019, CalOptima had initiatives for breast (BCS) and cervical (CCS) cancer screenings. The table below shows a trend analysis for Medi-Cal BCS and CCS for the last three years. The rates have been steady for BCS but show improvement for CCS.



HEDIS Measure	QC 50th Percentile	QC 75th Percentile	QC 90th Percentile	Goal	Reporting Requirements*
Breast Cancer Screening (BCS)	58.04%	64.12%	68.94%	65.30%	ACC, MPL, P4V, RS
Cervical Cancer Screening (CCS)	60.1%	66.01%	70.68%	63.26%	ACC,MPL, P4V, RS

*Red = less than 50th percentile, Green= met goal, MPL met
↑↓ statistically higher or lower ↔ statistically no difference
**RS=Health plan rating, MPL=DHCS Minimum Performance Level, ACC=NCQA Accreditation, P4V=Pay for Value

Completed Activities in 2019:

- Continued monitoring and tracking incentive for both screening measures.
- Collaborated with willing HNs with their call campaign outreach efforts.
- Promoted member incentives through website and other avenues.
- CCS and BCS member incentives were increased to $25 starting September 1, 2019. This incentive was shared with HNs to promote at point of service and aligned with HN campaigns.
- Facets reminder message campaign prompting Customer Service representatives to convey to members if they are eligible for breast cancer screening Sept. 30–Dec. 31, 2019.
- BCS IVR campaign targeting Medi-Cal population in October 2019 was completed.
- Breast and Cervical Cancer Screenings were incentivized in the 2019 P4V program.

Existing Barriers:

- Members do not go to their doctor in a timely manner even when they are referred for their screening tests.
- Members are afraid to know the result of the test and avoid getting screened because of that fear.
- Members may not be discussing the reasons for their fear and how to overcome it with their providers.
- The providers may not be spending enough time with their patients at the time of the referral to explain to them the importance of the screening and how early detection can improve outcomes.

Next Steps for 2020:
As a part of the quality initiative, CalOptima will focus on the following initiatives to improve screening for cancer:

- Continue and widely promote the $25 incentives for the BCS and CCS screenings.
- Implement a $50 OC/OCC member incentive for colorectal cancer screening to launch January 2020.
- Targeted outreach campaigns to promote BCS, CCS, and colorectal cancer screening (i.e. IVR, calls, etc.)
- CalOptima website will have educational message banner rotating with cervical, breast and colorectal cancer awareness messages in their corresponding awareness months in 2020.
- BCS and CCS screenings will continue to be incentivized in the 2020 P4V program.
- Member newsletter articles emphasizing adult preventive health screenings and wellness exams including BCS and CCS.

Follow-Up After Hospitalization for Mental Illness (FUH)

This is a quality initiative and HEDIS measure that the Behavioral Health Integration department has been monitoring since its inception. The intent of this measure is to ensure that a member has a follow-up care visit with a clinical provider within 7–30 days of discharge from the hospital. The behavioral health clinical team discusses strategy and interventions with the Managed Behavioral Health Organization (MBHO) on a bi-weekly basis. Some of the barriers identified by the MBHO include unable to contact members post discharge, members do not consider the follow-up appointment as a priority, and facilities not engaging members in discharge planning. The current MBHO is managing interventions (i.e., some outreach/coordination) until 12/31/19. CalOptima has offered additional interventions (e.g., flagging returning members to prompt call center staff to offer additional support when member calls in).

In 2020, CalOptima will stop working with the MBHO and bring BH services in house. CalOptima will be directly managing BH on 1/1/2020 and is currently looking at ways to improve follow-up after hospitalization. As a part of its quality initiative, CalOptima will continue to focus on improving rate for this measure by doing the following activities:

- Visit top three hospitals in the first quarter.
- Follow-up with facilities during regular joint operation meetings.
- Outreach to members post discharge to coordinate follow-up appointments.

Safety of Clinical Care

Plan All-Cause Readmission (PCR)

Completed activities in 2019:

- Updated Transition of Care post-discharge program, all diagnosis for all LOB (focused on Anaheim and Fountain Valley hospitals)
- New project proposal to identify ER visits in near real time versus claim based to reduce readmissions.
- CMS: CCN OCC Members with CHF and hospital admission. Health coaches contacted members to prevent unplanned readmission within 30 days (all hospitals excluding Anaheim and Fountain Valley).

Existing Barriers:
One of the main reasons that the all cause readmission rate is high is because there is a lack of communication between PCPs and inpatient facilities once the patient is discharged from the facilities. CalOptima identified the following as the key barriers that impacted this measure:

Facility Level Barriers:

- Practitioners often are not notified by hospitals when their member is hospitalized.

Plan Level Barriers:

- CalOptima does not have access to the electronic medical records (EMR) or health information exchange (HIE) systems at most inpatient facilities, which prevents it from playing a more proactive role in improving coordination of care between hospitals and PCPs. If CalOptima had access to the EMR systems and HIEs, it could ensure that the clinical notes were sent to the PCPs in a timely manner once the patient is discharged.
- CalOptima realizes that it needs to play a larger role in transitioning and coordinating care and is working on establishing more robust data sharing agreements with facilities. TOC is resource intensive for the low volume of member therefore strategy will be pivoted to allow greater impact on All Cause Readmissions.

Next Step for 2020s:

- Identification for ER visits in Data Warehouse through a new vendor.
- CMS: CCN OCC members with CHF and hospital admission. Health Coaches contact member to prevent unplanned readmission within 30 days
- Work with Office Ally to incorporate their EMR into CalOptima data warehouse for offices that are contracted with both entities.

Opioid Utilization

Opioid Utilization Data 2018-2019 Results

CalOptima Medi-Cal Opioid Analgesic Utilization	2018-Q3	2018-Q4	2019-Q1	2019-Q2	2019-Q3	% Change 3Q18 to 3Q19
Opioid Analgesic Rxs	44,697	41,335	38,819	38,585	38,426	-14.0%
% Members Utilizing Opioid Analgesic Rxs	1.23%	1.15%	1.10%	1.08%	1.09%	-11.6%
Opioid Analgesic Rxs PMPQ	0.0236	0.0222	0.0210	0.0206	0.0208	-11.5%
Members Receiving > 80mg Avg MME	793	716	647	638	604	-23.8%
% Utilizing Members Receiving > 80mg Avg MME	3.39%	3.34%	3.18%	3.16%	3.01%	-11.3%
Average Quantity/Rx for Short-Acting Opioid Analgesics	53.9	54.5	53.7	52.4	51.7	-4.1%

CalOptima Organization-Wide Opioid Utilization Goals Fiscal Year 18/19	2018-Q1	2018-Q2	2018-Q3	2018-Q4	2019-Q1
Average Morphine Milligram Equivalent (MME)/Member Goal = 10% Decrease (<17.5)	19.5	18.6	17.9	17.2	15.6
Number of Members Receiving Concomitant Benzodiazepines and Opioid Analgesics Goal = 5% Decrease (<4,295)	4,522	3,880	3,819	3,521	3,251

CMS Medicare Star Display Measures

Use of Opioids from Multiple Providers and/or at High Dosage in Persons without Cancer (Part D): Multi-provider and/or high dosage opioid use among individuals 18 years and older without cancer and not in hospice care.

- Measure 1: Use of Opioids at High Dosage (OHD): Members receiving prescriptions for opioids with a daily dosage greater than 120 mg morphine milligram equivalents (MME) for 90 consecutive days or longer.
- Measure 2: Use of Opioids from Multiple Providers (OMP): Members receiving prescriptions for opioids from four (4) or more prescribers AND four (4) or more pharmacies.
- Measure 3: Use of Opioids at High Dosage and from Multiple Providers (OHDMP): Members receiving prescriptions for opioids with a daily dosage greater than 120 mg morphine milligram equivalents (MME) for 90 consecutive days or longer, AND who received opioid prescriptions from four (4) or more prescribers AND four (4) or more pharmacies.

Patient Safety Measure	Plan	2019 Rate	MAPD Rate	Contract Performance Relative to Contract Type Overall
Use of Opioids at High Dosage in Persons without Cancer	OneCare	6%	7%	Equal or Better
Use of Opioids at High Dosage in Persons without Cancer	OneCare Connect	6%	7%	Equal or Better

Patient Safety Measure	Plan	2019 Rate	MAPD Rate	Contract Performance Relative to Contract Type Overall
Use of Opioids from Multiple Providers	OneCare	0%	0.52%	Equal or Better
Use of Opioids from Multiple Providers	OneCare Connect	0%	0.19%	Equal or Better

Patient Safety Measure	Plan	2019 Rate	MAPD Rate	Contract Performance Relative to Contract Type Overall
Use of Opioids at High Dosage and from Multiple Providers	OneCare	0%	0.04%	Equal or Better
Use of Opioids at High Dosage and from Multiple Providers	OneCare Connect	0%	0.04%	Equal or Better

Completed Pharmacy Management Interventions in 2019:

Prescriber:

- Quarterly prescriber report card: Intervention provided to providers whose average Milligram Morphine Equivalent (MME) dose per prescription fell above their practice specialty average.
- Prescriber Newsletters:
    - Deprescribing Benzodiazepines in Patients Receiving Opioids
    - Safe Medication Disposal in the Community
    - Co-prescribing Naloxone with Opioids
- Monthly Medicare Opioid Overutilization Intervention: Member opioid and benzodiazepine medication list faxed to most recent prescriber of members who meet CMS Opioid Monitoring System (OMS) Criteria.

Pharmacy:

- Implementation of opioid cumulative MME point-of-sale (POS) pharmacy edits such that members with claims exceeding a cumulative MME threshold of 90mg will trigger a soft rejection (overridable by the pharmacist) and exceeding 400mg will trigger a hard rejection (authorization required).
- Point of service soft drug utilization review (DUR) rejections for concomitant opioids and benzodiazepines.

Member:

- Retrospective identification of members meeting criteria for opioid overutilization for Medical Director Review and referral to Compliance, QI or Case management.
- Pharmacy Home Program Policy: Members filling prescriptions at four (4) or more pharmacies in a two-month period are restricted to a single pharmacy for a period of one year.
- Prescriber Restriction Program Policy: Pharmacy claims utilization reports indicate the Members filling controlled substance prescriptions from four (4) or more Prescribers in a two (2) month period are restricted to designated prescribers.

Formulary:

Medi-Cal

- Implementation of point-of-sale (POS) pharmacy edits triggering a soft rejection for opioid pharmacy claims attempted to be filled within 30 calendar days of a fill for buprenorphine-containing products.
- Require prior authorization for new starts for methadone doses above 30mg/day.
- Require prior authorization for new starts for all long-acting opioids.
- Stricter quantity limits for short-acting opioid analgesics.
- Concurrent use of opioids and benzodiazepines formulary safety edits that may be overridden at the pharmacy level when the pharmacist submits appropriate NCPDP codes upon review of drug therapy.

Medicare:

- Hard safety edit to limit initial opioid prescription fills to no more than a seven (7)-day supply.
- Pharmacist-driven care-coordination formulary safety edit for duplicative long-acting opioid therapy (excluding buprenorphine) with a prescriber count of at least two (2)

prescribers that may be overridden at the pharmacy level when the pharmacist submits appropriate NCPDP codes upon review of drug therapy.
- Pharmacist-driven opioid care coordination formulary safety edit would trigger when a member's cumulative MME per day across all opioid prescriptions reaches or exceeds 90 MME.
- Concurrent use of opioids and benzodiazepines formulary safety edits that may be overridden at the pharmacy level when the pharmacist submits appropriate NCPDP codes upon review of drug therapy.

Existing Barriers:
- Lack of timely data from DHCS for Medication Assisted Therapy (MAT) medication carve out claims for Medi-Cal members.
- No access to data for medications dispensed by Opioid Treatment Programs (OTP).

New Opioid Interventions in 2020:
- Effective October 1, 2019, CalOptima's Medi-Cal DUR program complies with section 1004 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act, and applicable guidance issued by DHCS: opioid pharmacy claims for members shall not exceed a cumulative morphine milligram equivalent (MME) of 500 MME/day without prior authorization.
- Promote Medication Assisted Therapy (MAT): The use of FDA- approved medications in combination with counseling and behavioral therapies for the treatment of substance use disorders.
- Contract with OTP for Medicare members effective January 1, 2020.

Be Safe Pilot Program
In addition to the pharmacy management interventions, CalOptima launched the Be Safe pilot program at the end of 2018 with the goals of decreasing opioid misuse, promoting appropriate prescribing, and decreasing adverse events related to opioid misuse.

Completed Activities in 2019:
- In 2019, CalOptima facilitated weekly Be Safe rounds to identify members at risk of opioid misuse and provide personalized outreach and assistance to members with high Morphine Milligram Equivalent (MME).
  - Each discipline had specific, timed interventions that approach and support each member's unique situation from their respective specialties.
  - Staff participants included Registered Nurse Case Managers, Behavioral Health clinician, Medical Director, and Clinical Pharmacist.
- The Be Safe rounds provided valuable information regarding the challenges of managing opioid use.

Existing Barriers:
- Resources for the Be Safe Program.

Next Steps for 2020:
- In 2020, Be Safe will take the lessons learned from the rounds and update the program to meet our objectives.

Post-Acute Infection Prevention Quality Incentive (PIPQI)

CalOptima engaged in a project with Nursing Facilities to reduce post-acute infections. At CalOptima we refer to this project as Shared Healthcare Intervention to Eliminate Life-threatening Dissemination (SHIELD) OC, and with Board approval began implementation on 10/1/2019. There are 25 Nursing Facilities participating, and of those, 12 were already participating with UCI since Q2 2017 in the SHIELD study. Participating facilities are required to use a solution of Chlorhexidine (CHG) soap to bathe all residents and administer Idophor (nasal swabs). CalOptima nurses are monitoring each facility monthly for CHG utilization and Hospital Acquired Infection (HAI) scores. Quality performance measures will be monitored in 2020. This program will be made available to additional facilities in 2020, with a kick-off mandatory training in Q1.

Facility Site Review (FSR)

Per DHCS, all PCP sites must have the capacity to support the safe and effective provision of primary care clinical services to Medi-Cal managed care health plans (MCP) members (Title 22, California Code of Regulations [CCR], Section 56230). The Site Review Process is part of a MCP's QI Program that focuses on the capacity of each PCP site to ensure and support the safe and effective provision of clinical services. In order to verify that PCP sites comply with all applicable local, state, and federal standards, CalOptima is required to conduct a Full Scope Facility Site Review (FSR), Medical Record Review (MRR), and Physical Accessibility Review Survey (PARS) for all PCP sites as part of the initial credentialing process and at least every 36 months thereafter.

In 2019, CalOptima continued to maintain safety standards and practices to their members by completing FSR/MRR/PARS at all contracted PCP offices, as well as PARS at high volume specialist offices. With a staff of three nurses, 64 Initial Facility Site Reviews, 282 Full Scope Reviews, and 462 PARS were conducted in 2019. There were 10 failed audits (3.5%) which increased from 2.4% in 2018. The number of CAPS issued in 2019 were 364, which increased from 285 in 2018. In April, DHCS proposed new criteria and scoring to the FSR/MRR tools. The changes to the MRR tool were significant and added additional criteria and guidelines to ensure member safety at provider offices. In December, DHCS issued a draft APL to supersede PL 14-004. The new tools are currently being field tested and evaluated with the intent to fully implement by 7/1/2020. Due to the volume of changes to the tools, additional resources and staffing will be required to meet the new DHCS requirements.

2019 Improvement Projects

The following are a summary of all Quality Improvement Projects (QIP), Chronic Care Improvement Programs (CCIP), Performance Improvement Projects (PIP) and PDSA projects for 2019 by each improvement project type.

Quality Improvement Projects (QIPs)

OCC QIP — Improving Statins Use for Patients with Diabetes (SPD) 2019–2020

- **Goal:** To increase statin use among members with diabetes by 5%.
- **Target Population:** All CalOptima Medi-Cal members with diabetes.

- **Interventions:** In tandem with an existing provider focused program to promote assessment of members with diabetes who might benefit from statin use in preventing cardiovascular risk, a member-focused multi-modal promotion campaign is in place to urge members with diabetes to have the discussion with their providers about whether a statin is right for them.
- **Activities:** Interactive Voice Recordings (IVR) messaging, quarterly member mailing campaign and newsletter articles promoting the discussion with their providers have been put into place to urge members to consider the potential benefits of preventing cardiovascular complications.
- **Summary of Results:** Program implemented in quarter 4, 2019. Data collection is in ongoing and in process.

Performance Improvement Projects (PIPs)

OCC PIP: Members with Individualized Care Plan Completed/Members with Documented Discussions of Care Goals 2018–2019

- **Goals:**
  1. CA 1.5 – Members with an Individualized Care Plan Completed. Year 1 Goal: High Risk: 79.9%; Low Risk: 71%
  2. CA 1.6 – Members with Documented Discussions of Care Goals. Year 1 Goal: 77.91%
- **Interventions:**
  1. Change language with Health Risk Assessment (implemented 1/3/18)
  2. Initiate Initial Care Plan (ICP) discussion goals at the first contact with member
- **Summary of Results:**

Study Indicator 1	
Study Indicator 1 Title	CA 1.5 High Risk with an ICP completed. (77.43%)
Measurement Year Goal	81.20%
Interim Measurement Period	Remeasurement 2 Period Quarter 1: 01/01/2019 to 03/31/2019 (PDSA cycle 4) Quarter 2: 04/01/2019 to 06/30/2019 (PDSA cycle 5) Quarter 3: 07/01/2019 to 09/30/2019 Quarter 4: 10/01/2019 to 12/31/2019
Results	High Risk (B/A) Quarter 1: (2019) 82.46% (PDSA cycle 4) Quarter 2: (2019) 82.79% (PDSA cycle 5) Quarter 3: (2019) 54.97% Quarter 4: (2019)
Study Indicator 2	
Study Indicator 2 Title	CA 1.5 Low Risk with an ICP completed. (68.48%) – 90 days continuous enrollment
Measurement Year Goal	73.48%

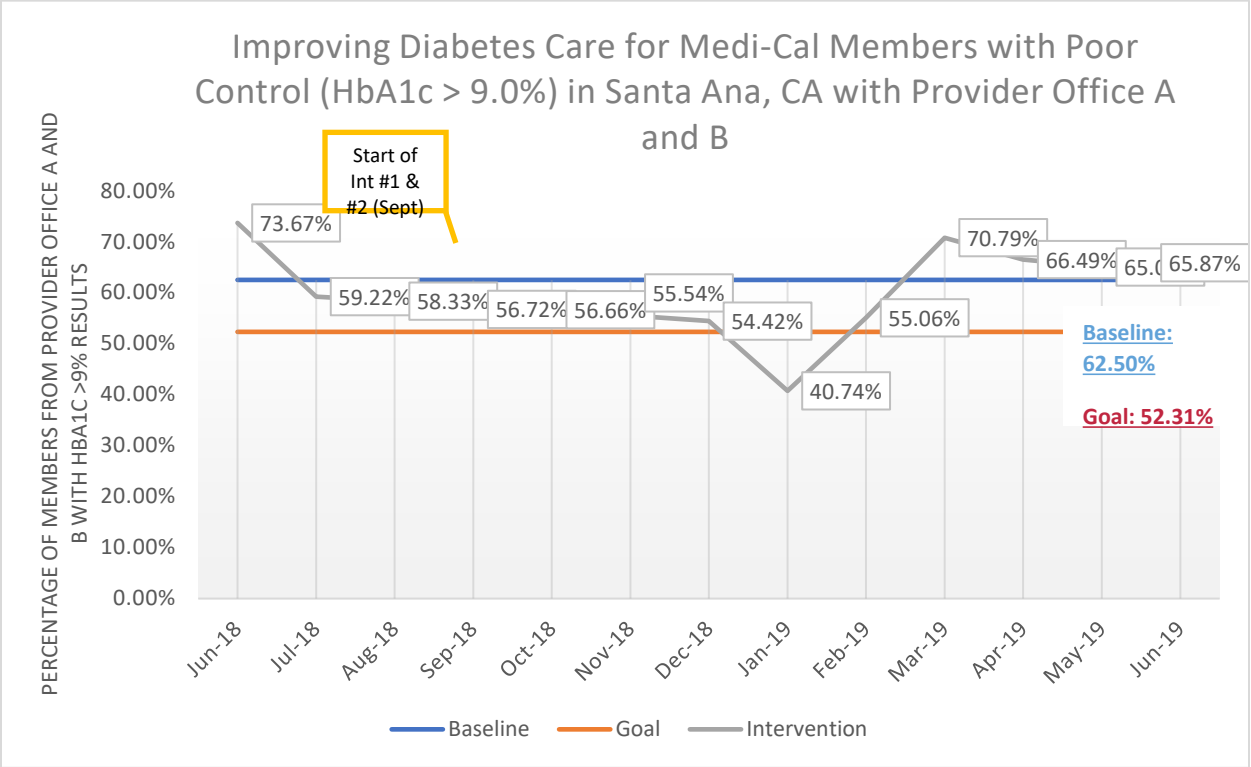
Interim Measurement Period	Remeasurement 2 Period Quarter 1: 01/01/2019 to 03/31/2019 (PDSA cycle 4) Quarter 2: 04/01/2019 to 06/30/2019 (PDSA cycle 5) Quarter 3: 07/01/2019 to 09/30/2019 Quarter 4: 10/01/2019 to 12/31/2019
Results	Low Risk (D/C) Quarter 1: (2019) 74.51% Quarter 2: (2019) 75.42% Quarter 3: (2019) 43.28% Quarter 4: (2019)
Study Indicator 3	
Study Indicator 3 Title	CA 1.6 OCC Members with Documented Discussion of Care Goals (74.81%)
Measurement Year Goal	81.57%
Interim Measurement Period	Remeasurement 2 Period Quarter 1: 01/01/2019 to 03/31/2019 (PDSA cycle 3) Quarter 2: 04/01/2019 to 06/30/2019 (PDSA cycle 4) Quarter 3: 07/01/2019 to 09/30/2019 (PDSA cycle 5) Quarter 4: 10/01/2019 to 12/31/2019
Results	Quarter 1: (2019) 93.01% (PDSA cycle 3) Quarter 2: (2019) 90.21% (PDSA cycle 4) Quarter 3: (2019) 91.02% (PDSA cycle 5) Cumulative Rate (up to end of each cycle/quarter): 1/1/18–3/31/19: 93.01% 1/1/18–6/30/19: 91.55%

For study indicators 1 and 2, changes made to our data collection process in response to regulatory guidance to only count care plans that had proof of member involvement resulted in a change to our data collection process. Our prior process did not have a positive review question that addressed member involvement. When we made the change, it allowed us to collect data specifically aimed at that question for each quarter going forward. However, since this is a cumulative measure, and the target criteria have been modified, when we applied the same logic, we lost the ability to count many care plans that were created prior to the question being implemented. We anticipate that our numbers will show improvement as we add new care plans with the new logic in upcoming quarters and we will see a decrease in the dilutional effect of the earlier care plans as the denominator increases.

For study indicator 3, results continue to show strong improvement, with Q3 results indicating that 91.02% of members had discussions of care goals. This intervention is proving to be effective and will be continued.

Medi-Cal PIP — Improving Diabetes Care for Medi-Cal Members with Poor Control (A1C >9%) residing in Santa Ana, CA — 2018–2019 COMPLETED

- **Goal:** By June 30, 2019, reduce the rate of poor or uncontrolled blood glucose levels (HbA1c >9) among diabetic CalOptima Medi-Cal members who are 18–75 years of age during the measurement period and enrolled in CCN at the two targeted provider offices from 62.5% to 52.31% in Santa Ana, CA.
- **Interventions:**
  1. Provider outreach — CalOptima provides targeted member registry list for providers to schedule health visit with member. Assess their diabetes status and provide appropriate health care services and referrals.
  2. Health coach targeted outreach — Health coach team will call members on the targeted member registry list to offer health coaching services. Follows the current health coaching process.
- **Summary of Results**:

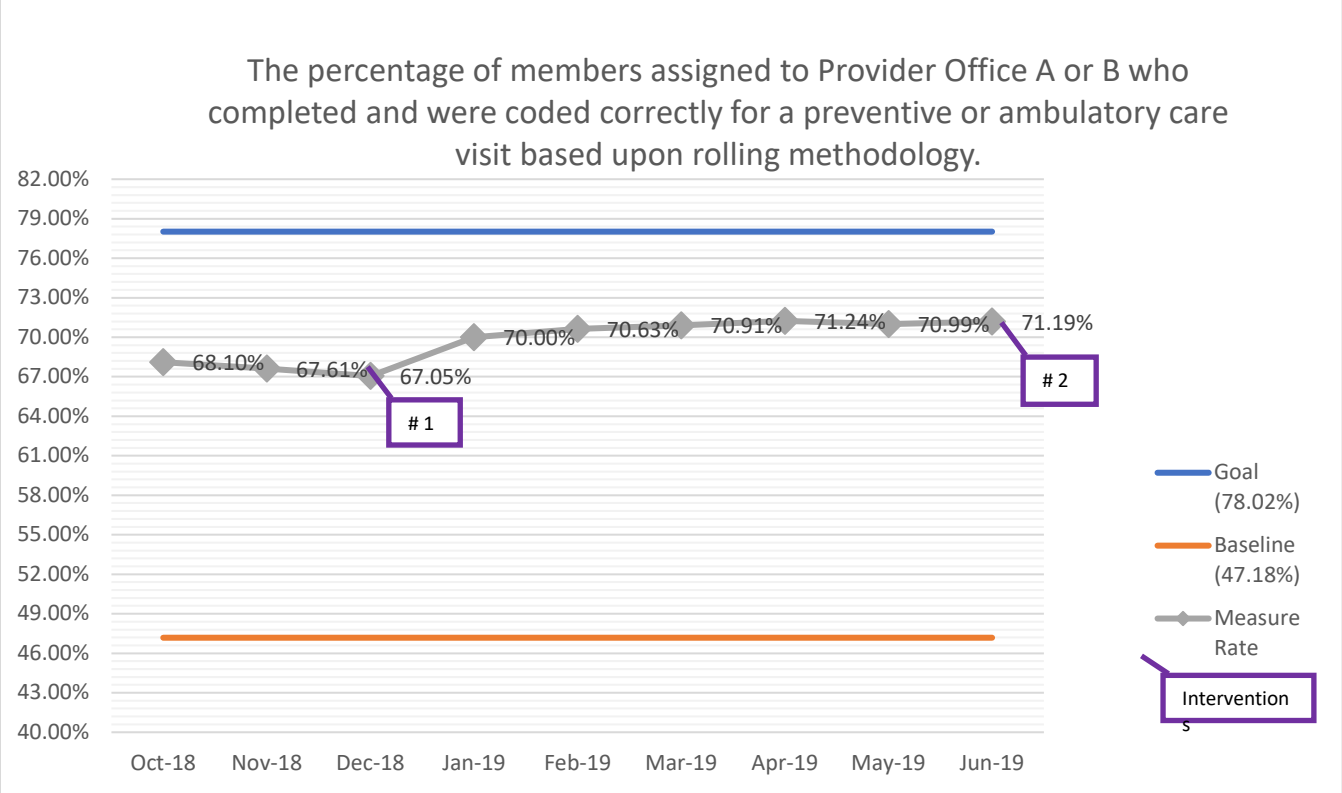


Intervention 1: Provider Outreach Start Date — September 2019
Intervention 2: Health Coaching Start Date — September 2019

CalOptima met our SMART Aim goal in January 2019, with the lowest rate of 40.74% in January 2019. We believe that the data reconciliation between CalOptima and Provider Office A and Provider Office B helped contribute to this decrease. The rate spiked up to 55.06% on February 2019, and 70.79% in March 2019, and the rate trended downward again before settling on 65.87% in June 2019. The increase in some of the denominators was due to the new HEDIS year and new diabetic members. For example, some of the diabetic members in 2019 were not part of the 2018 diabetic denominator since they were not eligible until 1/1/2019. Ultimately, we did not achieve our SMART Aim goal of 52.31% (lower than 52.31% is better). However, there were some good improvements from baseline for majority of the intervention period.

Medi-Cal PIP — Improving Adult's Access to Preventive/Ambulatory Health Services: Ages 45–65 years — 20018–2019 COMPLETED

- **Goal:** By 06/30/2019, increase the rate of adults' access to preventive/ambulatory health services among Medi-Cal members 45–64 years in CCN, from 78.02% to 82.49%.
- **Interventions:**
  1. Provider Office Staff Incentive — based on improvement from baseline.
  2. Member incentive ($25 for completing an adult well-care visit)
- **Summary of Results**:



Intervention 1: Launch of Provider Office Staff Incentive — December 2018
Intervention 2: Launch of Member Incentive — June 2019

From December 1, 2018 through June 30, 2019, Provider Office A and Provider Office B participated in outreach efforts to increase the number of preventive or ambulatory health care visits among CalOptima members between 45-64 years of age assigned to the CalOptima Community Network. The rate of completed preventive or ambulatory health visits in the target population at Provider Office A and Provider Office B increased from 47.18% to 71.19%. The SMART AIM goal of 78.02% was not achieved with this Performance Improvement Project. However, positive and incremental improvement was seen over the course of the intervention period. Specifically, the data illustrates that there was a rate increase in six out of the seven months of the intervention period. The exception was December 2019.

Chronic Care Improvement Programs (CCIPs)

OC CCIP — Emerging Risk — Improving A1C Control <8% for Members Recently Experiencing Poor Control >8% — 2019–2021

- **Goal:** Improve Comprehensive Diabetes Care (CDC) measure, specifically HbA1C good control (<8) by conducting proactive outreach to OneCare members with diabetes who were previously <8% but have moved to have an A1C ≥8% based on the most recent lab

results. The goal is to move 5% of OC members identified and who participate back to an A1C <8% within one year.

- **Target Population:** OC members at risk for poor control >8% who were previously in good control <8% based on recent labs.
    - These members have been enrolled by December 31st of the measurement year and be within 18–75 years old. Members must also have no more than one gap in enrollment of up to 45 days during the measurement year per HEDIS specifications.
    - Exclusion Criteria:
        - Ineligible CalOptima members
        - Members identified for long-term Care (LTC) or dementia
        - Members delegated to Kaiser
- **Interventions:** This intervention targets OC members with diabetes with A1C results trending upward from <8% to >8%. OC members that had an A1C result <8% but now have an A1C result ≥8% will be assigned to a health coach for telephonic coaching. Health coaches will be assigned approximately 15 emerging risk members every month and continue coaching the member on areas such as medication adherence, exercise and diet adjustments that will provide them success in decreasing A1C values <8%.
- **Summary of Results:**
  Program implemented in quarter 4, 2019. Data collection is in process. Preliminary results will be available quarter 1, 2020.

OCC CCIP — Emerging Risk – Improving A1C Control <8% for Members Recently Experiencing Poor Control >8% — 2019–2020

- **Goal:** Improve Comprehensive Diabetes Care (CDC) measure, specifically HbA1C good control (<8) by conducting proactive outreach to OCC members with diabetes who were previously <8% but have moved to have an A1C ≥8% based on the most recent lab results. The goal is to move 5% of OCC members identified and who participate back to an A1C <8% within one year.
- **Target Population:** OneCare Connect members at risk for poor control >8% who were previously in good control <8% based on recent labs.
    - These members have been enrolled by December 31st of the measurement year and be within 18-75 years old. Members must also have no more than one gap in enrollment of up to 45 days during the measurement year per HEDIS specifications. Exclusion Criteria:
    - Ineligible CalOptima Members
    - Members Identified for LTC or Dementia
    - Members Delegated to Kaiser
- **Interventions:** This intervention targets OCC members with diabetes with A1C results trending upward from <8% to >8%. OCC Members that had an A1C result <8% but now have an A1C result ≥8% will be assigned to a health coach for telephonic coaching. Health coaches will be assigned approximately 15 emerging risk members every month and continue coaching the member on areas such as medication adherence, exercise and diet adjustments that will provide them success in decreasing A1C values <8%.
- **Summary of Results:**
  Program implemented in quarter 4, 2019. Data collection is in process. Preliminary results will be available quarter 1, 2020.

PDSA Initiatives

OCC PDSA — Reducing Avoidable Hospitalizations and Other Adverse Events for Nursing Facility Residents LTC

- **Project:** Increasing post-hospitalization coordination and support among OCC LTC members in CNN to decrease acute readmission rates.
- **Reporting Period:** Cycle 6 (July 1, 2019–September 30, 2019)
- **Target Population:** OCC LTC members in CCN.
- **Goal:**
    - **Smart Objective 1:** By 6/30/2018, CalOptima will offer enhanced care coordination to all OCC CCN LTC members with ≥ two (2) acute admissions within the last rolling 12 months.
    - **Smart Objective 2:** By 12/31/2018, the rolling 12-month average acute admissions represented by OCC CCN LTC members with multiple admissions, 2.76 admissions per member per year at 2017 baseline, will decrease to ≤2.45 admissions per member per year.
    - **Smart Objective 3:** By 6/30/2019, the overall rolling 12-month average ratio of acute admissions represented by all OCC CCN LTC members, 0.88 admissions per member at 2017 baseline, will decrease to ≤0.79 admissions per member per year.
- **Interventions:** During the first phase of the new project, CalOptima will focus on providing enhanced care management strategies outlined below, for OCC CCN LTC members with ≥2 acute admissions within a rolling 12-month period, through assigned CalOptima Nurse Case Manager NCM's. These interventions will be initiated between 4/01/2018 through 6/30/2018. During the second or third phase of the project —pending feedback and outcomes from the initial implementation — CalOptima will extend the enhanced care management strategies to all OCC CCN LTC members with new acute admissions.

  Enhanced care management strategies for the targeted OCC CCN LTC members can involve the following interventions, as appropriate:
  1. Field visits with members
  2. Increased contact with member/family members
  3. Increased coordination with facility staff
  4. Increased participation with ICT meetings at the facility
  5. Pharmacy consult post-discharge
  6. Education and training with member/family member(s)
  7. Support in completing an advance directive
  8. Structured motivational interviewing/goal setting with members
  9. Additional coordination with ICT meetings, including PCP

  The assigned CalOptima NCM will be primarily responsible for either directly completing or supporting the facility staff's completion of the interventions outlined above, as appropriate. If a need for any of these interventions is identified, the NCM will attempt to ensure it is initiated within 30 days of making contact with the member/family member. While the assigned NCM will provide their availability to the member/family member and facility staff, the CalOptima PCC's, with their consistent availability in the office, will also act as additional contact points for the member/family members. The PCC can also follow-up on referrals and meetings, as needed.

  Summary of Results: (Cycle 6) — During 3Q2019, 22 hospital admissions by 17 OCC CCN LTC members were reported at the time of this update. Of these hospital admissions, 12 were a readmission within a 12 months period. That is, 12 of the members

have at least one other hospital admission during the preceding 12 months. During this cycle, all OCC CCN LTC members with a hospital admission in 3Q2019, regardless of whether they had a hospital admission in the preceding 12 months, were eligible for the project interventions. The assigned CalOptima NCM continued to follow-up with all identified members to complete the enhanced care coordination interventions previously outlined. For comparison, there were two readmissions within the same quarter during 2Q2019 compared to five readmissions within the same quarter during 3Q2019. There was an increase of 9 hospital admissions in Q32019, compared to Q22019.

During Cycle 6, CalOptima continued with one designated medical case manager (MCM) to follow-up with all acute admissions. The MCM spoke with members, facility staff and/or member's authorized representative, attended Interdisciplinary Care Team meetings, and developed interventions. Members and facility staff are beginning to recognize the MCM and understand her purpose. Many of the members are happy to see the MCM, they appreciate her "organizing their charts;" others appear indifferent to her, they answer her questions but don't engage in goal setting. Due to other assignments, it has been challenging to monitor the implementation of the interventions.

While some improvement in rapport building has been achieved, the advantage of a dedicated case manager to follow-up on acute admissions has not been clearly demonstrated by Cycle 6's outcomes. CalOptima will continue with this configuration for another cycle to gather additional results and feedback.

As of October 2019, there were 76 OCC CCN LTC members compared to the 115 OCC CCN LTC members at the end 2017 when this project started. For the 12-month period from 10/01/2018 through 9/30/2019, there were 90 acute admissions reported for all OCC CCN LTC members. The average ratio, based on the October 2019 OCC CCN LTC membership, was 0.84 admissions per member per year. SMART Objective 3 was not met.

SECTION 3: QUALITY OF SERVICE

Member Experience

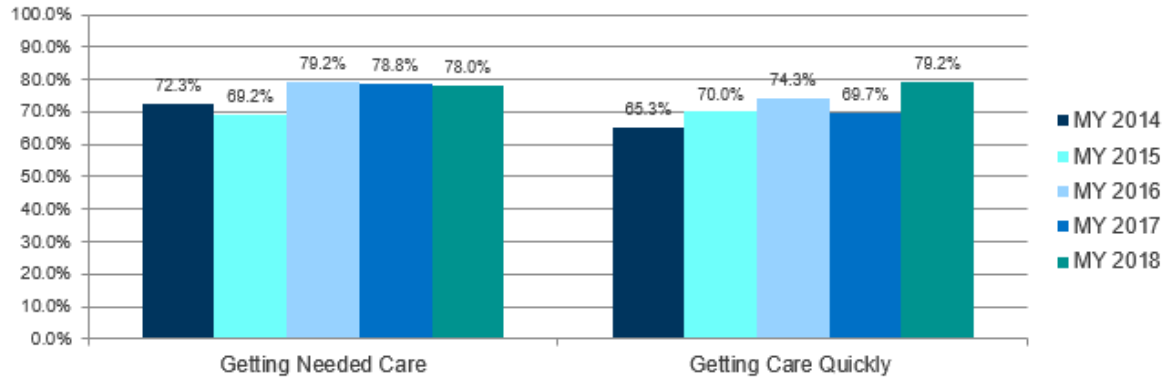
CalOptima annually monitors member satisfaction and identifies areas for improvement for all lines of business. CalOptima assesses member satisfaction by identifying the appropriate population and collecting valid data from the affected population about various areas of their health care experience. Opportunities for improvement are identified from this information and specific evidence-based interventions are implemented. The goal is to improve the overall member experience by better meeting our members' needs.

CalOptima monitors the CAHPS results, particularly the achievement score at various levels including plan and HN. The achievement score is the calculation of positive responses, typically identified as "Usually" or "Always" or rated top scores of "8, 9 or 10."

CAHPS Trend Analysis:
CalOptima identified that the "Getting Needed Care and Getting Care Quickly" measures were consistently performing below goal. The following tables includes the plan level survey achievement scores for the adult and child surveys for two key measures (i.e. getting needed care and getting care quickly).

Goal:
To meet the 50th percentile when compared to National Medicaid Benchmarks.

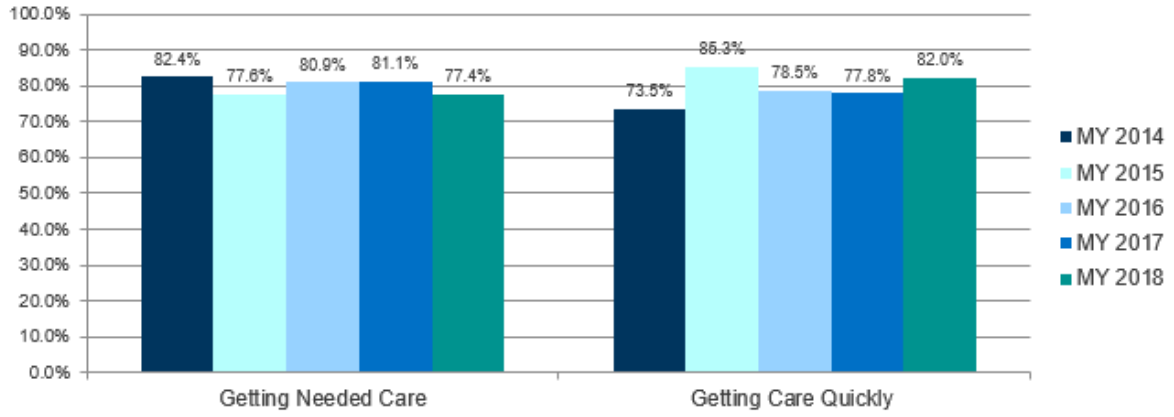
Medi-Cal Adult CAHPS Survey Results



National Quality Compass	CalOptima 2019	2019 Percentile	2018 Percentile	2019 25th Percentile	2019 50th Percentile	2019 75th Percentile	2019 90th Percentile
Getting Needed Care	78.0%	<25th	<25th	80.53%	83.06%	85.47%	86.84%
Getting Care Quickly	79.2%	<25th	<25th	80.02%	82.34%	85.08%	86.74%

Red = less than 25th percentile

Medi-Cal Child CAHPS Survey Results



National Quality Compass	CalOptima 2019	2019 Percentile	2018 Percentile	2019 25th Percentile	2019 50th Percentile	2019 75th Percentile	2019 90th Percentile
Getting Needed Care	77.4%	<25th	<25th	81.49%	84.85%	88.01%	89.98%
Getting Care Quickly	82.0%	<25th	<25th	87.01%	89.98%	92.43%	94.17%

Red = less than 25th percentile

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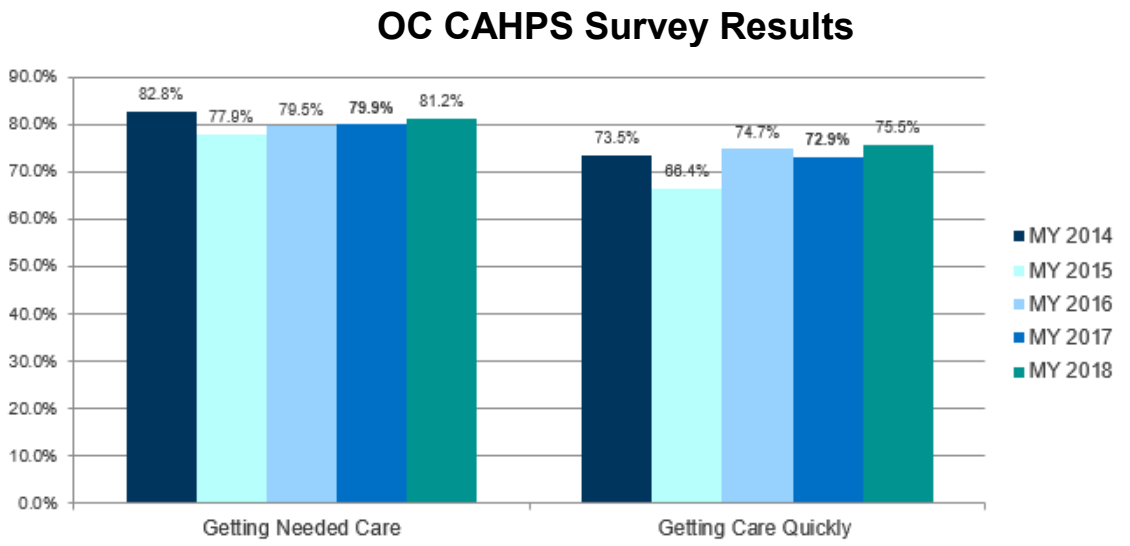
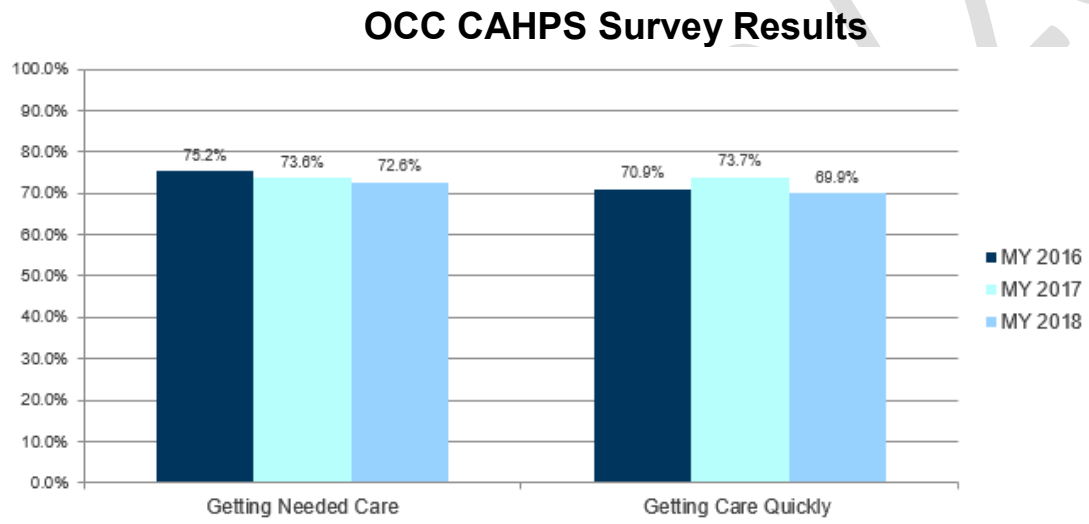




In 2019, CalOptima reviewed all the CAHPS rates in detail and compared them to the benchmarks and found getting needed care and getting care quickly to be high priority for the organization.

Access to Care

Timely Access Study:
CalOptima monitors appointment availability and accessibility on an annual basis. The evidence is clear that timely access to health care services results in better health outcomes, reduced health disparities, and lower spending, including avoidable emergency room visits and hospital care. CalOptima fields a survey to collect appointment wait times and compares them to standards from DHCS and CMS. A compliance rate is calculated by appointment type for each provider type.

Methodology Change:
In 2019, CalOptima adopted the mystery shopper methodology to monitor appointment availability performance for all primary care providers and identified provider specialty types. This allowed CalOptima and its HNs to determine exactly which providers are non-compliant

with the access standards, and provider outreach and education can be targeted. In addition, the data collected will be more accurate, since it will no longer be provider self-reported. As there was a major change in data collection methodology, it is not possible to trend data for access to care in 2019.

Goal:
To meet internal goal of 80% for each individual measure and practitioner types

Key Findings by LOB, (preliminary results):
Medi-Cal:

- The only providers that met the goal of 80% were:
  - Follow-up appointments met for BH specialists
  - Non urgent appointments met for Family Medicine and Pediatrics
  - Non urgent appointments met for physical medicine and rehabilitation providers
  - Appointments for regular physicals were met for all PCP types.
- None of the provider types met the goal for urgent appointment wait times.
- All providers specialty types did not meet the non-urgent appointment wait times goal. Only one did.

OCC

- The only providers that met the goal of 80% were:
  - Non urgent appointments met for (licensed clinical social worker (LCSW) for BH appointments
  - Non urgent appointments met Family Medicine and General Practice
  - Non urgent appointments met for Orthopedic and Podiatry
  - Appointments for regular physicals were met for all PCP types
- None of the provider types met the goal for urgent appointment wait times.
- 14 of 16 providers specialty types did not meet the non-urgent appointment wait times goal.

OC

- The only providers that met the goal of 80% were:
  - Urgent care appointment met for only one provider type (Family Medicine)
  - Non urgent appointments met for Family Medicine, General Practice and Pediatrics
  - Non urgent appointments met for Ear, Nose & Throat, Midwife, Orthopedic and Podiatry
  - Appointments for regular physicals were met for all PCP types
- All but one of the provider types met the goal for urgent appointment wait times.
- 12 of 16 providers specialty types did not meet the non-urgent appointment wait times goal.

Based on the review of timely access study results, appointment access is an area of concern. The data shows that of all the appointment types, urgent care, non-urgent care visits are areas where there are opportunities for improvement for almost all provider types, primary care and specialty care.

Network Adequacy - Time and Distance Analysis:
CalOptima monitors network adequacy on a quarterly basis by running reports to evaluate whether the Plan meets the time and distance standards established by CMS and DHCS. For all lines of business, the Plan has met the time and distance standards with the exception OB-GYN/PCPs in a few zip codes in South County where we have an approved alternative access standard with DHCS at the Plan level. When evaluating network adequacy for each of CalOptima's delegated HNs, the HNs did not meet all the time and distance standards.

Comparison to Complaints/Appeals:
When the CAHPS results were compared to the Access grievances, CalOptima found that access grievances make up about 10% of all grievances in 2019. Delays in service was a top reason for the HN and CCN. Although the Access related grievances have decreased, appointment availability continues to be a pain point for members.

The top 3 sub-categories of access grievances are specialty care, appointment availability, and telephone accessibility. The members complained that referrals were not made to a provider who is able to treat the member or to a provider that the member wants to see. These required referral modifications which resulted in delays. Another key finding was that providers are not submitting complete and timely referral to the Utilization Management (UM department). The providers also had long wait times and the authorizations expired by the time the member went in for the referral. Members also had challenges with providers when scheduling and obtaining appointments, particularly BH provider since many of these providers tend to have a solo practice. Some of these findings mirror the barriers the team identified in its discussions.

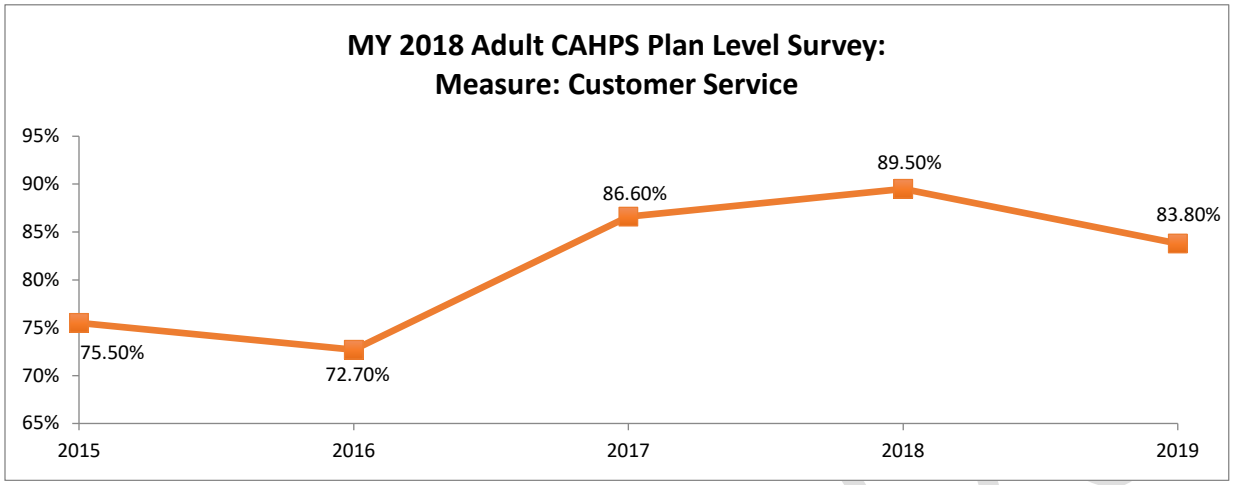
Member Experience Activities Completed in 2019

Homeless Clinical Access Program
In late 2019, CalOptima implemented a quality incentive for Community Health Centers participating in the Homeless Clinical Access Program (HCAP). HCAP is a means for CalOptima to coordinate with Community Health Centers to bring primary care services via mobile clinics at designated shelters and hot spots. Community Health Centers are incentivized for time spent at shelter and/or hot spot in addition to providing primary care services to CalOptima homeless population. At the close of 2019, CalOptima had three Community Centers identified to participate in the HCAP program.

In 2020, CalOptima intends to expand Community Health Center participation in HCAP, including identification of more shelters and hot spots where services via mobile clinic can be supported.

Provider Coaching
In 2018, CalOptima contracted with SullivanLuallin Group, a customer service improvement health care consultant, to conduct provider shadow coaching and to hold workshops on customer service for office staff, office managers/supervisors and physicians to improve overall patient experience. In 2019, there were 21 providers who participated in the shadow coaching. And 6 workshops (3 for staff and 3 for supervisor/management) were held on how to improve customer service. The feedback from these sessions has been very positive and CalOptima will be continuing this activity in 2020. The trend graph related to customer service for data collect from the plan level CAHPS survey for the adult population shows that there has been a decline in customer service from 2018 to 2019 but it does not reflect the work that is being conducted by the SullivanLuallin Group as the group only started work late in 2018. The 2020 CAHPS survey

results will be a clearer indicator of their performance as they were working with the large provider groups for the entire duration of 2019. This program will continue in 2020 as well.



*Scores are based upon the 2019 Adult Plan CAHPS Survey Report developed by DataStat.

The Member Experience Subcommittee identified referrals and authorizations and coordination of care as the areas of focus for 2019. A workgroup was formed to focus on mapping out the referral and authorization process from the members' perspective and identifying opportunities for improvement. Some of the other initiatives CalOptima considered were :

- Validating provider information prior to UM referral (e.g. accepting new patients, area of focus, sees children)
- Planning to call members who hit threshold of denials/grievances
- Auto approve referrals for selected specialists

A special Member Experience Subcommittee was held, and the committee determined that there were not enough resources to implement interventions listed above. However, in 2019 CalOptima was able to implement the following:

- CalOptima focused their efforts on improving access by making 'urgent care' services easily searchable in the online provider directory.
- CalOptima presented the HN Quality Rating program to the Board of Director's November Finance and Audit Committee and December Quality Assurance Committee. The HN Quality Rating is proposed to drive future P4V payments with a significant portion of the HN quality rating dependent upon excellent member experience scores.
- CalOptima developed and launched the CCN PCP report card and has started posting the results to the provider portal for CCN PCPs. The CCN report card includes information for each provider regarding over-capacity member assignments.
- Approximately 34 providers were sent a notification letter in September 2019 to address PCP member panel overcapacity with panel closures and member reassignment.
- The Member Portal was soft launched in April 2019 for members in all LOBs.
    - Average weekly member registrations: 275
    - Registered users as of 10/26/19: 6,756
    - Top five activities by members on portal:
        1. Update new address/e-email
        2. ID card mailing/download requests
        3. General inquiries to customer service
        4. Change of HN requests
        5. Telephone number updates

- CalOptima also reviewed the current auto-authorization rules. There was a total of 107 Auto Authorization rules in Cerecons. In March 2019, the UM team started reviewing these rules to ensure accuracy and to evaluate if they were working as anticipated.

Overall Assessment of Member Experience and Access to Care

Based on the review of CAHPS, Timely Access study, Time and Distance Analysis and complaints data, the general theme that stands out is that appointment access is an area of concern. The data shows that of all the appointment types, urgent care, non-urgent care visits are areas where there are opportunities for improvement for almost all provider types, primary care and specialty care. This has a significant impact on how members respond on the member CAHPS survey for questions related to getting care quickly and getting needed care. In 2020, CalOptima will continue focusing on the key initiatives that were implemented in 2019 and develop additional initiatives to improve timely access to care. The section below describes the barriers that continue to exist that maybe impacting timely access to care.

Existing Barriers: Based on the CAHPS and member complaints data, CalOptima has identified that getting needed care and getting care quickly are the most critical measures, and therefore are the highest priority in terms of making improvements.

A group of subject matter experts from across the organization completed a detailed barrier analysis:

1. **Prior Authorization Process**
    a. Timeliness of submission by PCP and specialist is an issue. Provider office staff wait to submit the authorization request and then submit the request as an urgent authorization when it truly doesn't meet the criteria for urgent.
    b. Providers also do not always send all the information needed to make a decision at the time of the initial submission. Resubmission is sometime required and may cause delay in obtaining services.
    c. Since a contracted hospital provides a tertiary level of care, all referrals need to be reviewed and cannot go through an auto authorization process. With this process, members may feel that it takes a long time to obtain an approval for the authorization.
2. **Provider Data Quality**
    a. Members are referred to and approvals are sent to specialists who cannot see the patient.
        - Specialists/subspecialties/area focus is not clear, or information is not captured.
    b. Open/close panel is not up-to-date
        - No real-time process to collect correct information about which specialists have open panels and available appointments to see patients.
    c. System issue: FACETS shows no longer accepting patients, but GC shows as participating without any restrictions.
3. **Network and Contract Issues**
    a. Some PCP and specialty groups are not open to see all members in their contracted HN.
        - CalOptima is a delegated model and members are only able to see a provider in their HN.

        - A particular PCP and specialist group will not see members that are not in their system.
    b. Not enough specialists are willing to contract with CalOptima
        - Low reimbursement rates in comparison to other types of health insurance providers (e.g., commercial plans) operating in these counties or cash paying patients.
    c. Not enough urgent care centers listed in the provider directory
        - Some HNs indicate no urgent centers in their network.
4. **Appointment Timeliness and Availability**
    a. Lack of extended office hours for urgent appointments can be a significant barrier.
    b. PCPs have too many members in their panel.
    c. There may be an adequate number of practitioners in CalOptima's panel but not all of them have open panels or are available to see CalOptima new patients.
    d. Certain geographic areas in the Orange County, particularly South Orange County, do not have an adequate number of specialists for a particular type of specialty (i.e. pediatric subspecialties, oncologists, rheumatologists, etc.).

Next Steps for Member Experience in 2020

The Member Experience Subcommittee identified access to care as the areas of focus for 2020. CalOptima has established the goal of improving member experience for getting needed care and getting care quickly from 25th to 50th percentile.

In order to accomplish this goal, CalOptima is developing several interventions that include, but are not limited, to the following:

- Continue to monitor PCPs to determine if their panel size is too large to provide care for our members. Ensure quarterly provider overcapacity notification letters are sent in a timely manner. Close panels for providers that are not meeting the capacity.
- Develop incentives for hard to access PCPs/specialists in challenged areas who have the capacity to open their panels and see CalOptima members.
- Increase payment rates to encourage hard to access specialists in challenged areas to contract with CalOptima and expand the network.
- Explore implementing telehealth services for members and primary care providers to access hard to access and in-demand specialty providers.
- Develop incentives for providers to expand after-hours care.
- Monitor Time and Distance Standards by HN. While DHCS is requiring all plans to certify their delegated networks on network adequacy access performance by July 1, 2021, CalOptima will begin monitoring adequacy of network at the HNs level and developing implementation plans, as needed, in 2020 to ensure that each HN meets time and distance standards.
- Expand the network of urgent care centers. Enhance contracting efforts with urgent care centers for CCN and work with the HNs to contract with more urgent care centers.

SUMMARY

CalOptima developed and implemented 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. Ongoing data analysis across multiple areas provides the basis for identifying over/under utilization of services. Our approach also uses support systems for our members with vulnerabilities, disabilities and chronic illnesses. Although individual measures may vary in their level of accomplishment, our overall effort has been a considerable success. As we continue to monitor our performance and refine our methods, we are confident that our QI efforts will continue to make a positive impact.

CalOptima
A Public Agency
Better. Together.

2019 Quality Improvement Program Evaluation

Board of Directors' Quality Assurance Committee Meeting
February 19, 2020

Betsy Ha
Executive Director, Quality and Population Health Management

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2019 Quality Improvement (QI) Accomplishments

- Continued to be one of the highest rated Medicaid plans in the state.
- Maintained “Commendable” accreditation status from the National Committee for Quality Assurance (NCQA).
  - Standards based on Healthcare Effectiveness Data and Information Set (HEDIS) and Healthcare Providers and Systems (CAHPS).
- Performed well on several HEDIS measures in comparison to national thresholds.
  - Out of the 62 reportable measures, CalOptima performed better on 42 measures in 2019, compared to 2018.
- Implemented CalOptima’s comprehensive health network (HN) Pay for Value (P4V) Performance Measurement Program to recognize outstanding performance and support ongoing improvement.

2019 QI Accomplishments (cont.)

- Performed successful incentive outreach to members to obtain preventive care for Well-Care Visits in first 15 months of life (W15), postpartum care, and breast and cervical cancer screening.
- Expanded and continued initiatives to address access to care and member satisfaction, such as:
  - Provider coaching to evaluate and improve services provided at point of care
  - CalOptima Days to improve access and promote preventive health screenings
  - Active recruitment of new providers (both primary and specialty care)
- Implemented a quality incentive for Community Health Centers that participate in the Homeless Clinical Access Program (HCAP).

2019 QI Accomplishments (cont.)

- Implemented several prescriber, pharmacy, member and formulary interventions to reduce opioid utilization.
- Implemented Post-Acute Infection Prevention Quality Incentive (PIPQI) which included 25 nursing facilities of which 12 were already participating with UCI.
- Implemented six quality initiatives and several required Quality Improvement Projects (QIP), Performance Improvement Projects (PIP), Chronic Care Improvement Programs (CCIP), and Plan-Do-Study-Act (PDSA) to improve chronic condition measures
- Viable QI committee structure with subcommittees reporting of QI activities to QI Committee through the QI Work Plan.

2019 QI Evaluation Summary

- QI Program Structure
  - Components of QI Program and Structure
  - Overall Assessment

- Quality of Clinical Care
  - HEDIS — Performance Highlights

HEDIS Overview

- Key Measures for Medi-Cal:

Measure	Quality Compass Percentiles Met	
	HEDIS 2018	HEDIS 2019
Comprehensive Diabetes Care (HbA1c Testing)*	75th	50th
Comprehensive Diabetes Care (Eye Exam)* (not a MCAS measure)	75th	50th
Cervical Cancer Screening	50th	50th
Breast Cancer Screening	50th	50th
Prenatal and Postpartum Care (Prenatal Care)	50th	50th
Prenatal and Postpartum Care (Postpartum Care)	75th	50th
Well-Child Visits in the First 15 Months of Life	<10th	<10th
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life	75th	50th

* *Drop-in rate may be due to change in specification from prior year. NCQA issued guidance to trend this measure with caution.*

HEDIS Overview (cont.)

- Key Measures for OneCare Connect Cal MediConnect Plan (Medicaid-Medicare Plan) (OCC)

Measure	Quality Compass Percentiles Met	
	HEDIS 2018	HEDIS 2019
Breast Cancer Screening	3 Star	2 Star
Plan All-Cause Readmissions (OCC Quality Withhold)	1 Star	2 Star
Antidepressant Medications Management (Acute Phase Treatment)	<=10th	25th
Follow-up After Hospitalization for Mental Illness (OCC Quality Withhold)	<10th	25th
Adults' Access to Preventive/Ambulatory Health Services (age 20–44) +C	<=10th	25th

HEDIS Overview (cont.)

- Key Measures for OneCare (HMO SNP) (OC):

Measure	Quality Compass Percentiles Met	
	HEDIS 2018	HEDIS 2019
Breast Cancer Screening (C01)	2 Star	3 Star
Colorectal Cancer Screening (C02) +C	3 Star	3 Star
Plan All-Cause readmissions — O/E Ratio 65+ (C21) +C	3 Star	2 Star
Adults' Access to Preventive/Ambulatory Health Services (Total) +C	50th	25th

2019 QI Evaluation Summary

- Quality of Clinical Care (cont.)
  - Evaluation of Priority Initiatives
    - Homeless Health Initiative
    - CalOptima Days
    - P4V
  - Evaluation of Interventions for:
    - Comprehensive Diabetes Care (CDC)
    - Prenatal/Postpartum Screenings (PPC)
    - Well-Child Visits 0-15 Months (W15)
    - Preventive Health Screenings (BCS/CCS)
      - Breast Cancer Screening and Cervical Cancer Screening
    - Follow-up After Hospitalization for Mental Illness (FUH)
- Safety of Clinical Care
  - Plan All-Cause Readmissions (PCR)
  - Opioid Utilization

Opioid Utilization Data 2018–2019

CalOptima Medi-Cal Opioid Analgesic Utilization	2018 Q3	2018 Q4	2019 Q1	2019 Q2	2019 Q3	% Change 3Q18 to 3Q19
Opioid Analgesic Rxs	44,697	41,335	38,819	38,585	38,426	**-14.0%**
% Members Utilizing Opioid Analgesic Rxs	1.23%	1.15%	1.10%	1.08%	1.09%	**-11.6%**
Opioid Analgesic Rxs PMPQ	0.0236	0.0222	0.0210	0.0206	0.0208	**-11.5%**
Members Receiving > 80mg Avg MME	793	716	647	638	604	**-23.8%**
% Utilizing Members Receiving > 80mg Avg MME	3.39%	3.34%	3.18%	3.16%	3.01%	**-11.3%**
Average Quantity/Rx for Short-Acting Opioid Analgesics	53.9	54.5	53.7	52.4	51.7	**-4.1%**

Opioid Utilization Data 2018–2019 (cont.)

CalOptima Organization-Wide Opioid Utilization Goals Fiscal Year 18/19	2018 Q1	2018 Q2	2018 Q3	2018 Q4	2019 Q1
Average Morphine Milligram Equivalent (MME)/Member Goal = 10% Decrease (<17.5)	19.5	18.6	17.9	17.2	15.6
Number of Members Receiving Concomitant Benzodiazepines and Opioid Analgesics Goal = 5% Decrease (<4,295)	4,522	3,880	3,819	3,521	3,251

2019 QI Evaluation Summary (cont.)

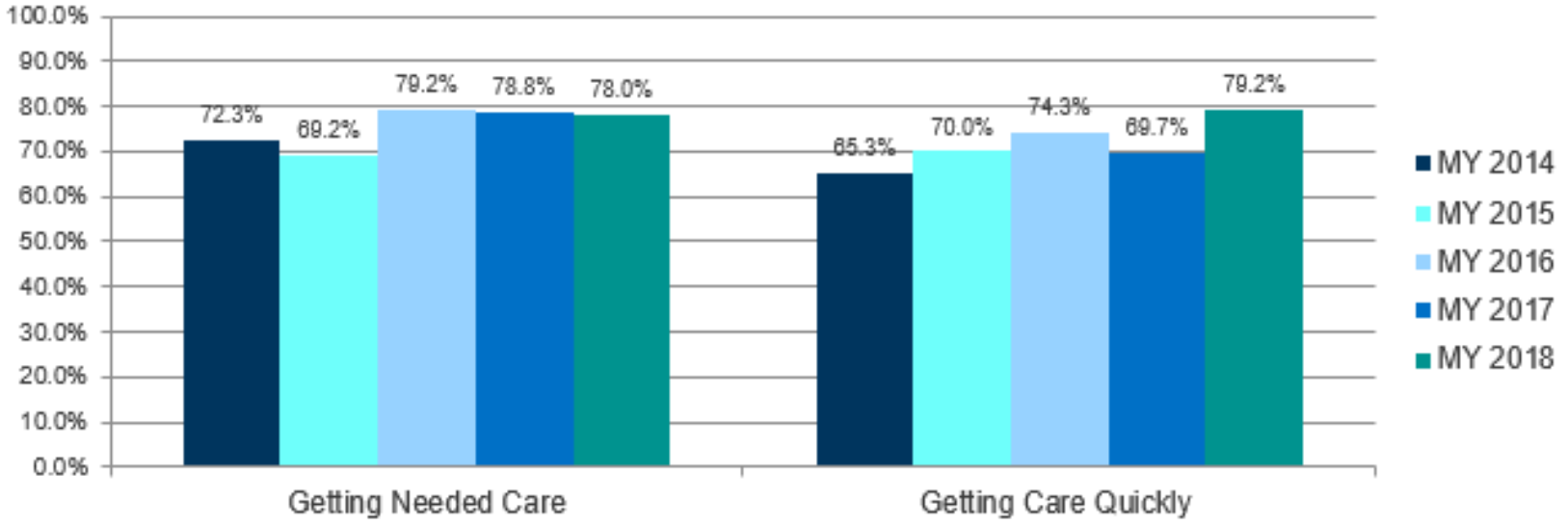
- Safety of Clinical Care (Cont.)
  - Post-Acute Infection Prevention Quality Incentive (PIPQI)
  - Facility Site Review (FSR)
  - Medical Record Review (MRR)
  - Physical Accessibility Review Survey (PARS)

- 2019 Improvement Projects
  - QIPs
  - PIPs
  - CCIPs
  - PDSA Initiatives

2019 QI Evaluation Summary (cont.)

- Quality of Service — Member Experience
  - Medi-Cal CAHPS (Adult and Child)
  - OC CAHPS
  - OCC CAHPS

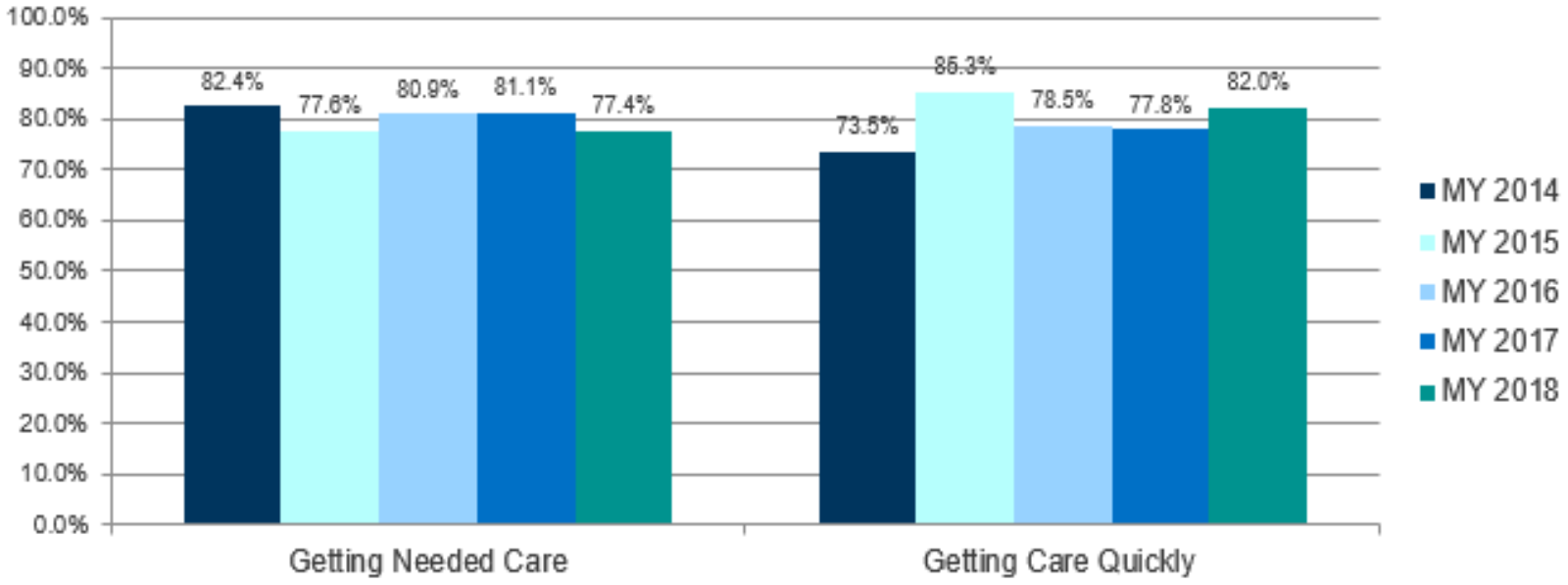
2019 Medi-Cal Adult CAHPS Survey



National Quality Compass	CalOptima 2019	2019 Percentile	2018 Percentile	2019 25th Percentile	2019 50th Percentile	2019 75th Percentile	2019 90th Percentile
Getting Needed Care	78.0%	<25th	<25th	80.53%	83.06%	85.47%	86.84%
Getting Care Quickly	79.2%	<25th	<25th	80.02%	82.34%	85.08%	86.74%

Red = less than 25th percentile

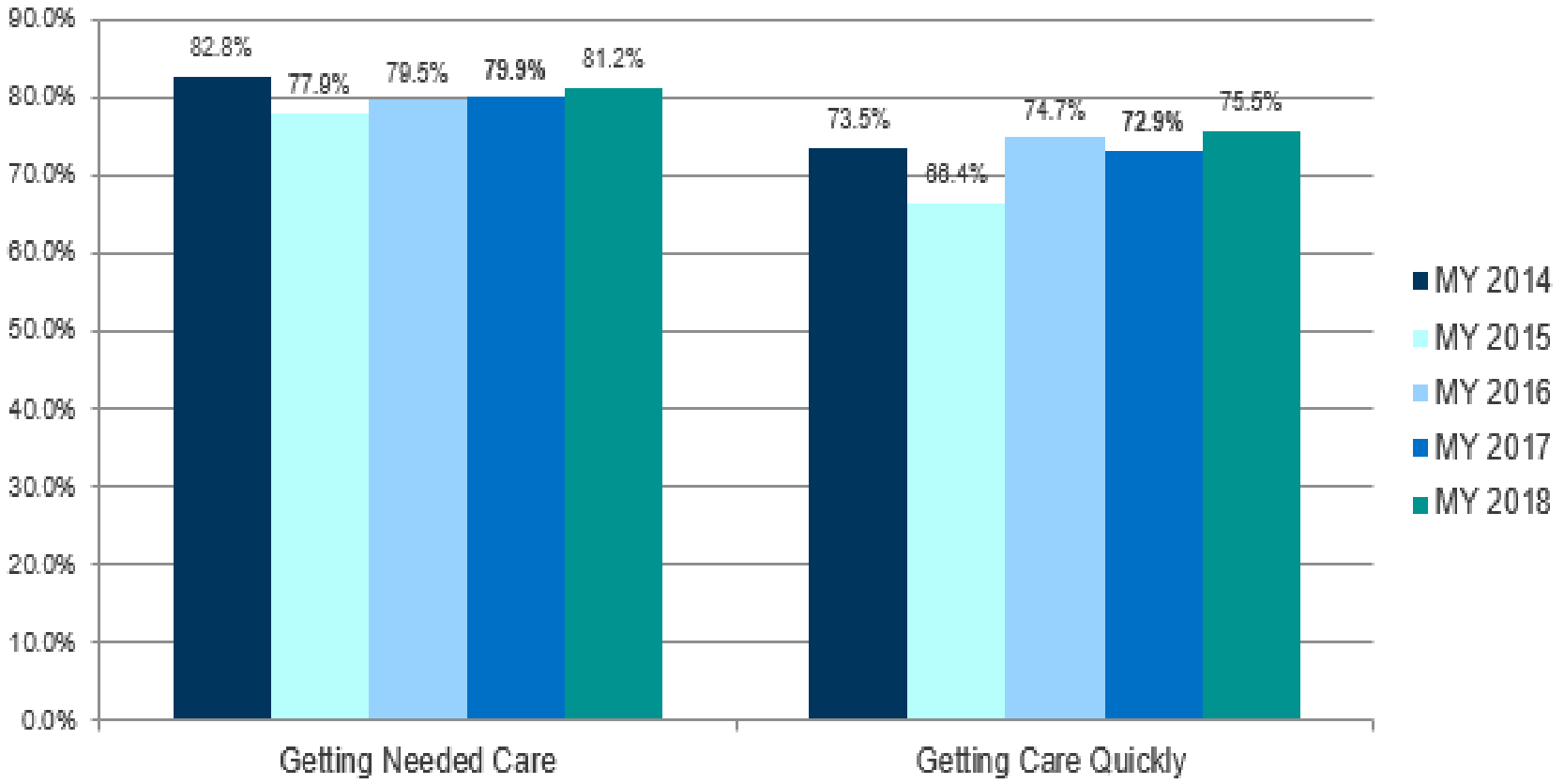
2019 Medi-Cal Child CAHPS Survey



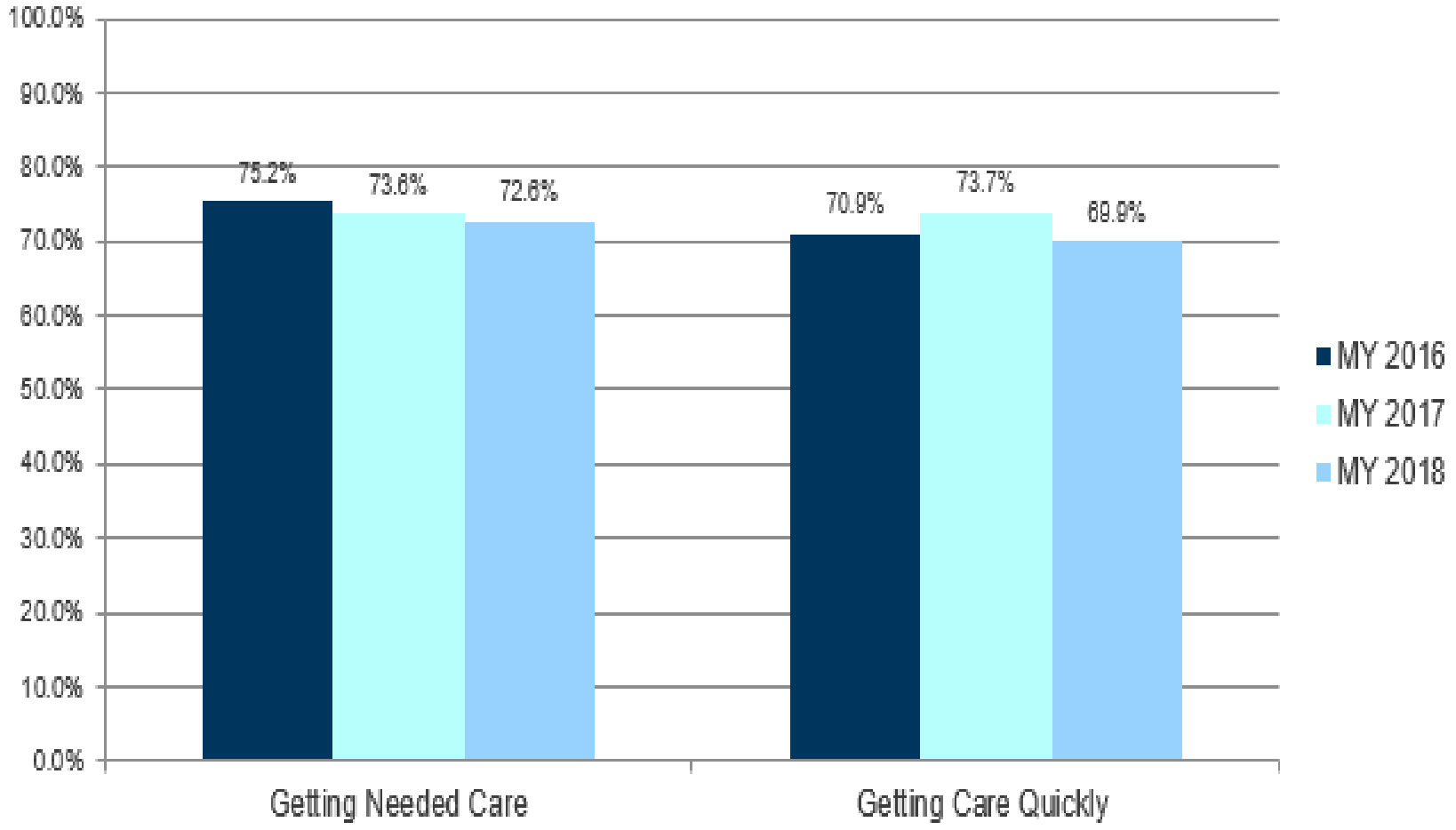
National Quality Compass	CalOptima 2019	2019 Percentile	2018 Percentile	2019 25th Percentile	2019 50th Percentile	2019 75th Percentile	2019 90th Percentile
Getting Needed Care	77.4%	<25th	<25th	81.49%	84.85%	88.01%	89.98%
Getting Care Quickly	82.0%	<25th	<25th	87.01%	89.98%	92.43%	94.17%

Red = less than 25th percentile

OC CAHPS Survey Results



OCC CAHPS Survey Results



2019 QI Evaluation Summary (cont.)

- Quality of Service — Access to Care
  - Timely Access Study — Key Findings
    - The only providers that met the goal of 80% were:
      - Follow-up appointments met for BH specialists
      - Non urgent appointments met for Family Medicine and Pediatrics
      - Non urgent appointments met for physical medicine and rehabilitation providers
      - Appointments for regular physicals were met for all PCP types.
    - None of the provider types met the goal for urgent appointment wait times.
    - All provider specialty types did not meet the non-urgent appointment wait times goal. Only one did.
  - Network Adequacy
  - Comparison to Complaints/Appeals

QI Opportunities for 2020

- Maintain “Commendable” accreditation status and meet managed care accountability set (MCAS) measures (minimum performance level) MPL
- Achieve 4.5 for overall NCQA Health Plan rating
- Streamline QI Committee structure
- Perform targeted initiatives to improve performance on clinical HEDIS metrics specifically those MCAS measures at risk to fall below the MPL
- Utilize CalOptima Days for more targeted measures with smaller denominators
- Implement new P4V program with HN rating

QI Opportunities for 2020 (cont.)

- Implement member and provider incentives for specific quality measures, and evaluate effectiveness with HEDIS 2020
- Improve exchange of hospital data through new vendor to revamp Transition of Care program
- Reduce opioid utilization through various planned interventions in 2020
- Develop Quality Measures for PIPQI
- Develop Quality Measures for Whole-Child Model (WCM)
- Implement new DHCS tools and All Plan Letter (APL) for Facility Site Review
- Implement 2020 planned improvement projects

QI Opportunities for 2020 (cont.)

- Improve member experience CAHPS results for access related measures
- Increase appointment access to timely (routine and urgent) primary and specialty care

Questions?

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CalOptima's Mission

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

CalOptima

Better. Together.

Healthy Families CalOptima

Better. Together.

Healthy Kids CalOptima

Better. Together.

Medi-Cal CalOptima

Better. Together.

OneCare-HMO CalOptima

Better. Together.

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 5, 2020
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

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

Contact

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

Recommended Action(s)

Recommend approval of the recommended revisions to the 2020 Quality Improvement Program and 2020 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 operational and functional component of the QI Program and outlines the key activities for the upcoming year. The QI Work Plan provides the detailed objectives, scope, timeline, monitoring, and accountable persons for each activity. Progress against the QI Work Plan is monitoring throughout the year and reported to QI Committee quarterly.

CalOptima staff has updated the 2020 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 National Committee of Quality Assurance (NCQA) accreditation standards are met in a consistent manner across all lines of business.

Discussion

The 2020 QI Program is based on the Board-approved 2019 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.

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The revisions are summarized as follows:

1. Updated signature page to replace Chief Medical Officer to David Ramirez, M.D.).
2. Updated 2019 to 2020 dates throughout program, including up-to-date demographics on membership
3. Updated Values section to reflect accurate accountability to various committees
4. Updated Strategic Plan to reflect 2020–2022 Strategic Priorities and Objectives
5. Updated What We Offer sections to reflect 2020 scope of services by line of business
6. Updated Program Initiatives section to initiatives for 2020:
    a. Whole Person Care
    b. Health Homes Program
    c. Homeless Health Initiative
    d. Behavioral Health for OC/OCC
7. Updated Role of CalOptima Officers for QI Program to reflect current organizational responsibilities
8. Updated QI Committee structure to streamline practitioner engagement and reporting efforts to the QIC
9. Updated 2020 QI Goals and Objectives:
    a. Increase NCQA Overall Rating from 4.0 to 4.5
    b. Improve Member Experience CAHPS Performance from 25th to 50th percentile focusing on Getting Needed Care and Getting Care Quickly
    c. Improve member access to schedule urgent and routine appointments for PCP's and Specialist
10. Updated QI Program Resources to reflect current organizational structure
11. Updated term for Health Care Delivery Organizations to industry term, Organizational Providers
12. Updated section on Population Health Management area, in line with the PHM strategy. Included reference to statewide efforts to reduce Adverse Childhood Experiences (ACE) in adult Medi-Cal members by promoting awareness
13. Updated Cultural & Linguistic Services section including description and approach for serving diverse membership
14. Updated 2020 Delegation Grid to include NCQA consistent with 2020 NCQA Standards

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 2020 QI Program and QI Work Plan has no additional fiscal impact for Fiscal Year (FY) 2019-20. To the extent there is any fiscal impact due to increases in Quality Improvement Program resources and incentives from July 1, 2020, through December 31, 2020, Staff will address the impact in separate Board actions or the CalOptima FY 2020-21 Operating Budget.

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

Attachments
1. Proposed 2020 Quality Improvement Program (Redline)
2. Proposed 2020 Quality Improvement Program (Clean)
3. Quality Improvement Work Plan
4. 2020 Delegation Grid
5. PowerPoint Presentation: 2020 Quality Improvement Program and Work Plan

/s/ Michael Schrader *02/26/2020*
Authorized Signature **Date**

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~~2019~~2020

QUALITY IMPROVEMENT PROGRAM

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~~2019~~2020 QUALITY IMPROVEMENT PROGRAM SIGNATURE PAGE

Quality Improvement Committee Chair:

_____ _____

David Ramirez, M.D. Date
Chief Medical Officer

Board of Directors' Quality Assurance Committee Chair:

_____ _____

Paul Yost, M.D. Date

Board of Directors Chair:

_____ _____

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. Our 25th anniversary serving our members is in 2020. 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. Committee mMeetings are open to the public are: Our Board of Directors, Board Finance and Audit Committee, Board Quality Assurance Committee, Investment Advisory Committee, Member Advisory Committee, OneCare Connect Member Advisory Committee, Provider Advisory Committee, Quality Assurance Committee and Whole-Child Model Family Advisory Committee., Provider Advisory Committee, Investment 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.

~~E~~**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.

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

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

Our Strategic Plan
~~CalOptima's 2017–19~~new 2020-2023 ~~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.~~
In late 2019, CalOptima's Board and executive team worked together to develop our next three-year Strategic Plan. After engaging a wide variety of stakeholders and collecting feedback, the strategic plan was approved in December 2019. Members are the essential focus of the 2020–2022 Strategic Plan, and our Priorities and Objectives are designed to enhance the programs and services provided to members by CalOptima.

The five Strategic Priorities and Objectives are:
- Innovate and Be Proactive
- Expand CalOptima's Member-Centric Focus
- Strengthen Community Partnerships
- Increase Value and Improve Care Delivery

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- Enhance Operational Excellence and Efficiency

WHAT IS CALOPTIMA?

Our Unique Dual Role
CalOptima is unusual in that it is both a public agency and a community health plan.

As both, CalOptima must:

- Provide quality health care to ensure ~~optional~~ 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. ~~In~~Year 2020 marks CalOptima's 25th year of service to~~For more than 20 years, CalOptima has been serving~~ Orange County's Medi-Cal population ~~for 25 years~~. ~~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% 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, including eligible conditions under California Children's Services (CCS) managed by CalOptima through the Whole-Child Model (WCM) Program~~,~~ that went into effect~~ive~~ in ~~7/1/~~2019.

Certain services are not covered by CalOptima~~,~~ but 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). Effective July 1, 2019, or such later date as the program becomes effective, this program will be managed by CalOptima through the Whole Child Model (WCM) program.~~

Members ~~With~~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 the Population Health Management (PHM) Strategy.

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 as special services ~~through CalOptima's member liaisons and~~ through specific Memoranda of Understanding (MOU) with certain community agencies, including Orange County Health Care Agency (OC HCA)~~,~~ and the Regional Center of Orange County (RCOC).~~,~~ ~~CCS (through June 30, 2019, or such later date as the Whole Child Model becomes effective) 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 (OC) 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.

OC provides a comprehensive scope of services for ~~the~~ dual eligible members~~,~~ enrolled in Medi-Cal and Medicare Parts A and B. To be a member of OC, a person must live in Orange County~~,~~ and not be eligible for OCC. Enrollment in OC is by member choice and voluntary.

Scope of Services
In addition to the comprehensive scope of acute~~,~~ ~~and~~ preventive care~~,~~ and behavioral health services covered under Medi-Cal and Medi-~~C~~care benefits, CalOptima OC members are eligible for enhanced services~~,~~ such as transportation to medical services and gym membership~~s~~.

OneCare Connect

The 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~~ frequently 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.

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 i~~s~~n 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 also apply.

Scope of Services
OCC simplifies and improves health care for low-income seniors and people with disabilities~~.~~, while ensuring timely access to the comprehensive scope of acute, ~~and~~ preventive care~~,~~ and behavioral health services covered under Medi-Cal and Medicare benefits. At no extra cost, OCC adds enhanced benefits such as vision care, ~~and~~ gym benefits, over-the-counter benefits and transportation. OCC also includes personalized services through the PCCs to ensure each member receives the services they need, when they need them.

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 seniors to help them continue living independently in the community.

To be a PACE participant, members must be at least 55 years old, live in Orange County, be determined to be 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, dieti~~e~~tians, 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 participants. 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.

Whole-Person Care

Whole-Person Care (WPC) is a five-year pilot established by DHCS as part of California's Medi-Cal ~~2020~~ 2017–2019 ~~s~~Strategic ~~p~~Plan ~~that is effective between January 1 2016 and December 31, 2020~~. In Orange County, the pilot is being led by the OC HCA. It focuses on improving health care outcomes for members who frequently visit the emergency department and are either homeless or have a serious mental illness. The WPC ~~Connect~~ information sharing platform was launched in November 2018. For ~~2019~~ 2020, the focus will be on enhancing information to and from CalOptima and WPC to support care coordination for participating members.

Whole-Child Model

California Children's Services (CCS) is a statewide program for children with certain serious 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. In Orange County, OC HCA manages the local CCS program. OC HCA provides case management, eligibility determination, service authorization and direct therapy under the Medical Therapy Program.~~

As of July 1, 2019, t~~T~~hrough SB 586, the ~~S~~state ~~has~~ required CCS services to become a CalOptima Medi-Cal managed care plan benefit ~~in select counties~~. The goal ~~-~~of this transition was~~is~~ to improve health care coordination by providing all needed care (most CCS and non-CCS services) under one entity rather than providing CCS services separately. ~~This approach is known as the~~ The Whole-Child Model (WCM) ~~was~~ successfully transitioned to CalOptima in 2019 ~~and will continue through 2020~~. ~~,~~ Under this program~~model,~~ in Orange County, medical eligibility determination processes, ~~and~~ the Medical Therapy Program and CCS service authorizations for non-CalOptima enrollees will remain with OC HCA~~, while other CCS program components are transferred to CalOptima. CalOptima had originally expected to launch WCM effective January 1, 2019, but recently DHCS delayed the WCM implementation in Orange County, and the new implementation date is now no sooner than July 1, 2019.~~

Health Homes Program

The Affordable Care Act gives states the option to establish health homes to improve care coordination for beneficiaries with chronic conditions. California has elected to implement the "Health Homes for Patients with Complex Needs Program" (often referred to as Health Homes Program or HHP), which includes person-centered coordination of physical health, behavioral health, CBAS and LTSS.

CalOptima plans to implement HHP in the following two phases: ~~July~~ January 1, ~~2019~~ 2020, for members with chronic physical conditions or substance use disorders (SUD), and ~~January~~ July 1, 2020, for members with serious mental illness (SMI) or serious emotional disturbance (SED). ~~Serious Emotional Disturbance (SMI).~~

~~DHCS~~ CalOptima's goal is to target~~ing~~ the highest-risk 3–5~~%~~ percent of the Medi-Cal members with multiple chronic conditions who present the best opportunity for improved health outcomes.

~~DHCS will send a targeted engagement list of members to CalOptima for review and outreach, as appropriate.~~ To be eligible, members must have:

1. Specific combinations of physical chronic conditions and/or SUD or specific SMI conditions~~;~~ and
2. Meet specified acuity/complexity criteria~~.~~

Members eligible for HHP must consent to participate and receive HHP services. CalOptima ~~will be the Lead Administrative Entity and~~ is responsible for HHP network development. Community-Based Care Management Entities (CB-CME) will be the primary HHP ~~health home~~ providers. In addition to CalOptima's Community Network, ~~some~~ all health networks (HN)~~s~~ ~~may~~ will serve in this role. CB-CMEs are responsible for coordinating care with members' existing providers and other agencies to deliver the following six core service areas:

1. Comprehensive care management
2. Care coordination
3. Comprehensive transitional care
4. Health promotion
5. Individual and family support services
6. Referral to community and social support services

CalOptima ~~is also contracting with a vendor to~~will provide housing related and accompaniment services to further support HHP members.~~-~~ Following implementation, CalOptima will consider opportunities for other entities to participate. ~~provide HHP related services.~~

Homeless Health Initiative (HHI)

In Orange County, as across the state, the homeless population has increased significantly over the past few years ~~because of increased housing costs and stagnant wages~~. To address this problem, Orange County has focused on creating a system of care that uses a multi-faceted approach to respond to the needs of County residents experiencing homelessness. The system of care includes five components: behavioral health~~,~~; health care~~,~~; housing~~,~~ support services; community corrections~~,~~; and ~~housing, benefits and support services~~public social services.~~i~~ The county's WPC~~P~~ program is an integral part of this work as it is structured to focus on Medi-Cal beneficiaries struggling with homelessness.

CalOptima has responded to this crisis by committing $100 million to fund homeless health programs in the County. Homeless health initiatives supported by CalOptima include:

- Recuperative Care –– As part of the Whole Person Care program, services provide post-acute care for up~~date~~ to 90-days ~~stay~~ for homeless CalOptima ~~M~~members.
- Medical Respite Care –– As an extension to the recuperative care program, CalOptima provides additional respite care beyond the 90 days of recuperative care under the Whole Person Care program.
- Clinical Field Teams –– In collaboration with Federally Qualified ~~Community~~ Health Centers (FQHC), Orange County Health Care Agency's Outreach and Engagement team, and CalOptima's Homeless Response Team, this pilot program provides immediate acute treatment/urgent care to homeless CalOptima ~~M~~members.

- Homeless Clinical Access Program —– The pilot program will focus on increasing access to care by providing incentives for community clinics to establish regular hours to provide primary and preventative care services at Orange County homeless shelters.
- Hospital Discharge Process for Members Experiencing Homelessness —– Support is designedprovided to assist hospitals with the increased cost associated with discharge planning under the new sState Llegislative requirements.
-

Behavioral Health for OC/OCC

CalOptima has previously contracted with Magellan Health Inc. to directly manage mental health benefits for OC and OCC members. Effective 1/1January 1,/2020, OC/OCC behavioral health will be fully integrated within CalOptima internal operations. CalOptima internal operations. OC and OCC members can access mental health services by calling the CalOptima Behavioral Health Line. -Members will be connected to a CalOptima representative for behavioral health assistance.

Population Health Management (PHM)

CalOptima has developed a comprehensive PHM Strategy for 2019. The 2019 PHM Strategy including plan of action for addressing our culturally diverse member needs across the continuum of care based on the National Quality Assurance Committee (NCQA) Population Health Management standards released in July 2018. CalOptima's PHM Strategy aims to ensure the care and services provided to our members are delivered in a whole-person-centered, safe, effective, timely, efficient, and equitable manner across the entire health care continuum and life span.

The 2019 PHM Strategy is based on numerous efforts to assess the health and well-being of CalOptima members, such as the Member Health Needs Assessment that was completed in March 2018. It focused on ethnic and linguistic minorities within the Medi-Cal population from birth to age 101. Additionally, CalOptima's annual Population Needs Assessment (requirement for California Medi-Cal Managed Care Health Plans) will aid the PHM strategy further in identifying member health status and behaviors, member health education and C&L needs, health disparities, and gaps in services related to these issues.

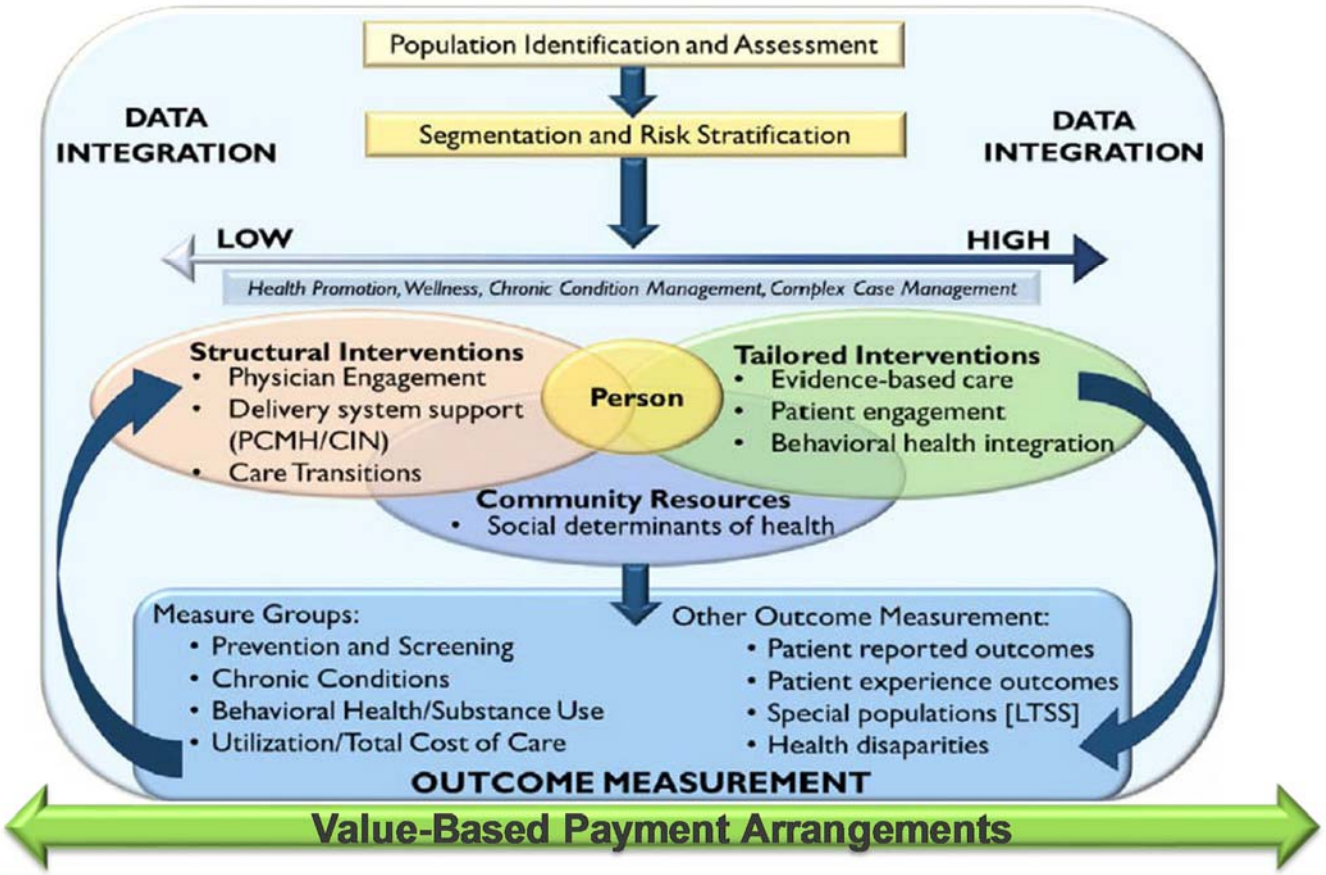
The PHM plan of action addresses the unique needs and challenges of specific ethnic communities including economic, social, spiritual, and environmental stressors, to improve health outcomes. CalOptima will conduct Quality Initiatives designed to achieve, through ongoing measurement and intervention, demonstrable and sustained improvement in significant aspects of clinical and non-clinical services that can be expected to have a beneficial effect on health outcomes and Member satisfaction. Initiatives that are conducted to improve quality of

~~care and health services delivery to members may include Quality Improvement Projects (QIP), Performance Improvement Projects (PIP) and Chronic Care Improvement Programs (CCIP), which leverage the rapid cycle improvement process (i.e., Plan-Do-Study-Act (PDSA) cycle).~~

~~In the first year, the PHM Strategy will be focused on expanding the Model of Care while integrating CalOptima's existing services, such as care coordination, case management, health promotion, preventive services and new programs with broader population health focus, with an integrated model as illustrated below in Figure 1. The PHM Conceptual Model is adapted from the model created by the Association of Community Affiliated Plans. CalOptima added the PHM Value Based Payment Arrangement as the foundation to align the future Pay for Value program methodology.~~

~~See Appendix C — 2019 PHM Strategy~~

Figure 1.PHM Conceptual Model



With [1] ~~http://ochmis.org/wp-content/uploads/2019/08/2019-PIT-FINAL-REPORT-7.30.2019.pdf~~

~~WITH~~ 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 participate through CalOptima Direct-Administrative and/or CalOptima Community Network (CCN) and/or contract with a CalOptima Health Network (HN). ~~, and/or participate through CalOptima Direct-Administrative, and/or the CalOptima Community Network.~~ CalOptima members can choose CCN or one of 134 HNs ~~,~~ representing more than 8,4500 practitioners.

~~**Health Networks**~~
~~CalOptima contracts with through a variety of HN financial models to provide care to members. Since 2008, CalOptima's HNs consist of:~~

- ~~Health Maintenance Organizations (HMOs)~~
- ~~Physician/Hospital Consortia (PHCs)~~
- ~~Shared Risk Medical Groups (SRGs)~~

~~Through these HNs, CalOptima members have access to nearly 1,600 Pprimary Ccare Pproviders (PCPs), more than 6,800 specialists, 23 40 hospitals, and 23 35 clinics and 100 long-term care facilities.~~

CalOptima Direct (COD)
CalOptima Direct is composed of two elements: CalOptima Direct-Administrative and the CalOptima Community Network.

CalOptima Direct-Administrative (COD-A)
CalOptima Direct-Administrative 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 OneCare Connect or OneCare programs), share of cost members~~,~~ and members residing outside of Orange County. Members enrolled in CalOptima Direct-Administrative are not HN eligible.

CalOptima Community Network (CCN)
The CalOptima Community Network provides doctors with an alternate path to contract directly with CalOptima to serve our members. CCN is administered internally by CalOptima and ~~is the 14th network~~ available for members to select, supplementing the existing HN delivery model and creating additional capacity for growth.

CalOptima Contracted Health Networks
CalOptima contracts through a variety of HN financial models to provide care to members. Since 2008, CalOptima's HNs consist of:

- Health Maintenance Organizations (HMOs)
- Physician/Hospital Consortia (PHCs)
- Shared Risk Medical Groups (SRGs)

Through these HNs, CalOptima members have access to nearly 1,600 primary care providers (PCPs), more than 6,800 specialists, 40 hospitals, 35 clinics and 100 long-term care facilities.

~~Currently,~~ CalOptima contracts with the following 13 Heath Networks:~~Ns for Medi-Cal. CCN is administered internally by CalOptima and is the 14th network available for members to select, supplementing the existing HN delivery model and creating additional capacity for growth.~~

~~The following are CalOptima's contracted HNs:~~

Health Network/Delegate	Medi-Cal	OneCare	OneCare Connect
AltaMed Health Services	SRG	SRG	SRG
AMVI/Prospect		SRG	
AMVI Care Health Network	PHC		PHC
Arta Western Medical Group	SRG	SRG	SRG
CHOC Health Alliance	PHC		
Family Choice Health Network	PHC	SRG	SRG
Heritage	HMO		HMO
Kaiser Permanente	HMO		
Monarch Family HealthCare	HMO	SRG	HMO
Noble Mid-Orange County	SRG	SRG	SRG
Prospect Medical Group	HMO		HMO
Talbert Medical Group	SRG	SRG	SRG
United Care Medical Group	SRG	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 Management and Complex Case Management
- Claims (professional and institutional)
- Contracting
- Credentialing of practitioners
- Customer Services activities
-

MEMBERSHIP DEMOGRAPHICS

CalOptima
A Public Agency
Better. Together.

Fast Facts: January 2019

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

Membership Data as of November 30, 2018

Total CalOptima Membership
769,216

Program	Members
Medi-Cal	752,888
OneCare Connect	14,610
OneCare (HMO SNP)	1,423
Program of All-Inclusive Care for the Elderly (PACE)	295

Note: The Fiscal Year 2018-19 Membership Data started on July 1, 2018.

Member Age (All Programs)

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

Languages Spoken (All Programs)

56%	English
28%	Spanish
11%	Vietnamese
2%	Other
1%	Korean
1%	Farsi
<1%	Chinese
<1%	Arabic

Medi-Cal Aid Categories

43%	Temporary Assistance for Needy Families
32%	Expansion
10%	Optional Targeted Low-Income Children
9%	Seniors
6%	People with Disabilities
<1%	Long-Term Care

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CalOptima
A Public Agency
Better. Together.

Fast Facts: December 2019

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

Membership Data as of October 31, 2019

Total CalOptima Membership
743,465

Program	Members
Medi-Cal*	727,437
OneCare Connect	14,093
OneCare (HMO SNP)	1,567
Program of All-Inclusive Care for the Elderly (PACE)	368

Note: The Fiscal Year 2019-20 Membership Data began on July 1, 2019.
*Includes prior year adjustment

Member Age (All Programs)

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

Languages Spoken (All Programs)

56%	English
27%	Spanish
11%	Vietnamese
2%	Other
1%	Korean
1%	Farsi
<1%	Chinese
<1%	Arabic

Medi-Cal Aid Categories

42%	Temporary Assistance for Needy Families
32%	Expansion
10%	Optional Targeted Low-Income Children
9%	Seniors
6%	People with Disabilities
<1%	Long-Term Care
<1%	Other

QUALITY IMPROVEMENT PROGRAM

CalOptima's Quality Improvement (QI) Program encompasses all clinical care, ~~clinical care, clinical services~~health and wellness services and customer service~~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 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 primary care, urgent care, acute and sub-acute care, long-term care~~,~~ and end of life care.~~preventive care, closing gaps in care, care coordination, PHM, complex case management, behavioral health integration, and palliative care.~~ Our comprehensive person-centered approach integrates physical and behavioral health, leverag~~es~~inges the care delivery systems and community partners 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.

Since 2010, the "Triple Aim" has been at the heart of the Centers for Medicare & Medicaid Services (CMS) Medicare Advantage and Prescription Drug Plan (Medicare Parts C and D) quality improvement strategy. The Triple Aim focuses on patient-centered improvements to the health care system including improving the care experience and population health and decreasing the cost of care. The Quadruple Aim adds a fourth element focused on provider satisfaction~~,~~ on the theory that providers who find satisfaction in their work will provide better service to patients. CalOptima's quality strategy embraces the Quadruple Aim as a foundation for its quality improvement strategy.

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-A, as well as our contracted ~~provider~~ health networks. Through the QI Program~~,~~ — and in collaboration with its providers and community partners~~,~~ — ~~-~~CalOptima strives to continuously improve the structure, processes and outcomes of its health care delivery system to serve our members.

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). The QI Program is organized around a systematic approach to accomplish the following annually:

- Identify and analyze significant opportunities for improvement in care and service to advance CalOptima's strategic mission, goals and objectives.
- Foster the development of improvement actions, along with systematic monitoring and evaluation, to determine whether these actions result in progress toward established benchmarks or goals.
- Focus on QI activities carried out on an ongoing basis to support early identification and timely correction of quality of care issues to ensure safe patient care and experiences.
- Maintain agency-wide practices that support accreditation by ~~NCQA, and~~NCQA and meet DHCS/CMS quality requirements and measurement reporting requirements.

In addition, the QI Program's ongoing responsibilities include the following:

- Sets expectations to develop plans to design, measure, assess, and improve the quality of the organization's governance, management and support processes.
- Supports the provision of a consistent level of high quality of care and service for members throughout the contracted provider networks, as well as monitors utilization practice patterns of practitioners, contracted hospitals, contracted services, ancillary services and specialty providers.
- Provides oversight of quality monitors from the contracted facilities to continuously assess that the care and service provided satisfactorily meet quality goals.
- Ensures certain contracted facilities report outbreaks of conditions and/or diseases to the public health authority — OC HCA — which may include, but are not limited to, methicillin resistant *Staphylococcus aureus* (MRSA), scabies, tuberculosis, etc., as reported by the HNs.
- 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)~~Oorganizational ~~P~~providers (O~~ps~~PS) to assure that steps are taken to resolve and prevent recurrences.
- Educates the workforce and promotes a continuous quality improvement culture at CalOptima.

In collaboration with the Compliance Internal and External Oversight departments, the QI Program ensures the following standards or outcomes apply to populations served by CalOptima's contracted HNs, including CCN and/or COD-A ~~N~~network ~~P~~providers, to:

- Support the agency's strategic quality and business goals by utilizing resources appropriately, effectively and efficiently.
- The continuous improvement of clinical care and services quality provided by the health care delivery system in all settings, especially as it pertains to the unique needs of the population.
- The timely identification of important clinical and service issues facing the Medi-Cal, OC and OCC populations relevant to their 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 identified opportunities.
- The accessibility and availability of appropriate clinical care and 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.
- The continuous improvement of member and provider satisfaction, including the timely resolution of complaints and grievances.
- The reliability of risk prevention and risk management processes.
- The compliance with regulatory agencies and accreditation standards.
- The accountability cadence of annual review and acceptance of the UM Program Description and other relevant Population Health Programs and Work Plans.
- The effectiveness and efficiency of internal operations.
- The effectiveness and efficiency of operations associated with functions delegated to the contracted HNs.
- The effectiveness of aligning ongoing quality initiatives and performance measurements with CalOptima's strategic direction in support of its mission, vision and values.
- The compliance with up-to-date Clinical Practice Guidelines and evidence-based medicine.

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.

AUTHORITY, BOARD OF DIRECTORS' COMMITTEES, AND RESPONSIBILITIES

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 systematic collection, integration, and analysis of clinical and administrative data ~~analysis~~ to identify the ~~clinical~~ member needs, risk levels and appropriate interventions to make certain that the program meets the specific needs of the individual member~~,~~ and promotes health equity among specific population segments, ~~-~~while improving overall population health and member experience. The CMO is charged with identifying appropriate interventions and allocating resources necessary to implement the QI Program. Such recommendations shall be aligned with Federal and State regulations, contractual obligations and fiscal parameters.

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 Board meetings are open to the public.

Board of Directors' Quality Assurance Committee
The Board of Directors appoints the Quality Assurance Committee (QAC) to review and make recommendations to the Board regarding accepting 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 makes recommendations for annual modifications of the QI Program and actions to achieve the Institute for Healthcare Improvement's Quadruple Aim moving upstream from the CMS' Triple Aim:

1. Enhancing patient experience
2. Improving population health
3. Reducing per capita cost
4. Enhancing provider satisfaction

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
- Consumers
- Family support
- Foster children

- LTSS
- Medi-Cal beneficiaries
- Medically indigent persons
- OC HCA
- Orange County Social Services Agency (OC SSA)
- Persons with disabilities
- Persons with mental illnesses
- Persons with special needs
- Recipients of CalWORKs
- Seniors

Two of the 15 positions — held by OC HCA and OC SSA — 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:
  - OC SSA
  - OC Community Resources Agency, Office on Aging
  - OC HCA, Behavioral Health
  - OC 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 held at least quarterly and 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 OC HCA, which maintains a standing seat. PAC meets at least quarterly and ~~The meetings~~ are open to the public. The 15 seats include:

- HN
- Hospitals
- Physicians (3 seats)
- Nurse
- Allied health services
- Community health centers
- OC HCA (1 standing seat)
- LTSS (LTC facilities and CBAS) (2 seats)
- Non-physician medical practitioner
- Traditional safety net provider
- Behavioral/mental health
- Pharmacy

Whole-Child Model Family Advisory Committee
In 2018~~8~~, CalOptima's Board of Directors established the Whole-Child Model Family Advisory Committee (WCM FAC), as required by the state as part of California Children's Services (CCS) becoming a Medi-Cal managed care plan benefit. The WCM FAC ~~will~~ provides advice and recommendations to the Board and staff on issues concerning WCM, serves as a liaison between interested parties and the Board, and assists 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 is 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

Members of the Committee shall serve staggered two-year terms. Of the above seats, five members serve an initial one-year term (after which representatives for those seats will be appointed to a full two-year term), and six will serve an initial two-year term. WCM FAC meets at least quarterly and meetings are open to the public.

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 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.

Chief Medical Officer (CMO) — ~~or physician designee — chairs the QIC~~oversees strategies, programs, policies and procedures as they relate to CalOptima's quality and safety of clinical care delivered to members. The CMO has overall responsibility of the QI program ~~, 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 Improvement (QI), Utilization Management (UM), Case Management (CM), Population Health Management (PHM), Pharmacy Management (PM), Behavioral Health Integration (BHI), Long-Term Services and Supports (LTSS), and Enterprise Analytics (EA)~~–~~.

~~**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.~~

Medical Director (Quality) is the physician designee who chairs the QIC and is responsible for overseeing QI activities and quality management functions. The medical director provides direction and support to CalOptima's Quality and Population Health Management teams to ensure QI Program objectives are met. The medical director is also the chair of the Credentialing Peer Review Committee (CPRC).

Medical Director (~~,~~ Behavioral Health) is the designated behavioral healthcare practitioner in the QI program, and serves as a participating member of the QIC, as well as the Utilization Management Committee (UMC), and CPRC~~redentialing Peer Review Committee~~. The medical director is also the chair of the Pharmacy & Therapeutics committee (P&T).

Executive Director, Quality & Population Health Management (ED of Q&PHM) is responsible for facilitating the company-wide QI Program deployment, driving performance results~~improvements~~ in Healthcare Effectiveness Data and Information Set (HEDIS), DHCS, CMS Star measures and ratings, and maintaining ~~commendable~~ accreditation standing as a high performing health plan with NCQA. The ED of Q&PHM 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 integrating behavioral health across the health care delivery system and populations served. ~~programs throughout the company and makes certain that quality initiatives are aligned with Clinical Operations within Medical Affairs.~~ Reporting to the ED of Q&PHM are the: Director, Quality Analytics; ~~Director,~~ Director, ~~of~~ Quality Improvement~~,~~; Director, ~~of~~ Population Health Management; Director, Behavioral Health Services (Clinical Operations); and Director, ~~of~~ Behavioral Health Integration.~~Quality Improvement.~~

Executive Director, 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, LTSS 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&PHM, makes certain that Medical Affairs is aligned with CalOptima's strategic and operational priorities.

Executive Director, ~~Public Affairs~~Program Implementation (ED of PI~~A~~) ~~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~~is responsible for maintaining the organization's strategic plan, development and implementation of new programs, operational process improvement activities and community relations. Reporting to ED of PI: Director, Process Excellence; and Director, ~~ also oversees~~ Strategic Development. ~~and the integration of activities for the Community Relations Program.~~

Executive Director, Compliance (ED of C) is responsible for monitoring and driving interventions so that CalOptima and its ~~HMOs, PHCs, SRGs~~HNs~~,~~ and other FDRs meet the requirements set forth by DHCS, CMS and DMHC. The Compliance staff works in collaboration with the CalOptima Audit & Oversight departments (external and internal) to refer any potential sustained noncompliance issues or trends encountered during audits of HNs, and other functional areas. The ED of C serves as the State Liaison and is responsible for legislative advocacy. ~~a~~Also, the ED of C 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, Network Operations (ED of NO) leads and directs the integrated operations of the HNs, 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 is maintained throughout the service delivery network.

Executive Director, Operations (ED of O) is responsible for overseeing and guiding Claims Administration, Customer Service, GARS, Coding Initiatives~~,~~ and Electronic Business.

QUALITY IMPROVEMENT COMMITTEES AND SUBCOMMITTEES

Quality Improvement Committee (QIC)
The QIC is the foundation of the QI program and is accountable to the QAC. 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 delegated health networks ~~HMOs, PHCs, and SRGs , and MBHOs~~ to achieve the result of improved care and services for members. The QIC oversees the performance of delegated functions by its delegated health networks ~~HMOs, PHCs, and SRGs, and MBHOs~~ and their contracted provider and practitioner partners.

The composition of the QIC includes a participating ~~B~~behavioral ~~H~~health practitioner to specifically address integration of behavioral and physical health, appropriate utilization of

recognized criteria, development of policies and procedures, 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 and priority alignment of the QI subcommittees for effective operation and achievement of objectives~~.~~
- Oversees the analysis and evaluation of QI activities~~.~~
- Makes certain that there is practitioner participation through attendance and discussion in the planning, design, implementation and review of QI program activities~~.~~
- Identifies and prioritizes needed actions and interventions to improve quality~~.~~
- Makes certain that there is follow~~-~~ up as necessary to determine the effectiveness of quality~~-~~ improvement-related actions and interventions.

Practice patterns of providers, practitioners and~~,~~ ~~HMOs, PHCs, and SRGs, and MBHOs~~ delegated health networks 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, and SRGs, and MBHOs~~and delegated health networks.

The QI Program adopts the classic Continuous Quality Improvement cycle with 4 basic steps:

- **Plan** Goals with d~~D~~etailed description of an implementation plan~~and goals~~
- **Do** Implementation of the plan
- **Study** Data and collection
- **Act** Analyze data and develop conclusions

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)~~ physicians or practitioners, with at least two ~~(2)~~ practicing physicians or practitioners
- County Behavioral Health ~~County~~ Representative
- CalOptima CMO (Chair or Designee)

- CalOptima Medical Directors
- CalOptima BH Medical Director (or Designee)
- Executive Director, Quality & Population Health Management
- Executive Director, Clinical Operations
- Executive Director, Network Management
- Executive Director, Operations

The QIC is supported by:

- ~~Executive Director, Quality & Population Health Management~~
- Director, Quality Improvement
- Director, Quality Analytics
- Director, Population Health Management
- Committee Recorder as assigned

Quorum

A quorum consists of a minimum of six ~~(6)~~ voting members 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 telephone.

The QIC shall meet at least eight times per calendar year, and report to the Board QAC 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 and Subcommittees

Contemporaneous minutes reflect all ~~C~~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
- 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 produced only ~~not reproduced~~ for committee approval. ~~All other quality documentation is not reproduced in order to (except for Quality Profile documentation) in order to maintain confidentiality, privilege and protection.~~

Credentialing 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~~ who serve CalOptima members meet generally accepted standards for their profession or industry. The CPRC reviews, investigates~~,~~ and evaluates the credentials of all CalOptima practitioners, which include internal and external physicians who participate on the committee. The committee~~internal CalOptima medical staff for membership, and~~ maintains a continuing review of the qualifications and performance of all practitioners every three years.~~external medical staff.~~ In addition, the CPRC reviews and monitors sentinel events, quality of care issues~~,~~ and identified ~~services~~ trends across the entire continuum of CalOptima's contracted providers~~:~~ — ~~HMOs, PHCs, SRGs~~delegated health networks~~,~~ and ~~health care delivery organizations~~OPs to ensure patient safety aiming for zero defects. The CPRC, chaired by the CalOptima CMO or designee, consists of representation of active physicians from CCN and HNs. Physician participants represent a range of practitioners and specialties from CalOptima's network. CPRC meets a minimum of six times per year and reports through the QIC. The voting member composition and quorum requirements of the CPRC are defined in its charter.

~~**Grievance and Appeals Resolution Services Committee (GARS)**~~
~~The GARS committee serves to protect the rights of our members, promote the provision of quality health care services, and ensure that the policies of CalOptima are consistently applied to resolve member complaints in an equitable and compassionate manner through oversight and monitoring. The GARS committee 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 committee meets at least quarterly and reports through the QIC. The voting member composition and quorum requirements of the GARS are defined in its charter.~~

Utilization Management Committee (UMC)
The UMC 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 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 monitors the utilization of ~~physical health~~medi~~d~~cal,~~health care~~, behavioral health and Long--Term Services and Support (LTSS) services ~~by CalOptima Direct~~for the CalOptima Care Network (CCN) and through the delegated ~~HMOs, PHCs, and SRGs, and MBHOs~~health networks to identify areas of under or over-utilization that may adversely impact member care. The UMC oversees Inter-R~~r~~ater Reliability (IRR) testing to support consistency of application in nationally recognized criteria for making medical necessity determinations, as well as development of e~~E~~vidence--b~~B~~ased c~~C~~linical p~~P~~ractice g~~G~~uidelines, and completes an annual review and updates ~~updates approves~~ 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. These clinical practice guidelines and nationally recognized evidenced--based guidelines are approved annually, at minimum, at the UMC. The UMC meets quarterly and reports through the QIC. The voting member composition (including a

~~B~~behavioral ~~H~~health practitioner*) and the quorum requirements of the UMC are defined in its charter.

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

Pharmacy & Therapeutics Committee (P&T)
The P&T committee is a forum for an evidence-based formulary review process. The P&T committee 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~~based on specific categories of drugs and formulary initiatives, as well as the overall program. In addition, the P&T committee reviews and evaluates current pharmacy-related issues that are interdisciplinary, involving interface between medicine, pharmacy and other practitioners involved in the delivery of health care to CalOptima's members. The P&T committee includes practicing physicians (including both CalOptima employee physicians and participating provider physicians), and the membership represents a cross section of clinical specialties and clinical pharmacists in order to adequately represent the needs and interests of all plan members. The P&T committee provides written decisions regarding all formulary development decisions and revisions. The P&T committee meets at least quarterly, and reports to the UMC. The voting member composition and quorum requirements of the P&T committee are defined in its charter.

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 UMC~~, and also~~and ensures that benefit updates are implemented~~,~~ and communicated accordingly to internal CalOptima staff, and are provided to contracted HMOs, PHCs, and SRGs~~, and MBHOs~~. The Regulatory 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. The voting member composition and quorum requirements of the BMSC are defined in its charter.

~~**Long-Term Services and Supports QI Subcommittee (LTSS-QISC)**~~
~~The LTSS subcommittee is composed of representatives from the LTC, CBAS, 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 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 the Clinical Operations subcommittee, and through the QIC. The voting member composition and quorum requirements of the LTSS-QISC are defined in its charter.~~

~~**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 designated chairman of the BHQIC is the Medical Director, Behavioral Health, who is responsible for chairing the committee and reporting through the QIC. The BHQIC meets, at a minimum, on a quarterly basis, or more often as needed. The voting member composition and quorum requirements of the BHQIC are defined in its charter.~~

Whole-Child Model Clinical Advisory Committee (WCM CAC)

The WCM CAC was formed in 2018 pursuant to DHCS All Plan Letter 18-011. The WCM CAC ~~will~~ advises on clinical and behavioral issues relating to CCS conditions, including such matters as treatment authorization guidelines, and ensuringe they are integrated into the design, implementation, operation~~,~~ and evaluation of the CalOptima WCM program in collaboration with county CCS, the WCM Family Advisory Committee~~,~~ and HN CCS providers. The WCM CAC meets ~~4~~four times a year and reports to the QIC. -The voting member composition and quorum requirements of the WCM CAC are defined in its charter.

Member Experience Committee ~~Subcommittee~~ (MEMX)
Improving member experience is a top priority of CalOptima. The MEMX committee was formed to ensure strategic focus on the issues and factors that influence the member's experience with the health care system for Medi-Cal, OC~~,~~ and OCC. NCQA's Health Insurance Plan Ratings ~~Medicaid Plan Ratings~~ measure three dimensions ~~—~~ ~~—~~ ~~P~~prevention, ~~T~~treatment and c~~C~~ustomer ~~S~~satisfaction. ~~CalOptima's QI Program focuses on the performance in each of these areas.~~ The MEMX committee 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. In 2020~~2019~~, the MEMX committee, which includes the Access ~~&~~and Availability workgroup, will ~~be~~ continue to meet at least bi-monthly and will be held accountable to implement targeted initiatives to improve member experience and demonstrate significant improvement in the 2020 and 2021 CAHPS survey results. ~~This subcommittee meets at least bi-monthly and is reported through the QIC. The voting member composition and quorum requirements of the MEMX are defined in its charter.~~

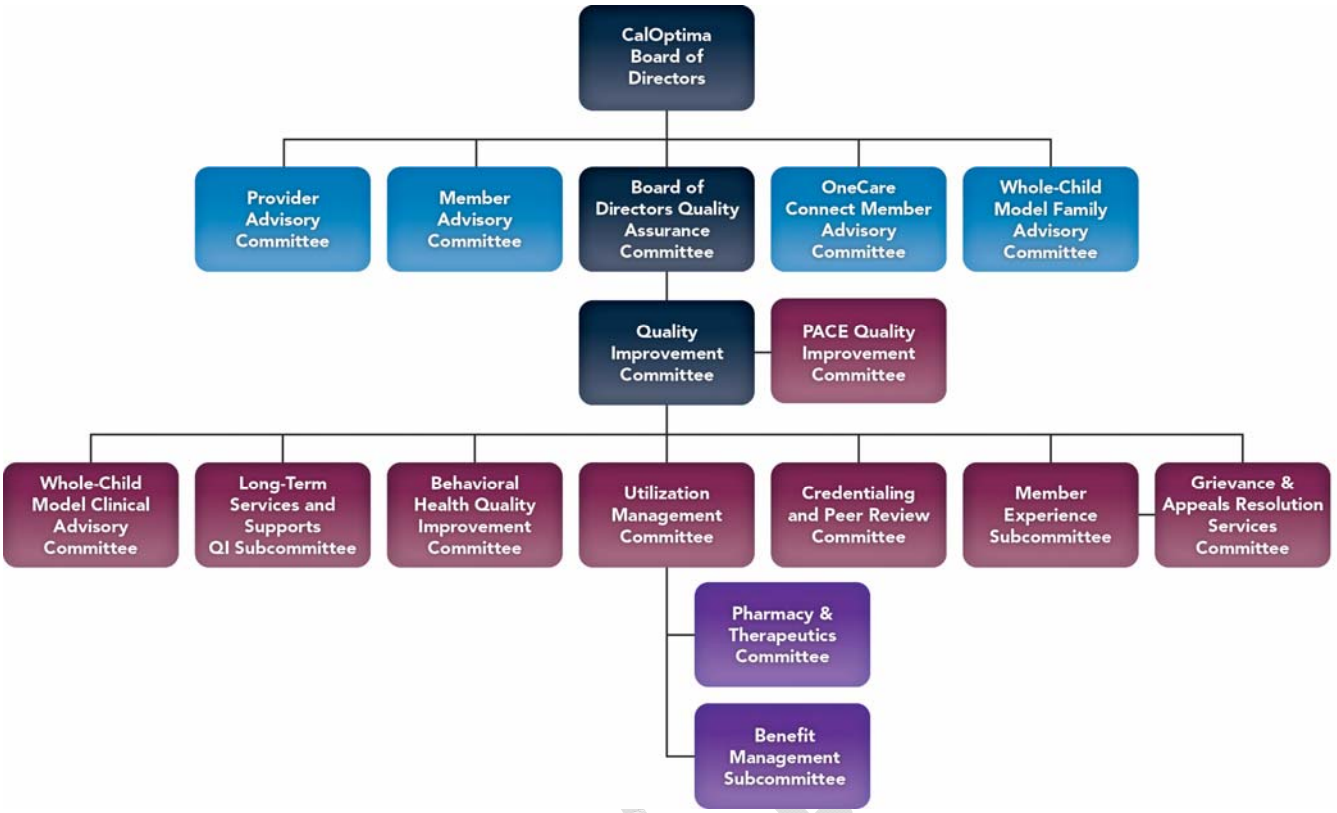
Grievance and Appeals Resolution Services Committee (GARS)
The GARS committee serves to protect the rights of our members, promote the provision of quality health care services, and ensure that the policies of CalOptima are consistently applied to resolve member complaints in an equitable and compassionate manner through oversight and monitoring. The GARS committee 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 committee meets at least quarterly and reports through the QIC. The voting member composition and quorum requirements of the GARS are defined in its charter.

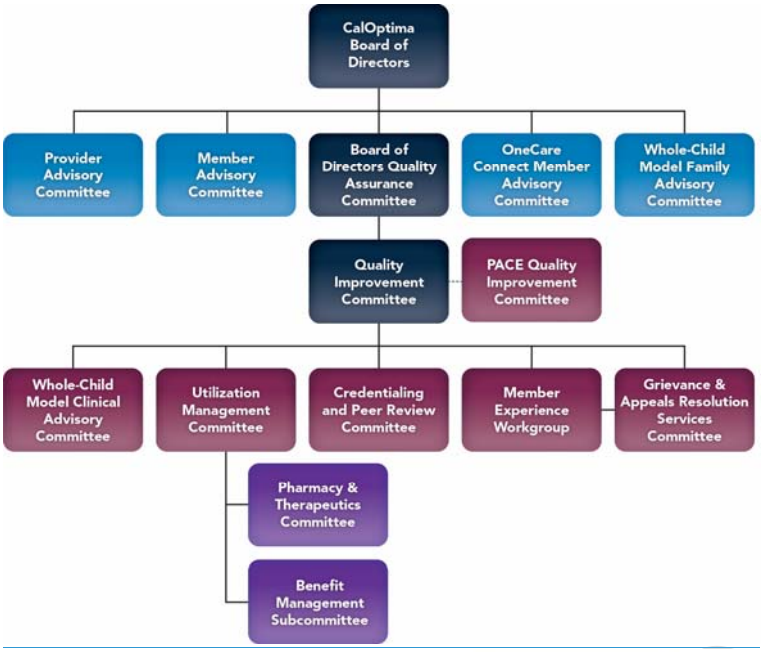
Program of All-Inclusive Care for the Elderly Quality Improvement Committee (PQIC)
The PQIC committee provides oversight for the overall administrative and clinical operations of CalOptima PACE. The PQIC assures compliance to all state and federal regulatory bodies. The PQIC may create new ad-hoc committees or task forces to improve specific clinical or administrative processes that have been identified as critical to participants, families or staff. The PQIC meets, at a minimum, quarterly and is chaired by the PACE Medical Director. A summary of the PQIC meetings are submitted to the CalOptima Quality Improvement Committee (QIC) which are then included in the QIC summary submitted to the CalOptima Board of Directors Quality Assurance Committee (QAC). Annually, the PQIC will assess all PACE quality improvement 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. Potential areas for improvement will be identified through analysis of the data and through root cause analysis.

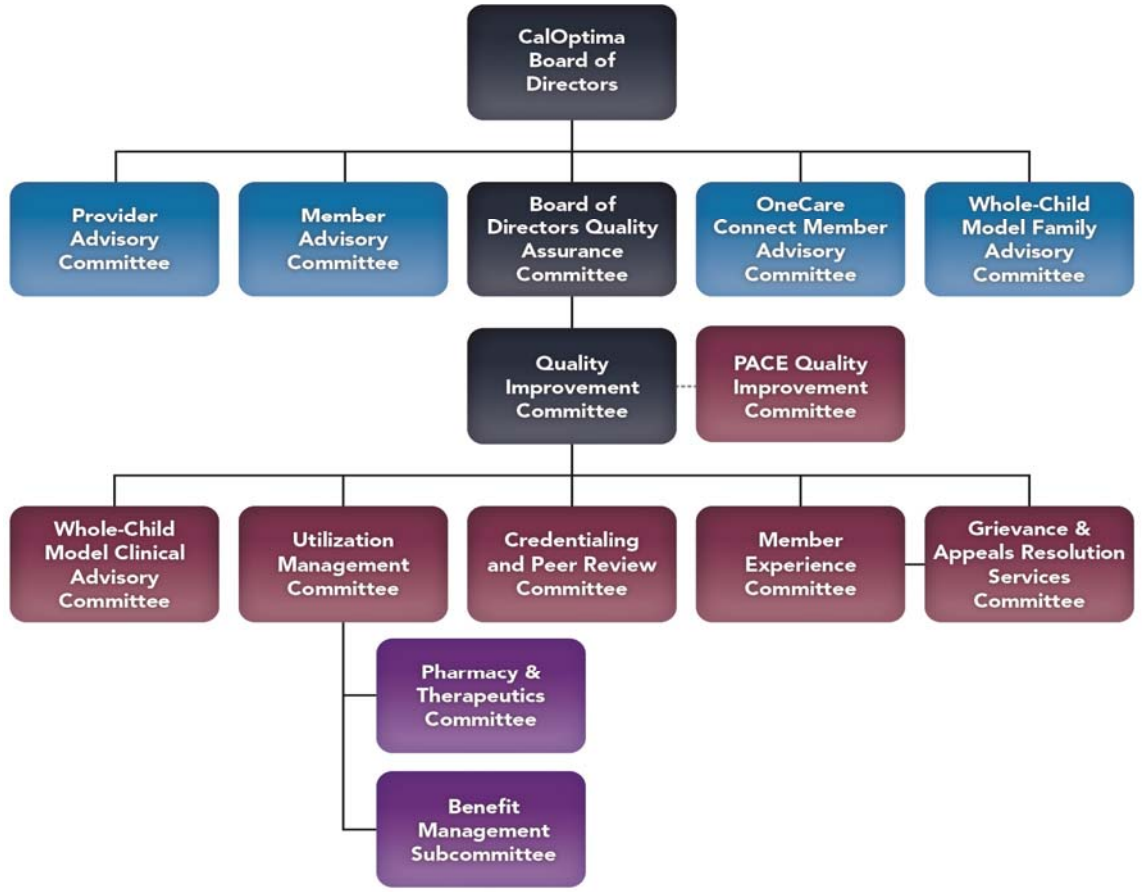
~~**Whole-Child Model Clinical Advisory Committee (WCM CAC)**~~
~~The WCM CAC was formed in 2018 pursuant to DHCS All Plan Letter 18-011. The WCM CAC will advise on clinical and behavioral issues relating to CCS conditions, including such matters as treatment authorization guidelines, and ensure they are integrated into the design, implementation, operation, and evaluation of the CalOptima WCM program in collaboration with county~~

~~CCS, the WCM Family Advisory Committee, and HN CCS providers. The WCM CAC meets 4 times a year and reports to the QIC. The voting member composition and quorum requirements of the WCM CAC are defined in its charter.~~

~~2019~~2020 Committee Organization Structure — Diagram







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 ~~C~~committee members of each entity are required to sign a ~~C~~confidentiality ~~A~~agreement on an annual basis. Invited guests must sign a ~~C~~confidentiality ~~A~~agreement at the time of ~~C~~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, and SRGs~~delegated networks ~~and MBHOs~~ hold all information in the strictest confidence. Members of the QI Committee and the subcommittees sign a c~~C~~onfidentiality a~~A~~greement. This a~~A~~greement 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 ~~S~~state ~~C~~contract.

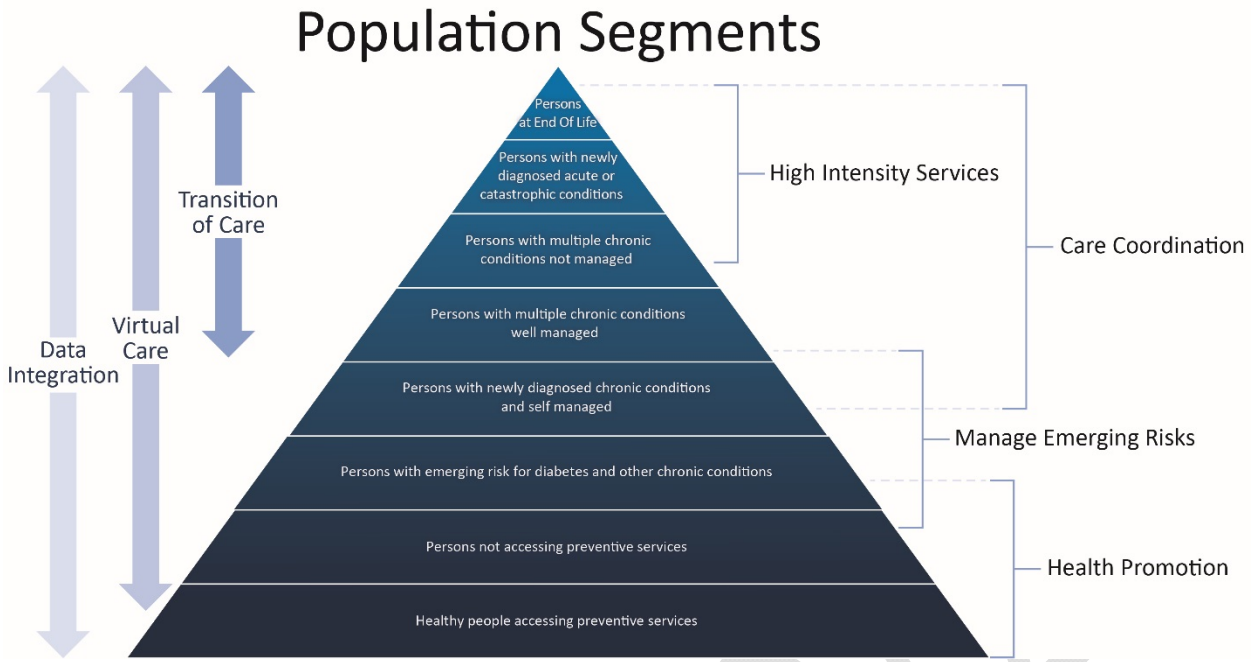
Conflict of Interest

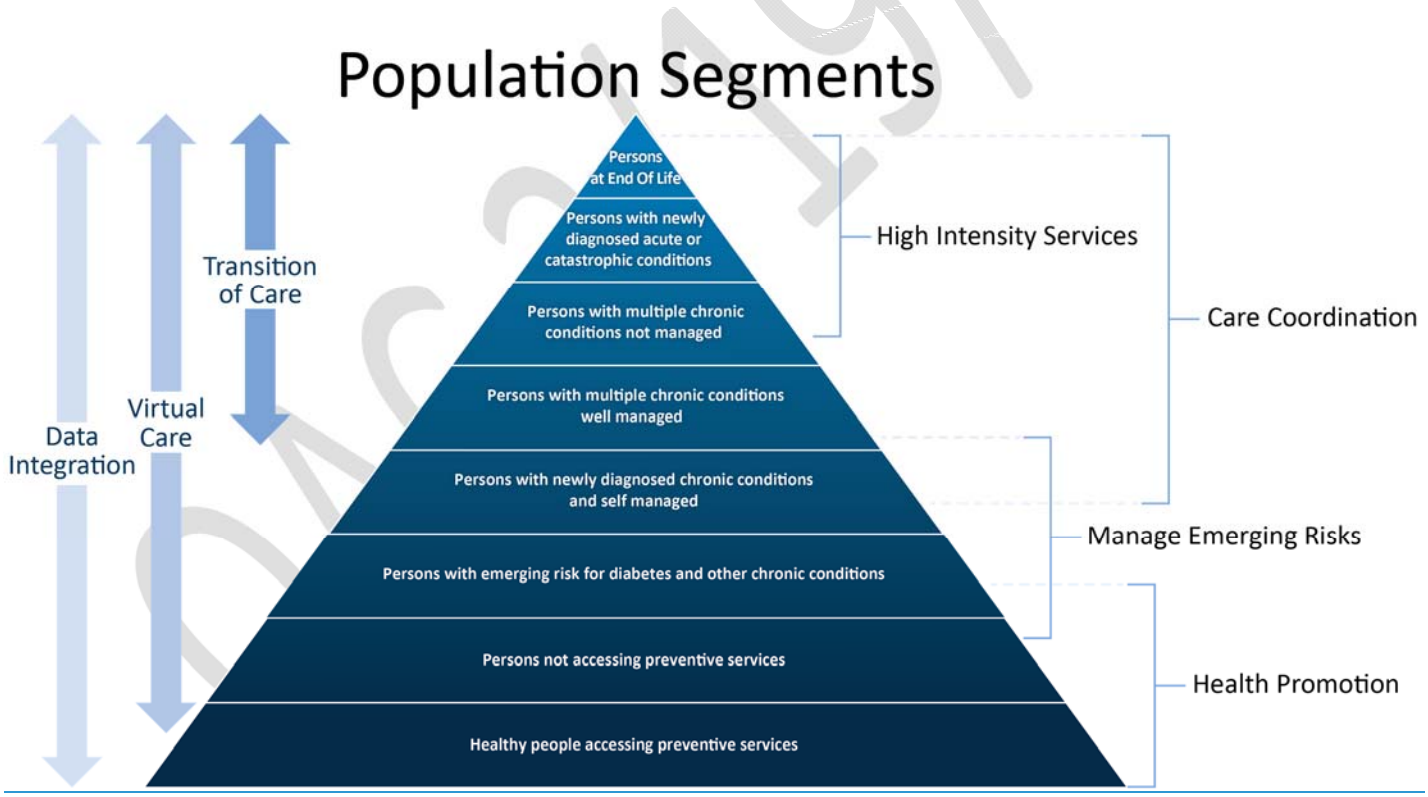
CalOptima maintains a Conflict of Interest policy that addresses the process to identify and evaluate potential social, economic and professional conflicts of interest and take appropriate actions so that they do not compromise or bias professional judgment and objectivity in quality, credentialing and 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 employed positions serving on the QI/UM ~~C~~committees and subcommittees.~~-~~ Additionally, 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.

QUALITY IMPROVEMENT STRATEGIC GOALS

The QI Program supports a Population Health Management (PHM) approach, stratifying our population based on their health needs, conditions~~,~~ and issues, and aligns the appropriate resources to meet these needs. Building upon CalOptima's existing innovative Model of Care (MOC), the ~~2019~~2020 QI Work Plan will focus on building out additional services leveraging telehealth technology to engage the new population segments currently not served, such as the population with emerging risk or experiencing social determinants of health. The Population Segments with an integrated intervention hierarchy, is shown below.

~~The Population Segments and Homeless Population Segments with an integrated intervention hierarchy, is are shown below:~~





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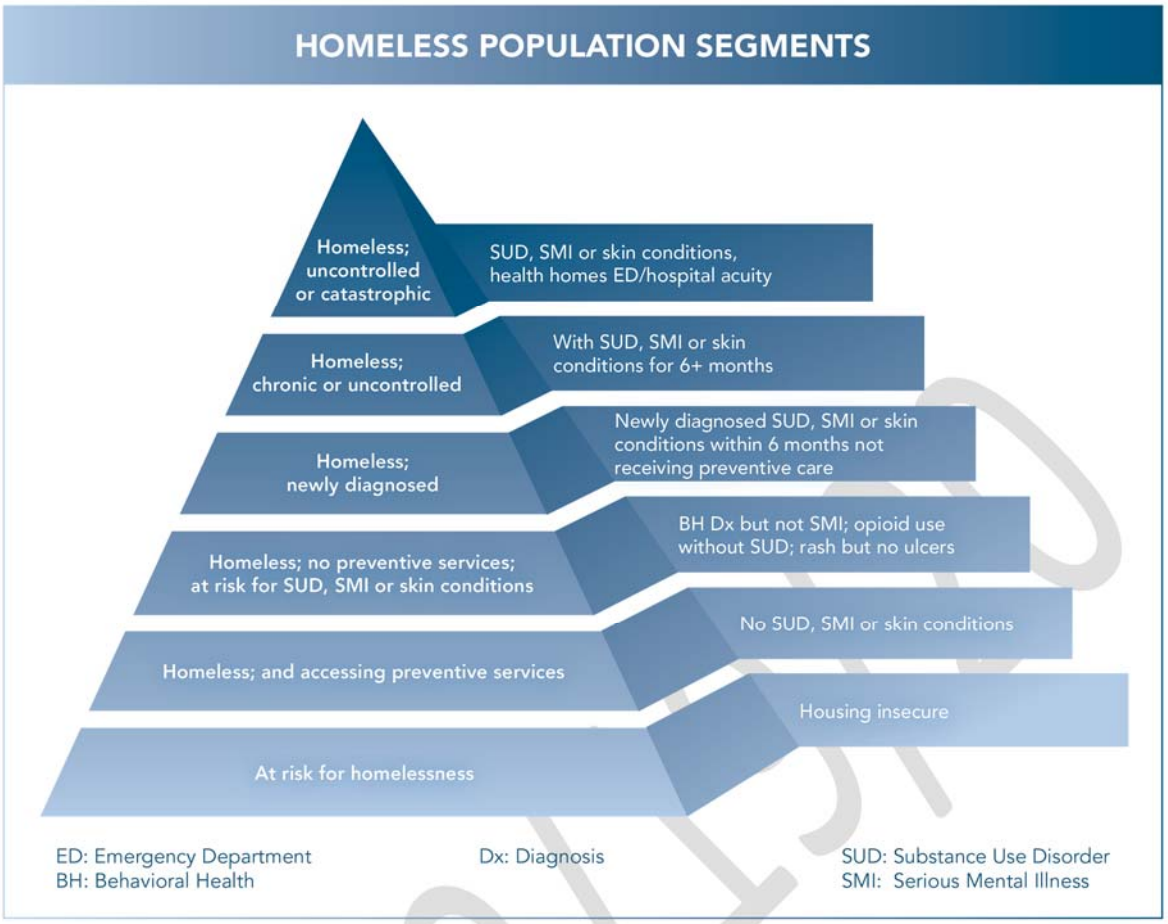

CalOptima's ~~Model of Care (~~MOC~~)~~ recognizes the importance of mobilizing multiple resources to support our members' health needs. The coordination between our various medical and behavioral health providers, pharmacists~~,~~ and care settings, plus our internal experts, supports a member-centric approach to care/care coordination. The current high-touch MOC is very effective in managing the health care needs of ~~the~~ high-risk members one-by-one. By enhancing the service capabilities and the transition of care process leveraging telehealth and mobile technology, the current MOC can be scaled to address the health care needs of the population segments identified through systematic member segmentation and stratification using integrated data sets.

~~2019~~2020 QI Goals and Objectives

CalOptima's QI Goals and objectives are aligned with CalOptima's 2020–2021 ~~2017–2019~~ strategic goals.

1. ~~Goal:~~ Increase~~Achieve~~ NCQA overall rating~~ of~~ from 4.0 to 4.5~~.~~ ~~as the #1 Medi-Cal Health Plan in California by:~~

~~1.1. Improving NCQA ratings in Member Experience from 1.5 to 3.0~~
~~1.2. Improving NCQA ratings in Treatment from 3.5 to 4.0~~

2. ~~Goal: Improve overall Health Networks, including CCN, quality performance rankings by:~~

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~~2.1. Implementing practice transformation technical assistance in 5 high volume CCN practices by December 2019.~~2020

~~2.2. Expanding provider coaching and customer services training to include all health networks and all PQI providers and office staff in CCN by December 2019~~2020~~.~~

2. ~~Goal:~~ Improve Member Experience CAHPS performance from 25th to 50th percentile, focusing on Getting Needed Care and Getting Care Quickly~~from 25th percentile to exceed 50th percentile~~

~~**3.** thththth by:~~

~~3.1. Increasing the number of providers who have a high rate of grievances and PQIs who will participate in provider coaching and customer services training by December 2019.~~2020

~~3.2. Expanding provider coaching and customer services training to all health networks providers and office staff on the PQI list by December 2019.~~2020

3. Improve member's ability to access primary and specialty care timely, for urgent and routine appointments, from 2019 baseline to goal of 80% ~~.~~

Detailed strategies for achieving ~~2019~~2020 Goals and Objectives are measured and monitored in the QI Work Plan, reported to QIC quarterly~~,~~ and evaluated annually.

QI Measurable Goals for the Model of Care

The 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~~programs. The MOC meets the needs of special member populations through strategic activities. Measurable goals are established and reported annually.

The MOC goals are:

- Improving access to essential services
- Improving access to preventive health services
- Assuring appropriate utilization of services
- Assuring proper identification of Social Determinants of Health (SDOC)
- Improving coordination of care through an identified point of contact
- Improving seamless transitions of care across health care settings, providers and health services~~,pbhcmo~~
- 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. Results are evaluated and reported annually.

QI 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. A ~~QI Work Plan~~

~~addenda~~QI Work Plan addendum 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 and~~&~~ Systems (CAHPS), Stars and Health Outcomes Survey (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, which includes, but is not limited to:

- Quality of ~~C~~clinical ~~C~~care
- Safety of ~~C~~clinical ~~C~~care
- Quality of ~~S~~service
- Member ~~E~~experience
- ~~Compliance~~
- QI Program ~~O~~oversight
- 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. In addition, o~~O~~ngoing 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.

- These activities are included in Quality Improvement Project (QIP), Performance Improvement Project (PIP), Plan-Do-Study-Act (PDSA) and Chronic Care Improvement Projects (CCIP). They are ~~and~~ reflected in the QI Work Plan.
- ~~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 — ~~2019~~2020 QI Work Plan

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 internal monitoring activities, including, but not limited to, (a) potential quality ~~concern~~ issue (PQI) review processes, (b) provider and facility reviews, (c) preventive care audits, (d) access to care studies, (e) ~~satisfaction~~ member experience surveys, (f) HEDIS results, and (g) other opportunities for improvement as identified by subcommittee's data analysis~~.~~
- 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, with specific emphasis on the following areas:

- 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 case 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. For example:

- 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, QIC, UMC, 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 measures

Quality measures may be process measures (lead quality measures) or outcome measures (lag quality measures) where there is strong clinical evidence of the correlation between the process and member outcomes. This evidence and the rationale for selection of the lead quality measure must be cited in the project description, when appropriate.

Each QI Project will have at least one (and frequently more) lead measure(s) that are actionable in real time. The selected lead measures should be levers, drivers, or predictors of the desired outcome measures or lag quality measure such as HEDIS and STARS measures. While at least one lead measure must be identified at the start of a project, more may be identified after analysis of baseline measurement or re-measurement. Since quality measures will measure changes in health status, functional status, member satisfaction, and provider/staff, ~~HMO, PHC, and SRG, and MBHO~~delegated HNs, or system performance, quality measures will be clearly defined and objectively measurable.

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 outcomes 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% percent 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. Also, smaller sample size may be appropriate for QI pilot projects that are designed as small tests of change using rapid improvement cycle methodology. For example, a pilot sample of 30 or 100 %percent of the sample size when sample target population is less than 30, can be statistically significant for QI pilot projects.

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

Communication of QI 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 Quality Assurance Committee of 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
- HN Forums, Medical Directors meetings, Quality Forum and other ongoing ad-hoc meetings

- Annual synopsized QI report ~~(both web-site and hardcopy availability for both practitioners and members) shall be~~ posted on CalOptima's website (both web-site and hardcopy are available for both practitioners and members)~~., in addition to the annual article in both practitioner and member newsletter.~~ The information includes a QI Program Executive Summary ~~or outline~~and ~~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~~paper~~ copy of QI Program information is posted on the web, and is made available upon request
- MAC, OCC MAC, WCM FAC and PAC.

QUALITY IMPROVEMENT PROGRAM RESOURCES

CalOptima's budgeting process includes personnel, IS 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.

In addition to CalOptima CMO and ED of Q&PHM, the following staff positions provide direct support for organizational and operational QI Program functions and activities:

Director, Quality Improvement
Responsibilities include assigned day-to-day operations of the Quality Management (QM) functions ~~I department~~, including Credentialing, Facility Site Reviews, Physical Accessibility Compliance and working with the ED of Q&PHM to oversee the QI Program and maintain NCQA accreditation. This position is also responsible for implementation of the QI Program and Work Plan implementation.

- The following positions report to the Director, Quality Improvement:
  - Manager, Quality Improvement
  - Supervisor, Quality Improvement (PQI)
  - ~~Supervisor, Quality Improvement (Credentialing)~~
  - Supervisor, Quality Improvement, and Master Trainer (FSR)
  - Supervisor, Credentialing
  - ~~QI Program Specialists~~
  - QI Nurse Specialists
  - ~~o~~
  - Program Policy Analyst ~~and Data Analyst~~
  - Credentialing Coordinators
  - Program Specialists
  - Program Assistants
  - Outreach Specialists
  -

Director, Quality Analytics
Provides data analytical direction to support quality measurement activities for the 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, Quality Analytics:
  - Quality Analytics HEDIS Manager
  - Quality Analytics Pay for Value Manager
  - Quality Analytics ~~QI Initiatives~~ Network Adequacy Manager
  - Quality Analytics Analysts
  - Quality Analytics Project Managers
  - Quality Analytics Program Coordinators
  - Quality Analytics Program Specialists

Director, Population Health Management
Provides direction for program development and implementation for agency-wide population health initiatives, including telehealth. Ensures linkages supporting a whole-person perspective to ~~health and~~ health care with Case Management, UM, Pharmacy and Behavioral Health Integration. Provides direct care coordination and health education for members participating in non-delegated health programs such as Perinatal Support Services (Bright Steps) and Childhood Obesity Prevention Program (Shape Your Life). Also, supports the MOC 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, Population Health Management:
  - Population Health Management Manager (Program Design)
  - Population Health Management Manager (Operations)
  - Population Health Management Supervisor (Operations)
  - Health Education Manager
  - Health Education Supervisor
  - Population Health Management Health Coaches
  - Senior Health Educator
  - Health Educators
  - Registered Dieticians
  - Data Analyst
  - Program Manager
  - Program Specialists
  - Program Assistant

Director, Behavioral Health ~~Services~~ (~~Integration~~) provides program development and leadership to the implementation, expansion, and/or improvement of processes and services that lead to the integration of physical and behavioral health care services for CalOptima members across all lines of business. ~~operational oversight for behavioral health benefits and services provided to members.~~ The director is responsible for the management and strategic direction of the Behavioral Health Integration Department efforts in integrated care, quality initiatives, and community partnerships. ~~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.~~ The Director ensures departmental compliance with all local, state and federal regulations and that accreditation standards and all policies and procedures meet current requirements.

Director, Behavioral Health Services (Clinical Operation) provides operational oversights of the Behavioral Health Integration Dd~~d~~epartment clinical services. ~~-~~The Director leads a team that provides behavioral health telephonic clinical triage, care coordination~~,~~ and utilization management for members in all lines of business.

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

Director, 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 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 Committees, and participates in the QIC and the Benefit Management subcommittee.

Director, 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 committee and ~~QI~~ UMC Committees. The director also guides the identification and interventions on key pharmacy quality and utilization measures.

Director, 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, and ~~-~~develops and implements policies, procedures and processes related to program operations and quality measures.

Director, Long-Term Services and Supports is responsible for LTSS programs, which include CBAS, LTC, and MSSP. The position supports a "Member-Centric" approach and helps keep members in the least restrictive living environment, collaborates with community partners and other stakeholders, and ensures LTSS are available to appropriate populations. The director also develops and implements policies, procedures, and processes related to LTSS program operations and quality measures.

Director, 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 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.

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 intensive orientation and job specific training with a staff 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 ~~&~~ and procedures, etc.
- Seniors and Persons with Disabilities Awareness training
- Cultural Competency and Trauma~~-~~-Informed Care training
- QI Lean training curriculum ~~will be~~ (added to CalOptima University in 2019)
-

MOC-related employees, contracted providers and practitioner 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.

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 education reimbursement for employees.

~~***MOC-related employees, contracted providers and practitioner 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.***~~

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 a~~A~~ctivities~~y~~, including QIPs, PIPs, PDSAs, and CCIPs. ~~QI Projects (QIPs), Programs (s~~

- ~~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 measures and identification of significant trends~~.~~
- A critical review of the organizational resources involved in the QI Program through the CalOptima strategic planning process~~.~~
- Recommended changes included in the revised QI Program Description for the subsequent year, for QIC, QAC, and the Board of Directors review and approval~~.~~

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 ~~C~~care, by definition, is accessible, comprehensive, coordinated~~,~~ and continual care delivered by accountable providers of personal health services.
- Community~~-~~ ~~O~~oriented ~~P~~primary ~~C~~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 ~~C~~care and ~~S~~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 ~~C~~case ~~M~~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

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- Organizational ethics
- Effective utilization of resources
- Management of information
- Financial management
- Management of human resources
- Regulatory and contract compliance
- Customer satisfaction
- Fraud and abuse* as it relates to quality of care

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

QUALITY IMPROVEMENT

The QI department is responsible for ~~the execution and coordination of 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 ensure 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 ~~agency-wide~~agency wide.
- Evaluate and monitor provider credentials.
- Support the maintenance of quality standards across the continuum of care for all lines of business.
- Monitor and maintain agency-~~-~~wide practices that support accreditation and meeting regulatory requirements.

Peer Review Process f~~F~~or Potential Quality Issues

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, and

tracking and trending of service and access issues are reported to the CPRC and are also reviewed at the 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 GARS.

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, CMS and NCQA). The scope of the credentialing program includes all licensed MDs, DOs, DPMs (doctors of podiatric medicine), DCs (doctors of chiropractic medicine), DDSs (doctors of dental surgery), allied health and midlevel practitioners, which include, but are not limited to: non-physician behavioral health practitioners, certified nurse midwives, certified nurse specialists, nurse practitioners, optometrists, physician assistants, registered physical therapists, occupational therapists, speech therapists and audiologists, both in the delegated and CalOptima direct environments. Credentialing and re-credentialing activities for CCN are performed at CalOptima, and ~~also~~ delegated to ~~Health Networks~~HNs and other sub-delegates for their providers.~~are delegated to the HNs and performed by CalOptima for CCN.~~

~~Health Care Delivery Organizations~~Organizational Providers
CalOptima performs credentialing and re-credentialing of ~~Health Care Delivery Organizations (HDOs), also known as O~~organizational ~~P~~providers (OPs) ~~for providers~~ such as, but not limited to, acute care hospitals, home health agencies, skilled nursing facilities, free standing surgery centers, dialysis centers, etc. 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 QI Activities in the Re-credentialing Process
Findings from QI activities and other performance monitoring 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 ~~P~~primary ~~C~~care ~~P~~practitioner (PCP) site and medical records review to its contracted HMOs, PHCs~~,~~ and SRGs. CalOptima does, however, delegate this function to designated health plans in accordance with standards set forth by Medi-Cal Managed

Care Division (MMCD) Policy Letter 14-004. CalOptima assumes responsibility and conducts and coordinates fFacility Ssite Rreview (FSR) and Mmedical Rrecord Rreview (MRR) for the non-delegated HNs. CalOptima retains coordination, maintenance, and oversight of the FSR/MRR process. CalOptima collaborates with the SRGs 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 lpast three years, in accordance with MMCD Policy Letter 14-004 and CalOptima policies. Medical records of new providers shall be reviewed within ninety 90 calendar days of the date on whichthat members are first assigned to the provider. An additional extension of ninety 90 calendar days may be allowed only if the provider does not have enough 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 physical accessibility review for Americans with Disabilities Act (ADA) compliance for SPD members, which includes access evaluation criteria to determine compliance with ADA requirements.

- Parking
- Building interior and exterior
- Participant areas including the exam room
- Restroom
- Exam room
- Exam table/scale

Medical Record Documentation Standards
CalOptima requires that its contracted HMOs, PHCs, and SRGsdelegated HNs 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.

The medical record should be protected to ensure that medical information is released only in accordance with applicable Federal and State law.

Corrective Action Plan(s) To Improve Quality of Care and, Service

When monitoring by either CalOptima's QI department, or Audit & Oversight department or other functional areas identifiessd as an opportunity for improvement, the delegated orappropriate functional areas will determine the appropriate action(s) to be taken to correct the

problem. Those activities specific to delegated entities will be conducted at the direction of the Audit & 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 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.
- Formal or informal discussion of the data/problem with the involved practitioner, either in the respective committee or by a mMedical Ddirector.
- Further observation and monitoring of performance via the appropriate clinical monitor. (This process shall determine if follow-up action has resolved the original problem.)
- Intensified evaluation/investigation 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 or office training
- De-delegation
- De-Ccredentialing
- Contract termination
-

~~**Performance Improvement Evaluation Criteria for Effectiveness**~~

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

QUALITY ANALYTICS

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~~ performance of specific quality metrics and measure improvement.
- Coordinate and communicate organizational, ~~health network~~HN- and provider specific performance on quality metrics, as required~~information, both division and department specific, and agency-wide.~~

- Participate in various reviews through the QI Program such as, but not limited to, ~~the All Cause Readmission monitoring,~~ network adequacy, access to care, and 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
- Lab data
- CMS Stars Ratings (Stars) and Health Outcomes Survey (HOS) scores data
- Population Needs Assessment~~Group Needs Assessments~~
- Results of ~~R~~risk s~~S~~tratification
- HEDIS p~~P~~erformance
- Member and ~~P~~provider satisfaction surveys
- QIPs, PIPs, PDSAs, and CCIPs
  - ~~QI Projects: Quality Improvement Project (QIP), Performance Improvement Project (PIP), Plan-Do-Study-Act (PDSA) and Chronic Care Improvement CCIP)~~
  - ~~Health Risk Assessment (HRA) data~~

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 and our delegated ~~networks~~HNs in identifying gaps in care and metrics requiring improvement. ~~not only targeting the members, but also the HMOs, PHCs, and SRGs, and MBHOs, and providers who need additional assistance.~~

Medical Record Review

Wherever possible, administrative data is utilized to obtain measurement for some or all project quality measures. 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 measure) is accompanied by clear guidelines for interpretation.

Interventions

For each QI Project, specific interventions to achieve stated goals and objectives are developed and implemented, as part of the ~~Population Health Management~~PHM program. ~~.~~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 measures selected. In subsequent measurements, evidence of significant improvement over the initial performance to the measure(s) must be sustained over time.

B. Sustained Improvement

Sustained improvement is documented through the continued re-measurement of quality measures 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 measures). Where data elements are process measures, 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 measure.
- 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 measure.

POPULATION HEALTH MANAGEMENT

CalOptima strives to provide integrated care of physical health, behavioral health, LTSS, care coordination and complex case management to improve coordination of care between health care departments. This streamlined interaction will ultimately result in optimized member care. CalOptima's PHM strategy outlines programs that will focus on four key strategies:

1. Keeping Members Healthy
2. Managing Members with Emerging Risks
3. Patient Safety or Outcomes ~~a~~Across ~~s~~Settings
4. Managing Multiple Chronic Conditions

This is achieved through functions described in Health Promotion, Health Management, Care Coordination and Members with Complex Needs, LTSS, ~~ and~~ Behavioral Health Services~~,~~ and telehealth areas.

CalOptima developed a comprehensive PHM Strategy for 2019. The 2019 PHM Strategy will continue in 2020 including a plan of action for addressing our culturally diverse member needs across the continuum of care. CalOptima's PHM Strategy aims to ensure the care and services provided to our members are delivered in a whole-person-centered, safe, effective, timely, efficient, and equitable manner across the entire health care continuum and life span.

The PHM Strategy is based on numerous efforts to assess the health and well-being of CalOptima members, such as the Member Health Needs Assessment that was completed in March 2018. It focused on ethnic and linguistic minorities within the Medi-Cal population from birth to age 101. Additionally, CalOptima's annual Population Needs Assessment (requirement for California Medi-Cal Managed Care Health Plans) will aid the PHM strategy further in identifying member health status and behaviors, member health education and C&L needs, health disparities, and gaps in services related to these issues.

The PHM plan of action addresses the unique needs and challenges of specific ethnic communities including economic, social, spiritual~~,~~ and environmental stressors, to improve health outcomes. CalOptima will conduct Quality Initiatives designed to achieve, through ongoing measurement and intervention, demonstrable and sustained improvement in significant aspects of clinical and non-clinical services that can be expected to have a beneficial effect on health outcomes and ~~M~~member satisfaction. Quality Initiatives that are conducted to improve quality of care and health services delivery to members may include QIPs, PIPs, PDSAs, and CCIPs. Quality Initiatives for 2020 are tracked~~ing~~ in the QI Workplan and reported to the QIC.

In 2020, the PHM Strategy will be focused on expanding the ~~Model of Care~~MOC while integrating CalOptima's existing services, such as care coordination, case management~~,~~, health promotion, preventive services and new programs with broader population health focus~~,~~ with an integrated model.

Additionally, as one of the high performing Medi-Cal managed care plans of California, CalOptima is positioned to increase provider awareness and support of the Office of the California Surgeon General's (CA-OSG) statewide effort to cut Adverse Childhood Experiences (ACE) and toxic stress in half in one generation starting with Medi-Cal members. Identifying and addressing ACE in adults could improve treatment adherence through seamless medical and behavioral health integration and reduce further risk of developing co-morbid conditions. Addressing ACE upstream as public health issues in children can reverse the damaging epi~~c~~

genetic effect of ACE, improve population health outcomes, and promote affordable health care for the next generation. -Implementing the evidence-based ACE screening and Trauma-Informed Care in the primary care setting will require CalOptima's commitment to promote awareness and consider proactive practice transformation and care delivery system to improve member -focused trauma informed care which isto be consistent with NCQA 2020 Population Health Management (PHM) Standards and Guidelines. The CalOptima Health Improvement Project (CHIP) is a Trauma- Informed Care Plan of Action aims to promote awareness and reduce the impact of Adverse Childhood ExperiencesACE. The Board approved Trauma-Informed Care Plan of Action is attachedin Appendix C.

Health Promotion

Health Education provides program development and implementation for agency-wide population health programs**.** 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 include 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-grade reading level and are culturally and linguistically appropriate for our members.

PHM supports CalOptima members with customized interventions, which that 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
- Execution and coordination of programs with Case Management, QA and our HN providers.

Managing Members with Emerging Risk

CalOptima staff provides 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 PHM 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 PHM program supports the CA-OSG Office of Surgeon General and Prop 56 requirements for ACE screening, as well as identification of Social Determinants of Health (SDOH). It

proactively ~~also~~ identifies those members in need of closer management, coordination and intervention. CalOptima assumes responsibility for the PHM program for ~~all of~~all its lines of business, however members with more acute needs receive coordinated care with delegated entities.

Care Coordination and Case Management

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 including Health Risk Assessment (HRA) 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 the member, care giver, primary care provider, specialists, social worker~~,~~ and providers involved in care management, as necessary~~.~~
  - Coordinati~~o~~n~~g~~ of services for members for appropriate levels of care and resources~~.~~
  - Document~~in~~gation of 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 an 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 HN level (care coordination or complex), 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, such as a ~~M~~medical ~~D~~director, specialist(s), case management team, behavioral health specialist, pharmacist, social worker, dieti~~e~~tian~~,~~ 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

- ICT for Moderate to High-Risk Members — ICT occurs at the HN, or ~~h~~Health ~~P~~plan CalOptima for CCN ~~Community Network~~ Members
  - ICT Composition (appropriate to identified needs): member, caregiver, or authorized representative, 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

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~~ members 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.
- Hospital case management program designed to coordinate care for patients during an inpatient admission and discharge planning.

Care management program focuses~~ed~~ 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.

Long-Term Services and Supports

CalOptima ensures LTSS are available to members with health care needs that meet program eligibility criteria and guidelines. LTSS include both institutional and community-based services. CalOptima LTSS department monitors and reviews the quality and outcomes of services provided to members in both settings.

Nursing Facility Services for Long-Term Care:

- CalOptima LTSS is responsible for the clinical review and medical necessity determination for members receiving long-term Nursing Facility Level A, Nursing Facility Level B, and Subacute levels of care. CalOptima LTSS monitors the levels of overall program utilization as well as care setting transitions for members in the program.

Home- and Community-Based Services:

- CBAS: An outpatient, facility-based program that offers health and social services to seniors and persons with disabilities. CalOptima LTSS monitors the levels of member access to, utilization of, and satisfaction with the program, as well as its role in diverting members from institutionalization.
- MSSP: Intensive 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 institutionalization. CalOptima LTSS monitors the level of member access to the program as well as its role in diverting members from institutionalization.

Behavioral Health Integration Services

Medi-Cal

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.

In addition, CalOptima covers behavioral health treatment (BHT) for members 20 years of age and younger ~~that~~ who meet medical necessity criteria. BHT services are provided under a specific behavioral treatment plan that has measurable goals over a specific time frame. CalOptima provides direct oversight, review~~,~~ and authorization of BHT services.

CalOptima offers Alcohol Misuse Screening and Counseling (AMSC) services at the primary care physician setting 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 members can access mental health services directly, without a physician referral, by contacting the CalOptima Behavioral Health Line at **855-877-3885**. A CalOptima representative will conduct a brief mental health telephonic screening~~. The screening is~~ to make an initial determination of the member's impairment level. If the member has mild to moderate impairments, the member will be referred to behavioral health practitioners within the CalOptima provider network. If the member has significant to severe impairments, the member will be referred to specialty mental health services through the Orange County Mental Health Plan.

CalOptima ensures members with coexisting medical and mental health care needs have adequate coordination and continuity of their care. Communication with both the medical and mental health specialists occur~~s~~ as needed to enhance continuity by ensuring members receive timely and appropriate access and to facilitate communication between the medical and mental health practitioners involved.

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.

OC and OCC

CalOptima has previously contracted with Magellan Health Inc. to directly manage mental health benefits for OC and OCC members. Effective ~~1/1/2020~~January 1, 2020, OC/OCC behavioral health will be fully integrated ~~and operationalized~~ within CalOptima internal operations. ~~CalOptima internal operations.~~ OC and OCC members can access mental health services by calling the CalOptima Behavioral Health Line.~~-~~ Members will be connected to a CalOptima representative for behavioral health assistance.~~Functions delegated to Magellan include provider network, UM, credentialing, and customer service.~~

~~CalOptima OC and OCC members can access mental 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 Alcohol Misuse Screening and Counseling (AMSC) services at the PCP setting 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.

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 that are established as safe and effective, consistent with symptoms and 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 20202018 UM Program, all review staff are trained and audited in these principles. Licensed clinical staff reviews and approves requested services based on medical necessity, utilizing evidence-based review criteria. Requests not meeting medical necessity criteria are reviewed by a physician reviewer or other qualified reviewer.

Further details of the UM Program, activities and measurements can be found in the 20192020 UM Program Description, and related Work Plan.

Enterprise Analytics

Enterprise Analytics (EA) provides leadership across CalOptima in the development and distribution of analytical capabilities. In conjunction with the executive team and key leaders across the organization, EA 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 road map. Working with departments that supply data, notably, Information Services, Claims, Customer Service, Provider Services and Medical Affairs, the EA team develops or extends the data architecture and data definitions which expresses a future state for the CalOptima Data Warehouse. Through work with key users of data, EA develops the platform(s) and capabilities to meet CalOptima's critical information needs. This capability for QI in the past has included provider preventable conditions, trimester-specific member mailing lists, high-impact specialists, PDSA on LTC inpatient admissions, and under-utilization information. As QI needs evolve, so will the EA contribution.

Safety Program

Member 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, and~~delivery 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 is based on a needs assessment, and includes the following areas:

- Identification and prioritization of member 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
- Health education and promotion
- Over/Under utilization monitoring
- ~~Group needs assessment~~
- Medication management
- PHM
- 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, culture 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 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 ensure the amount of the appropriate drug is being delivered
- Improving continuity and coordination between sites of care, such as hospitals and skilled nursing facilities, to assure timely and accurate communication
- Utilizing facility site review, Physical Accessibility Review Survey (PARS) and medical record review results from practitioner and health care delivery organization at the time of credentialing to improve safe practices, and incorporating ADA and 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 keeping equipment in good working order
    - Fire, disaster, and evacuation plan, testing and annual training
- Institutional settings including CBAS, SNF, and MSSP 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 vaccines
- Administrative offices
    - Fire, disaster, and evacuation plan, testing and annual training

Cultural & Linguistic Services

As a health care organization in the diverse community of Orange County, CalOptima, strongly believes in the importance of providing culturally and linguistically appropriate services to its members. To ensure effective communication regarding treatment, diagnosis, medical history, and health education, ~~. As a result,~~ CalOptima has developed a program that integrates culturally and linguistically appropriate services at all levels of the operation. Such services include, but are not limited~~,~~ to, Face-to-Face Interpreter services, including American Sign Language, at key points of contact; 24-hour access to telephonic interpreter services; ~~M~~member information materials translated into CalOptima's threshold languages and in alternate formats, such as ~~B~~braille, large-print, PDF or audio.

Since CalOptima serves a large and culturally diverse population, t~~. T~~he seven most common languages spoken for all CalOptima programs are: English 56~~%~~ percent, Spanish 28~~%~~ percent, Vietnamese 11~~%~~percent, Farsi 1~~%~~percent, Korean 1~~%~~ percent, Chinese 1 percent~~%~~, Arabic 1~~%~~ percent and all others at 3~~%~~ percent, combined. CalOptima provides member materials ~~in~~as follows:

- 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 seven languages: English, Spanish, Vietnamese, Korean, Farsi, Chinese and 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:

- Reduce health care disparities in clinical areas.
- Improve cultural competency in materials and communications.
- Improve network adequacy to meet the needs of underserved groups.
- Improve other areas of needs the organization deems appropriate.

The approach for serving a culturally and linguistically diverse membership include:

- Analyzing significant health care disparities in clinical areas to ensure health equity.
- Using practitioner and provider medical record reviews to understand the differences in care provided and outcomes achieved.
- Considering outcomes of member grievances and complaints.
- Conducting memberpatient-focused interventions with culturally competent outreach materials that focus on race-/ethnicity-/language- or gender-specific risks.
- Conducting member-focused groups or key informant interviews with cultural or linguistic members to determine how to meet their needs
- Identifying and reducing a specific health care disparity affecting a cultural, racial or gender group. Providing information, training and toiols to staff and practitioners to support culturally competent communication
- ~~Identifying and reducing a specific health care disparity affecting a cultural, racial or gender group.~~
- ~~**Providing information, training and tools to staff and practitioners to support culturally competent communication.**~~

DELEGATED AND NON-DELEGATED ACTIVITIES

CalOptima delegates certain functions and/or processes to ~~HMO, PHC, and~~ SRG, and ~~MBHO~~delegated HNs ~~contractors~~ ~~who~~ that 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. A Readiness Assessment is conducted by the Audit & Oversight department and overseen by the Audit & 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, and SRGs, and MBHOs~~delegated HNs must comply with all quality-related operational, regulatory and accreditation standards.
- ~~Medi-Cal~~ Behavioral Health for MC, OC~~,~~ and OCC ~~L~~lines of ~~b~~business.
- PHM Program, previously referred to as Disease Management or 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 measures, 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 ~~(~~OP~~HDOs).~~
- Credentialing and re-credentialing of OP~~HDO~~s.
- 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 ~~S~~state and ~~F~~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 202018 Delegation Grid.

See Appendix B — 20192020 Delegation Grid

IN SUMMARY

As stated ~~earlier~~previously, we cannot achieve our mission and our vision alone. We must work together with providers, community health centers, county agencies, s~~S~~tate and ~~F~~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 — 20192020 QI WORK PLAN

APPENDIX B — 20192020 DELEGATION GRID

~~APPENDIX C — 20192020 PHM STRATEGY~~ACE CHIP ~~APPENDIX C~~

~~The CalOptima Health Improvement Project to reduce the impact of Adverse Childhood Experiences (The ACE CHIP)~~

[i] ~~http://ochmis.org/wp-content/uploads/2019/08/2019-PIT-FINAL-REPORT-7.30.2019.pdf~~

2020

QUALITY IMPROVEMENT PROGRAM

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2020 QUALITY IMPROVEMENT PROGRAM SIGNATURE PAGE

Quality Improvement Committee Chair:

_____ _____

David Ramirez, M.D. Date
Chief Medical Officer

Board of Directors' Quality Assurance Committee Chair:

_____ _____

Paul Yost, M.D. Date

Board of Directors Chair:

_____ _____

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. Our 25th anniversary serving our members is in 2020. 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 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. Meetings open to the public are: Board of Directors, Board Finance and Audit Committee, Board Quality Assurance Committee, Investment Advisory Committee, Member Advisory Committee, OneCare Connect Member Advisory Committee, Provider Advisory Committee, and Whole-Child Model Family Advisory Committee.

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
In late 2019, CalOptima's Board and executive team worked together to develop our next three-year Strategic Plan. After engaging a wide variety of stakeholders and collecting feedback, the strategic plan was approved in December 2019. Members are the essential focus of the 2020–2022 Strategic Plan, and our Priorities and Objectives are designed to enhance the programs and services provided to members by CalOptima.

The five Strategic Priorities and Objectives are:

- Innovate and Be Proactive
- Expand CalOptima's Member-Centric Focus
- Strengthen Community Partnerships
- Increase Value and Improve Care Delivery
- Enhance Operational Excellence and Efficiency

WHAT IS CALOPTIMA?

Our Unique Dual Role
CalOptima is unusual 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. Year 2020 marks CalOptima's 25th year of service to Orange County's Medi-Cal population.

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, including eligible conditions under California Children's Services (CCS) managed by CalOptima through the Whole-Child Model (WCM) Program that went into effect in 2019.

Certain services are not covered by CalOptima but 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.

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 the Population Health Management (PHM) Strategy.

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 as special services through specific Memoranda of Understanding (MOU) with certain community agencies, including Orange County Health Care Agency (OC HCA) 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 (OC) 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.

OC provides a comprehensive scope of services for dual eligible members enrolled in Medi-Cal and Medicare Parts A and B. To be a member of OC, a person must live in Orange County and not be eligible for OCC. Enrollment in OC is by member choice and voluntary.

Scope of Services
In addition to the comprehensive scope of acute, preventive care and behavioral health services covered under Medi-Cal and Medicare benefits, CalOptima OC members are eligible for enhanced services, such as transportation to medical services and gym memberships.

OneCare Connect

The 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 both Medicare and Medi-Cal.

These members frequently 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.

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 also apply.

Scope of Services
OCC simplifies and improves health care for low-income seniors and people with disabilities, while ensuring timely access to the comprehensive scope of acute, preventive care and behavioral health services covered under Medi-Cal and Medicare benefits. At no extra cost, OCC adds enhanced benefits such as vision care, gym benefits, over-the-counter benefits and transportation. OCC also includes personalized services through the PCCs to ensure each member receives the services they need, when they need them.

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 seniors to help them continue living independently in the community.

To be a PACE participant, members must be at least 55 years old, live in Orange County, be determined to be 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 participants. 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.

PROGRAM INITIATIVES

Whole-Person Care
Whole-Person Care (WPC) is a five-year pilot established by DHCS as part of California's Medi-Cal 2017–2019 Strategic Plan. In Orange County, the pilot is being led by the OC HCA. It focuses on improving health care outcomes for members who frequently visit the emergency department and are either homeless or have a serious mental illness. The WPC information sharing platform was launched in November 2018. For 2020, the focus will be on enhancing information to and from CalOptima and WPC to support care coordination for participating members.

Whole-Child Model
California Children's Services (CCS) is a statewide program for children with certain serious medical conditions. CCS provides medical care, case management, physical/occupational therapy and financial assistance. As of July 1, 2019, through SB 586, the state required CCS services to become a CalOptima Medi-Cal managed care plan benefit. The goal of this transition was to improve health care coordination by providing all needed care (most CCS and non-CCS services) under one entity rather than providing CCS services separately. The Whole-Child Model (WCM) successfully transitioned to CalOptima in 2019. Under this program in Orange County, medical eligibility determination processes, the Medical Therapy Program and CCS service authorizations for non-CalOptima enrollees will remain with OC HCA.

Health Homes Program
The Affordable Care Act gives states the option to establish health homes to improve care coordination for beneficiaries with chronic conditions. California has elected to implement the "Health Homes for Patients with Complex Needs Program" (often referred to as Health Homes Program or HHP), which includes person-centered coordination of physical health, behavioral health, CBAS and LTSS.

CalOptima plans to implement HHP in the following two phases: January 1, 2020, for members with chronic physical conditions or substance use disorders (SUD), and July 1, 2020, for members with serious mental illness (SMI) or serious emotional disturbance (SED).

CalOptima's goal is to target the highest-risk 3–5 percent of the Medi-Cal members with multiple chronic conditions who present the best opportunity for improved health outcomes. To be eligible, members must have:

1. Specific combinations of physical chronic conditions and/or SUD or specific SMI conditions and
2. Meet specified acuity/complexity criteria

Members eligible for HHP must consent to participate and receive HHP services. CalOptima is responsible for HHP network development. Community-Based Care Management Entities (CB-CME) will be the primary HHP providers. In addition to CalOptima's Community Network, all health networks (HN) will serve in this role. CB-CMEs are responsible for coordinating care with members' existing providers and other agencies to deliver the following six core service areas:

1. Comprehensive care management
2. Care coordination
3. Comprehensive transitional care
4. Health promotion
5. Individual and family support services
6. Referral to community and social support services

CalOptima will provide housing related and accompaniment services to further support HHP members. Following implementation, CalOptima will consider opportunities for other entities to participate.

Homeless Health Initiative (HHI)

In Orange County, as across the state, the homeless population has increased significantly over the past few years. To address this problem, Orange County has focused on creating a system of care that uses a multi-faceted approach to respond to the needs of County residents experiencing homelessness. The system of care includes five components: behavioral health; health care; housing support services; community corrections; and public social services. The county's WPC program is an integral part of this work as it is structured to focus on Medi-Cal beneficiaries struggling with homelessness.

CalOptima has responded to this crisis by committing $100 million to fund homeless health programs in the County. Homeless health initiatives supported by CalOptima include:

- Recuperative Care — As part of the Whole Person Care program, services provide post-acute care for up to 90-days for homeless CalOptima members.
- Medical Respite Care — As an extension to the recuperative care program, CalOptima provides additional respite care beyond the 90 days of recuperative care under the Whole Person Care program.
- Clinical Field Teams — In collaboration with Federally Qualified Health Centers (FQHC), Orange County Health Care Agency's Outreach and Engagement team, and CalOptima's Homeless Response Team, this pilot program provides immediate acute treatment/urgent care to homeless CalOptima members.

- Homeless Clinical Access Program — The pilot program will focus on increasing access to care by providing incentives for community clinics to establish regular hours to provide primary and preventive care services at Orange County homeless shelters.
- Hospital Discharge Process for Members Experiencing Homelessness — Support is provided to assist hospitals with the increased cost associated with discharge planning under new state requirements.

Behavioral Health for OC/OCC

CalOptima has previously contracted with Magellan Health Inc. to directly manage mental health benefits for OC and OCC members. Effective January 1,2020, OC/OCC behavioral health will be fully integrated within CalOptima internal operations. OC and OCC members can access mental health services by calling the CalOptima Behavioral Health Line. Members will be connected to a CalOptima representative for behavioral health assistance.

With Whom We Work

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 participate through CalOptima Direct-Administrative and/or CalOptima Community Network (CCN) and/or contract with a CalOptima Health Network (HN). CalOptima members can choose CCN or one of 13 HNs representing more than 8,500 practitioners.

CalOptima Direct (COD)
CalOptima Direct is composed of two elements: CalOptima Direct-Administrative and the CalOptima Community Network.

CalOptima Direct-Administrative (COD-A)
CalOptima Direct-Administrative 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 OneCare Connect or OneCare programs), share of cost members and members residing outside of Orange County. Members enrolled in CalOptima Direct-Administrative are not HN eligible.

CalOptima Community Network (CCN)
The CalOptima Community Network provides doctors with an alternate path to contract directly with CalOptima to serve our members. CCN is administered internally by CalOptima and available for members to select, supplementing the existing HN delivery model and creating additional capacity for growth.

CalOptima Contracted Health Networks
CalOptima contracts through a variety of HN financial models to provide care to members. Since 2008, CalOptima's HNs consist of:
- Health Maintenance Organizations (HMOs)
- Physician/Hospital Consortia (PHCs)
- Shared Risk Medical Groups (SRGs)

Through these HNs, CalOptima members have access to nearly 1,600 primary care providers (PCPs), more than 6,800 specialists, 40 hospitals, 35 clinics and 100 long-term care facilities.

CalOptima contracts with the following 13 Heath Networks:

Health Network/Delegate	Medi-Cal	OneCare	OneCare Connect
AltaMed Health Services	SRG	SRG	SRG
AMVI/Prospect		SRG	
AMVI Care Health Network	PHC		PHC
Arta Western Medical Group	SRG	SRG	SRG
CHOC Health Alliance	PHC		
Family Choice Health Network	PHC	SRG	SRG
Heritage	HMO		HMO
Kaiser Permanente	HMO		
Monarch Family HealthCare	HMO	SRG	HMO
Noble Mid-Orange County	SRG	SRG	SRG
Prospect Medical Group	HMO		HMO
Talbert Medical Group	SRG	SRG	SRG
United Care Medical Group	SRG	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 Management and Complex Case Management
- Claims (professional and institutional)
- Contracting
- Credentialing of practitioners
- Customer Services activities

MEMBERSHIP DEMOGRAPHICS

CalOptima
A Public Agency
Better. Together.

Fast Facts: December 2019

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

Membership Data as of October 31, 2019

Total CalOptima Membership
743,465

Program	Members
Medi-Cal*	727,437
OneCare Connect	14,093
OneCare (HMO SNP)	1,567
Program of All-Inclusive Care for the Elderly (PACE)	368

Note: The Fiscal Year 2019-20 Membership Data began on July 1, 2019.
*Includes prior year adjustment

Member Age (All Programs)

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

Languages Spoken (All Programs)

56%	English
27%	Spanish
11%	Vietnamese
2%	Other
1%	Korean
1%	Farsi
<1%	Chinese
<1%	Arabic

Medi-Cal Aid Categories

42%	Temporary Assistance for Needy Families
32%	Expansion
10%	Optional Targeted Low-Income Children
9%	Seniors
6%	People with Disabilities
<1%	Long-Term Care
<1%	Other

QUALITY IMPROVEMENT PROGRAM

CalOptima's Quality Improvement (QI) Program encompasses all clinical care, health and wellness services and customer service 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 our members.

CalOptima 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 primary care, urgent care, acute and sub-acute care, long-term care and end of life care. Our comprehensive person-centered approach integrates physical and behavioral health, leveraging the care delivery systems and community partners 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.

Since 2010, the "Triple Aim" has been at the heart of the Centers for Medicare & Medicaid Services (CMS) Medicare Advantage and Prescription Drug Plan (Medicare Parts C and D) quality improvement strategy. The Triple Aim focuses on patient-centered improvements to the health care system including improving the care experience and population health and decreasing the cost of care. The Quadruple Aim adds a fourth element focused on provider satisfaction on the theory that providers who find satisfaction in their work will provide better service to patients. CalOptima's quality strategy embraces the Quadruple Aim as a foundation for its quality improvement strategy.

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-A, as well as our contracted health networks. Through the QI Program — and in collaboration with its providers and community partners — CalOptima strives to continuously improve the structure, processes and outcomes of its health care delivery system to serve our members.

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). The QI Program is organized around a systematic approach to accomplish the following annually:

- Identify and analyze significant opportunities for improvement in care and service to advance CalOptima's strategic mission, goals and objectives.
- Foster the development of improvement actions, along with systematic monitoring and evaluation, to determine whether these actions result in progress toward established benchmarks or goals.
- Focus on QI activities carried out on an ongoing basis to support early identification and timely correction of quality of care issues to ensure safe patient care and experiences.
- Maintain agency-wide practices that support accreditation by NCQA and meet DHCS/CMS quality requirements and measurement reporting requirements.

In addition, the QI Program's ongoing responsibilities include the following:

- Sets expectations to develop plans to design, measure, assess, and improve the quality of the organization's governance, management and support processes.
- Supports the provision of a consistent level of high quality of care and service for members throughout the contracted provider networks, as well as monitors utilization practice patterns of practitioners, contracted hospitals, contracted services, ancillary services and specialty providers.
- Provides oversight of quality monitors from the contracted facilities to continuously assess that the care and service provided satisfactorily meet quality goals.
- Ensures certain contracted facilities report outbreaks of conditions and/or diseases to the public health authority — OC HCA — which may include, but are not limited to, methicillin resistant *Staphylococcus aureus* (MRSA), scabies, tuberculosis, etc., as reported by the HNs.

- 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 organizational providers (OPS) to assure that steps are taken to resolve and prevent recurrences.
- Educates the workforce and promotes a continuous quality improvement culture at CalOptima.

In collaboration with the Compliance Internal and External Oversight departments, the QI Program ensures the following standards or outcomes apply to populations served by CalOptima's contracted HNs, including CCN and/or COD-A network providers, to:

- Support the agency's strategic quality and business goals by utilizing resources appropriately, effectively and efficiently.
- The continuous improvement of clinical care and services quality provided by the health care delivery system in all settings, especially as it pertains to the unique needs of the population.
- The timely identification of important clinical and service issues facing the Medi-Cal, OC and OCC populations relevant to their 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 identified opportunities.
- The accessibility and availability of appropriate clinical care and 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.
- The continuous improvement of member and provider satisfaction, including the timely resolution of complaints and grievances.
- The reliability of risk prevention and risk management processes.
- The compliance with regulatory agencies and accreditation standards.
- The accountability cadence of annual review and acceptance of the UM Program Description and other relevant Population Health Programs and Work Plans.
- The effectiveness and efficiency of internal operations.
- The effectiveness and efficiency of operations associated with functions delegated to the contracted HNs.
- The effectiveness of aligning ongoing quality initiatives and performance measurements with CalOptima's strategic direction in support of its mission, vision and values.
- The compliance with up-to-date Clinical Practice Guidelines and evidence-based medicine.

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.

AUTHORITY, BOARD OF DIRECTORS' COMMITTEES, AND RESPONSIBILITIES

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 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 approves and evaluates the QI Program annually.

The QI Program is based on ongoing systematic collection, integration, and analysis of clinical and administrative data to identify the member needs, risk levels and appropriate interventions to make certain that the program meets the specific needs of the individual member and promotes health equity among specific population segments, while improving overall population health and member experience. The CMO is charged with identifying appropriate interventions and allocating resources necessary to implement the QI Program. Such recommendations shall be aligned with Federal and State regulations, contractual obligations and fiscal parameters.

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 Board meetings are open to the public.

Board of Directors' Quality Assurance Committee
The Board of Directors appoints the Quality Assurance Committee (QAC) to review and make recommendations to the Board regarding accepting 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 also makes recommendations for annual modifications of the QI Program and actions to achieve the Institute for Healthcare Improvement's Quadruple Aim moving upstream from the CMS' Triple Aim:

1. Enhancing patient experience
2. Improving population health
3. Reducing per capita cost
4. Enhancing provider satisfaction

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
- Consumers

- Family support
- Foster children
- LTSS
- Medi-Cal beneficiaries
- Medically indigent persons
- OC HCA
- Orange County Social Services Agency (OC SSA)
- Persons with disabilities
- Persons with mental illnesses
- Persons with special needs
- Recipients of CalWORKs
- Seniors

Two of the 15 positions — held by OC HCA and OC SSA — 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:
    - OC SSA
    - OC Community Resources Agency, Office on Aging
    - OC HCA, Behavioral Health
    - OC 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 held at least quarterly and 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 OC HCA, which maintains a standing seat. PAC meets at least quarterly and are open to the public. The 15 seats include:

- HN
- Hospitals
- Physicians (3 seats)
- Nurse
- Allied health services
- Community health centers
- OC HCA (1 standing seat)
- LTSS (LTC facilities and CBAS) (2 seats)
- Non-physician medical practitioner
- Traditional safety net provider
- Behavioral/mental health
- Pharmacy

Whole-Child Model Family Advisory Committee
In 2018, CalOptima's Board of Directors established the Whole-Child Model Family Advisory Committee (WCM FAC), as required by the state as part of California Children's Services (CCS) becoming a Medi-Cal managed care plan benefit. The WCM FAC provides advice and recommendations to the Board and staff on issues concerning WCM, serves as a liaison between interested parties and the Board, and assists 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 is composed of the following 11 voting seats:

- Family representatives: 7–9 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

Members of the Committee shall serve staggered two-year terms. Of the above seats, five members serve an initial one-year term (after which representatives for those seats will be appointed to a full two-year term), and six will serve an initial two-year term. WCM FAC meets at least quarterly and meetings are open to the public.

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 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.

Chief Medical Officer (CMO) — oversees strategies, programs, policies and procedures as they relate to CalOptima's quality and safety of clinical care delivered to members. The CMO has overall responsibility of the QI program 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 Improvement (QI), Utilization Management (UM), Case Management (CM), Population Health Management (PHM), Pharmacy Management (PM), Behavioral Health Integration (BHI), Long-Term Services and Supports (LTSS) and Enterprise Analytics (EA).

Medical Director (Quality) is the physician designee who chairs the QIC and is responsible for overseeing QI activities and quality management functions. The medical director provides direction and support to CalOptima's Quality and Population Health Management teams to ensure QI Program objectives are met. The medical director is also the chair of the Credentialing Peer Review Committee (CPRC).

Medical Director (Behavioral Health) is the designated behavioral healthcare practitioner in the QI program, and serves as a participating member of the QIC, as well as the Utilization Management Committee (UMC), and CPRC. The medical director is also the chair of the Pharmacy & Therapeutics committee (P&T).

Executive Director, Quality & Population Health Management (ED of Q&PHM) is responsible for facilitating the company-wide QI Program deployment, driving performance results in Healthcare Effectiveness Data and Information Set (HEDIS), DHCS, CMS Star measures and ratings, and maintaining accreditation standing as a high performing health plan with NCQA. The ED of Q&PHM 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 integrating behavioral health across the health care delivery system and populations served. Reporting to the ED of Q&PHM are the: Director, Quality Analytics; Director, Quality Improvement; Director, Population Health Management; Director, Behavioral Health Services (Clinical Operations); and Director, Behavioral Health Integration.

Executive Director, 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, LTSS 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&PHM, makes certain that Medical Affairs is aligned with CalOptima's strategic and operational priorities.

Executive Director, Program Implementation (ED of PI) is responsible for maintaining the organization's strategic plan, development and implementation of new programs, operational

process improvement activities and community relations. Reporting to ED of PI: Director, Process Excellence; and Director, Strategic Development.

Executive Director, Compliance (ED of C) is responsible for monitoring and driving interventions so that CalOptima and its HNs and other FDRs meet the requirements set forth by DHCS, CMS and DMHC. The Compliance staff works in collaboration with the CalOptima Audit & Oversight departments (external and internal) to refer any potential sustained noncompliance issues or trends encountered during audits of HNs, and other functional areas. The ED of C serves as the State Liaison and is responsible for legislative advocacy. Also, the ED of C 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, Network Operations (ED of NO) leads and directs the integrated operations of the HNs, 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 is maintained throughout the service delivery network.

Executive Director, Operations (ED of O) is responsible for overseeing and guiding Claims Administration, Customer Service, GARS, Coding Initiatives and Electronic Business.

QUALITY IMPROVEMENT COMMITTEES AND SUBCOMMITTEES

Quality Improvement Committee (QIC)
The QIC is the foundation of the QI program and is accountable to the QAC. 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 delegated health networks to achieve the result of improved care and services for members. The QIC oversees the performance of delegated functions by its delegated health networks and their 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, 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, 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 and priority alignment of the QI subcommittees for effective operation and achievement of objectives
- Oversees the analysis and evaluation of QI activities
- Makes certain that there is practitioner participation through attendance and discussion in the planning, design, implementation and review of QI program activities
- Identifies and prioritizes needed actions and interventions to improve quality
- Makes certain that there is follow up as necessary to determine the effectiveness of quality improvement-related actions and interventions.

Practice patterns of providers, practitioners and delegated health networks 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, and delegated health networks.

The QI Program adopts the classic Continuous Quality Improvement cycle with 4 basic steps:

- **Plan** Goals with detailed description of an implementation plan
- **Do** Implementation of the plan
- **Study** Data and collection
- **Act** Analyze data and develop conclusions

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

Voting Members

- Four physicians or practitioners, with at least two practicing physicians or practitioners
- County Behavioral Health Representative
- CalOptima CMO (Chair or Designee)
- CalOptima Medical Directors
- CalOptima BH Medical Director (or Designee)
- Executive Director, Quality & Population Health Management
- Executive Director, Clinical Operations
- Executive Director, Network Management
- Executive Director, Operations

The QIC is supported by:

- Director, Quality Improvement
- Director, Quality Analytics
- Director, Population Health Management
- Committee Recorder as assigned

Quorum
A quorum consists of a minimum of six voting members of which at least four are physicians or practitioners. Once a quorum is attained, the meeting may proceed, and any vote will be considered official, even if the quorum is not maintained. Participation is defined as attendance in person or participation by telephone.

The QIC shall meet at least eight times per calendar year, and report to the Board QAC 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 and Subcommittees
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
- 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 produced only for committee approval.

Credentialing 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 who serve CalOptima members meet generally accepted standards for their profession or industry. The CPRC reviews, investigates and evaluates the credentials of all CalOptima practitioners, which include internal and external physicians who participate on the committee. The committee maintains a continuing review of the qualifications and performance of all practitioners every three years. In addition, the CPRC reviews and monitors sentinel events, quality of care issues and identified trends across the entire continuum of CalOptima's contracted providers — delegated health networks and OPs to ensure patient safety aiming for zero defects. The CPRC, chaired by the CalOptima CMO or designee, consists of representation of active physicians from CCN and HNs. Physician participants represent a range of practitioners and specialties from CalOptima's network. CPRC meets a minimum of six times per year and reports through the QIC. The voting member composition and quorum requirements of the CPRC are defined in its charter.

Utilization Management Committee (UMC)
The UMC 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 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 monitors the utilization of medical, behavioral health and Long-Term Services and Support (LTSS) services for the CalOptima Care Network (CCN) and through the delegated health networks to identify areas of under or overutilization that may adversely impact member care. The UMC oversees Inter-Rater Reliability (IRR) testing to support consistency of application in nationally recognized criteria for making medical necessity 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. These clinical practice guidelines and nationally recognized evidenced-based guidelines are approved annually, at minimum, at the UMC. The UMC meets quarterly and reports through the QIC. The voting member composition (including a behavioral health practitioner*) and the quorum requirements of the UMC are defined in its charter.

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

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

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 UMC and ensures that benefit updates are implemented and communicated accordingly to internal CalOptima staff, and are provided to contracted HMOs, PHCs, and SRGs. The Regulatory 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. The voting member composition and quorum requirements of the BMSC are defined in its charter.

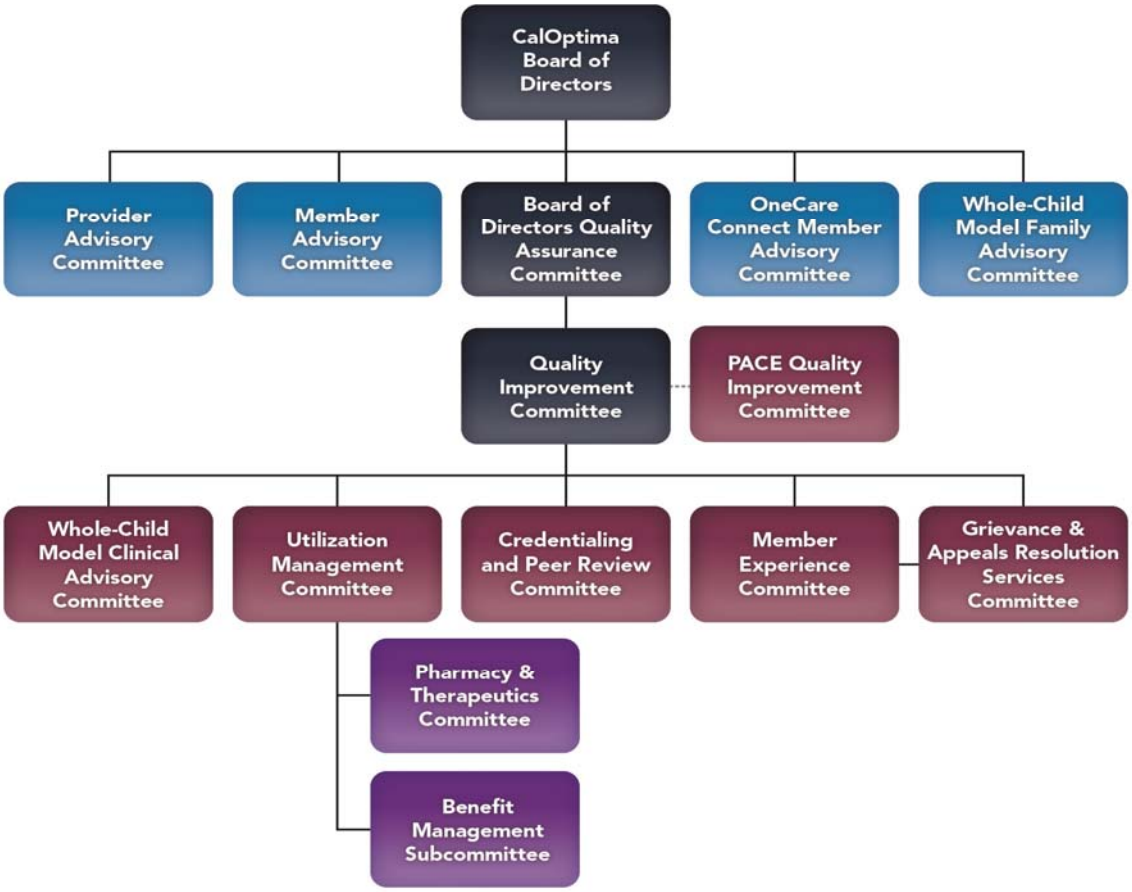
Whole-Child Model Clinical Advisory Committee (WCM CAC)
The WCM CAC was formed in 2018 pursuant to DHCS All Plan Letter 18-011. The WCM CAC advises on clinical and behavioral issues relating to CCS conditions, including such matters as treatment authorization guidelines, and ensuring they are integrated into the design, implementation, operation and evaluation of the CalOptima WCM program in collaboration with county CCS, the WCM Family Advisory Committee and HN CCS providers. The WCM CAC meets four times a year and reports to the QIC. The voting member composition and quorum requirements of the WCM CAC are defined in its charter.

Member Experience Committee (MEMX)
Improving member experience is a top priority of CalOptima. The MEMX committee was formed to ensure strategic focus on the issues and factors that influence the member's experience with the health care system for Medi-Cal, OC and OCC. NCQA's Health Insurance Plan Ratings measure three dimensions — prevention, treatment and customer satisfaction. The MEMX committee 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. In 2020, the MEMX committee, which includes the Access and Availability workgroup, will continue to meet at least bi-monthly and will be held accountable to implement targeted initiatives to improve member experience and demonstrate significant improvement in the 2020 and 2021 CAHPS survey results.

Grievance and Appeals Resolution Services Committee (GARS)
The GARS committee serves to protect the rights of our members, promote the provision of quality health care services, and ensure that the policies of CalOptima are consistently applied to resolve member complaints in an equitable and compassionate manner through oversight and monitoring. The GARS committee 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 committee meets at least quarterly and reports through the QIC. The voting member composition and quorum requirements of the GARS are defined in its charter.

Program of All-Inclusive Care for the Elderly Quality Improvement Committee (PQIC)
The PQIC committee provides oversight for the overall administrative and clinical operations of CalOptima PACE. The PQIC assures compliance to all state and federal regulatory bodies. The PQIC may create new ad-hoc committees or task forces to improve specific clinical or administrative processes that have been identified as critical to participants, families or staff. The PQIC meets, at a minimum, quarterly and is chaired by the PACE Medical Director. A summary of the PQIC meetings are submitted to the CalOptima Quality Improvement Committee (QIC) which are then included in the QIC summary submitted to the CalOptima Board of Directors Quality Assurance Committee (QAC). Annually, the PQIC will assess all PACE quality improvement 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. Potential areas for improvement will be identified through analysis of the data and through root cause analysis.

2020 Committee Organization Structure — Diagram



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 delegated networks 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

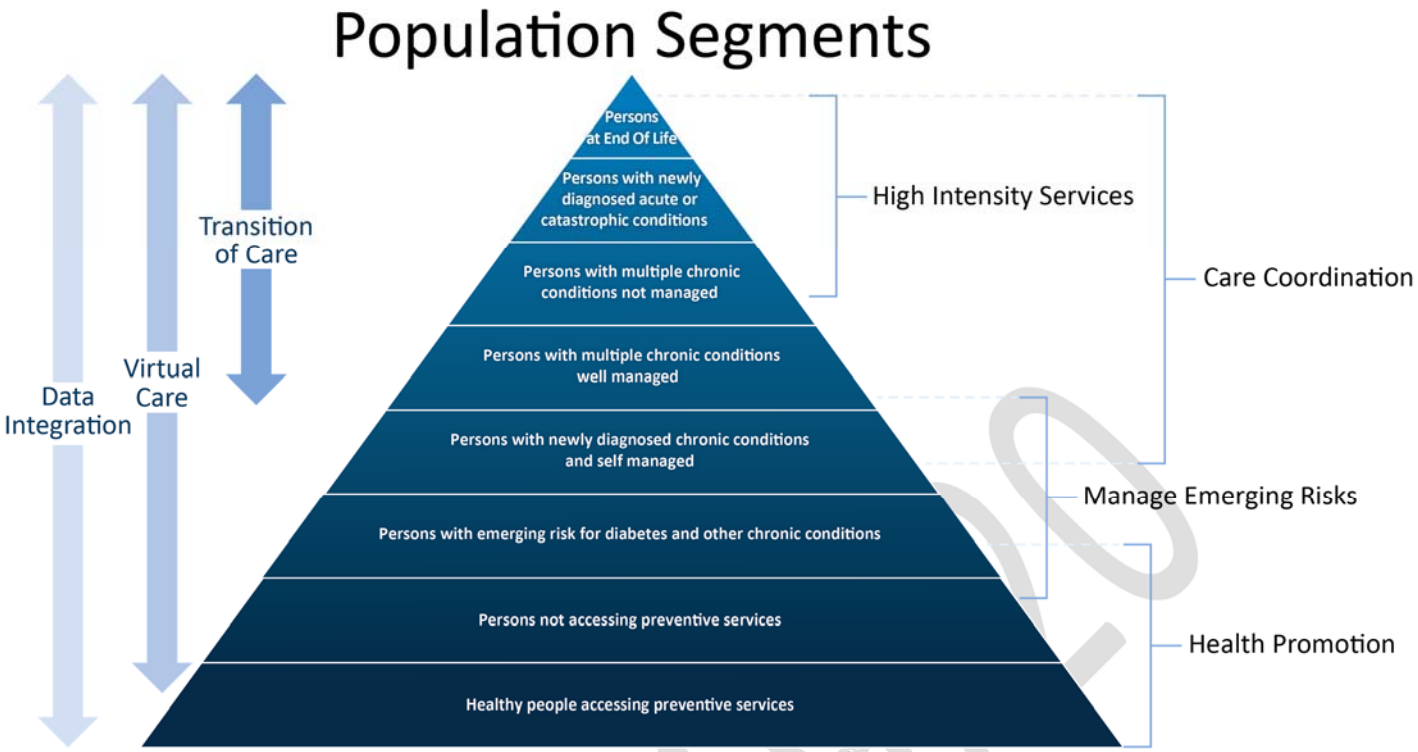
applicable laws regarding confidentiality, issues any QI reports required by law or by the state contract.

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 employed positions serving on the QI/UM committees and subcommittees. Additionally, 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.

Quality Improvement Strategic Goals

The QI Program supports a Population Health Management (PHM) approach, stratifying our population based on their health needs, conditions and issues, and aligns the appropriate resources to meet these needs. Building upon CalOptima's existing innovative Model of Care (MOC), the 2020 QI Work Plan will focus on building out additional services leveraging telehealth technology to engage the new population segments currently not served, such as the population with emerging risk or experiencing social determinants of health. The Population Segments with an integrated intervention hierarchy, is shown below.



CalOptima's MOC recognizes the importance of mobilizing 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. The current high-touch MOC is very effective in managing the health care needs of high-risk members one-by-one. By enhancing the service capabilities and the transition of care process leveraging telehealth and mobile technology, the current MOC can be scaled to address the health care needs of the population segments identified through systematic member segmentation and stratification using integrated data sets.

2020 QI Goals and Objectives

CalOptima's QI Goals and objectives are aligned with CalOptima's 2020–2021 strategic goals.

1. Increase NCQA overall rating from 4.0 to 4.5
2. Improve Member Experience CAHPS performance from 25th to 50th percentile, focusing on Getting Needed Care and Getting Care Quickly
3. Improve member's ability to access primary and specialty care timely, for urgent and routine appointments, from 2019 baseline to goal of 80%

Detailed strategies for achieving 2020 Goals and Objectives are measured and monitored in the QI Work Plan, reported to QIC quarterly and evaluated annually.

QI Measurable Goals for the Model of Care

The 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 programs. The MOC meets the needs of special member populations through strategic activities. Measurable goals are established and reported annually.

The MOC goals are:

- Improving access to essential services
- Improving access to preventive health services
- Assuring appropriate utilization of services
- Assuring proper identification of Social Determinants of Health (SDOC)
- Improving coordination of care through an identified point of contact
- Improving seamless transitions of care across health care settings, providers and health 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. Results are evaluated and reported annually.

QI 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. A QI Work Plan addendum 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 and Systems (CAHPS), Stars and Health Outcomes Survey (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, which includes, but is not limited to:

- Quality of clinical care
- Safety of clinical care
- Quality of service
- Member experience
- QI Program oversight
- 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 CalOptima's organizational needs and specific needs of CalOptima's populations for key areas or issues identified as opportunities for improvement. In addition, 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. These activities are included in Quality Improvement Project (QIP), Performance Improvement Project (PIP), Plan-Do-Study-Act (PDSA) and Chronic Care Improvement Projects (CCIP). They are reflected in the QI Work Plan.

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 — 2020 QI Work Plan

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 internal monitoring activities, including, but not limited to, (a) potential quality issue (PQI) review processes, (b) provider and facility reviews, (c) preventive care audits, (d) access to care studies, (e) member experience surveys, (f) HEDIS results, and (g) other opportunities for improvement as identified by subcommittee's data analysis
- 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, with specific emphasis on the following areas:

- Access to and availability of services, including appointment availability
- Coordination and continuity of care for SPD
- Provisions of chronic, complex case 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. For example:

- 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, QIC, UMC, 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

Back to Agenda

QI Project Quality measures

Quality measures may be process measures (lead quality measures) or outcome measures (lag quality measures) where there is strong clinical evidence of the correlation between the process and member outcomes. This evidence and the rationale for selection of the lead quality measure must be cited in the project description, when appropriate.

Each QI Project will have at least one (and frequently more) lead measure(s) that are actionable in real time. The selected lead measures should be levers, drivers, or predictors of the desired outcome measures or lag quality measure such as HEDIS and STARS measures. While at least one lead measure must be identified at the start of a project, more may be identified after analysis of baseline measurement or re-measurement. Since quality measures will measure changes in health status, functional status, member satisfaction, and provider/staff, delegated HNs, or system performance, quality measures will be clearly defined and objectively measurable.

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 outcomes 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 5–10 percent 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. Also, smaller sample size may be appropriate for QI pilot projects that are designed as small tests of change using rapid improvement cycle methodology. For example, a pilot sample of 30 or 100 percent of the sample size when target population is less than 30, can be statistically significant for QI pilot projects.

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

Communication of QI 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 Quality Assurance Committee of the Board of Directors, through the CMO or designee, on a quarterly basis. 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
- HN Forums, Medical Directors meetings, Quality Forum and other ongoing ad-hoc meetings
- Annual synopsized QI report posted on CalOptima's website (both web-site and hardcopy are available for both practitioners and members). The information includes a QI Program Executive Summary and 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
- MAC, OCC MAC, WCM FAC and PAC.

QUALITY IMPROVEMENT PROGRAM RESOURCES

CalOptima's budgeting process includes personnel, IS 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.

In addition to CalOptima CMO and ED of Q&PHM, the following staff positions provide direct support for organizational and operational QI Program functions and activities:

Director, Quality Improvement
Responsibilities include assigned day-to-day operations of the Quality Management (QM) functions , including Credentialing, Facility Site Reviews, Physical Accessibility Compliance and working with the ED of Q&PHM to oversee the QI Program and maintain NCQA accreditation. This position is also responsible for implementation of the QI Program and Work Plan implementation.

- The following positions report to the Director, Quality Improvement:
  - Manager, Quality Improvement
  - Supervisor, Quality Improvement (PQI)
  - Supervisor, Quality Improvement, and Master Trainer (FSR)
  - Supervisor, Credentialing
  - QI Nurse Specialists
  - Program Policy Analyst
  - Credentialing Coordinators

- Program Specialists
- Program Assistants
- Outreach Specialists

Director, Quality Analytics
Provides data analytical direction to support quality measurement activities for the 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, Quality Analytics:
  - Quality Analytics HEDIS Manager
  - Quality Analytics Pay for Value Manager
  - Quality Analytics Network Adequacy Manager
  - Quality Analytics Analysts
  - Quality Analytics Project Managers
  - Quality Analytics Program Coordinators
  - Quality Analytics Program Specialists

Director, Population Health Management
Provides direction for program development and implementation for agency-wide population health initiatives, including telehealth. Ensures linkages supporting a whole-person perspective to health care with Case Management, UM, Pharmacy and Behavioral Health Integration. Provides direct care coordination and health education for members participating in non-delegated health programs such as Perinatal Support Services (Bright Steps) and Childhood Obesity Prevention Program (Shape Your Life). Also, supports the MOC 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, Population Health Management:
  - Population Health Management Manager (Program Design)
  - Population Health Management Manager (Operations)
  - Population Health Management Supervisor (Operations)
  - Health Education Manager
  - Health Education Supervisor
  - Population Health Management Health Coaches
  - Senior Health Educator
  - Health Educators
  - Registered Dieticians
  - Data Analyst
  - Program Manager
  - Program Specialists
  - Program Assistant

Director, Behavioral Health Integration provides program development and leadership to the implementation, expansion, and/or improvement of processes and services that lead to the integration of physical and behavioral health care services for CalOptima members across all lines of business. The director is responsible for the management and strategic direction of the Behavioral Health Integration Department efforts in integrated care, quality initiatives, and community partnerships. The Director ensures departmental compliance with all local, state and

federal regulations and that accreditation standards and all policies and procedures meet current requirements.

Director, Behavioral Health Services (Clinical Operation) provides operational oversights of the Behavioral Health Integration Department clinical services. The Director leads a team that provides behavioral health telephonic clinical triage, care coordination and utilization management for members in all lines of business.

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

Director, 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 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 Committees, and participates in the QIC and the Benefit Management subcommittee.

Director, 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 committee and UMC Committees. The director also guides the identification and interventions on key pharmacy quality and utilization measures.

Director, 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, and develops and implements policies, procedures and processes related to program operations and quality measures.

Director, Long-Term Services and Supports is responsible for LTSS programs, which include CBAS, LTC, and MSSP. The position supports a "Member-Centric" approach and helps keep members in the least restrictive living environment, collaborates with community partners and other stakeholders, and ensures LTSS are available to appropriate populations. The director also develops and implements policies, procedures, and processes related to LTSS program operations and quality measures.

Director, 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 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.

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 intensive orientation and job specific training with a staff 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 and procedures, etc.
- Seniors and Persons with Disabilities Awareness training
- Cultural Competency and Trauma-Informed Care training
- QI Lean training curriculum (added to CalOptima University in 2019)

MOC-related employees, contracted providers and practitioner 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.

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 education reimbursement for employees.

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 QI activities, including QIPs, PIPs, PDSAs, and CCIPs.
- An evaluation of member satisfaction surveys and initiatives
- A report to the QIC and QAC of a summary of all quality measures and identification of significant trends

- A critical review of the organizational resources involved in the QI Program through the CalOptima strategic planning process
- Recommended changes included in the revised QI Program Description for the subsequent year, for QIC, QAC, and the Board of Directors review and approval

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

CalOptima provides comprehensive acute and preventive care services, which are based on the philosophy of a medical "home" for each member. The primary care practitioner is this medical "home" for members who previously found it difficult to access services within their community.

The Institute of Medicine describes the concepts of primary care and community oriented primary care, which apply to the CalOptima model:

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

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

- Clinical care and service
- Access and availability
- Continuity and coordination of care
- Preventive care, including:
  - Initial Health Assessment
  - Initial Health Education
  - Behavioral Assessment
- Patient diagnosis, care and treatment of acute and chronic conditions
- Complex case management: CalOptima coordinates services for members with multiple and/or complex conditions to obtain access to care and services via the Utilization and Case Management departments, which details this process in its UM/CM Program and other related policies and procedures.
- Drug utilization
- Health education and promotion
- Over/underutilization
- Disease management

Administrative oversight:

- Delegation oversight
- Member rights and responsibilities
- Organizational ethics
- Effective utilization of resources
- Management of information
- Financial management
- Management of human resources

- Regulatory and contract compliance
- Customer satisfaction
- Fraud and abuse* as it relates to quality of care

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

QUALITY IMPROVEMENT

The QI department is responsible for 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 ensure 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 agency wide.
- Evaluate and monitor provider credentials.
- Support the maintenance of quality standards across the continuum of care for all lines of business.
- Monitor and maintain agency-wide practices that support accreditation and meeting regulatory requirements.

Peer Review Process for Potential Quality Issues

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, and tracking and trending of service and access issues are reported to the CPRC and are also reviewed at the 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 GARS.

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, CMS and NCQA). The scope of the credentialing program includes all licensed MDs, DOs, DPMs (doctors of podiatric medicine), DCs (doctors of chiropractic medicine), DDSs (doctors of dental surgery), allied health and midlevel practitioners, which include, but are not limited to: non-physician behavioral health practitioners, certified nurse midwives, certified nurse specialists, nurse practitioners, optometrists, physician assistants, registered physical therapists, occupational therapists, speech therapists and audiologists, both in the delegated and CalOptima direct environments. Credentialing and re-credentialing activities for CCN are performed at CalOptima, and delegated to HNs and other sub-delegates for their providers.

Organizational Providers
CalOptima performs credentialing and re-credentialing of organizational providers (OPs) such as, but not limited to, acute care hospitals, home health agencies, skilled nursing facilities, free standing surgery centers, dialysis centers, etc. 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 QI Activities in the Re-credentialing Process
Findings from QI activities and other performance monitoring 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. CalOptima does, however, delegate this function to designated health plans in accordance with standards set forth by Medi-Cal Managed Care Division (MMCD) Policy Letter 14-004. CalOptima assumes responsibility and conducts and coordinates facility site review (FSR) and medical record review (MRR) for delegated HNs. CalOptima retains coordination, maintenance and oversight of the FSR/MRR process. CalOptima collaborates with the SRGs 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 past three years, in accordance with MMCD Policy Letter 14-004 and CalOptima policies. Medical records of new providers shall be reviewed within 90 calendar days of the date that members are first assigned to the provider. An additional extension of 90 calendar days may be allowed only if the provider does not have enough 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 physical accessibility review for Americans with Disabilities Act (ADA) compliance for SPD members, which includes access evaluation criteria to determine compliance with ADA requirements.

- Parking
- Building interior and exterior
- Participant areas including the exam room
- Restroom
- Exam room
- Exam table/scale

Medical Record Documentation Standards
CalOptima requires that its contracted delegated HNs 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.

The medical record should be protected to ensure that medical information is released only in accordance with applicable Federal and State law.

Corrective Action Plan(s) To Improve Quality of Care and Service

When monitoring by either CalOptima's QI department, Audit & Oversight department or other functional areas identifies an opportunity for improvement, the appropriate functional areas will determine the appropriate action(s) to be taken to correct the problem. Those activities specific to delegated entities will be conducted at the direction of the Audit & 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 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.

- Formal or informal discussion of the data/problem with the involved practitioner, either in the respective committee or by a medical director.
- Further observation and monitoring of performance via the appropriate clinical monitor. (This process shall determine if follow-up action has resolved the original problem.)
- Intensified evaluation/investigation 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 or office training
- De-delegation
- De-credentialing
- Contract termination

QUALITY ANALYTICS

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.
- 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 performance of specific quality metrics and measure improvement.
- Coordinate and communicate organizational, HN and provider specific performance on quality metrics, as required
- Participate in various reviews through the QI Program such as, but not limited to, network adequacy, access to care and availability of practitioners
- 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
- Lab data

- CMS Stars Ratings (Stars) and Health Outcomes Survey (HOS) scores data
- Population Needs Assessment
- Results of risk stratification
- HEDIS performance
- Member and provider satisfaction surveys
- QIPs, PIPs, PDSAs, and CCIPs

By analyzing data that CalOptima currently receives (i.e., claims data, pharmacy data, and encounter data), the data warehouse can identify 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 and our delegated HNs in identifying gaps in care and metrics requiring improvement.

Medical Record Review
Wherever possible, administrative data is utilized to obtain measurement for some or all project quality measures. 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 measure) is accompanied by clear guidelines for interpretation.

Interventions
For each QI Project, specific interventions to achieve stated goals and objectives are developed and implemented, as part of the PHM program. 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 measures selected. In subsequent measurements, evidence of significant improvement over the initial performance to the measure(s) must be sustained over time.

B. Sustained Improvement
Sustained improvement is documented through the continued re-measurement of quality measures 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 measures). Where data elements are process measures, 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 measure
- 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 measure

POPULATION HEALTH MANAGEMENT

CalOptima strives to provide integrated care of physical health, behavioral health, LTSS, care coordination and complex case management to improve coordination of care between health care departments. This streamlined interaction will ultimately result in optimized member care. CalOptima's PHM strategy outlines programs that will focus on four key strategies:

1. Keeping Members Healthy
2. Managing Members with Emerging Risks
3. Patient Safety or Outcomes Across Settings
4. Managing Multiple Chronic Conditions

This is achieved through functions described in Health Promotion, Health Management, Care Coordination and Members with Complex Needs, LTSS, Behavioral Health Services and telehealth areas.

CalOptima developed a comprehensive PHM Strategy for 2019. The 2019 PHM Strategy will continue in 2020 including a plan of action for addressing our culturally diverse member needs across the continuum of care. CalOptima's PHM Strategy aims to ensure the care and services provided to our members are delivered in a whole-person-centered, safe, effective, timely, efficient, and equitable manner across the entire health care continuum and life span.

The PHM Strategy is based on numerous efforts to assess the health and well-being of CalOptima members, such as the Member Health Needs Assessment that was completed in March 2018. It focused on ethnic and linguistic minorities within the Medi-Cal population from birth to age 101. Additionally, CalOptima's annual Population Needs Assessment (requirement

for California Medi-Cal Managed Care Health Plans) will aid the PHM strategy further in identifying member health status and behaviors, member health education and C&L needs, health disparities, and gaps in services related to these issues.

The PHM plan of action addresses the unique needs and challenges of specific ethnic communities including economic, social, spiritual and environmental stressors, to improve health outcomes. CalOptima will conduct Quality Initiatives designed to achieve, through ongoing measurement and intervention, demonstrable and sustained improvement in significant aspects of clinical and non-clinical services that can be expected to have a beneficial effect on health outcomes and member satisfaction. Quality Initiatives that are conducted to improve quality of care and health services delivery to members may include QIPs, PIPs, PDSAs, and CCIPs. Quality Initiatives for 2020 are tracked in the QI Workplan and reported to the QIC.

In 2020, the PHM Strategy will be focused on expanding the MOC while integrating CalOptima's existing services, such as care coordination, case management, health promotion, preventive services and new programs with broader population health focus with an integrated model.

Additionally, as one of the high performing Medi-Cal managed care plans of California, CalOptima is positioned to increase provider awareness and support of the Office of the California Surgeon General's (CA-OSG) statewide effort to cut Adverse Childhood Experiences (ACE) and toxic stress in half in one generation starting with Medi-Cal members. Identifying and addressing ACE in adults could improve treatment adherence through seamless medical and behavioral health integration and reduce further risk of developing co-morbid conditions. Addressing ACE upstream as public health issues in children can reverse the damaging epigenetic effect of ACE, improve population health outcomes and promote affordable health care for the next generation. Implementing the evidence-based ACE screening and Trauma-Informed Care in the primary care setting will require CalOptima's commitment to promote awareness and consider proactive practice transformation and care delivery system to improve member -focused trauma informed care to be consistent with NCQA 2020 Population Health Management (PHM) Standards and Guidelines. The CalOptima Health Improvement Project (CHIP) is a Trauma- Informed Care Plan of Action aims to promote awareness and reduce the impact of ACE.

Health Promotion

Health Education provides program development and implementation for agency-wide population health programs. 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 include 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-grade reading level and are culturally and linguistically appropriate for our members.

PHM supports CalOptima members with customized interventions, that 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
- Execution and coordination of programs with Case Management, QA and our HN providers.

Managing Members with Emerging Risk

CalOptima staff provide 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 PHM 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 PHM program supports the CA-OSG and Prop 56 requirements for ACE screening, as well as identification of SDOH. It proactively identifies those members in need of closer management, coordination and intervention. CalOptima assumes responsibility for the PHM program for all its lines of business, however members with more acute needs receive coordinated care with delegated entities.

Care Coordination and Case Management

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 including Health Risk Assessment (HRA) 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 the member, care giver, primary care provider, specialists, social worker and providers involved in care management, as necessary
- Coordination of services for members for appropriate levels of care and resources
- Documentation of 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 an 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 HN level (care coordination or complex), 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, such as a medical director, specialist(s), case management team, behavioral health specialist, pharmacist, social worker, dietitian 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

- ICT for Moderate to High-Risk Members — ICT occurs at the HN, or CalOptima for CCN Members
  - ICT Composition (appropriate to identified needs): member, caregiver, or authorized representative, 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 care and stabilize member's medical condition

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 members 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
- Hospital case management program designed to coordinate care for patients during an inpatient admission and discharge planning

Care management program focuses 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.

Long-Term Services and Supports

CalOptima ensures LTSS are available to members with health care needs that meet program eligibility criteria and guidelines. LTSS include both institutional and community-based services. CalOptima LTSS department monitors and reviews the quality and outcomes of services provided to members in both settings.

Nursing Facility Services for Long-Term Care:

- CalOptima LTSS is responsible for the clinical review and medical necessity determination for members receiving long-term Nursing Facility Level A, Nursing

Facility Level B, and Subacute levels of care. CalOptima LTSS monitors the levels of overall program utilization as well as care setting transitions for members in the program.

Home- and Community-Based Services:

- CBAS: An outpatient, facility-based program that offers health and social services to seniors and persons with disabilities. CalOptima LTSS monitors the levels of member access to, utilization of, and satisfaction with the program, as well as its role in diverting members from institutionalization.
- MSSP: Intensive 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 institutionalization. CalOptima LTSS monitors the level of member access to the program as well as its role in diverting members from institutionalization.

Behavioral Health Integration Services

Medi-Cal

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.

In addition, CalOptima covers behavioral health treatment (BHT) for members 20 years of age and younger who meet medical necessity criteria. BHT services are provided under a specific behavioral treatment plan that has measurable goals over a specific time frame. CalOptima provides direct oversight, review and authorization of BHT services.

CalOptima offers Alcohol Misuse Screening and Counseling (AMSC) services at the primary care physician setting 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 members can access mental health services directly, without a physician referral, by contacting the CalOptima Behavioral Health Line at **855-877-3885**. A CalOptima representative will conduct a brief mental health telephonic screening to make an initial determination of the member's impairment level. If the member has mild to moderate impairments, the member will be referred to behavioral health practitioners within the CalOptima provider network. If the member has significant to severe impairments, the member will be referred to specialty mental health services through the Orange County Mental Health Plan.

CalOptima ensures members with coexisting medical and mental health care needs have adequate coordination and continuity of their care. Communication with both the medical and mental health specialists occur as needed to enhance continuity by ensuring members receive timely and appropriate access and to facilitate communication between the medical and mental health practitioners involved.

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.

OC and OCC
CalOptima has previously contracted with Magellan Health Inc. to directly manage mental health benefits for OC and OCC members. Effective January 1, 2020, OC/OCC behavioral health will be fully integrated within CalOptima internal operations. OC and OCC members can access mental health services by calling the CalOptima Behavioral Health Line. Members will be connected to a CalOptima representative for behavioral health assistance.

CalOptima offers Alcohol Misuse Screening and Counseling (AMSC) services at the PCP setting 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 refer to mental health and/or alcohol use disorder services as medically necessary.

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 that are established as safe and effective, consistent with symptoms and 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 2020 UM Program, all review staff are trained and audited in these principles. Licensed clinical staff review and approve requested services based on medical necessity, utilizing evidence-based review criteria. Requests not meeting medical necessity criteria are reviewed by a physician reviewer or other qualified reviewer.

Further details of the UM Program, activities and measurements can be found in the 2020 UM Program Description and related Work Plan.

Enterprise Analytics

Enterprise Analytics (EA) provides leadership across CalOptima in the development and distribution of analytical capabilities. In conjunction with the executive team and key leaders across the organization, EA 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 road map. Working with departments that supply data, notably, Information Services, Claims, Customer Service, Provider Services and Medical Affairs, the EA team develops or extends the data architecture and data definitions which express a future state for the CalOptima Data Warehouse. Through work with key users of data, EA develops the platform(s) and capabilities to meet CalOptima's critical information needs. This capability for QI in the past has included provider

preventable conditions, trimester-specific member mailing lists, high-impact specialists, PDSA on LTC inpatient admissions and under-utilization information. As QI needs evolve, so will the EA contribution.

SAFETY PROGRAM

Member 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 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 is based on a needs assessment, and includes the following areas:

- Identification and prioritization of member 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
- Health education and promotion
- Over/Under utilization monitoring
- Medication management
- PHM
- 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, culture 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 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 ensure the amount of the appropriate drug is being delivered
- Improving continuity and coordination between sites of care, such as hospitals and skilled nursing facilities, to assure timely and accurate communication

- Utilizing facility site review, Physical Accessibility Review Survey (PARS) and medical record review results from practitioner and health care delivery organization at the time of credentialing to improve safe practices, and incorporating ADA and 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 keeping equipment in good working order
  - Fire, disaster, and evacuation plan, testing and annual training
- Institutional settings including CBAS, SNF, and MSSP 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 vaccines
- Administrative offices
  - Fire, disaster, and evacuation plan, testing and annual training

Cultural & Linguistic Services

As a health care organization in the diverse community of Orange County, CalOptima, strongly believes in the importance of providing culturally and linguistically appropriate services to its members. To ensure effective communication regarding treatment, diagnosis, medical history, and health education, CalOptima has developed a program that integrates culturally and linguistically appropriate services at all levels of the operation. Such services include, but are not limited to, Face-to-Face Interpreter services, including American Sign Language, at key points of contact; 24-hour access to telephonic interpreter services; member information materials translated into CalOptima's threshold languages and in alternate formats, such as braille, large-print, PDF or audio.

Since CalOptima serves a large and culturally diverse population, the seven most common languages spoken for all CalOptima programs are: English 56 percent, Spanish 28 percent, Vietnamese 11percent, Farsi 1percent, Korean 1 percent, Chinese 1 percent, Arabic 1 percent and all others at 3 percent, combined. CalOptima provides member materials as follows:

- 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 seven languages: English, Spanish, Vietnamese, Korean, Farsi, Chinese and 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.

Objectives for serving a culturally and linguistically diverse membership include:

- Reduce health care disparities in clinical areas.
- Improve cultural competency in materials and communications.
- Improve network adequacy to meet the needs of underserved groups.
- Improve other areas of needs the organization deems appropriate.

The approach for serving a culturally and linguistically diverse membership include:

- Analyzing significant health care disparities in clinical areas to ensure health equity
- Using practitioner and provider medical record reviews to understand the differences in care provided and outcomes achieved
- Considering outcomes of member grievances and complaints
- Conducting member-focused interventions with culturally competent outreach materials that focus on race-/ethnicity-/language- or gender-specific risks
- Conducting member-focused groups or key informant interviews with cultural or linguistic members to determine how to meet their needs
- Identifying and reducing a specific health care disparity affecting a cultural, racial or gender group. Providing information, training and tools to staff and practitioners to support culturally competent communication

DELEGATED AND NON-DELEGATED ACTIVITIES

CalOptima delegates certain functions and/or processes to delegated HNs that 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. A Readiness Assessment is conducted by the Audit & Oversight department and overseen by the Audit & 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, delegated HNs must comply with all quality-related operational, regulatory and accreditation standards.
- Behavioral Health for MC, OC and OCC lines of business

- PHM Program, previously referred to as Disease Management or 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 measures, 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 OP
- Credentialing and re-credentialing of OPs
- 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 2020 Delegation Grid.

See Appendix B — 2020 Delegation Grid

IN SUMMARY

As stated previously, 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 — 2020 QI WORK PLAN

APPENDIX B — 2020 DELEGATION GRID

I. PROGRAM OVERSIGHT

A. 2020 QI Annual Oversight of Program and Work Plan
B. 2019 QI Program Evaluation
C. 2020 UM Program
D. 2019 UM Program Evaluation
E. Population Health Management Strategy
F. Credentialing Peer Review Committee (CPRC) Oversight
G. Utilization Management Committee (UMC) Oversight
H. Member Experience (MEMX) Committee Oversight
I. Whole Child Model - Clinical Advisory Committee (WCM CAC)
J. Grievance and Appeals Resolution Services (GARS) Committee
K. PACE QIC - Quarterly review and update of PACE QIC activities
L. Quality Withold for OCC
M. Quality Program updates (Health Network Quality Rating, MCAS, P4V)
N. Improvement Projects (All LOB)
PPME and SNP-MOC Monitoring (OC)
QIPE Monitoring (OCC)

II. QUALITY OF CLINICAL CARE- ADULT WELLNESS

A. Adult's Access to Preventive/Ambulatory Health Services (AAP) (Total)
B. Cervical Cancer Screening (CCS)
C. Colorectal Cancer Screening (COL)
D. Breast Cancer Screening (BCS)

III. QUALITY OF CLINICAL CARE - BEHAVIORAL HEALTH

A. Follow-up After Hospitalization for Mental illness within 7 and 30 days of discharge (FUH).
B. 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.

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:

David Ramirez, MD Date:

Board of Directors' Quality Assurance Committee Chairperson:

Paul Yost, MD Date:

IV. QUALITY OF CLINICAL CARE - CHRONIC CONDITIONS

A. Statin Therapy for People with Cardiovascular Disease (SPC) and Statin Therapy for People with Diabetes (SPD)
B. Persistence of Beta Blocker Treatment after a Heart Attack (PBH)
C. Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): HbA1c Testing
Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): HbA1c Good Control (<8.0%)
Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): Eye Exam

V. QUALITY OF CLINICAL CARE - MATERNAL CHILD HEALTH

A. Prenatal and Postpartum Care Services (PPC): Timeliness of Prenatal Care and Postpartum Care

VI. QUALITY OF CLINICAL CARE - PEDIATRIC /ADOLESCENT WELLNESS

A. 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.

B. Depression Screening and Follow-Up for Adolescents (12+) and Adults (DSF)
C. Well-Care Visits in first 15 months of life (W15)
D. Adolescent Well-Care Visits (AWC)
E. Children and Adolescents' Access to Primary Care Practitioners (CAP)

VII. QUALITY OF SERVICE

A. Review of Member Experience (CAHPS)
-Increase CAHPS score on Getting Needed Care
B. Review of Timely Access
- Increase appointment availability

VIII. SAFETY OF CLINICAL CARE

A. Plan All-Cause Readmissions (PCR)

B. Opiods Utlization
C. Post-Acute Infection Prevention Quality Incentive (PIPQI),aka as SHIELD OC

2020 QI Work Plan

2020 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion	Staff Responsible	**Results/Metrics: Assessments, Findings, Monitoring of Previous Issues**	**Next Steps Interventions / Follow-up Actions**
Program Oversight						
2020 QI Annual Oversight of Program and Work Plan	Obtain Board Approval of 2020 QI Program and Workplan by March 2020	QI Program and QI Work Plan will be adopted on an annual basis; QI Program Descritpion-QIC-BOD; QI Work Plan-QIC-QAC	Annual Adoption	Betsy Ha		
2019 QI Program Evaluation	Complete Evaluation 2019 QI Program by January 2020	QI Program and QI Work Plan will be evaluated for effectiveness on an annual basis	Annual Evaluation	Betsy Ha		
2020 UM Program	Obtain Board Approval of 2020 UM Program by June 2020	UM Program will be adopted on an annual basis; Delegate UM annual oversight reports-from DOC	Annual Adoption	Mike Shook		
2019 UM Program Evaluation	Complete Evaluation of 2019 UM Program by March 2020	UM Program and UM Work Plan will be evaluated for effectiveness on an annual basis; Delegate oversight from DOC	Annual Evaluation	Mike Shook		
Population Health Management Strategy	Review and implement strategy in 2020	Review and adopt on an annual basis	Annual Adoption	Pshyra Jones		
Credentialing Peer Review Committee (CPRC) Oversight - Conduct Peer Review of Provider Network by reviewing Credentialing Files, Quality of Care cases, and Facility Site Review, to ensure quality of care delivered to members		Review of Initial and Recredentialing applications approved and denied; Facility Site Review (including Physical Accessibility Reviews); Quality of Care cases leveled by committee.	Quarterly Adoption of Report	Miles Masastugu, MD/ Esther Okajima		
Utilization Management Committee (UMC) Oversight - Conduct Internal and External oversight of UM Activities to ensure over and under utilization patters do not adversely impact member's care.		UMC meets quarterly; monitors medical necessity, cost-effectiveness of care and services, reviewed utilization patterns, monitored over/under-utilization, and reviewed inter-rater reliability results. P&T and BMSC reports to the UMC, and minutes are submitted to UMC quarterly.	Quarterly Adoption of Report	Mike Shook		
Member Experience (MEMX) Committee Oversight - Oversight of Member Experience activities to improve quality of service and member experience to achieve the 2020 QI Goal of improving CAHPS and Access to Care.		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	Kelly Rex-Kimmet/Marsha Choo		
Whole Child Model - Clinical Advisory Committee (WCM CAC)- Conduct Clinical Oversight for WCM and provide clinical advice for issues related to implementation.		Meet quaterly, provide clinical advice regarding Whole Child Model operations to Medical Affairs.	Quarterly Adoption of Report	T.T. Nguyen, MD		
Grievance and Appeals Resolution Services (GARS) Committee - Conduct oversight of Grievances and Appeals to resolve complaints and appeals for members and providers in a timely manner.		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	Ana Aranda		
PACE QIC - Quarterly review and update of PACE QIC activities		The PACE QIC oversees the activities and processes of the PACE center. Results are presented to PACE-QIC, and summarized quarterly at QIC	Quarterly Adoption of Report	Miles Masatsugu, MD		

2020 QI Work Plan

2020 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion	Staff Responsible	**Results/Metrics: Assessments, Findings, Monitoring of Previous Issues**	**Next Steps Interventions / Follow-up Actions**
Quality Withold for OCC	Earn **75**% of Quality Withhold Dollars back for OneCare Connect in OCC QW program end of MY 2020	Monitor and report to QIC	Annual Assessment	Kelly Rex-Kimmet/ Sandeep Mital		
Quality Program updates (Health Network Quality Rating, MCAS, P4V)	Achieve 50th percentile on all MCAS measures in 2020	**Varies per measure**. Activities requiring intervention are listed below in the Quality of Clinical Care measures.	Quarterly Adoption of Report	Kelly Rex-Kimmet/ Paul Jiang		
Improvement Projects (All LOB) PPME and SNP-MOC Monitoring (OC) QIPE Monitoring (OCC)	Meet and exceed goals set forth on all improvement projects (See individual projects for individual goals) and SNP-MOC goals.	Conduct quarterly oversight of specific goals on QIPE/PPME dashboard for OC/OCC measures. Reference dashboard for SMART goals **PPME (OC):** Emerging Risk (A1C), HRA's, HN MOC Oversight(Review of MOC ICP/ICT bundles) **QIPE (OCC):** HRA's, ICP High/Low Risk, ICP Completed within 90 days, Reducing Avoidable Hospitalizations and Other Adverse Events for Nursing Facility Residents, Statins, Emerging Risk (A1C), HN MOC Oversight (Review of MOC ICP/ICT bundles)	Quarterly/Annual Assessment	Helen Syn/ Mimi Cheung/Sloane Petrillo		
Quality of Clinical Care						
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.	**HEDIS 2020 Goal:** MC 44.82%; OC 58.82%; OCC 50.39%	Educate providers and members on importance of follow up appointments through newsletters/outreach to increase follow up appointments for Rx management associated with AMM treatment plan. Track number of educational events on depression screening and treatment.	12/31/2020	Edwin Poon		
Follow-up After Hospitalization for Mental illness within 7 and 30 days of discharge (FUH).	**HEDIS 2020 Goal:** 30-Days: OC: NA; OCC: 56% 7-Days: OC: NA; OCC: 18.20%	1) Visit top 3 hospitals in the first quarter. 2) Follow up with facilities during regular joint operation meetings. 3) Outreach to members post discharge to coordinate follow-up appointments. 4) Track the number of members that have a follow up appointment at discharge.	12/31/2020	Edwin Poon		
Statin Therapy for People with Cardiovascular Disease (SPC) and Statin Therapy for People with Diabetes (SPD)	**HEDIS 2020 Goal:** SPC - Therapy MC 77.57%; OC 79%; OCC 79% SPD - Therapy MC 70.19%; OC 74.13%; OCC 74.13%	1) Quarterly faxes to Provider offices with lists of members missing an appopriate statin (SPD: any potency statin; SPC: moderate to high potency statin) or members who fall below adherence thresholds (PDC< 80%). (Rx) 2) SPD targeted mailings to members based on list provided from Pharmacy Provider outreach. (PHM) 3) Conduct IVR outreach calls to targeted members. (PHM) 4) Track the number of new members starting appropriate statins medications from targeted outreach list. 5) Track the number of members who were adherent to appropriate statins using calculated PDC rates.	12/31/2020	Nicki Ghazanfarpour/ Helen Syn		

2020 QI Work Plan

2020 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion	Staff Responsible	**Results/Metrics: Assessments, Findings, Monitoring of Previous Issues**	**Next Steps Interventions / Follow-up Actions**
Persistence of Beta Blocker Treatment after a Heart Attack (PBH)	**HEDIS 2020 Goal:** MC 77.93%; OC N/A; OCC N/A	1) Quarterly faxes to Provider offices for members missing persistent beta blocker use for a total of 6 months post-ASCVD date. 2) Track the number of members who are persistently using beta blockers 6 months post-ASCVD date.	12/31/2020	Nicki Ghazanfarpour		
Adult's Access to Preventive/Ambulatory Health Services (AAP) (Total)	**HEDIS 2020 Goal:** MC 76.07%; OC 95.66%; OCC 93.70%	1) Continue Homeless Clinical Access Program (HCAP) program. This program started in late 2019 and will be available for members in 2020 2) Support health networks and provider offices with targeted outreach (i.e. CalOptima Day activities) 3) Implement the Health Equity PIP to improve access to acute/preventive care services for homeless members. 4) Track the number of homeless members accessing preventive care services at Homeless clinic events, and help transition members back to PCP	12/31/2020	Pshyra Jones/ Helen Syn/ Mimi Cheung		
Cervical Cancer Screening (CCS)	**HEDIS 2020 Goal:** MC 63.99%	1) Implement $25 member incentive program for completing a CCS. 2) Targeted outreach campaigns to promote cervical cancer screenings 3) Track the number of member incentives paid out for cervical cancer screening. 4) Track the number of cervical exams scheduled through targeted outreach (IVR, call campaigns, etc.)	12/31/2020	Pshyra Jones/ Helen Syn/ Mimi Cheung		
Colorectal Cancer Screening (COL)	**HEDIS 2020 Goal:** OC 73%; OCC 73%	1) Implement new member incentive program; $50 per screening incentive for OC/OCC 2) Track the number of member incentives paid out colorectal cancer screening; (specifically sigmoidoscopy and colonoscopy)	12/31/2020	Pshyra Jones/ Helen Syn/ Mimi Cheung		
Breast Cancer Screening (BCS)	**HEDIS 2020 Goal:** MC 63.98%; OC 76%; OCC 66%	1) Implement $25 member incentive program for completing a BCS and track the number of member incentives paid out for the breast cancer screening. 2) Targeted outreach campaigns to promote breast cancer screenings. Track the number of calls listened to from targeted outreach campaigns (i.e. IVR or direct phone outreach) 5) Track the number of mammograms scheduled through targeted call campaigns.	12/31/2020	Pshyra Jones/ Helen Syn/ Mimi Cheung		

2020 QI Work Plan

2020 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion	Staff Responsible	**Results/Metrics: Assessments, Findings, Monitoring of Previous Issues**	**Next Steps Interventions / Follow-up Actions**
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.	**HEDIS 2020 Goal:** MC 55.50%	1) Develop CORE report and track the numbers of members that filled Rx and their providers. 2) Coordination for members and providers through outreach and assistance with appointment setting and reminders. 2)Track the number of members that have a follow up appointment scheduled.	12/31/2020	Edwin Poon		
Depression Screening and Follow-Up for Adolescents (12+) and Adults (DSF)*	DHCS required, for MC, no external benchmarks **HEDIS 2020 Goal:** **MC: NA**	1) Develop way to load PHQ scores from Guiding Care to HEDIS software. Develop way to capture information (i.e., PHQ scores and scheduled f/u appt.s) from provider offices. 2) Educate providers on depression screening tools and importance of screening. 3) Educate providers and members on importance of follow up appointments via newsletters/ outreach. 4) Track depression screening scores completed by internal staff in GC. 5) Track number of eduational events for depression screening and treatment, and increase # compared to last year.	12/31/2020	Edwin Poon		
Well-Care Visits in first 15 months of life (W15)	**HEDIS 2020 Goal:** MC 65.83%	1) Implement CalOptima Days targeting the W15 population only and track the number of members who engaged in W15 CalOptima Day events. 2) Implement **Member** incentive program for completing 1-3 and 4-6 well-child visits in the first 15 months of life and Track the number of W15 incentives paid out to members 3) Implement **Provider** incentive program for the W15 measures; members must complete 1-3 and 4-6 visits. Track the number of W15 incentives paid out to providers.	12/31/2020	Pshyra Jones/ Helen Syn/ Mimi Cheung		
Adolescent Well-Care Visits (AWC)	**HEDIS 2020 Goal:** MC 60.34%	1) Implement $25 member incentive program for adolescents 12-17 years old and Track the number of AWC incentives paid out to members. 2) Implement "Back-to-School" events to promote well-care visits and immunizations for adolescents and Track the number of participants for targeted adolescent "back-to-school" events.	12/31/2020	Pshyra Jones/ Helen Syn/ Mimi Cheung		
Children and Adolescents' Access to Primary Care Practitioners (CAP)	**HEDIS 2020 Goal:** **MC:** 12-24 Months 95.62% 25 months-6 years: 87.87% 7-11 years: 92.33% 12-19 years: 90.21%	1) Targeted outreach campaigns (IVR, call campaigns, etc.) 2) Also see other measure activities: [W15, AWC, IMA, CIS activities] 3) Track number of members who have an office visit after targeted outreach campaigns (i.e. IVR/Text messaging) 4) CAP measures is impacted by the following measures: W15, AWC, IMA, CIS and it's activities.	12/31/2020	Pshyra Jones/ Helen Syn/ Mimi Cheung		

2020 QI Work Plan

2020 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion	Staff Responsible	**Results/Metrics: Assessments, Findings, Monitoring of Previous Issues**	**Next Steps Interventions / Follow-up Actions**
Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): HbA1c Testing	**HEDIS 2020 Goal:** MC: HbA1c Testing: 89.78% OC: HbA1c Testing: 93% OCC: HbA1c Testing: 93%	1) Implement $25 member incentive program for HbA1c testing and Track the number of Diabetes A1C testing incentives paid out	12/31/2020	Pshyra Jones/ Helen Syn/ Mimi Cheung		
Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): HbA1c Good Control (<8.0%)	**HEDIS 2020 Goal:** MC: HbA1c Control (<8.0%): 60.77% OC: HbA1c Control (<8.0%): 71.97% OCC: HbA1c Control (<8.0%): 71.97%	1) Targeted outreach to members in "emerging risk" category (8.0-9.0) 2) Track the number of completed calls to emerging risk members identified	12/31/2020	Pshyra Jones/ Helen Syn/ Mimi Cheung		
Improve HEDIS measures related to Comprehensive Diabetes Care (CDC): Eye Exam	**HEDIS 2020 Goal:** MC: Eye Exam: 64.72% OC: Eye Exam: 78% OCC: Eye Exam: 78%	1) Implement $25 member incentive program for completion of diabetic eye exams and Track the number of Diabetes Eye Exam incentives paid out. 2) Update VSP contract to ensure barrier is removed for annual eye exam for members with diabetes 3) VSP diabetic eye exam utilization	12/31/2020	Pshyra Jones/ Helen Syn/ Mimi Cheung		
Prenatal and Postpartum Care Services (PPC): Timeliness of Prenatal Care and Postpartum Care	**HEDIS 2020 Goal:** Prenatal MC 86.37% Postpartum MC 68.36%	1) Implement $50 member incentive program for completing a postpartum. 2) Track number of Incentives paid out PPC 3) Conduct Bright Step post partum assessment 4) # of Bright Steps Post Partum Assessments	12/31/2020	Ann Mino		
Quality of Service						
Review of Member Experience (CAHPS) -Increase CAHPS score on Getting Needed Care	Improve Member Experience for **Getting Needed Care** from 25th to 50th percentile AND Improve Member Experience for **Getting Care Quickly** from 25th to 50th percentile	1) Continue Provider Data Initiative 2) Update the CalOptima Website (Provider Directory) so that providers and services are easily accessible to members 3) To have HN meet Time and Distance Standards 4) To have HN have at least 1 urgent care enter int he provider directory. 5)Provider Coaching and Workshops, report on # of Physician Shadow Coaching and Customer Service Improvement Workshops	12/31/2020	Marsha Choo		

2020 QI Work Plan

2020 QI Work Plan Element Description	Goals	Planned Activities	Target Date(s) for Completion	Staff Responsible	**Results/Metrics: Assessments, Findings, Monitoring of Previous Issues**	**Next Steps Interventions / Follow-up Actions**
Review of Timely Access - Increase appointment availability	Improve Timely Access for **Compliance with Routine/Urgent Appointment Wait Times for PCPs/Specialists** from current rate to 80%	1) Increase payment rates for hard to access specialists 2) Contract with Telehealth vendor and initiate telehealth services for identified specialities. 3) Incentive for hard to access PCPs/Specialists to open their panels 4) PCP Overcapacity Monitoring and closing of panels 5) Offer After Hours Incentive	12/31/2020	Marsha Choo		
Safety Of Clinical Care						
Plan All-Cause Readmissions (PCR)	**HEDIS 2020 Goal:** OC 8%; OCC 8%	1) Complete RFP and select vendor to collect ER data, and reinstate ER discharge program 2) Track # of Members receiving health coaching 3) Track # of member with a hospital admission versus unplanned readmission	12/31/2020	Sloane Petrillo Helen Syn/ Jocelyn Johnson		
Opioids Utilization	Optimal utilization of opioid analgesics.	Formulary Management quarterly meetings a. Quantity limits b. Duration limits c. Prior Authorization criteria d. Prescriber Report Cards e. Pharmacy Home f. Prescriber Restriction	Quarterly	Kris Gericke		
Post-Acute Infection Prevention Quality Incentive (PIPQI), aka as SHIELD OC	1. To reduce the number of nosocomial infections for LTC members. 2. To reduce the number of acute care hospitalizations related to infections for LTC members.	1) Nurses monitor once a month. 2) Facility Staff bathe residents in Chlorhexidine (CHG) antiseptic soap for routine bathing and showering. and administer Iodofor (nasal swabs). 3)CalOptima will pay participating facilities via quality incentive. 4) Once the PDSA is approved. Project Update can be reported on a Quarterly basis to QIC.	12/31/2020	Cathy Osborn		

2020 Medi-Cal Delegation Grid

"Appendix B"

Domain/ Element Name	CalOptima	HN	Kaiser	MedImpact	Comments CO=CalOptima; S&P = Structural & Procedural
QI1A: QI Program Structure	X		X		CO responsibility S&P component, even if delegated
QI1B: Annual Work Plan	X				CO responsibility S&P component, even if delegated
QI1C: Annual Evaluation	X		X		CO responsibility S&P component, even if delegated
QI1D: QI Committee Responsibilities	X		X		CO responsibility S&P component, even if delegated
QI2A: Practitioner Contracts	X		X		CO responsibility S&P component, even if delegated
QI2B: Provider Contracts	X		X		CO responsibility S&P component, **this element is not required for renewal surveys.**
QI3A: Identifying Opportunities-Continuity & Coordination of Care of Medical Care (C&C)	X		X		
QI3B: Acting on Opportunities-Continuity & Coordination of Care of Medical Care (C&C)	X		X		
QI3C: Measuring Effectiveness-Continuity & Coordination of Care of Medical Care (C&C)	X		X		
QI3D: Transition to other Care-Continuity & Coordination of Care of Medical Care (C&C)	X		X		
QI4A: Data Collection- C&C Between Medical Care and Behavioral Health	X		X		
QI4B: Collaborative Activities- C&C Between Medical Care and Behavioral Health	X		X		

NCQA Standards Abbreviations: QI = Quality Improvement; PHM – Population Health Management; NET – Network Management; UM – Utilization Management; CR – Credentialing; ME –Statement of Members' Rights and Responsibilities; Standards include multiple "factors" identified by a number & letter. Please contact CalOptima for details on particular standards or elements.

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2020 Medi-Cal Delegation Grid

"Appendix B"

Domain/ Element Name	CalOptima	HN	Kaiser	MedImpact	Comments CO=CalOptima; S&P = Structural & Procedural
QI4C: Measuring Effectiveness- C&C Between Medical Care and Behavioral Health	X		X		
PHM1A: Strategy Description-PHM	X		X		CO responsibility S&P component
PHM1B: Informing Members-PHM	X		X		
PHM2A: Data Integration-PHM	X		X		
PHM2B: Population Assessment-PHM	X		X		
PHM2C: Activities and Resources-PHM	X		X		
PHM2D: Segmentation-PHM	X		X		
PHM3A: Practitioner or Provider Support	X		X		
PHM3B: Value-Based Payment Arrangement	X		X		
PHM4A: Frequency of HA Completion	X		X		
PHM4B: Topics of Self- Management Tools	X		X		
PHM5A: Access to Case Management-CCM	X	X	X		
PHM5B: Case Management Systems-CCM	X	X	X		

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2020 Medi-Cal Delegation Grid

"Appendix B"

Domain/ Element Name	CalOptima	HN	Kaiser	MedImpact	Comments CO=CalOptima; S&P = Structural & Procedural
PHM5C: Case Management Process-CCM	X	X	X		CO responsibility S&P component, **this element will not be reviewed for Renewal Surveys.**
PHM5D: Initial Assessment-CCM	X	X	X		
PHM5E: Case Management- Ongoing Management-CCM	X	X	X		
PHM6A: Measuring Effectiveness-PHM	X		X		CO responsibility S&P component, even if delegated
PHM6B: Improvement and Action -PHM	X		X		CO responsibility S&P component, even if delegated
NET1A: Cultural Needs and Preferences	X		X		
NET1B: Practitioners Providing Primary Care	X				CO responsibility S&P component Factors 1&2, even if delegated
NET1C: Practitioners Providing Specialty Care	X				CO responsibility S&P component Factors 1-4, even if delegated
NET1D: Practitioners Providing Behavioral Health (BH)	X		X		CO responsibility S&P component Factors 1-3, even if delegated. Factor 4 Kaiser
NET2A: Access to Primary Care	X		X		CO responsibility S&P component, even if delegated
NET2B: Access to BH	X		X		CO responsibility S&P component, even if delegated
NET2C: Access to Specialty Care	X		X		
NET3A: Assessment of Member Experience Accessing the Network	X		X		Kaiser Factors 1-3

NCQA Standards Abbreviations: QI = Quality Improvement; PHM – Population Health Management; NET – Network Management; UM – Utilization Management; CR – Credentialing; ME –Statement of Members' Rights and Responsibilities; Standards include multiple "factors" identified by a number & letter. Please contact CalOptima for details on particular standards or elements.

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2020 Medi-Cal Delegation Grid

"Appendix B"

Domain/ Element Name	CalOptima	HN	Kaiser	MedImpact	Comments CO=CalOptima; S&P = Structural & Procedural
NET3B: Opportunities to Improve Access to Non-behavioral Healthcare Services	X		X		Kaiser Factors 1-3
NET3C: Opportunities to Improve Access to BH Services	X		X		Kaiser Factors 1-3
NET4A: Notification of Termination	X	X	X		
NET4B: Continued Access to Practitioners	X	X	X		
NET5A: Physician Directory Data	X		X		
NET5B: Physician Directory Updates	X		X		
NET5C: Assessment of Physician Directory Accuracy	X		X		
NET5D: Identifying and Acting on Opportunities	X		X		
NET5E: Searchable Physician Web-Based Directory	X		X		
NET5F: Hospital Directory Data	X		X		
NET5G: Hospital Directory Updates	X		X		
NET5H: Searchable Hospital Web-Based Directory	X		X		
NET5I: Usability Testing	X		X		

NCQA Standards Abbreviations: QI = Quality Improvement; PHM – Population Health Management; NET – Network Management; UM – Utilization Management; CR – Credentialing; ME –Statement of Members' Rights and Responsibilities; Standards include multiple "factors" identified by a number & letter. Please contact CalOptima for details on particular standards or elements.

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2020 Medi-Cal Delegation Grid

"Appendix B"

Domain/ Element Name	CalOptima	HN	Kaiser	MedImpact	Comments CO=CalOptima; S&P = Structural & Procedural
NET5J: Availability of Directories	X		X		
UM1A: Written Program Description	X		X		CO responsibility S&P component, even if delegated
UM1B: Annual Evaluation	X				CO responsibility S&P component, even if delegated
UM2A: UM Criteria	X	X	X		CO responsibility S&P component, even if delegated
UM2B: Availability of Criteria	X	X	X		CO responsibility S&P component, **this element is not required for Renewal surveys.**
UM2C: Consistency in Applying Criteria	X	X	X	X	
UM3A: Access to Staff	X	X	X		
UM4A: Licensed Health Professionals	X	X	X	X	CO responsibility S&P component, even if delegated
UM4B: Use of Practitioners for UM Decisions	X	X	X	X	CO responsibility S&P component, 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		

NCQA Standards Abbreviations: QI = Quality Improvement; PHM – Population Health Management; NET – Network Management; UM – Utilization Management; CR – Credentialing; ME –Statement of Members' Rights and Responsibilities; Standards include multiple "factors" identified by a number & letter. Please contact CalOptima for details on particular standards or elements.

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2020 Medi-Cal Delegation Grid

"Appendix B"

Domain/ Element Name	CalOptima	HN	Kaiser	MedImpact	Comments CO=CalOptima; S&P = Structural & Procedural
UM5A: Notification of Non-Behavioral Decisions	X	X	X		
UM5B: Notification of Behavioral Healthcare Decisions	X		X		
UM5C: Notification of Pharmacy Decisions	X		X	X	
UM5D: UM Timeliness Report	X		X	X	
UM5E: Interim- Policies and Procedures	X				
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		

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"Appendix B"

Domain/ Element Name	CalOptima	HN	Kaiser	MedImpact	Comments CO=CalOptima; S&P = Structural & Procedural
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	
UM8A: Internal Appeals (Policies and Procedures)	X		X		CO responsibility S&P component, even if delegated
UM9A: Pre-service and Post-service Appeals	X		X		
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		

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"Appendix B"

Domain/ Element Name	CalOptima	HN	Kaiser	MedImpact	Comments CO=CalOptima; S&P = Structural & Procedural
UM11E: Considering Exceptions	X		X		
UM12A: UM Denial System Controls	X	X	X		
UM12B: UM Appeal System Controls	X		X		
CR1A: Practitioner Credentialing Guidelines	X	X	X		CO responsibility S&P component, even if delegated
CR1B: Practitioner Rights	X	X	X		CO responsibility S&P component, even if delegated
CR1C: Credentialing System Controls	X	X	X		
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 S&P component, **this element is not required for Renewal Surveys.**

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"Appendix B"

Domain/ Element Name	CalOptima	HN	Kaiser	MedImpact	Comments CO=CalOptima; S&P = Structural & Procedural
CR7A: Review and Approval of Provider	X	X	X		**This element is not required for Renewal Surveys.**
CR7B: Medical Providers	X	X	X		**This element is not required for Renewal Surveys.**
CR7D: Assessing Medical Providers	X	X	X		
ME1A: Rights and Responsibility Statement	X				
ME1B: Distribution of Rights Statement	X				
ME2A: Subscriber Information	X				
ME2B: Interpreter Services	X				
ME4A: Functionality: Website	X				**This element is not required for Renewal Surveys**
ME4B: Functionality: Telephone Requests	X	X	X		**This element is not required for Renewal Surveys**
ME5A: Pharmacy Benefit Information: Website	X		X	X	PBM delegate possibility for Factors 6-8, **this element is not required for Renewal Surveys.**
ME5B: Pharmacy Benefit Information: Telephone	X		X		**This element is not required for Renewal Surveys.**
ME5C: QI Process on Accuracy of Information	X		X		
ME5D: Pharmacy Benefit Updates	X		X		

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"Appendix B"

Domain/ Element Name	CalOptima	HN	Kaiser	MedImpact	Comments CO=CalOptima; S&P = Structural & Procedural
ME6A: Functionality: Web Site	X		X		CO: Factors 1-3; Kaiser Factors 1,2,3; Factor4 NA
ME6B: Functionality: Telephone	X	X	X		
ME6C: Quality and Accuracy of Information	X		X		
ME6D: E-Mail Response Evaluation	X		X		
ME7A: Policies and Procedures for Complaints	X		X		CO responsibility S&P component, even if delegated
ME7B: Policies and Procedures for Appeals	X		X		CO responsibility S&P component, even if delegated
ME7C: Annual Assessment-Member Experience	X				CO fields CAHPS, Kaiser complaint data included
ME7D: Opportunities for Improvement-Member Experience	X				
ME7E: Annual Assessment of BH and Services-Member Experience	X		X		Kaiser: Factor1 & Factor2
ME7F: BH Opportunities for Improvement-Member Experience	X				
Additional CMS/DHCS					
Contracts Opt-Out Provisions (CMS)	*X*	*X*	*X*		*CMS Requirement*
Medicare-Exclusions/Sanctions (CMS)	*X*	*X*	*X*		*CMS Requirement*

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"Appendix B"

Domain/ Element Name	CalOptima	HN	Kaiser	MedImpact	Comments CO=CalOptima; S&P = Structural & Procedural
Preclusion List (CMS)	*X*	*X*	*X*		*CMS Requirement*
Hospital Admitting Privileges (CMS/DHCS)	*X*	*X*	*X*		*CMS/DHCS Requirement*
Facility Site Review DHCS)	*X*		*X*		*DHCS Requirement*
Enrollment & Screening (DHCS APL 19-004)	*X*	*X*	*X*		*DHCS Requirement*
Review of Performance Information -Recred (CMS/DHCS)	*X*	*X*	*X*		*CMS/DHCS Requirement*
Monitoring Medicare opt Out (CMS)	*X*	*X*	*X*		*CMS Requirement*
Monitoring Medi-Cal Suspended and Ineligible Provider Reports (DHCS)	*X*	*X*	*X*		*DHCS Requirement*
Appeals Process for Termination/Suspension (CMS)	*X*	*X*	*X*		*CMS Requirement*
ID of HIV/AIDS Specialists: Written Process	*X*	*X*	*X*		*DHCS Requirement*
ID of HIV/AIDS Specialists: Evidence of Implementation	*X*	*X*	*X*		*DHCS Requirement*
ID of HIV/AIDS Specialists: Distribution of Findings	*X*	*X*	*X*		*DHCS Requirement*

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CalOptima
A Public Agency
Better. Together.

2020 Quality Improvement Program and Work Plan

Board of Directors' Quality Assurance Committee Meeting
February 19, 2020

Betsy Ha
Executive Director, Quality and Population Health Management

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2019 Quality Improvement (QI) Accomplishments

- Continued to be one of the highest rated Medicaid plans in the state.
- Maintained “Commendable” accreditation status from the National Committee for Quality Assurance (NCQA).
  - Standards based on Healthcare Effectiveness Data and Information Set (HEDIS) and Healthcare Providers and Systems (CAHPS).
- Performed well on several HEDIS measures in comparison to national thresholds.
  - Out of the 62 reportable measures, CalOptima performed better on 42 measures in 2019, compared to 2018.
- Implemented CalOptima’s comprehensive health network (HN) Pay for Value (P4V) Performance Measurement Program to recognize outstanding performance and support ongoing improvement.

2019 QI Accomplishments (cont.)

- Performed successful incentive outreach to members to obtain preventive care for Well-Care Visits in first 15 months of life (W15), postpartum care, and breast and cervical cancer screening.
- Expanded and continued initiatives to address access to care and member satisfaction, such as:
  - Provider coaching to evaluate and improve services provided at point of care
  - CalOptima Days to improve access and promote preventive health screenings
  - Active recruitment of new providers (both primary and specialty care)
- Implemented a quality incentive for Community Health Centers that participate in the Homeless Clinical Access Program (HCAP).

2019 QI Accomplishments (cont.)

- Implemented several prescriber, pharmacy, member and formulary interventions to reduce opioid utilization.
- Implemented Post-Acute Infection Prevention Quality Incentive (PIPQI) which included 25 nursing facilities of which 12 were already participating with UCI.
- Implemented six quality initiatives and several required Quality Improvement Projects (QIP), Performance Improvement Projects (PIP), Chronic Care Improvement Programs (CCIP), and Plan-Do-Study-Act (PDSA) to improve chronic condition measures
- Viable QI committee structure with subcommittees reporting of QI activities to QI Committee through the QI Work Plan.

QI Opportunities for 2020

- Maintain “Commendable” accreditation status and meet managed care accountability set (MCAS) measures (minimum performance level) MPL
- Achieve 4.5 for overall NCQA Health Plan rating
- Streamline QI Committee structure
- Perform targeted initiatives to improve performance on clinical HEDIS metrics specifically those MCAS measures at risk to fall below the MPL
- Utilize CalOptima Days for more targeted measures with smaller denominators
- Implement new P4V program with HN rating

QI Opportunities for 2020 (cont.)

- Implement member and provider incentives for specific quality measures, and evaluate effectiveness with HEDIS 2020
- Improve exchange of hospital data through new vendor to revamp Transition of Care program
- Reduce opioid utilization through various planned interventions in 2020
- Develop Quality Measures for PIPQI
- Develop Quality Measures for Whole-Child Model (WCM)
- Implement new DHCS tools and All Plan Letter (APL) for Facility Site Review
- Implement 2020 planned improvement projects

QI Opportunities for 2020 (cont.)

- Improve member experience CAHPS results for access related measures
- Increase appointment access to timely (routine and urgent) primary and specialty care

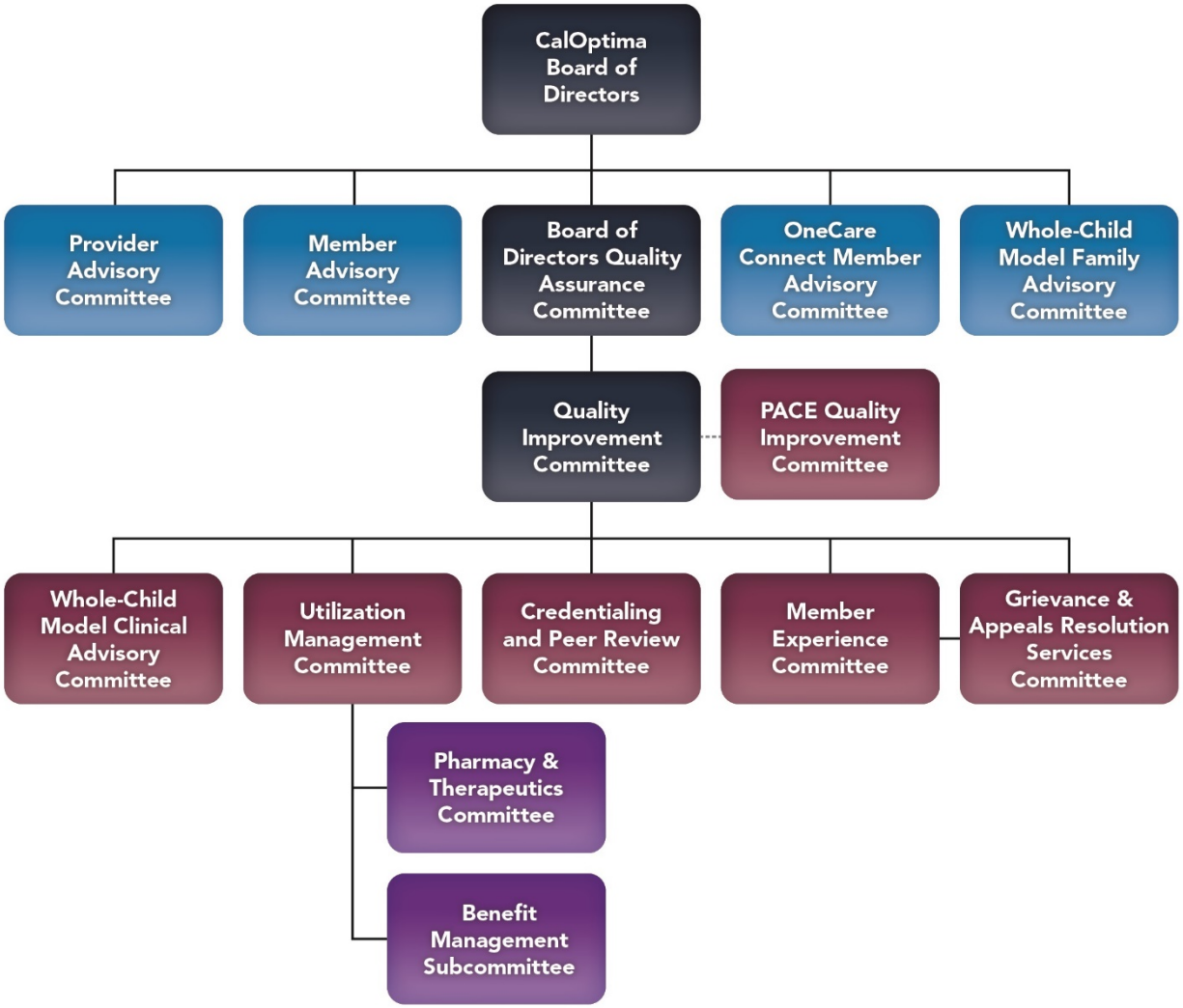
2020 QI Program Description

- Describes the quality and safety of clinical care, and organizational services provided to our members
- Aligns with the CalOptima's 2020–2022 strategic priorities:
  - Innovate and Be Proactive
  - Expand CalOptima's Member-Centric Focus
  - Strengthen Community Partnerships
  - Increase Value and Improve Care Delivery
  - Enhance Operational Excellence and Efficiency

2020 QI Program Description Revisions

- Description of scope of services for each line of business
- Updated the new program initiatives
  - Whole Person Care
  - Health Homes Program
  - Homeless Health Initiative
  - Behavioral Health for OC/OCC
- Updated QI Committee Structure

2020 QI Program Description Revisions (cont.)



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2020 QI Program Description Revisions (cont.)

- Established 2020 QI Goals and Objectives
  - Goal 1 — Improve NCQA overall rating 4.0 to 4.5 rating by 2021
  - Goal 2 — Improve Member Experience CAHPS performance from 25th percentile to 50th percentile focusing on Getting Needed Care and Getting Care Quickly
  - Goal 3 — Improve member's ability to access primary and specialty care timely, for urgent and routine appointments, from 2019 baseline to goal of 80%

2020 QI Program Description Revisions (cont.)

- Other revisions:
  - Updated program dates throughout document to reflect 2020
  - Updated values section to reflect accurate accountability to various committees
  - Updated Strategic Plan to reflect 2020–2022 strategic priorities and objectives
  - Updated what we offer sections to reflect 2020 scope of services
  - Updated Program Initiatives to include:
    - Whole Person Care
    - Health Homes Program
    - Homeless Health Initiative
    - Behavioral Health for OC/OCC

2020 QI Program Description Revisions (cont.)

- Other revisions (cont.):
  - Updated QI Program resources to reflect current organizational structure
  - Updated term for Health Care Delivery Organizations to industry term, Organizational Providers
  - Updated section on Population Health Management, in line with the PHM strategy. Included reference to statewide efforts to reduce Adverse Childhood Experiences (ACE) in adult Medi-Cal members by promoting awareness
  - Updated Cultural & Linguistic Services section including description and approach for serving diverse membership

2020 QI Program Description Revisions (cont.)

- Updated 2020 QI Work Plan (Appendix A)
- Updated delegated and non-delegated activities (Appendix B)
  - Changed pre-delegation review to Readiness Assessment
  - Population Health Management program renamed from Disease Management or Chronic Care Improvement Program
  - Renumbered based on 2018 Standards

2020 QI Work Plan (Appendix A)

- QI Work Plan measures aligned with 2020 QI Goals and Objectives
- Retired LTSS-QISC Committee from Work Plan. LTSS metrics are being reported as part of UMC Committee, BHQI Committee became part of QIC, and all respective measures will be reported to
  - Utilization Management Committee (UMC)
  - Member Experience Committee (MEMX)
  - Credentialing and Peer Review Committee (CPRC)
  - Grievance & Appeals Resolution Services Committee (GARS)
- Carried over measures that did not meet goals in 2019, and included measures requiring extra focus and attention

2020 QI Work Plan (Appendix A) (cont.)

- Removed maintenance of business goals on the Work Plan, measures tracked in other areas, and measures that are performing well.
  - Use of imaging studies for Lower Back Pain (LBP)
  - Appropriate testing for Children with Pharyngitis (CWP)
  - Antidepressant Medication Management (AMM): Acute Phase Treatment

2020 Delegation Grid (Appendix B)

- QI2 Element B: Informing members, this element was moved to MED 8 Element.
- QI3 Element B: Affirmative Statement.
  - In 2020 removed affirmative statement and incorporated the text into the policies and procedures Section 2: Accreditation Scoring and Status requirements
- The following elements were retired in the 2020 HP Standards:
  - QI4 Element A: Member Services Telephone Access
  - QI4 Element B: BH Telephone Access Standards
  - QI4 Element G: Assessing Experience with UM Process Member Experience

2020 Delegation Grid (Appendix B) (cont.)

- The following elements were retired in the 2020 HP Standards (cont.):
  - PHM4 Elements A–E: Health Appraisal
  - PHM4 Element G: Health Appraisal Review and Update Process
  - PHM4 Element I: Usability Testing of Self-Management Tools
  - PHM4 Element J: Review and Update Process for Self-Management Tools.
  - PHM4 Element K: Self-Management Tool Formats
  - PHM5 Element F: Experience with Case Management
  - MEM4 Element A: Supportive Technology

2020 Delegation Grid (Appendix B) (cont.)

- The following elements were retired in the 2020 HP Standards (cont.):
  - NET6 Element E: Physician Information Transparency
  - NET6 Element I: Hospital Information Transparency
  - UM5 Element A: Timeliness of Nonbehavioral UM Decision Making
  - UM5 Element C: Timeliness of Behavioral Health Care UM Decision Making.
  - UM5 Element E: Timeliness of Pharmacy UM Decision Making

2020 Delegation Grid

- New Requirements
  - **UM12 Element A:** UM Denial System Controls
    - Requires the organization to have policies and procedures describing how UM denial notification information is stored, modified and secured.
  - **UM12 Element B:** UM Appeal System Controls
    - Requires the organization to have policies and procedures describing how UM appeal information is stored, modified and secured.
  - **CR1 Element C:** Credentialing System Controls
    - Requires the organization to have policies and procedures describing how credentialing information is stored, modified and secured.

2020 Delegation Grid (cont.)

- Elements not Reviewed for Renewal Survey called out on the delegation grid
  - QI2 Element B: Provider Contracts
  - PHM5 Element C: Case Management Process
  - UM2 Element B: Availability of Criteria
  - CR7 Element A: Review and Approval of Provider
  - CR7 Element B: Medical Providers
  - CR7 Element C: Behavioral Health Providers

- Renumbered standards to account for standards and elements that were incorporated into other categories or eliminated from the Standards.

Questions?

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CalOptima's Mission

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

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CALOPTIMA PACE

2019 CALOPTIMA PACE QUALITY IMPROVEMENT (QI) PLAN ANNUAL EVALUATION

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SIGNATURE PAGE

Quality Improvement Subcommittee Chairperson:

_____ _____

David Ramirez, M.D. **Date:**
Chief Medical Officer

Board of Directors' Quality Assurance Committee Chairperson

_____ _____

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

Board of Directors Chairperson

_____ _____

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

TABLE OF CONTENTS

2019 CalOptima PACE Quality Improvement (QI) Plan Annual Evaluation

Executive Summary

CalOptima PACE opened for operations on October 1st, 2013. We have seen steady growth over the years with 13 participants at the end of 2013, and 393 participants at the end of 2019. Our participant represents six different social groups per the definition of the U.S. Census Bureau. Currently, 10 different languages are spoken by our participants with 82% of the participants speaking English as their second language. Out of our 393 participants, 58% use Spanish as their preferred language, followed by 18% using English as their preferred language and 16% citing Vietnamese as their preferred language. Other languages spoken include Korean, Tagalog, Chinese, Hindu, Urdu and Telugu. The multi-cultural and the diversity of our participant population provides a very vibrant and engaging environment.

The purpose of the CalOptima PACE QI Plan is to improve the quality of health care for participants, improve on the patient experience, ensure appropriate use of resources, provide oversight to contracted services, communicate all quality and process improvement activities and outcomes and reduce the potential risk to safety and health of PACE participants through ongoing risk management. This is done via data-driven assessments of the program which in turn drives continuous QI for the entire PACE organization. It is designed and organized to support the mission, values, and goals of CalOptima PACE.

The goals of the CalOptima PACE QI 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 2019 PACE QI Evaluation helps to identify key areas that offer opportunities for improvement that will be incorporated into the 2020 PACE QI Plan.

Section 1: Program Structure

The CalOptima's PACE QI Plan is developed by the PACE QI Committee (PQIC). It is then reviewed and approved by the CalOptima Board of Directors Quality Assurance Committee (QAC) and then approved by the CalOptima Board of Directors annually. The 2019 PACE QI Plan was reviewed and approved by the CalOptima Board of Directors on February 20, 2019.

The CalOptima PACE Medical Director has oversight and responsibility for implementation of the PACE QI Plan. The PACE QI Manager will ensure timely collection and completeness of data with the support of the PACE QI Program Specialists. Overall, oversight of the PACE QI is provided by the CalOptima Board of Directors.

The CalOptima PACE QI Plan incorporates continuous QI methodology that focuses on the specific needs of CalOptima's PACE participants.

- 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 towards established benchmarks or goals.
- It is focused on QI activities carried out on an ongoing basis to ensure that quality of care issues are identified and corrected.

SECTION 2: PACE QAPI PROGRAM

Major Accomplishments

In 2019, CalOptima PACE accomplishments include:

1. Successful Department of Health Care Services (DHCS) Level of Care (LOC) Audits.
2. Program growth to 393 participants, of which 63 receive services at Alternative Care Setting (ACS) sites.
3. Solidifying partnerships with five ACS sites, thereby meeting our expansion goals and improving access for participants into the PACE program.
4. Completion of three Quality Initiatives (Program Growth, Participant Care Plans and Participant Triage).
5. Met 20 out of 25 Work Plan goals.
6. Of participants enrolled in PACE for 6 months, 100% completed Physician's Orders for Life-Sustaining Treatment (POLST).
7. 97% of participants received their annual influenza vaccine.
8. 95% of participants received the Pneumococcal vaccine.
9. Respiratory infection rates in the elderly were lower than national benchmarks.
10. 95% of participants that had their medications reconciled within 30 days of hospital discharge.
11. The rate of day center falls fell by over 10% compared to 2018.
12. Quality of Diabetes Care
    a. 94% of participants with diabetes completed an annual eye exam.
    b. 97% of participants with diabetes went through nephropathy monitoring.
    c. 84% of participants with diabetes had their blood pressure controlled.
13. Utilization:
    a. Only 1.3% participants were placed in Long-Term Care in 2019.
    b. Refined the PACE Emergency Room (ER) Diversion program.
    d. Brought specialists in-house including podiatry, dental, and optometry for improved access and coordination of care.
14. Transportation:
    a. Over 60,000 one-way trips with an on-time performance of 94%.
15. Participant Satisfaction
    a. Overall satisfaction with care received of 96% compared to the national average of 94.7%
    b. 96% of participants would recommend the program to a close friend compared to the national average of 93.2%
    c. Of the 10 participant satisfaction domains:
        i. We scored higher than the national average in all 10 domains
        ii. Overall satisfaction composite score of 92% compared to the national average of 88.8%.
        iii. Improvement was seen in 7 of the 10 domains.
14. 100% of staff competency assessments were completed. Year-round staff trainings covering a broad area of topics included coding, infection control, wound care, emergency responses, grievances, appeals, service delivery requests and rights.

SECTION 3: STRATEGIC GOALS AND OBJECTIVES

Accomplishments

1. The QI program is organized to identify and analyze significant opportunities for improvement in clinical services, care and utilization.

    a. Accomplished as evidenced by the ongoing Health Plan Management System (HPMS) and QI individual metric data collection and analysis.
    b. Accomplished as evidenced by the ongoing PACE QI activities and initiatives.
2. The quality of clinical care and services and patient safety provided by the health care delivery system in all settings, especially as it pertains to the unique needs of the population.
    a. Accomplished as evidenced by the ongoing HPMS and QI individual metric data collection and analysis.
    b. Accomplished as evidenced by the ongoing PACE QI initiatives.
    c. Accomplished as evidenced by monitoring of member grievances and complaints, and regular review of delegated entities.
    d. Accomplished by the monthly meeting with the transportation vendor.
    e. Accomplished as evidenced by the daily morning inpatient and nursing facility clinical reviews.
    f. Accomplish by the ongoing infection control activities.
    g. Collaborated with the Compliance Department for identification of potential quality issues that may involve fraud, waste, abuse, confidentiality, security, etc.
    h. Accomplished as evidenced by the annual approval of Up-to-date Clinical Practice Guidelines and the National PACE Association Preventative Guidelines.
    i. Redesigned the PACE Clinic Workflow/Triage to efficiently address participant population growth and the increase in same-day appointment requests.
3. The continuity and coordination of care between specialists and primary care practitioners, and between medical and behavioral health practitioners.
    a. Accomplished as evidenced by the daily Interdisciplinary Care Team (IDT) meetings at CalOptima PACE.
    b. Accomplished by adding the hospital and nursing home attending physicians to the IDT.
    c. Accomplished by the addition of preferred specialists who agree to participate in IDT.
    d. Accomplished by the coordination of care found in the ER Diversion Program.
4. The accessibility and availability of appropriate clinical care and to a network of providers with experience in providing care to the population.
    a. Accomplished as evidenced by the number of grievances that have been tracked and trended.
    b. Accomplished by the Podiatrist, Optometrist and Dentist coming to the PACE center to see and treat the PACE participants.
    c. Accomplished by the Podiatrist, Psychiatrist, Nephrologist and Dentist participating in the IDT meetings.
5. The qualifications and practice patterns of all individual providers in the Medi-Cal network to deliver quality care and service.
    a. Accomplished as evidenced by the credentialing and peer review process.
    b. Accomplished as evidenced by annual evaluations of all CalOptima PACE employees.
6. Member and provider satisfaction, including the timely resolution of complaints and grievances.
    a. Accomplished as evidenced by the improvements in the PACE Participant Satisfaction Survey.
    b. Accomplished as evidenced by the summary of GARs activities.
    c. Accomplished through the ongoing PACE Member Advisory Committee meetings.
7. Risk prevention and risk management processes.
    a. Accomplished as evidenced by the QI activities which occur around all Unusual Incidents.
    b. Accomplished as evidenced by physical therapy driven groups such as Fall Prevention Group, Fall Committee, Fallers Anonymous and Matter of Balance groups.
    c. Accomplished as evidenced by root cause analysis done on Unusual Quality Incidences.

8. Compliance with regulatory agencies and accreditation standards.
    a. Accomplished as evidenced by the two successful DHCS Level of Care Audits.
9. Compliance with clinical practice guidelines and evidence-based medicine.
    a. Accomplished as evidenced by the adoption of the National PACE Association Preventative Guidelines
    b. Accomplished as evidenced by the adoption of Uptodate.com clinical practice standards.
    c. Accomplished as evidenced by on-going staff training.
10. Support of the organization's strategic quality and business goals by utilizing resources appropriately, effectively and efficiently.
    a. Accomplished as evidenced by tracking, trending and analyzing utilization management (UM) data monthly.
    b. Accomplished by the provider incentive program.
    c. Accomplished by the coordination of care found in the ER Diversion Program.
    d. Accomplished by the weekly PACE management team meetings.
    e. Accomplished by the participation in the CalOptima QI, UM, and Credentialing and Peer Review Committee meetings.
    f. Accomplished by the participation in the CalOptima Board of Directors and the Board of Directors Quality Assurance Committee meetings.
    g. Accomplished by the completion of the PACE 2.0 quality initiative which focused on program growth and employee engagement. PACE 2.0 was a collaborative partner with other PACE entities in California under CalPACE. In 2020, we will monitor improvements and interventions.

SECTION 4: SUMMARY OF ACCOMPLISHMENTS, BARRIERS AND ACTIONS

2019 Quality Improvement Work Plan — Elements by Category:

Quality of Care and Services

QAPI19.01 PACE QAPI Plan and Work Plan will be evaluated annually

Received and filed by the CalOptima Board of Directors on February 7, 2019.

QAPI19.02 PACE QAPI Plan and Work Plan will be reviewed and updated annually

Approved by the CalOptima Board of Directors on February 7, 2019.

QAPI19.03 Increase Influenza immunization rates for all eligible PACE participants

Goal: Greater than or equal to 90% of eligible participants will have their annual influenza vaccination by December 31, 2019.

Goal: Met

Data/Analysis: 97% percent of participants received the influenza vaccination by the year end.

Summary and Key Findings/Opportunities for Improvement:

In order to meet our goal of vaccinating 90% or more of the participants by year end, we employed an effective strategy of a robust flu vaccine campaign for the 2019/2020 influenza season. By the

end of 2019, 97% of the participants had received the influenza vaccine. This was a slight decrease from the 98% who met this metric in 2018. We dedicated staff on multiple occasions to host a "Flu Booth" where participants received their flu vaccine from the PACE Clinic Nurse and received an acknowledgement button. PACE staff also received their vaccines through employee health services, expanding the scope and engagement of the flu vaccine campaign. We plan to implement this campaign again for the 2020/2021 flu season. As a highlight, CalOptima PACE reported no influenza outbreaks among our participants or staff in 2019. It is important to note that enrollees in the month of December were part of the statistical data and may not have had the vaccine due to their short involvement in the PACE program.

One of our challenges was in receiving the flu vaccine promptly from our vaccine vendor. Although we placed our order as soon as the vaccine was released, we did encounter a delay in one of our expected shipments, however we still met our goal.

QAPI19.04 Increase Pneumococcal immunization rates for all eligible PACE participants

Goal: Greater than or equal to 90% of eligible participants will have their pneumococcal vaccination by December 31, 2019.

Goal: Met

Data/Analysis: 95% of participants received the pneumococcal vaccination by the year end.

Summary and Key Findings/Opportunities for Improvement:

By the end of 2019, 95% of our participants had received the pneumococcal vaccine, exceeding our goal. This was an improvement from the 90% who met this metric in 2018. Much of our success is attributed to the implementation of the following protocols:

a. Standing orders and standardized procedures in vaccine administration. This eliminates the need to wait for a physician order by delegating this responsibility to a registered nurse who has demonstrated the required competency.

b. Utilizing the EMR's quality analytics for tracking of missed opportunities for immunization.

The PACE QI department provided detailed monthly reports which specified which participants still needed the vaccination. One of the main barriers in vaccinating our participant population was the difficulty in obtaining previous medical records with prior vaccination documentation for new participants. An additional challenge was the complex interval periodicity between the Pneumococcal 13 and Pneumococcal 23 vaccines.

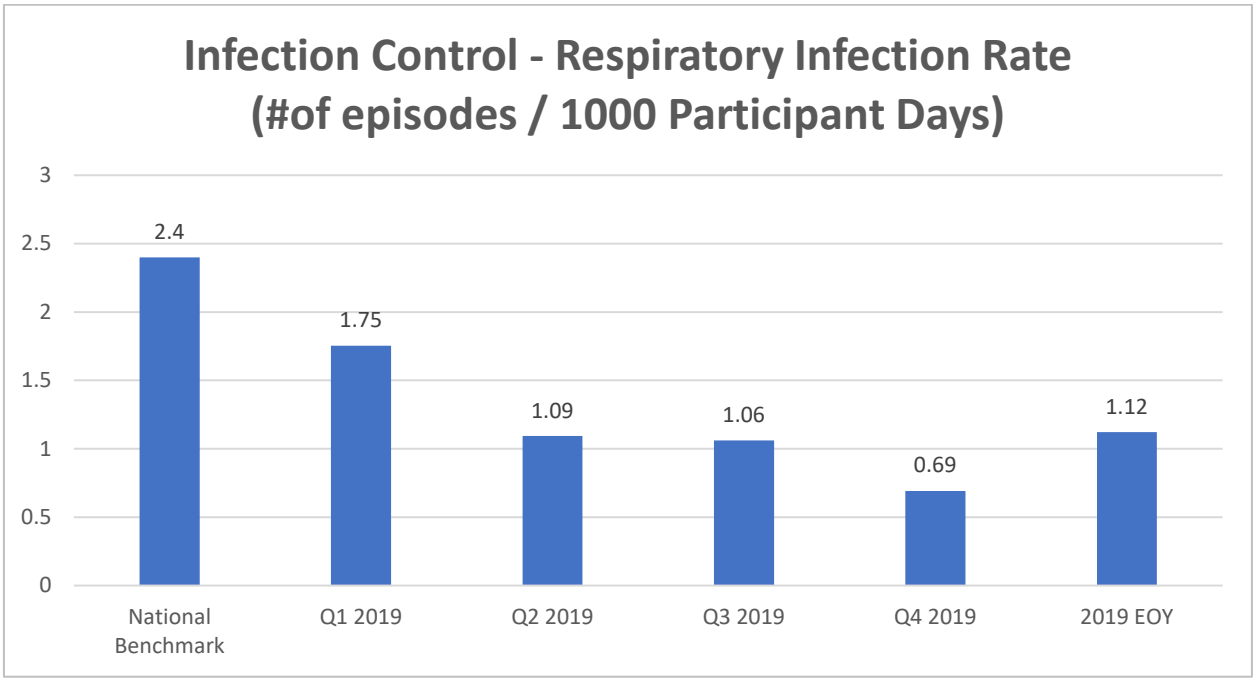
Looking forward into 2020, we plan to integrate the administration of the pneumococcal vaccines concurrently with the flu vaccine campaign for those participants who still require the vaccination. This will mitigate missed opportunities. It is important to note that enrollees in the month of December were part of the statistical data and may not have had the vaccine due to their short involvement in the PACE program.

QAPI19.05 Reduce common infectious in PACE participants (Respiratory Infection)

Goal: Maintain common respiratory infection rate less than the following national benchmarks: Respiratory Tract 0.1–2.4 episodes/1000 participant days.

Goal: Met

Data/Analysis: The 2019 rate is 1.12 episodes per 1000 participant days.



Summary and Key Findings/Opportunities for Improvement: Overall, rates were consistently below benchmarks.

As in previous years, we focused heavily on infection control in 2019. As an example, we began our influenza vaccination program as soon as the vaccine was released. This assured a high number of vaccinated individuals early in the flu season thereby reducing potential influenza outbreaks among our participants. In June 2019, our staff participated in a robust infection control training facilitated by the associate medical director of epidemiology at UCI Medical Center. Concepts such as universal precautions, droplet precautions and airborne precautions were discussed, highlighting the significant roles of health care workers in managing preventable infections. Additionally, CalOptima PACE's contracted after-hours on-call providers were instrumental in addressing participant's concerns regarding potential illnesses by responding to calls by using either a physician or a registered nurse. Often a medical provider would visit the patient in the home, providing immediate interventions and averting serious consequences.

In October 2019, we encountered our first case of infectious tuberculosis. Swift action was taken, and our infection control plan was enacted, initiating collaboration with the County of Orange Health Care Agency. The PACE QI team identified 256 PACE participants and 30 staff members as having potential exposure with the source contact. All participants were screened and tested for tuberculosis. Weekly TB status meetings were convened with the PACE Infection Control sub-committee, apprising all members of actions taken and pending actions. The activation of our exposure control plan was a smooth process, demonstrating an effective partnership between CalOptima PACE and the County of Orange Health Care Agency.

QAPI19.06 Increase Physician Orders for Life-Sustaining Treatment (POLST) utilization for PACE participants

Goal: Greater than or equal to 95% of participants who have been enrolled in the PACE program for 6 months will have a POLST completed.

Goal: Met

Data/Analysis: 100% of participants who have been enrolled in the PACE program for 6 months had PLOST by the end of 2019.

Quarter 2019	Completion Rate
Q1	100%
Q2	100%
Q3	100%
Q4	100%

Summary and Key Findings/Opportunities for Improvement: At the end of 2019, 100% of PACE participants had a completed POLST on file. This had been one of the program's key initiatives to ensure that we understood and delivered the end-of-life care which is consistent with the participants wishes. End-of-life and palliative care discussions have now been integrated into our Interdisciplinary Team meetings (IDT) and are documented in the participant's care plan.

QAPI19.07 Increase the number of PACE participants who have a designated emergency, family decision maker documented on the POLST

Goal: Greater than or equal to 90% of participants who a completed POLST will have the designated family member make decisions in emergency situations identified and documented on the POLST by December 31, 2019.

Goal: Not Met

Data/Analysis: 19% participants had POLST by the end of 2019. See table below:

Quarter 2019	Completion Rate
Q1	19%
Q2	20%
Q3	19%
Q4	19%

Summary and Key Findings/Opportunities for Improvement:

Designation of a family member as a decision maker has been a challenge for us. This may be a result of several factors. First, end-of-life discussions are difficult for many participants and their families, particularly in our diverse participant population where cultural traditions and practices influence such conversations. Second, we frequently experience a lack of family involvement in the care of many of our participants. To increase family involvement and identify the decision-maker, we will be moving in the direction of having participants, together with their family member, complete an Advance Health Care Directive at the time of enrollment. The Advance Health Care Directive will contain three components: (1) Designation of an Agent and (2) Instructions for Health Care (end-of-life decisions, relief from pain); and (3) organ donation. The

conversation concerning Advance Health Care Directive will begin early in the enrollment process, beginning with the initial nursing Level of Care assessment during the pre-enrollment process. This element will be retired next year and will be replaced by an Advanced Health Care Directive quality initiative.

QAPI19.08 Ensure all PACE participants have a functional status assessment completed every 6 months by the disciplines required by CMS

Goal: 100% of participants have functional status assessment completed every 6 months by the disciplines required by CMS.

Goal: Met

Data/Analysis:

Functional Status Assessment	Q1 2019	Q2 2019	Q3 2019	Q4 2019	EOY
Charts with All Assessments	319	324	354	391	1388
Census at End of Quarter	319	326	356	393	1394
Rate	100%	99.4%	99.4%	100%	100%

Care for Older Adults: Functional Status Assessment				
	2019 Star Rating Measure Cut Points			
MY 2019 PACE	2 Stars	3 Stars	4 Stars	5 Stars
100%	27% to 68%	68% to 77%	77% to 90%	≥ 90%

Summary and Key Findings/Opportunities for Improvement:

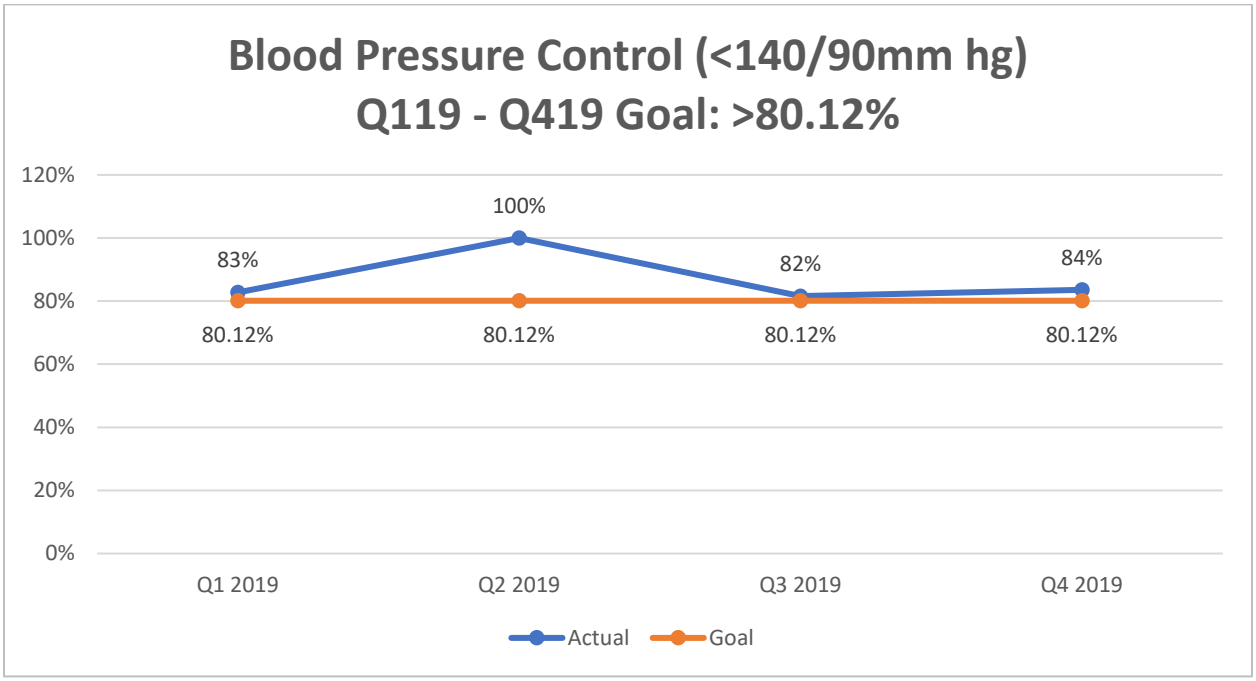
A key factor in achieving this has been the monthly reports generated by the QI department and sent to the PACE clinical team, specifying which participants required the functional assessment. This prompts the clinical team to schedule the appointment, communicate with the family/caregiver regarding the appointment and coordinating transportation for the participant. The result is comparable to a 5-Star Medicare rating based on the 2019 Star Rating Measure Cut Points.

QAPI19.09 Increase the percentage of PACE participants with diabetes who have controlled blood pressured (<140/90 mm hg)

Goal: > 80.12% of Diabetics will have a Blood Pressure of <140/90

Goal: Met

Data/Analysis: The 2019 final rate is 84%.



Diabetics with Controlled Blood Pressure				
	Medicare Quality Compass 2019 HEDIS Percentiles			
MY 2019 PACE	50th Percentile	75th Percentile	90th Percentile	95th Percentile
84%	69.53%	76.56%	81.50%	84.91%

Summary and Key Findings/Opportunities for Improvement:

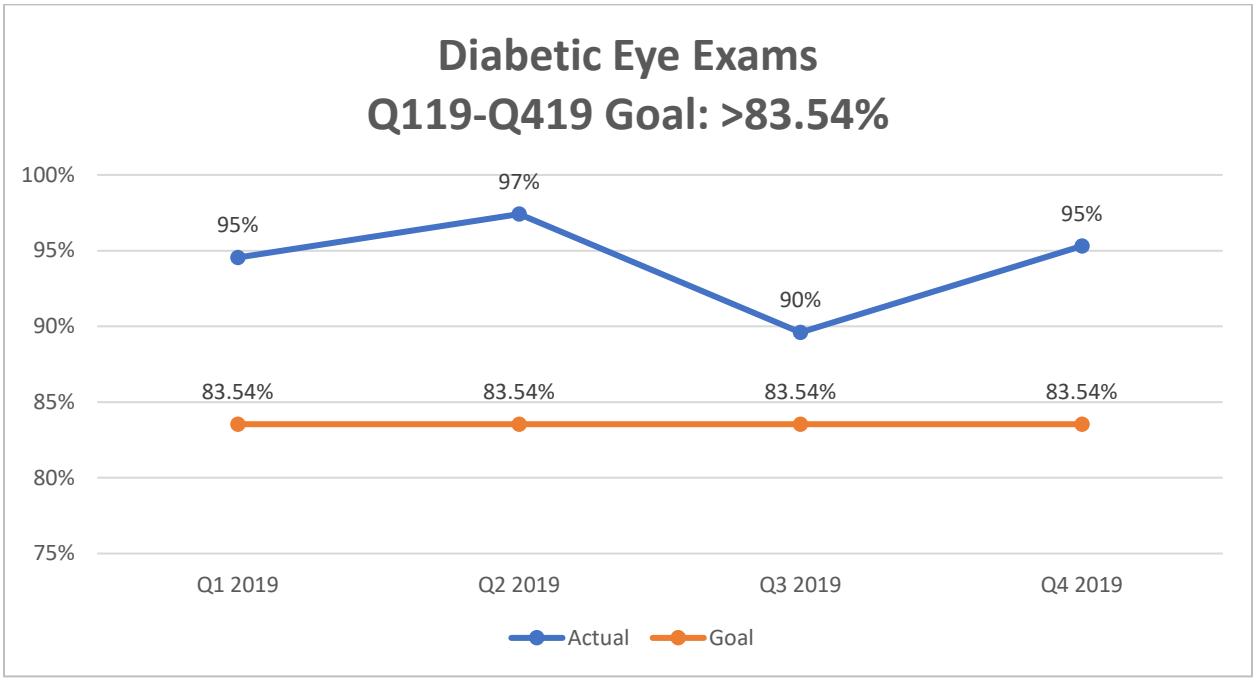
We exceeded our goals in this element due to the prompt identification of participants with poor control of their blood pressure, although a decrease from the 100% of participants who met this metric in 2018. The PACE QI department remits a monthly report to the PACE clinical team, specifying which participants have poorly controlled blood pressure. These identified participants are monitored with out-of-range numbers leading to direct intervention. Close supervision on the day center floor of those participants who may be symptomatic or have had a change-of-condition adds an extra layer of oversight with appropriate immediate intervention. Interventions include in-house pharmacist consults as well as adjustments by the medical provider. These results would have put us in the 90th percentile based on the 2019 Medicare HEDIS Quality Compass.

QAPI19.09 Increase the percentage of PACE participants with diabetes who have had their annual diabetic eye exam completed

Goal: Greater than or equal to 83.54% of Diabetics will have an Annual Eye Exam

Goal: Met

Data/Analysis: The 2019 final rate is 95%.



Comprehensive Diabetes Care: Annual Diabetic Eye Exam				
	Medicare Quality Compass 2019 HEDIS Percentiles			
MY 2019 PACE	50th Percentile	75th Percentile	90th Percentile	95th Percentile
95%	75.28%	82%	85.33%	87.10%

Diabetes Care: Eye Exam					
	2019 Star Cut Points				
MY 2019 PACE	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
95%	<56%	56% to 64%	64% to 73%	73% to 80%	>/= 80%

Summary and Key Findings/Opportunities for Improvement:

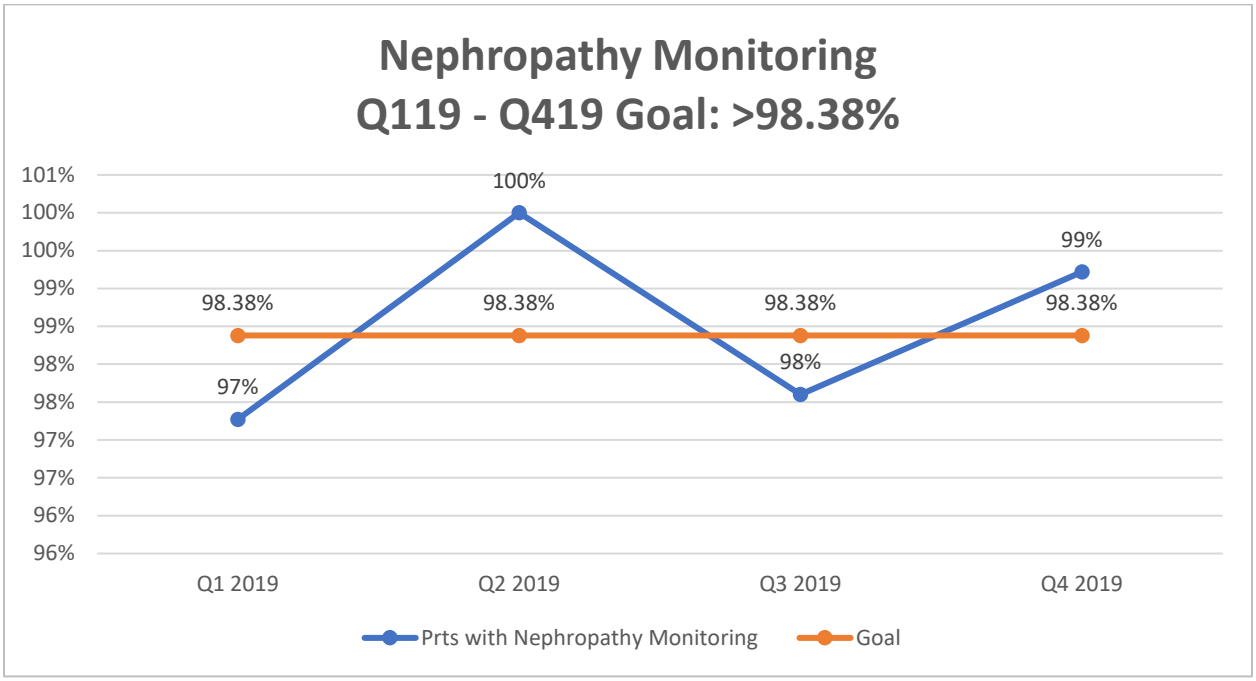
We exceeded our target goal with 95% of diabetic participants receiving an annual eye exam in 2019. This was an improvement from the 90% who met this metric in 2018. In late 2019, PACE purchased Optometry equipment and contracted with an optometrist to conduct on-site eye exams for our participants. The optometrist comes on-site at the PACE clinic twice per month and provides eye exams for approximately 15 participants on a monthly basis. This assures prompt access to eye exams as well as any immediate interventions. These results are comparable to a 5-Star Medicare rating based on the 2019 Star Cut Points and would have put us in the 95th percentile based on the 2019 Medicare HEDIS Quality Compass.

QAPI19.09 Increase the percentage of PACE participants with diabetes who receive nephropathy monitoring

Goal: Greater than 98.38% of Diabetics will have Nephropathy Monitoring

Goal: Met

Data/Analysis: The 2019 final rate is 99%.



Comprehensive Diabetes Care: Medical Attention for Nephropathy				
	Medicare Quality Compass 2019 HEDIS Percentiles			
MY 2019 PACE	50th Percentile	75th Percentile	90th Percentile	95th Percentile
99%	95.95%	97.08%	98.30%	98.78%

Comprehensive Diabetes Care: Nephropathy Monitoring				
	2019 Star Rating Measure Cut Points			
MY 2019 PACE	2 Stars	3 Stars	4 Stars	5 Stars
99%	NA	87% to 95%	95% to 97%	≥ 97%

Summary Key Findings/Opportunities for Improvement: In 2019, 99% of our participants had received nephropathy monitoring. This was an improvement from the 96% who met this metric in 2018. The PACE QI department provided the PACE clinical team with monthly reports specifying which participants required nephropathy screening/monitoring. Compliance to screening/monitoring includes meeting one of the criteria: (1) labs as indicated; (2) medications as indicated, and (3) a follow-up with a nephrologist. Looking ahead into 2020, we will have our clinical pharmacist review the diabetic regimen as it correlates to nephropathy screening. These results are comparable to a 5-Star Medicare rating based on the 2019 Star Cut Points and would have put us in the 95th percentile based on the 2019 Medicare HEDIS Quality Compass.

QAPI19.10 Decrease the rate of participant falls occurring at the PACE day centers

Goal: <10% (6.65 Falls per 1000 member months)

Goal: Met

Data/Analysis: The 2019 rate is 6.34 falls per 1000 member months.

Quarter 2019	# falls	Member Months	# falls per 1000 members months
Q1	10	932	10.73
Q2	4	976	4.10
Q3	5	1037	4.82
Q4	7	1155	6.06
EOY	26	4100	6.34

Summary Key Findings/Opportunities for Improvement:

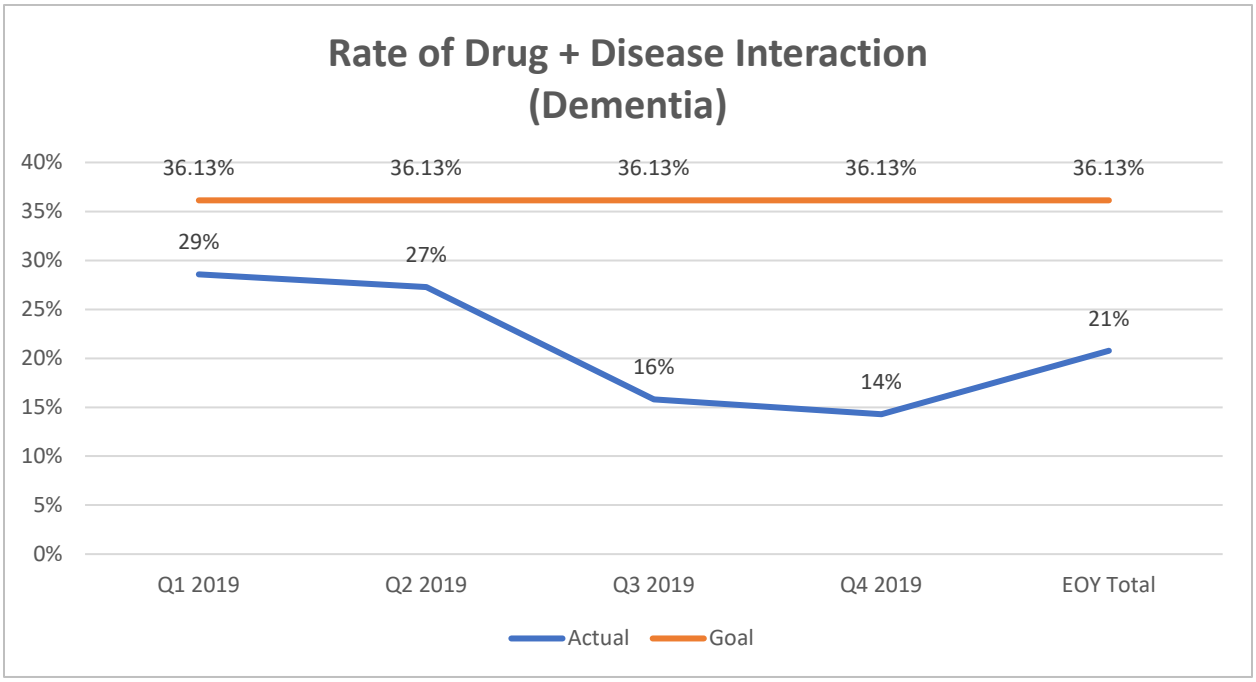
This was the first year of this measurement and the goal was met. Our success in the low fall rate in the day center is attributable to our preventive efforts. The day center floor is adequately staffed with personal care attendants who provide supervision and support. Aside from working on a 1:1 basis with our participants, the PACE rehabilitation team identifies those participants who are fall-risks and provides numerous fall prevention programs such as "Fallers Anonymous," a Fall Recovery Workshop and a Fall Prevention Committee. The day center is free of obstacles which may hinder safe ambulation and mobility of our participants. This is one of the measures we are using to ensure the quality of care delivered across the Alternative Care Setting (ACS) sites. There were no falls of any participants at any of the ACS sites.

QAPI19.11 Potentially Harmful Drug/Disease Interactions in the Elderly (DDE): Dementia + tricyclic antidepressant or anticholinergic agents

Goal: <36.13%

Goal: Met

Data/Analysis: The 2019 rate is 21% (23 out of 96 participants).



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DDE: Dementia + tricyclic antidepressant or anticholinergic agents				
	Medicare Quality Compass 2019 HEDIS Percentiles			
MY 2019 PACE	50th Percentile	75th Percentile	90th Percentile	95th Percentile
21%	44.44 %	40%	35.73%	33.96%

Summary and Key Findings/Opportunities for Improvement:

In 2019, we had 21% of participants with dementia who took a tricyclic antidepressant or anticholinergic agent which is a decrease from the 24% in 2018. We added a clinical medical director who receives monthly reports from our QI department of potential drug/disease interactions for a frail population. In collaborating with PACE staff medical providers, specific participants are identified and changes in medication regimen may be implemented, preventing adverse outcomes. Our on-site clinical pharmacist also reviews medication for appropriate use and dosing. These results would have put us in the 95th percentile based on the 2019 Medicare HEDIS Quality Compass.

QAPI19.12 Potentially Harmful Drug/Disease Interactions in the Elderly (DDE): Chronic Renal Failure + Nonaspirin NSAIDS or Cox2 Selective NSAIDs

Goal: <3.85%

Goal: Met

Data/Analysis: The 2019 rate is 0%.

DDE: CKD+ Nonaspirin NSAIDS or Cox2 Selective NSAIDs				
	Medicare Quality Compass 2019 HEDIS Percentiles			
MY 2019 PACE	50th Percentile	75th Percentile	90th Percentile	95th Percentile
0%	9.31%	6.36%	3.90%	2.47%

Summary and Key Findings/Opportunities for Improvement:

In 2019, we had no participants with Chronic Kidney Disease (CKD) who took a NSAID or Cox2 Selective NSAID. This is a decrease from the 1% of CKD participants who were on a NSAID or Cox2 Selective NSAID in 2018. The coordinated efforts of the PACE medical providers and the PACE clinical pharmacist will assure optimal scrutiny in the use of NSAIDs among our participants with chronic kidney disease. These results would have put us in the 95th percentile based on the 2019 Medicare HEDIS Quality Compass.

QAPI19.13 Monitor participants who are receiving prescription opioids for 15 days or more days at an average milligram morphine equivalent (MME) dose of 120mg

Goal: 100% of participants receiving opioids for 15 or more days at an average milligram morphine doses (MME) 120mg will be reevaluated monthly by their treating provider.

Goal: Not Met

Data/Analysis: The 2019 rate is 70% (7 out of 10 participants were reevaluated monthly)

Quarter 2019	# Participants with high dosage of opioids
Q1	0 out of 2 participants were reevaluated (0%)
Q2	1 out of 2 participants were reevaluated (50%)
Q3	4 out of 4 participants were reevaluated (100%)
Q4	2 out of 2 participants were reevaluated (100%)

Summary and Key Findings/Opportunities for Improvement:

This was the first year of this metric. It steadily improved over the course of the year as the quarterly rate increased from 0% to 50% to 100%. We had challenges with keeping these monthly appointments for some participants who were in skilled nursing facilities and or who were in hospitals for extended periods of time as we had not created any exemption criteria which we will look to add in 2020. Although the number of participants receiving high dosages of opioids is small, it nevertheless requires attentive management.

QAPI19.14 Increase the percentage of participants for whom medications were reconciled within 30 days of hospital discharge

Goal: ≥ 90% of participants will have their medications reconciled within 30 days of hospital discharge in 2019

Goal: Met

Data/Analysis: 95% percent of participants had medications reconciled within 30 days post discharge in 2019.

Medication Reconciliation Post-Discharge	Q1 2019	Q2 2019	Q3 2019	Q4 2019	EOY
Total # of Discharges	40	29	45	52	166
Received Reconciliation	39	28	43	49	157
Rate	98%	97%	91%	96%	95%
Goal	90%	90%	90%	90%	90%

Medication Reconciliation Post-Discharge				
	Medicare Quality Compass 2019 HEDIS Percentiles			
MY 2019 PACE	50th Percentile	75th Percentile	90th Percentile	95th Percentile
95%	59.40%	74.45%	84.91%	88.08%

Medication Reconciliation Post-Discharge					
	2019 Star Rating Measure Cut Points				
MY 2019 PACE	1 Star	2 Stars	3 Stars	4 Stars	5 Stars
95%	<37%	37% to 54%	54% to 66%	66% to 79%	≥ 79%

Summary and Key Findings/Opportunities for Improvement:

Medication reconciliation post hospital discharge remains one of our top priorities. In 2018, we contracted with House Calls Medical Associates which serves as our after-hours call center and provides our hospitalists and nursing home physicians. In 2019, the contract with House Calls Medical Associates extended to the provision of primary care providers within the PACE clinic. Through this partnership, our providers maintain a close relationship with our participants and can take care of our participants across all levels of care thereby improving continuity of care. This allows for prompt medication reconciliation. These results are comparable to a 5-Star Medicare rating based on the 2019 Star Cut Points and would have put us in the 95th percentile based on the 2019 Medicare HEDIS Quality Compass.

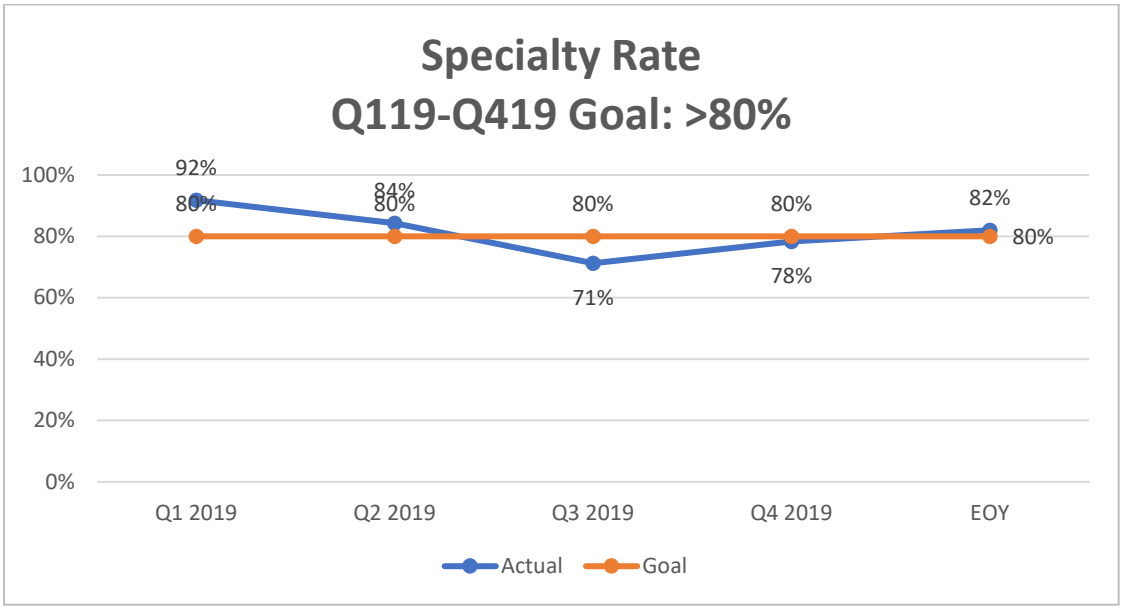
Access and Availability

QAPI19.15 Improve access to specialty practitioners

Goal: ≥ 80% of specialty care authorizations will be scheduled within 10 days

Goal: Met

Data/Analysis: The 2019 rate was 82%.



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Summary and Key Findings/Opportunities for Improvement:

Over the past years, we have concentrated efforts on scheduling specialty care authorized visits in a timely manner. As the PACE population grows, so do the number of specialty referrals. To improve our outcome in this measure, we recently implemented the following:

1. Addition of two scheduling staff members for a total of three scheduling assistants. Not only do they schedule appointments and coordinate transportation needs, they also remind participants, coordinate with participant's family, provide interpreters or escorts (if needed), send relevant medical records to the authorized specialist and follow-up on specialty consult notes.
2. Contracting additional specialists, thereby enlarging our specialty pool and permitting timely access.
3. Bringing specialist in-house (podiatry, dental, and optometry).

We currently work with two nephrologists, a podiatrist, a psychiatrist, an ophthalmologist and an optometrist who work closely with the program. In addition to their private practice, the podiatrist, dentist and optometrist offer care and services to our participants on-site at the PACE clinic. Looking forward into 2020, we are looking to identify additional core specialists who understand the PACE model of care and are willing to work closely with the program. This will improve scheduling access as well as care coordination through prompt consult notes and real-time dialogue between the specialist and the PACE medical provider.

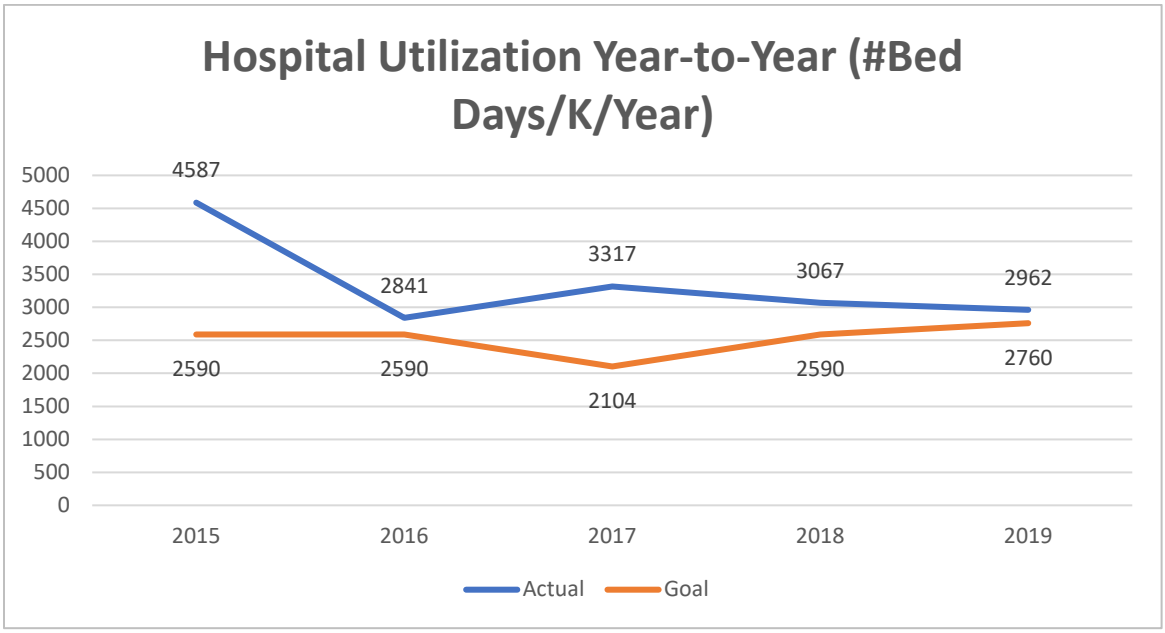
Utilization Management

QAPI19.16 Reduce the rate of acute hospital days by PACE participants

Goal: < 2,670 hospital days per 1000 per year

Goal: Not Met

Data/Analysis: The 2019 rate was 2,962 bed days per 1000 per year.



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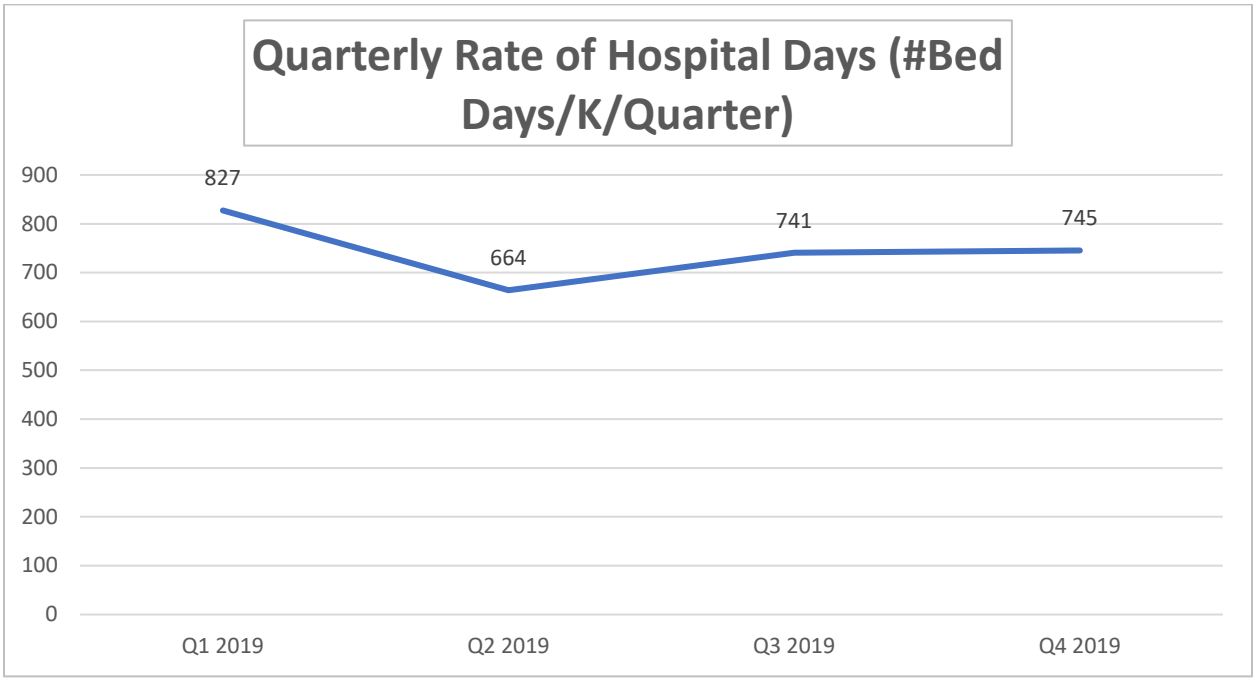
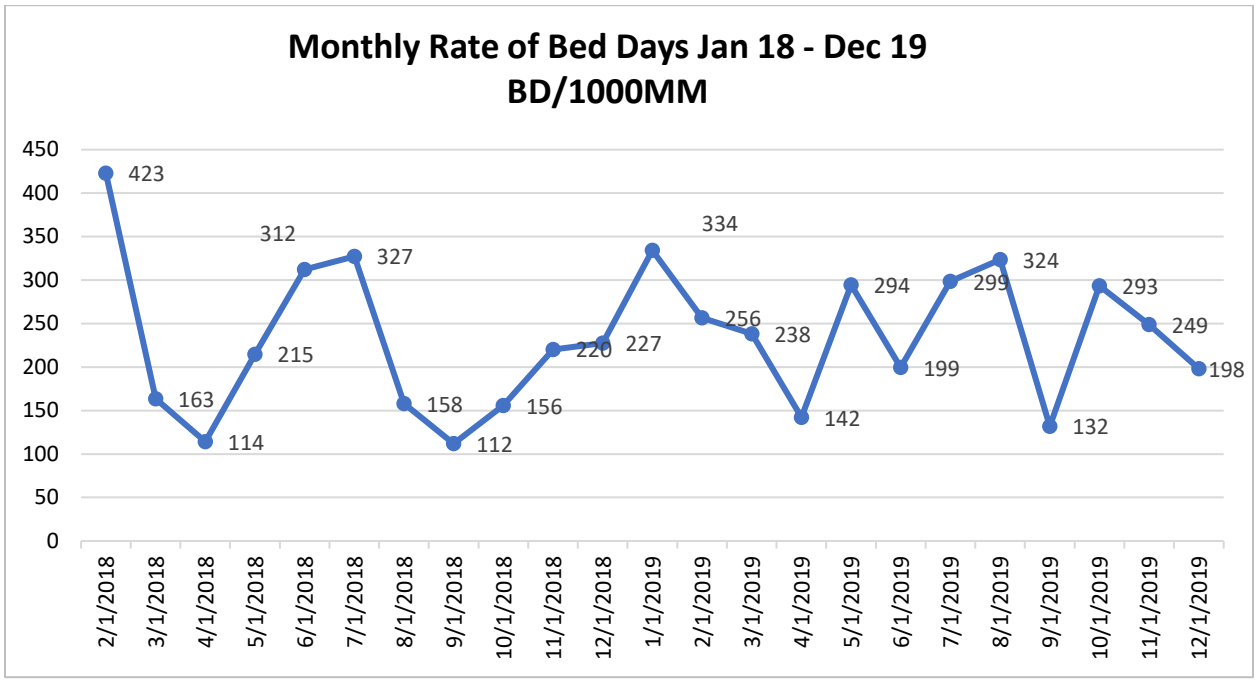




Summary/Key Findings/Opportunities for Improvement

Over the last 12 months, the monthly rate of bed days has had an overall slightly improving trend line, but inpatient hospital utilization remains a challenge. The 2018–2019 flu season was particularly severe resulting in a very high Q1 rate which increased the overall 2019 rate. Outside of the 2018–2019 flu season, we found that most of the visits came from a small subset of participants. One of the largest subsets were participants on dialysis. We have found two trends which we will be working on closely to change. First, there is a group of dialysis participants who were often sent directly to the ER from the dialysis center, many for minor issues. We have begun to work more closely with two specific nephrologists/dialysis centers to help improve coordination

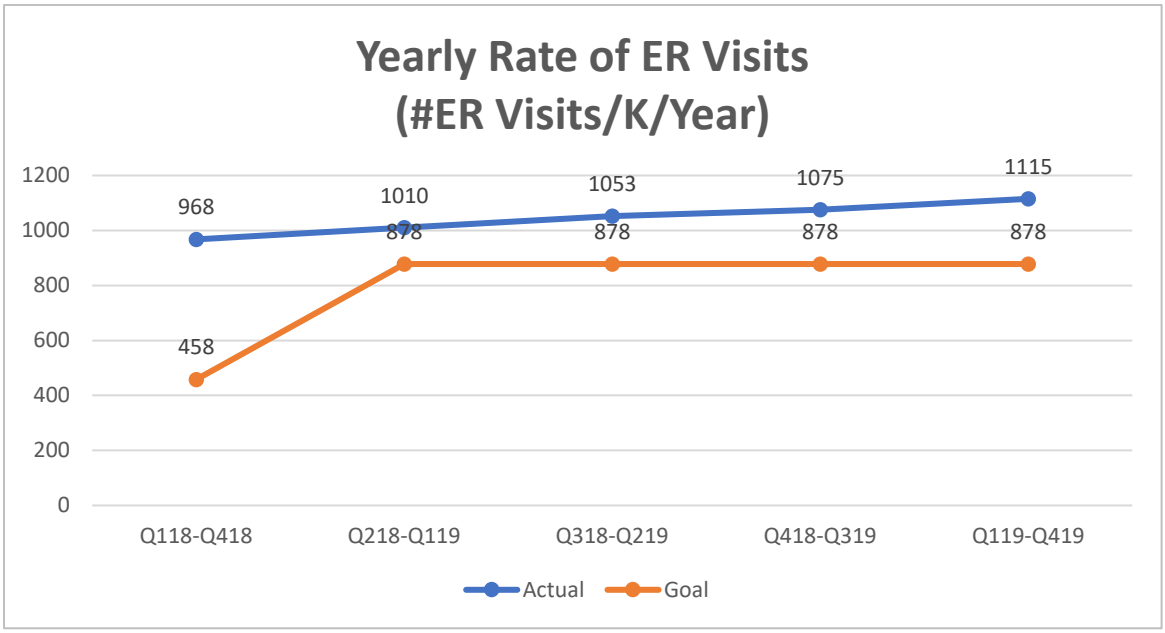
and remedy this situation. Second, another small group of the same dialysis participants occasionally miss their dialysis appointments which often lead directly to an admission. We are looking to add a new nurse case manager who will focus part of their time providing enhanced case management to these dialysis participants. In addition, in 2020, we will continue to refine our ER Diversion program. Not only will they provide direct participant after-hours home visits, but they will also take into consideration the admission of a participant into a skilled nursing facility or custodial care as opposed to an inpatient hospitalization.

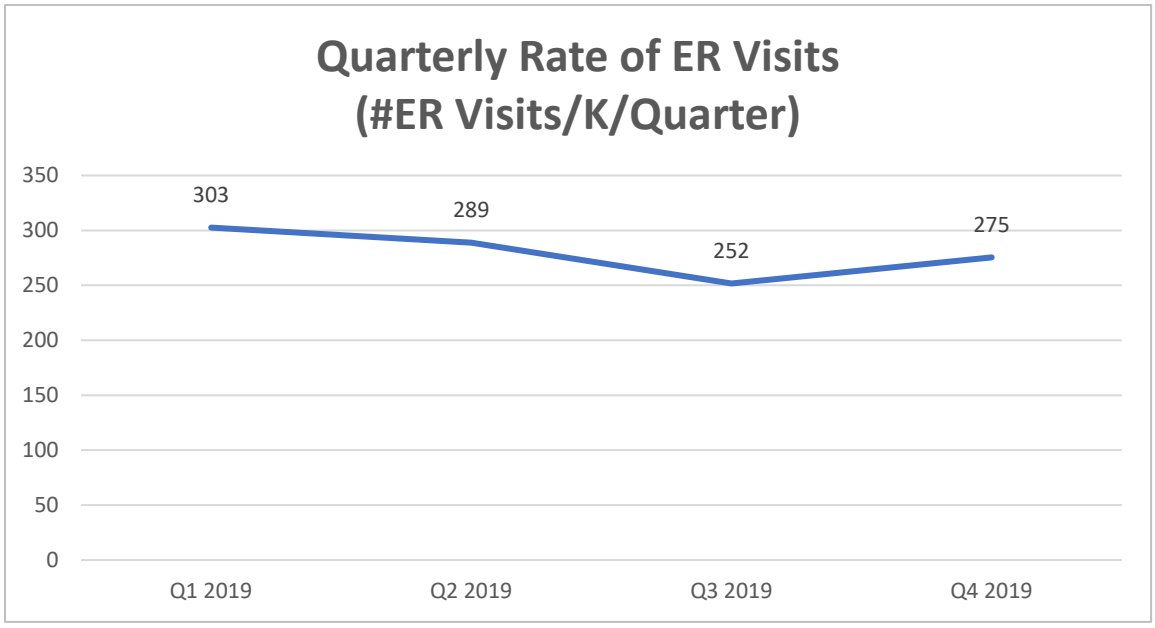
QAPI19.17 Reduce the rate of ER utilization by PACE participants

Goal: < 878 emergency room visits per 1000 per year

Goal: Not Met

Data/Analysis: The 2019 rate was 1,115 emergency room only visits per 1000 per year.





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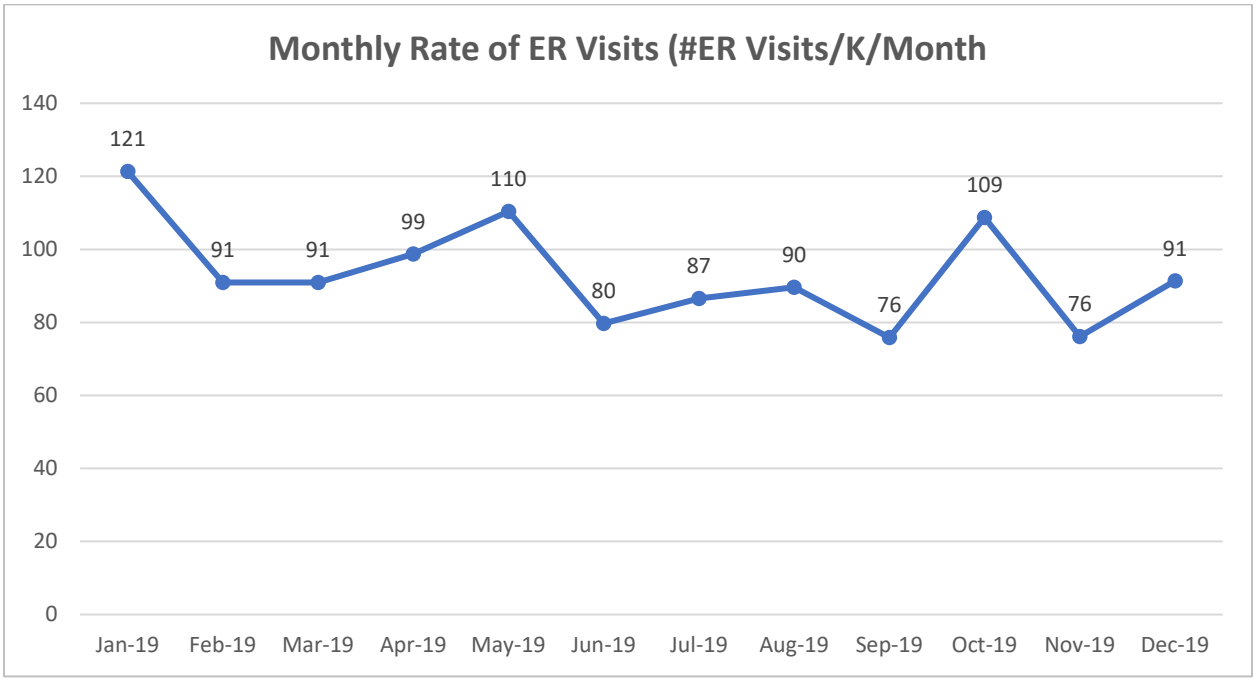


Summary and Key Findings/Opportunities for Improvement:

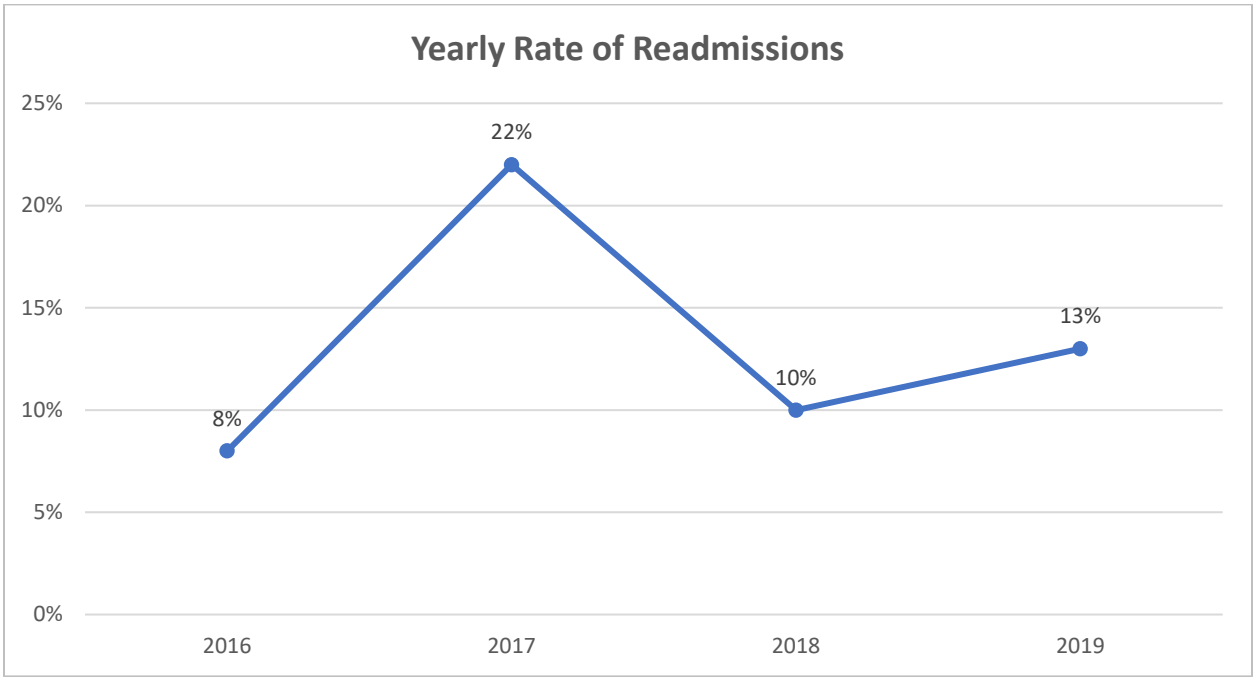
Similar to our inpatient bed days, the ER visits have been trending down over the course of 2019. However, the overall ER rate did slightly increase year over year due to the challenging 2018–2019 flu season. The ER diversion program continued to expand this year which correlates with the slightly decreasing rates. This is where the on-call physicians can employ triage strategies (i.e. send a RN to the participant home, divert to a nursing facility or do a home visit) and eliminate the need for an ER visit. As with the previous measure, our new RN case manager will focus on working with on our frequent ER utilizers. Additionally, this nurse will start to work closely with the vendors (Board and Care and Assisted Living Facilities) who are frequently sending our participants to the ER. Vendor education regarding our after-hours service will play an important role in over-utilization of emergency room visits. The strategy implemented regarding the missed dialysis appointments should also favorably impact the number of ER visits. Finally, in 2020, we will also focus on providing greater family engagement for our high-risk participants in hopes that they will offer greater support and guidance to the participant.

QAPI19.18 Reduce the 30-day all cause readmission rates by PACE participants

Goal: Less than 15% 30-day all cause readmissions

Goal: Met

Data/Analysis: The 2019 rate was 13%.



Summary and Key Findings/Opportunities for Improvement:

The readmission rates tend to have a great deal of variance year over year due to the small total number of participants and readmissions. We ended 2019 with a 13% 30-day readmission rate which is a slight increase over last year. Our major challenges in readmissions are the medical complexity of our participants, non-compliance on the part of the participant and lack of family support. In 2020, the new RN case manager will focus more specifically on these participants. Additionally, we have begun incorporating the morning clinical huddles into the IDT meetings this year. This concept was piloted in Q4 of 2019 with one IDT with great success and will be adopted program wide in 2020.

QAPI19.19 Decrease the percentage of participants who are placed in a long-term care facility

Goal: < 3% of participants will reside in long-term care (LTC)

Goal: Met

Data/Analysis: We had 5 participants who were in LTC in 2019, which was 1.27% of the PACE enrollment

Summary and Key Findings/Opportunities for Improvement:

This is one of our key elements, as the goal of PACE is to help nursing home eligible participants to live safety at home as long as possible. Although the number of participants residing in LTC facilities is approximately 1%, we recognize that as our program matures, we will see an increase in the percentage of participants who are placed in a LTC facility.

Enrollment

QAPI19.20 Reduce the percentage of participants who disenroll for controllable reasons from the PACE program within the first 90 days of enrollment.

Goal: Reduce the percentage of participants who disenroll for controllable reasons within the first 90 days of enrollment in 2019 by 10%

Goal: Met

Data/Analysis:

Disenrollment Data in the First 90 Days

	Total Disenrollment	Uncontrollable Disenrollment	Controllable Disenrollment	% Controllable Disenrollment
2018	8	1	7	88%
2019	14	5	9	64%

Summary and Key Findings/Opportunities for Improvement:

In 2019, nine participants disenrolled for controllable reasons with the dominant reason of wanting to keep their pre-enrollment PCP. This information was shared with the enrollment team throughout the year to ensure we are communicating effectively with participants prior to enrollment. Overall, this resulted in a 24% improvement in controllable disenrollment compared to 2018. In 2020, we will continue to monitor and share this information with staff to ensure continuous improvement.

QAPI19.21 Increase the Inquiry to enrollment conversion rate to 7%

Goal: Increase the Inquiry to enrollment conversion rate to 7% (Baseline of 5% in the last 6 months of 2018)

Goal: Not Met

Data/Analysis: Final rate was 5%.

Quarter 2019	Rate
Q1	5%
Q2	4%
Q3	6%
Q4	8%
EOY	5%

Summary and Key Findings/Opportunities for Improvement:

In 2020, we are changing the description of this quality indicator to “Qualified Leads to Enrollment.” Inquiry to Enrollment as in the 2019 quality indicator description, encompasses a broad spectrum of potential enrollees including those who actually had no interest in joining PACE after an inquiry and those who were too high-functioning and would not be eligible per State certification although they initiated an inquiry. By changing the description from inquiry to qualified lead, we have a more accurate assessment of enrollment rates.

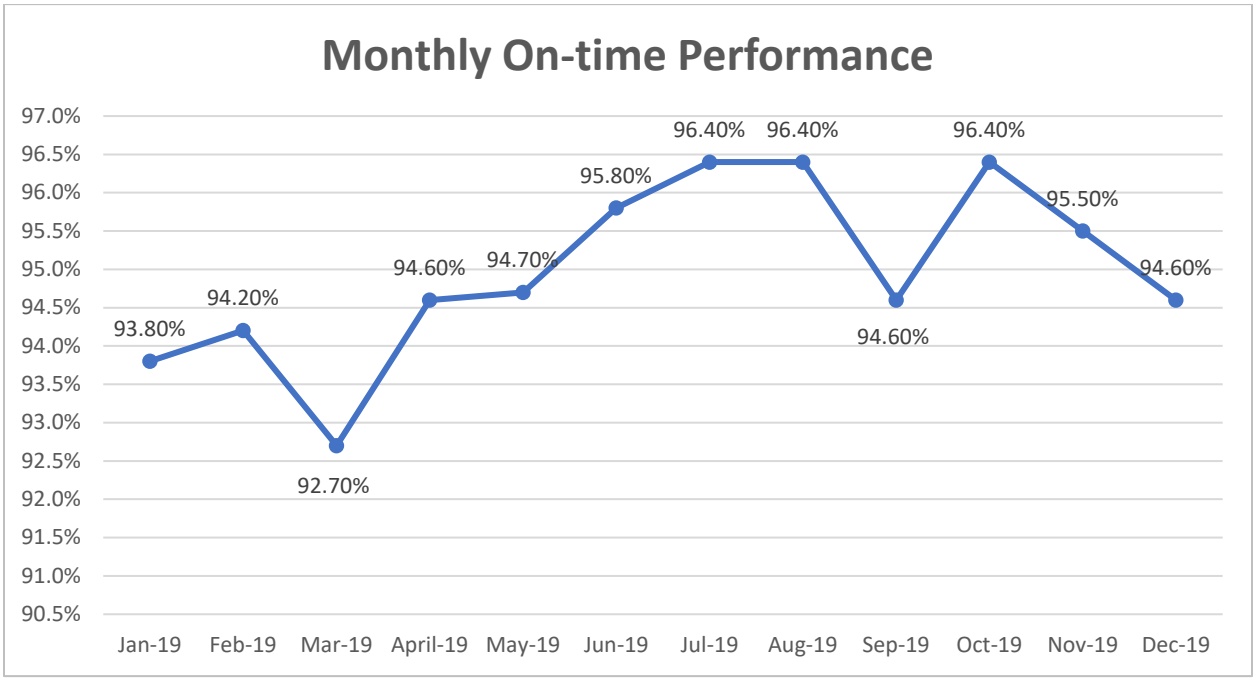
Transportation

QAPI19.22 and QAPI19.23: Transportation

Goal: Ensure PACE transportation ride times are less than 60 minutes per trip with a goal: 0 trips > 60 minutes in duration and improve participant experience by providing timely transportation services with a goal of ≥ 90% on-time performance.

Goal: Less than 60 minutes in ride duration: **Goal Met**
On-time performance: **Goal Met**

Data/Analysis:



Summary and Key Findings/Opportunities for Improvement:

Towards the end of 2019, our Transportation department provided approximately 60,000 one-way trips for our participants as a result of a substantial growth in enrollment. Nevertheless, we met our goal of providing timely transportation services with a greater than 94% on-time performance. With over 60,000 one-way trips, we only had four one-hour violations (Q4) which were in large part due to major street repairs. Looking ahead into 2020, we plan to streamline the transportation workflow to assure that we remain compliant with no one-hour violations. This involves restructuring our Transportation Department and designing workflow to assure efficiency and participant satisfaction.

Meals

QAPI19.24 Improve the overall satisfaction of participants with meals within the PACE program

Goal: ≥ 64% on Satisfaction with Meals summary score on the 2019 PACE Satisfaction Survey

Goal: Met

Data/Analysis: 75% overall weighted participant satisfaction summary score.

2019 Participant Survey Satisfaction with Meals Domains

Domain	2018	2019	2019 National Average
Do the lunches look good?	62%	75%	70.3%
Do the lunches taste good?	52%	72%	62.8%
Do you get a variety of foods here?	61%	85%	81.2%
Meal satisfaction composite score	55%	77%	71.3%
Overall, would you rate the lunches as excellent, very good and/or good.	74%	81%	79.4%

Summary and Key Findings/Opportunities for Improvement:

In 2018, 59% of the participants were satisfied with meals served at PACE. As a result, meal satisfaction was added as one of our 2019 quality indicators and meals became an area of focus. We worked with different vendors who would be able to provide a variety of meal options which would be consistent with our multi-cultural population. We formed a food committee whereby participants could express their food likes and dislikes. We added "food enhancements" such as guacamole and sour cream and added ethnic specialties such as porridge. Finally, we surveyed participants regularly throughout the year and responded quickly to the feedback. As a result of these efforts, our meal satisfaction domain increased by 18% and is nearly 6% above the national average.

Overall Satisfaction

QAPI19.25 Improve the overall satisfaction of participants and their families with the CalOptima PACE program

Goal: Greater than or equal to 88% on the Overall Satisfaction Weighted Average on the 2019 PACE Satisfaction Survey.

Goal: Met

Data/Analysis: 92% overall weighted participant satisfaction summary score.

Participant Survey Overall Satisfaction Domains

Domain	2018	2019	2019 National Average
Would you recommend the program to a close friend or relative?	93%	96%	93.2%
Overall satisfaction with the care received	97%	96%	94.7%

2019 Participant Survey Domains

Domain	2018	2019	2019 National Averages
Transportation	93%	96%	94.3%
Center Aids	92%	94%	91%
Home Care	91%	89%	86.8%
Medical Care	88%	93%	91.1%
Health Care Specialist	90%	98%	90.1%
Social Worker	97%	96%	94.9%
Meals	59%	77%	71.3%
Rehabilitation Therapy and Exercise	98%	98%	94.4%
Recreational Therapy	77%	91%	80.9%
Environment and Safety	92%	93%	88.2%
Weighted Summary Score	87%	92%	88.8%

Summary and Key Findings/Opportunities for Improvement:

In the fall of 2019, CalOptima PACE contracted with Vital Research to conduct the Participant Satisfaction Survey. Vital Research interviewed 116 participants to gauge the participant's satisfaction with CalOptima PACE services. This is a standardized survey taken by most of the PACE programs in the country.

The overall satisfaction score was 96%, and also 96% would recommend PACE to a close friend or relative.

Overall, 7 of the 10 satisfaction domains increased from 2018 along with the weighted summary score. All 10 participant satisfaction domains were above the national average.

SECTION 5: 2019 HEALTH PLAN MANAGEMENT SYSTEM (HMPS)

2019 HPMS Updates: In 2018, CMS implemented changes to the Level I event and Level II reporting structure. Level I and Level II events are now referred to as Unusual Quality Incidents and are reported to CMS on a quarterly basis via the Health Plan Management System (HPMS). The following elements are reported:

1. Grievances
2. Appeals
3. Unusual Quality Incidents
4. Medication Errors

5. Immunizations (evaluated in the Quality of Care section of this report)
6. Falls without Injury
7. ER Visits (evaluated in the Utilization Management section of this report)
8. Denials of Prospective Enrollees

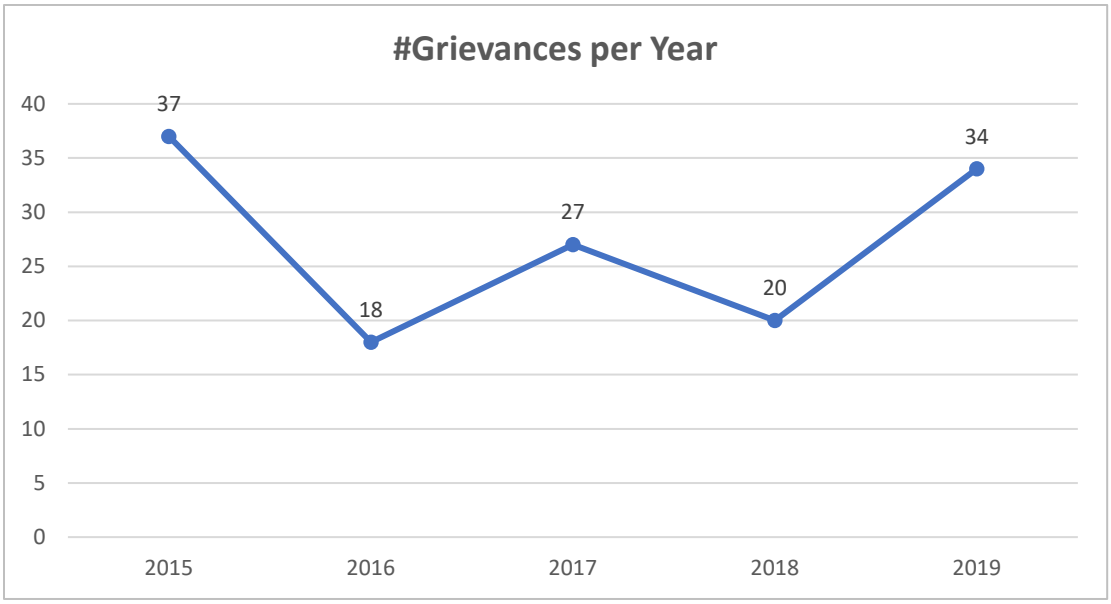
Grievances

Data Analysis:

Quarterly Grievances Q4 2014–Q4 2019

	CENTER							CLINIC			
					Transportation			Clinical Care/			
	# Grievance	Other	Food	Home Car	Timelines	Prt-Driver	Escort	Dissatisfaction	Timeliness	Comm-unication about care	Scheduling/ Communication
Q4 2014	2	0									
Q1 2015	0	0									
Q2 2015	7	0	1	1	1	0	0	1	1	1	1
Q3 2015	17	0	0	0	4	1	2	3	4	1	1
Q4 2015	13	0	0	0	1	1	1	8	1	0	1
Q1 2016	1	0	0	0	0	0	0	0	0	0	1
Q2 2016	7	0	0	0	4	0	0	2	0	0	1
Q3 2016	6	0	0	0	2	1	0	1	0	0	2
Q4 2016	4	0	0	0	0	2	0	0	2	0	0
Q1 2017	9	0	0	1	0	0	0	3	1	1	3
Q2 2017	2	0	0	0	2	0	0	0	0	0	0
Q3 2017	10	0	0	0	7	0	0	2	1	0	0
Q4 2017	6	1	0	0	2	1	0	1	0	0	1
Q1 2018	10	1	0	0	2	1	0	2	2	0	2
Q2 2018	4	0	1	0	0	0	0	2	0	1	0
Q3 2018	5	0	0	0	1	0	0	3	0	1	0
Q4 2018	1	1	0	0	0	0	0	0	0	0	0
Q1 2019	2	0	0	0	1	0	0	0	0	1	0
Q2 2019	9	0	0	0	8	0	0	0	0	1	0
Q3 2019	14	7	0	0	4	0	1	0	0	0	2
Q4 2019	9	0	0	2	4	0	0	1	0	1	1

Grievances Per Year 2015–2019



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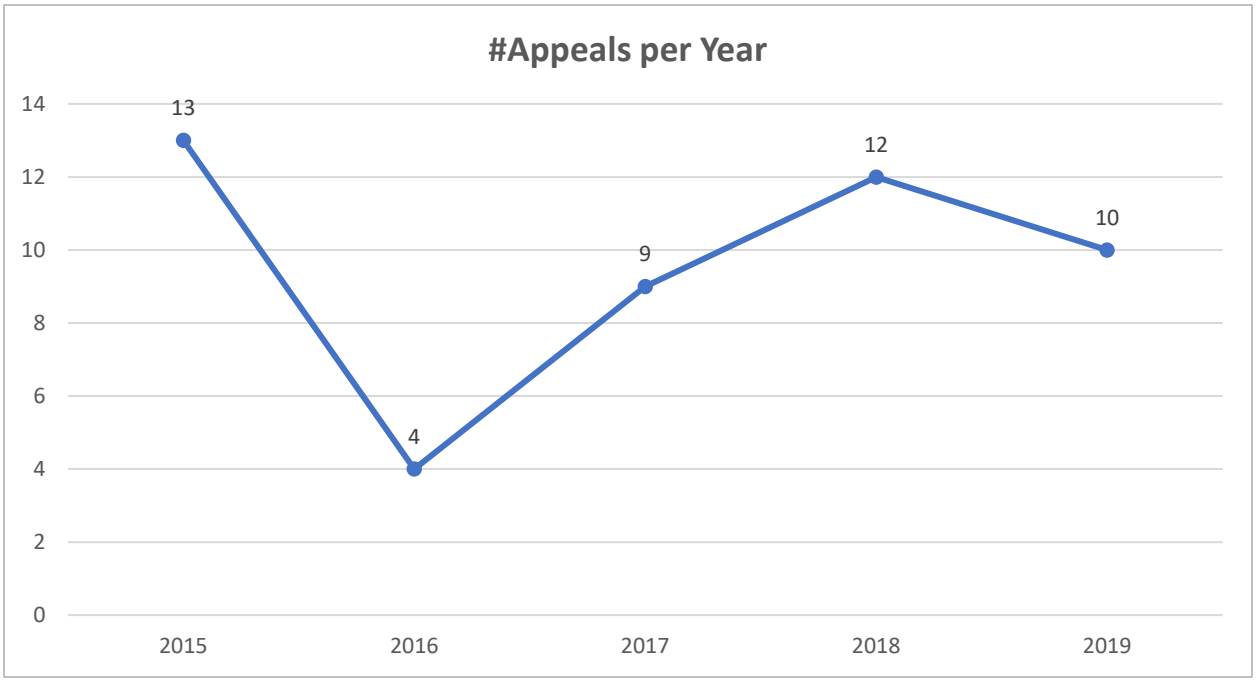
In proportion to our overall growth in enrollment, we did see an increase in the number of participant grievances. Although transportation related issues were the most the most common type of grievance, the overall transportation participant satisfaction score increased from 93% in 2018 to 96% in 2019 which is higher than the PACE national average of 94.3%. The transportation department averages approximately 6,000 one-way trips per month, transporting participants to and from PACE as well as specialty appointments including dialysis. In 2019, we received 34 grievances with the majority centered around issues with transportation services. In response, we initiated a corrective action plan which led to positive feedback from participants. Additionally, the transportation vendor has agreed to add additional on-site transportation staff supervision due to our increasing participant enrollment.

Appeals

Data Analysis:

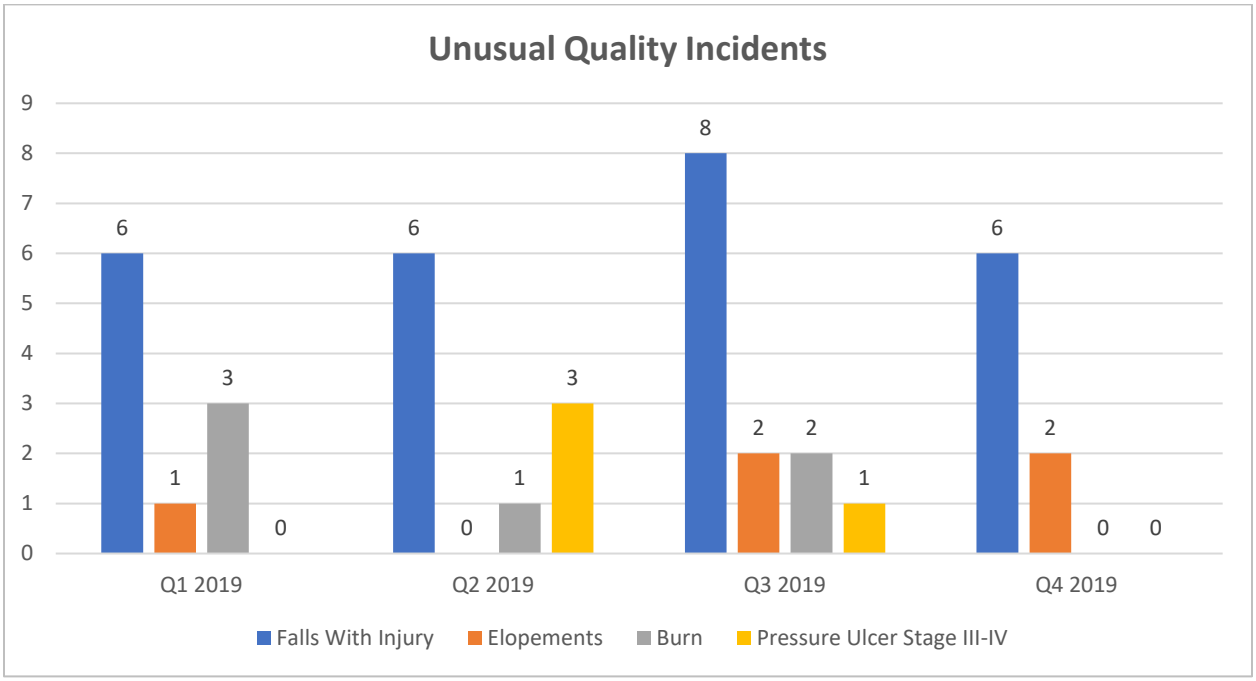
Appeals Per Year 2015–2019



Appeals by participants continue to be minimal in 2019. A total of 10 appeals were submitted in 2019, the majority concerning requests for either increased center day attendance or home care hours. Of the 10 appeals, 3 were overturned. No trends were identified in these 3 cases. PACE QI closely monitors appeals from a quality and compliance standpoint.

Level II Events/Unusual Quality Incidents

Data Analysis:



System Changes

Resulting From Unusual Quality Incidents Root Cause Analyses

Category	Issue	System Change
Participant Safety on PACE Day Center Floor	Participant sustained burn to hand while ambulating with a cup of coffee	1. Changed way that coffee is dispensed on Day Center floor 2. Purchased a new coffee machine which maintains appropriate temperature 3. Sought feedback from participants regarding new process Evaluation: No further burns have been cited. Participant Satisfaction increased.

Falls with injury are the most prevalent event followed by burns and elopements. The majority of falls occur in the home and are either a result of non-use of durable medical equipment or lack of family supervision. A root cause analysis is conducted after each unusual quality incident which involves discussion from the appropriate disciplines (i.e. rehabilitation, home care, etc.) and identifies any potential systemic or operational concerns. Remediation is initiated as appropriate. Although no significant trends were found in the Unusual Quality Incidences, a systemic change to the way coffee was dispended was made based on the findings of a root cause analysis as listed above.

Medication Errors

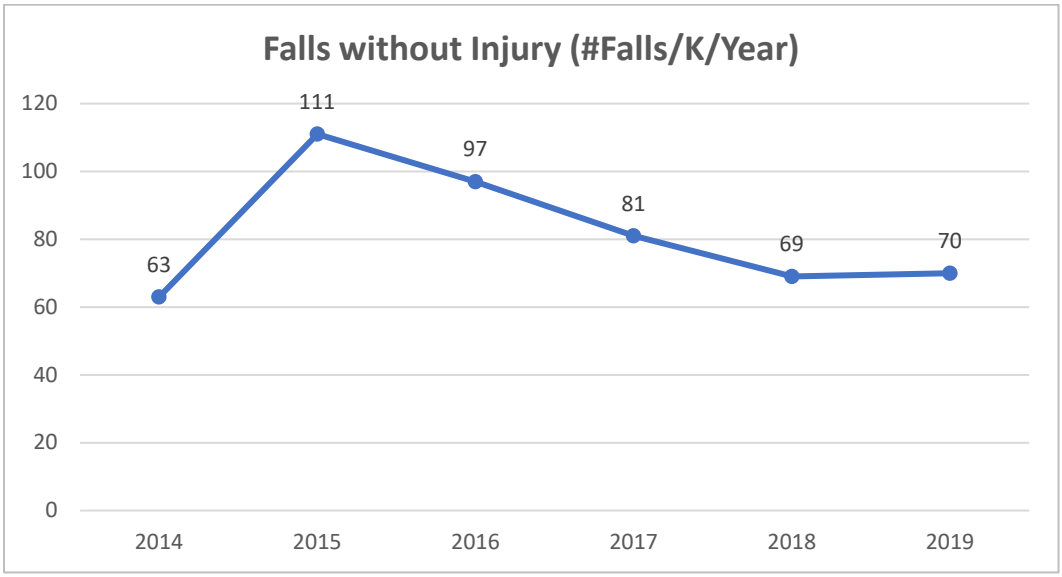
A total of 6 medication errors were reported in 2019 which reflects a 50% decrease from the previous year. Most errors were attributable to either staff errors or errors in transcription. In

response, internal corrective action plans were implemented which involved staff training and a performance improvement plan.

Falls Without Injury

Data Analysis**:**

Falls without Injury 2014–2019



We have continued to maintain the low rate of falls accomplished in 2018. Most falls are continuing to occur in the community, specifically in the participant's home environment. CalOptima PACE has spearheaded fall prevention groups among the high fall risk participants, with the goal to decrease in the numbers of falls in 2019 and continuing into 2020. Ongoing falls prevention groups include:

1. *PACE Fall Committee*: Comprised of PACE rehabilitation staff which reviews those participants who have incurred a fall.
2. *PACE Fall Prevention*: Comprised of PACE participants who are educated by the rehabilitation staff in fall recovery mechanisms.
3. *Fallers Anonymous*: Comprised of PACE participants who meet quarterly with the rehabilitation team to discuss safety in the home and environment.
4. *Matter of Balance*: Targets those participants with cognitive impairment. Discusses the many misconceptions surrounding falls.

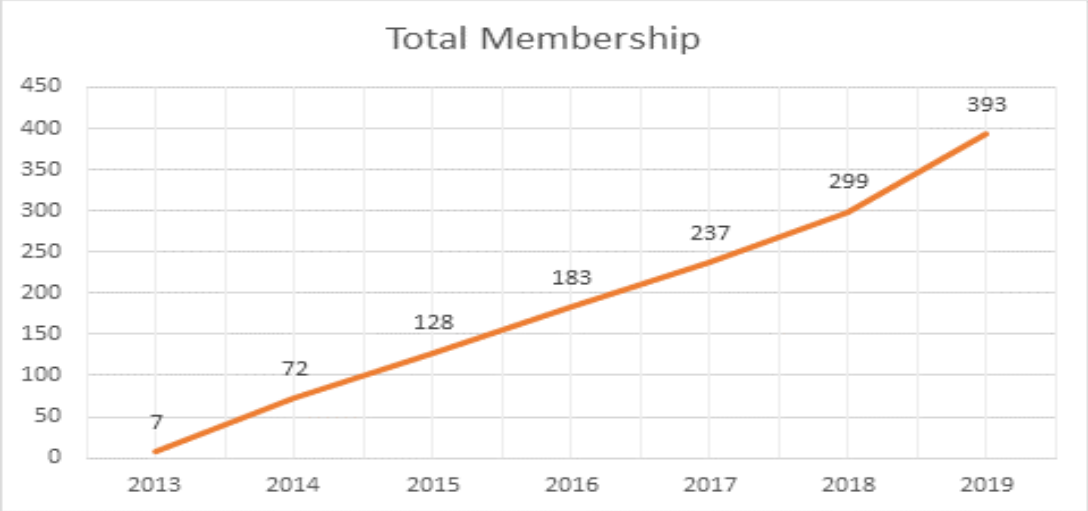
Denials of Prospective Enrollees

Three prospective enrollees were denied enrollment by the State.

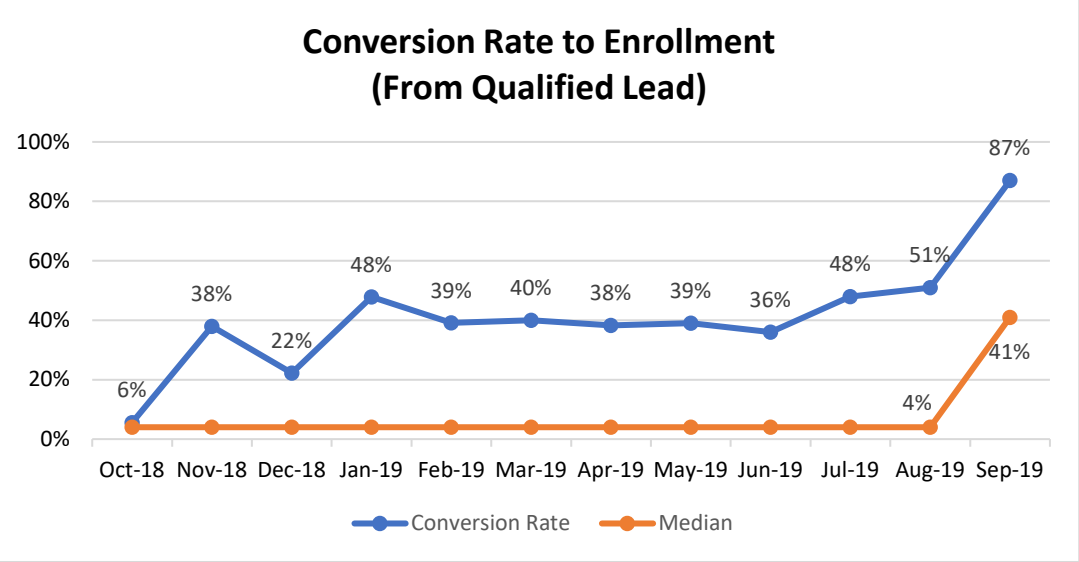
Quality Initiatives

In 2019, we focused on our Quality Initiatives to improve the participant experience and assure optimal clinical outcomes:

(1) PACE 2.0 Initiative: Focused on PACE program growth including outreach strategies, streamlining the enrollment process and capacity building. Since the initiation of this initiative in October 2018, we have seen as significant enrollment growth from 293 participants to 393 participants and more importantly an increase in the rate of growth. We have also seen a significant increase in the conversion rate to enrollment from a qualified lead. We have streamlined the enrollment process, reducing the time from a participant's inquiry into PACE services, and adding a RN to conduct the level of care assessments required for eligibility. We have aggressively hired new staff to accommodate the growth and have re-designed workspaces to accommodate the staff. As a result of the positive outcome of the PACE 2.0 Initiative, we will continue with this initiative into 2020, renaming it to PACE 2.1.



This graph illustrates the increase in the rate of membership in 2019.

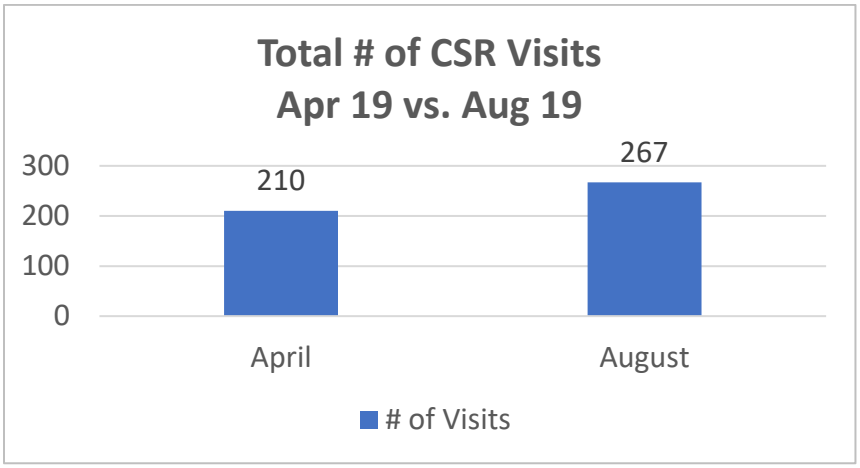


This graph illustrates the dramatic increase in the conversion rate from qualified inquiry to enrollment.

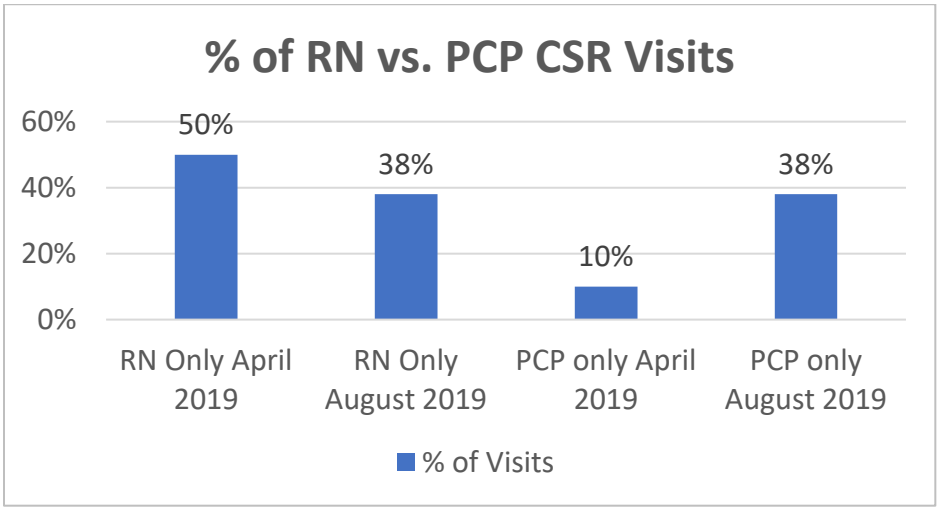
(2) Care Plan Initiative: Focused on consistent and accurate documentation of a participant's care plan which included elements such as identifying a participant's problem with noted specificity, assuring that the problem is addressed by the appropriate discipline, documenting interventions, assuring that interventions were measurable with an end-date, and coding the problem. At the end of 2019, internal PACE chart audits revealed that we achieved compliance

in the 95th percentile in 3 of the 5 elements. Proper notation of the measurable interventions with an end-date was in the 7th percentile upon internal PACE audit.

(3) Triage Workflow: Focused on revising the triage workflow within the PACE Clinic. This was to address and accommodate the large volume of participants seeking same-day appointment requests. After a thorough analysis of the triage workflow, we implemented a new system — Clinic Service Requests (CSR). Same-day appointment requests (CSR's), were categorized by conditions which were within the scope of the RN to address and those which required a PCP intervention. A new scheduling system was designed where same-day appointment requests were built into the PCP's schedule. This initiative has led to an increase in the timeliness of appointment requests, a reduction in the wait-time for participants to be seen, greater overall clinic efficiency and ultimately, an increase in participant satisfaction.



The growth in enrollment correlated to the number of same day walk-in requests (27% increase in walk-in requests). This necessitated a change in the workflow where appointment slots were built-in to the PCP's schedule. This allowed the PCP to see their paneled participants, improving not only continuity of care, but also participant satisfaction.



This graph illustrates the result of the implementation of the new workflow process (CSR). The new workflow, where same-day request appointments are integrated into the PCP schedule, show that many visits which had been previously delegated to the RN, are now being assigned to the

PCP. This allowed the PCP to see their paneled participants, improving not only continuity of care, but also participant satisfaction.

SECTION 5: OPPORTUNITIES FOR IMPROVEMENT IN 2020

1. Improve the Quality of Care (QOC) for Participants
    a. Implement enhanced care coordination program for participants with dialysis.
    b. Further develop the operational/utilization dashboard to reflect the oversight needed as PACE expands ACS partners.
    c. A new advanced health care directive quality improvement initiative will be started in 2020.
2. Ensure the Safety of Clinical Care
    a. Increase the percentage of specialty medications ordered by outside specialists which are reviewed in real time by the pharmacist.
    b. Participants receiving more than an average milligram morphine equivalent (MME) dose of 120mg will continued to be closely monitored.
    c. The QI team will focus on strengthening oversight activities of external providers and vendors specifically related to home care, skilled nursing facilities, board and care facilities and transportation.
    d. The grievances and potential quality issues involving downstream vendors will be track and trended to assure no service or clinical trend is emerges.
3. Ensure the Appropriate Use of Resources
    a. Inpatient/ER Utilization
        i. The morning clinical huddles will be incorporated into the IDT meetings for all teams.
        ii. Further expansion of our complex case management program with individualized interventions with a focus on high-risk dialysis participants.
        iii. Continue to refine the ER Diversion program.
    b. Specialty Care
        i. Increase the number of core PACE specialists who are willing to work closely with the PACE program, receive training in the PACE Model of Care and will attend some IDT meetings.
        ii. PACE will leverage CalOptima's Provider Relations department to ensure that the specialist network meets the needs of PACE.
    c. Pharmacy
        i. Retrospective quarter reviews of medication utilization will be analyzed and shared with IDT and the PACE PCPs.
        ii. Increase the percentage of specialty medications ordered by outside specialists which are reviewed in real time by the pharmacist.
4. Improve Participant Experience
    a. Participants will be updated on the satisfaction survey process.
    b. The PACE QI team will survey a sample of participants semi-annually and use the metrics as a lead indicator and help find opportunities for improvement.
    c. Grievances and potential quality issues will be monitored and analyzed to find opportunities for improvement.
    d. We will continue the monthly meal satisfaction surveys and make refinements to our meal program based on the feedback.
5. Ensure Appropriate Access and Availability

a. Full implementation of the PACE 2.1 initiative, promoting program growth and employee engagement.
b. Update the inquiry to enrollment conversion rate element to qualified lead to enrollment conversion rate.
c. Expanding the number of ACS sites will be considered in 2020
d. Trail expansion of the Garden Grove PACE Center clinic to weekday evenings and Saturdays.
e. Expanded us of the Community Based Physicians.
f. Expansion of PACE at Home program.
g. Continued development of our list of preferred specialists who are willing to work closely with PACE, be trained in the PACE model of care and attend occasional interdisciplinary care team meetings.

SUMMARY

CalOptima PACE developed and implemented systems using evidence-based guidelines that incorporate data and best practices tailored to the frail and elderly participants within our community. Our focus is to prevent institutionalization of these participants and enable them to live safely in our community with the support of PACE services. To accomplish our goals, we target many aspects of the health care continuum, such as preventive care, care management and disease management, closing any potential gaps in care. Through our ongoing data analysis, we are positioned to identify opportunities for improvement resulting in optimal clinical outcomes and participant satisfaction. Although individual measures may vary in their level of accomplishment, our overall effort has been a considerable success. As we continue to monitor our performance and refine our methods, we are confident that our QI efforts will continue to make a positive impact amongst our participants.

2019 CalOptima PACE Quality Improvement (QI) Work Plan

QI Item#	Goal	Description	Objective	Sub-Objective	Activity	Reporting Frequency	Target completion	Responsible Person	Q1 Results	Q1 Action	Q2 Results	Q2 Action	Q3 Results	Q3 Action	Q4 Results	Q4 Action	EOY Total	MET/NOT MET
QI19.01	Improve the Quality of Care for Participants	2018 PACE QI Plan and Work Plan Annual Evaluation	2018 PACE QI Plan will be evaluated by March 1st, 2019	N/A	PACE QI Plan and QI Work Plan will be evaluated for effectiveness on an annual basis	Annually	3/1/2019	PACE Medical Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Met
QI19.02	Improve the Quality of Care for Participants	2019 PACE QI Plan and Work Plan Annual Oversight	PACE QI Plan and Work Plan will be reviewed and updated by March 1st, 2019	N/A	PACE QI Plan and QI Work Plan will be approved and adopted on an annual basis	Annually	3/1/2019	PACE Medical Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Met
QI19.03	Improve the Quality of Care for Participants	Influenza Immunization Rates	>/= 90% of eligible participants will have their annual influenza vaccination by December 31st, 2019	N/A	Improve compliance with influenza immunization recommendations	Quarterly	12/31/2019	PACE Clinical Operations Manager	92%	Met	N/A	N/A	N/A	N/A	97%	Met	97%	Met
QI19.04	Improve the Quality of Care for Participants	Pneumococcal Immunization Rates	>/= 90% of eligible participants will have had their pneumococcal vaccination by December 31st, 2019	N/A	Improve compliance with pneumococcal immunization recommendations.	Quarterly	12/31/2019	PACE Clinical Operations Manager	95%	Met	94%	Met	99%	Met	95%	Met	95%	Met
QI19.05	Improve the Quality of Care for Participants	Infection Control	In 2019, maintain respiratory infection rates of less than the national benchmarks of 0.1-2.4 respiratory infections/1000 participant days	N/A	Monitor and analyze the incidence of respiratory infections in the elderly at PACE and compare against national benchmark to find opportunities for quality improvement.	Quarterly	12/31/2019	PACE Clinical Operations Manager	1.75	Met	1.09	Met	1.06	Met	0.69	Met	1.12	Met
QI19.06	Improve the Quality of Care for Participants	Care for Older Adults (COA): Advance Directive Planning	>/=95% of participants who have been enrolled in the PACE program for 6 months will have a POLST completed by December 31st, 2019	N/A	Ensure all PACE members are offered POLST upon enrollment and every six months until they have one completed in order to improve POLST utilization.	Quarterly	12/31/2019	PACE Center Manager	98%	Met	99%	Met	96%	Met	100%	Met	100%	Met
QI9.07	Improve the Quality of Care for Participants	Care for Older Adults (COA): Advance Directive Planning	>/=90% of participants who a completed POLST will have the designated family member who will make decisions in emergency situations identified and documented on the POLST by December 31st, 2019	N/A	Increase the number of PACE participants who have a designated emergency, family decision maker documented on the POLST.	Quarterly	12/31/2019	PACE Center Manager	18%	Not Met	19%	Not Met	20%	Not Met	19%	Not Met	19%	Not Met
QI19.08	Improve the Quality of Care for Participants	Care for Older Adults (COA): Functional Status Assessment	Ensure that 100% of PACE participants have a functional status assessment completed every 6 months by the disciplines required by CMS	N/A	Ensure all PACE participants have a functional status assessment completed by the required disciplines every 6 months.	Quarterly	12/31/2019	PACE Center Manager	100%	Met	99%	Not Met	99%	Not Met	100%	Met	100%	Met
QI19.09	Improve the Quality of Care for Participants	Comprehensive Diabetes Care (CDC)	100% of CDC Sub Objectives will be met in 2019	>80.12% of Diabetics will have a Blood Pressure of <140/90 (MEDICARE Quality Compass - 2017 HEDIS 90th percentile)	PACE participants with diabetes will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams to develop strategies for improvement.	Quarterly	12/31/2019	PACE Clinical Medical Director	83%	Met	100%	Met	82%	Met	84%	Met	84%	Met
				> 83.54% of Diabetics will have an Annual Eye Exam (MEDICARE Quality Compass - 2017 HEDIS 90th percentile)		Quarterly	12/31/2019		95%	Met	97%	Met	90%	Met	95%	Met	95%	Met
				>98.38% of Diabetics will have Nephropathy Monitoring (MEDICARE Quality Compass - 2017 HEDIS 90th percentile)		Quarterly	12/31/2019		97%	Not Met	100%	Met	98%	Not Met	99%	Met	99%	Met
QI19.10	Ensure the Safety of Clinical Care	Reduce the Rate of Day Center Falls	Decrease the rate of participate falls occurring at the PACE day centers (ACS and Garden Grove PACE) by 10% (<6.65 Falls per 1000 member months) in 2019	N/A	Falls occurring at the PACE or ACS centers will be monitored by the PACE QI department who will work with the interdisciplinary teams, clinical teams and day center staff to develop strategies for improvement.	Quarterly	12/31/2019	PACE Center Manager	1%	Met	0.41%	Met	0%	Met	0.61%	Met	0.63%	Met
QI19.11	Improve the Quality of Care for Participants	Reduce Potentially Harmful Drug/Disease Interactions in the Elderly (DDE): Dementia + tricyclic antidepressant or anticholinergic agents	<36.13% (MEDICARE Quality Compass - 2017 HEDIS 90th percentile)	N/A	PACE participants with a diagnosis of Dementia will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams as well as the PACE pharmacist to develop strategies for improvement.	Quarterly	12/31/2019	PACE Clinical Medical Director	29%	Met	27%	Met	16%	Met	14%	Met	21%	Met
QI19.12	Improve the Quality of Care for Participants	Reduce Potentially Harmful Drug/Disease Interactions in the Elderly (DDE): Chronic Renal Failure + Nonaspirin NSAIDS or Cox2 Selective NSAIDs	<3.85% (MEDICARE Quality Compass - 2017 HEDIS 90th percentile)	N/A	PACE participants with a diagnosis of Chronic Renal Failure will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams as well as the PACE pharmacist to develop strategies for improvement.	Quarterly	12/31/2019	PACE Clinical Medical Director	0%	Met	0%	Met	0%	Met	0%	Met	0%	Met

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QI Item#	Goal	Description	Objective	Sub-Objective	Activity	Reporting Frequency	Target completion	Responsible Person	Q1 Results	Q1 Action	Q2 Results	Q2 Action	Q3 Results	Q3 Action	Q4 Results	Q4 Action	EOY Total	MET/NOT MET
QI19.13	**Ensure the Safety of Clinical Care**	**Decrease the Use of Opioids at High Dosage (UOD)**	100% of members receiving opioids for 15 or more days at an average milligram morphine dose (MME) 120mg will be reevaluated monthly by their treating provider in 2019	N/A	The PACE QI Department will monitor any participant who is receiving prescription opioids for >/= 15 days at an average milligram morphine dose (MME) >120mg	Quarterly	12/31/2019	PACE Clinical Medical Director	0 out of 2 seen monthly (0%)	Not Met	1 out of 2 prts seen monthly (50%)	Not Met	4 out of 4 prts were seen monthly (100%)	Met	2 out of 2 prts were seen monthly (100%)	Met	7 out of 10 prts were seen monthly (70%)	Not Met
QI19.14	**Improve the Quality of Care for Participants**	**Medication Reconciliation Post Discharge (MRP)**	>/=90% of participants will have their medications reconciled within 30 days of hospital discharge in 2019	N/A	The PACE QI Department will work with the PACE Interdisciplinary Team, Pharmacist and Providers to develop strategies for improvement	Quarterly	12/31/2019	PACE Pharmacist	98%	Met	97%	Met	91%	Met	96%	Met	95%	Met
QI19.15	**Ensure Appropriate Access and Availability**	**Improve Access to Specialty Care**	>/= 80% of specialty care authorizations will be scheduled within 10 days in 2019	N/A	Appointments for specialty care will be scheduled within 10 days to improve access to specialty care for initial consultations	Quarterly	12/31/2019	PACE Clinical Operations Manager	92%	Met	84%	Met	71%	Not Met	78%	Not Met	82%	Met
QI19.16	**Ensure Appropriate Use of Resources**	**Reduce Acute Hospital Day Utilization**	< 2,760 hospital days per 1000 per year (10% decrease from 2018)	N/A	PACE participants hospital days will be monitored and analyzed by the PACE QI department who will work with the PACE interdisciplinary and clinical teams to develop strategies to lower that rate through preventative care and education	Quarterly	12/31/2019	PACE Medical Director	2962	Not Met	2828	Not Met	2875	Not Met	2974	Not Met	2974	Not Met
QI19.17	**Ensure Appropriate Use of Resources**	**Reduce Emergency Room Utilization**	< 878 emergency room visits per 1000 per year (10% decrease from 2018)	N/A	ER utilization by PACE participants will be monitored and analyzed by the PACE QI department who will work with the PACE interdisciplinary and clinical teams to develop strategies to lower that rate through preventative care and education	Quarterly	12/31/2019	PACE Medical Director	1017	Not Met	1053	Not Met	1075	Not Met	1115	Not Met	1115	Not Met
QI19.18	**Ensure Appropriate Use of Resources**	**30-Day All Cause Readmission Rates**	<15% 30-day all cause readmission (July 2018 CalPACE average)	N/A	30-day all cause readmission rates for hospitalized PACE participants will be monitored and analyzed by the PACE QI department who will work with PACE interdisciplinary and clinical teams to find opportunities for quality improvement	Quarterly	12/31/2019	PACE Medical Director	20%	Not Met	14%	Met	13%	Met	9%	Met	13%	Met
QI19.19	**Ensure Appropriate Use of Resources**	**Long Term Care Placement**	<3% of members (July 2018 CalPACE average) will reside in long term care	N/A	PACE participants placed in long term care will be monitored and analyzed by the PACE QI department who will work with the PACE interdisciplinary and clinical teams to develop strategies to lower that rate through preventative care and education	Quarterly	12/31/2019	PACE Center Manager	0.3%	Met	0.3%	Met	0.6%	Met	0.5%	Met	0.5%	Met
QI19.20	**Improve Participant Experience**	**Enrollment/Disenrollment**	Reduce the percentage of participants who disenroll for controllable reasons from the PACE program within the first 90 days of enrollment in 2019 by 10% (<27 disenrollments/K/Y)	N/A	Review and analyze the participants who disenrolled from PACE within 90 days of enrollment, excluding deaths and withdrawals, to develop strategies for improvement	Quarterly	12/31/2019	PACE Marketing and Enrollment Manager	2 out of 2 disenrollment are controllable	N/A	7 out of 11 disenrollment are controllable	N/A	0	N/A	0 out of 1 disenrollment is controllable	N/A	9 out of 14 disenrollment are controllable	Met
QI19.21	**Improve Participant Experience**	**Enrollment/Disenrollment**	Increase the Inquiry to enrollment conversion rate to 7% in 2019 (Baseline of 5% in the last 6 months of 2018)	N/A	Review and analyze the inquiry to enrollment conversion rate and develop strategies for improvement.	Quarterly	12/31/2019	PACE Marketing and Enrollment Manager	5%	Not Met	4%	Not Met	6%	Not Met	8%	Met	5%	Not Met

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QI Item#	Goal	Description	Objective	Sub-Objective	Activity	Reporting Frequency	Target completion	Responsible Person	Q1 Results	Q1 Action	Q2 Results	Q2 Action	Q3 Results	Q3 Action	Q4 Results	Q4 Action	EOY Total	MET/NOT MET
QI19.22	**Improve Participant Experience**	**Transportation**	I00% of transportation trips will be less than 60 minutes in 2019	N/A	Ensure all PACE participants are on the vehicle for less than 60 minutes per trip. Monitor and analyze one-hour violations, define areas for improvement and implement interventions to maintain compliance with regulation	Quarterly	12/31/2019	PACE Center Manager	100%	Met	100%	Met	100%	Met	99.97%	Not Met	100%	Met
QI19.23	**Improve Participant Experience**	**Transportation**	>/= 90% of all transportation rides will be on-time in 2019	N/A	Review and analyze transportation records to track transportation rides with a scheduled and actual trip time of +/- 15 minutes. Validate reports by sampling GPS records and monthly ride-along	Quarterly	12/31/2019	PACE Center Manager	93.57%	Met	95.03%	Met	95.80%	Met	95.50%	Met	94.98%	Met
QI19.24	**Improve Participant Experience**	**Increase Participant Satisfaction with Meals**	>/= 64% on Satisfaction with Meals summary score (2018 CalPACE average) on the 2019 PACE Satisfaction Survey	N/A	Define areas for improvement and implement interventions to improve the participant and their families satisfaction with the meals within the PACE program.	Quarterly	12/31/2019	PACE Center Manager	68%	Not Met	89%	Met	N/A	N/A	N/A	N/A	77%	Met
QI19.25	**Improve Participant Experience**	**Increase Overall Participant Satisfaction**	>/=88% on the Overall Satisfaction Weighted Average (2018 CalPACE Average) on the 2019 PACE Satisfaction Survey	N/A	Review and analyze the annual satisfaction survey results, define areas for improvement and implement interventions to improve the participant and their families satisfaction with the PACE program	Annually	12/31/2019	PACE Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	92%	Met

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 5, 2020
Regular Meeting of the CalOptima Board of Directors

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

Contact
David Ramirez, M.D., Chief Medical Officer, (714) 246-8400

Recommended Action
Recommend approval of the 2020 CalOptima PACE Quality Improvement (QI) 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, 2019, CalOptima PACE had 393 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.

PACE organizations are required to have a written Quality Improvement (QI) Plan that is reviewed and approved annually by the PACE governing body and, if necessary, revised. The QI Plan reflects the full range of services furnished by CalOptima PACE. The goal of the QI 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.

Discussion

The 2020 CalOptima PACE QI Plan is based on CalOptima's first six 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 2019 CalOptima PACE QI Plan Evaluation. In 2020, we will continue most of the new elements added in 2019 including those focused on reducing falls, increasing participant satisfaction with meals, and monitoring participants on high dosages of opioids. However, the "inquiry to enrollment conversion" element was modified to "qualified lead to enrollment conversion" to get a more accurate assessment of enrollment conversion rates. Additionally, a new advanced health care directive QI initiative will be added in place of the removed advanced care planning element which focused on identifying a family member who can

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make decisions in emergency situations. Finally, the diabetes element was unbundled into three separate elements. The target goals are based on national benchmarks, CalPACE data, or internal CalOptima PACE metrics.

Fiscal Impact

The recommended action to approve the 2020 CalOptima PACE QI Plan does not have a fiscal impact beyond what was incorporated in the Board-approved Fiscal Year (FY) 2019-20 Operating Budget. Staff will include updated expenditures for the period of July 1, 2020, through December 31, 2020, in the FY 2020-21 Operating Budget.

Rationale for Recommendation

PACE organizations are required to establish a Quality Improvement (QI) program. Through 42 CFR §460.132(b), the Centers for Medicare & Medicaid Services (CMS) requires PACE Organizations to have their QI 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 QI plan and any revisions to their governing body for annual approval to assure effective organizational oversight. CMS and the State will review the plan during subsequent monitoring visits.

Concurrence

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

Attachments

1. Proposed 2020 CalOptima PACE Quality Improvement (QI) Plan Description
2. PowerPoint Presentation – 2020 PACE QI Plan Description
3. Appendix A - Proposed 2020 CalOptima PACE QI Work Plan

/s/ Michael Schrader *02/26/2020*
Authorized Signature **Date**

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CALOPTIMA PACE
QUALITY IMPROVEMENT PLAN DESCRIPTION

2020

Quality Improvement Subcommittee Chairperson:

David Ramirez, M.D. **Date**
Chief Medical Officer

Board of Directors' Quality Assurance Committee Chairperson:

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

Board of Directors Chairperson:

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

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INTRODUCTION

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

Overview

- The goal of the CalOptima PACE QI 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 QI 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 and approve the QI Plan annually and direct the PACE Medical Director to revise the QI Plan, as necessary and appropriate. The PACE QI Plan is comprised of both the PACE QI Program Description and specific goals and objectives described in the PACE QI Work Plan. (See Appendix B).
- The PACE Medical Director has oversight and responsibility for implementation of the PACE QI Plan. The PACE QI Manager will ensure timely collection and completeness of data.
- The CalOptima PACE QI Committee (PQIC) will complete an annual evaluation of the approved QI Plan. This evaluation and analysis will help to find opportunities for quality improvement and will drive appropriate additions or revisions in the QI Plan to the goals and objectives for the following year.

Goals

- **Improve the quality of health care for participants.**
    - Ensure all QI activities fit into a well-integrated system that oversees quality of care and coordination of all services.
    - Ensure the QI program involves all providers of care within the PACE program.
    - Implement population health management (PHM) techniques, such as immunizations, for specific participant populations.
    - Identify and address areas for improvement that arise from unusual incidents, and sentinel events.
    - Monitor, analyze and report the aggregated data elements required by the Centers for Medicare & Medicaid Services (CMS) via the Health Plan Management System (HPMS) in order to identify areas needing quality improvement.
    - Meet or exceeds minimum levels of performance on standardized quality measures as established by CMS and the state administering agencies (SAA) which includes achieving an immunization rate for both influenza and pneumococcal vaccinations of 90% for the appropriate participant population.
    - Communicate relevant QI activities and outcomes to the PACE staff and contractors, the PACE Member Advisory Committee (PMAC), and the Board of Directors.
    - Share results of QI identified benchmarks with staff and contracted providers at least annually.
    - 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 agencies in the State of California (e.g. California Board of Nursing, etc.).
    - Ensure that all levels of care are consistent with professionally recognized standards of practice.
    - Assure compliance with regulatory requirements of all responsible agencies.

- **Improve the participant 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 (e.g., menu selection and PMAC).
    - Evaluate customer service, access, and timeliness of care provided by contracted licensed providers.
    - Ensure participant's end of life wishes are discussed and documented in the Physician's Order for Life Sustaining Treatment (POLST) which honors members' wishes as well as advance directive rights.
- **Ensure the appropriate use of resources.**
    - Review and analyze utilization data regularly, including hospital admissions, hospital readmissions, Emergency Room (ER) visits, and hospital 30-day all-cause readmissions, to identify high-risk members and opportunities for improvement.
    - Review documentation and coordination of care for participants receiving care in institutional settings and perform site visits on an ongoing basis.
    - Ensure high levels of coordination and communication between specialists and primary care providers (PCPs).
    - Ensure high levels of coordination and communication between inpatient facilities, nursing facilities and PACE PCPs.
    - Review and analyze clinic medical records to ensure appropriate documentation and coding.
- **Ensure the safety of clinical care**
    - Reduce potential risks to safety and health of PACE participants through ongoing risk management.
    - Ensure that every member of the PACE staff organization has responsibility for risk assessment and management.
    - 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.
    - Meet or exceed community standards for credentialing of licensed providers.
    - Monitor staff and contractors to ensure that appropriate standards of care are met.
- **Ensure appropriate access and availability.**
    - Monitor and analyze the PACE provider network continuously to ensure appropriate levels of access.
    - Continue to develop the network of Alternate Care Setting (ACS) sites to ensure the program can provide services to all Orange County residents who qualify and are interested in joining the PACE program.

Organizational and Committee Structure

CalOptima Board of Directors provides oversight and direction to CalOptima PACE. The Board has the final authority to ensure that adequate resources are committed and that a culture is created that allows the QI Plan efforts to flourish. The Board, while maintaining ultimate authority, has delegated the duty of immediate oversight of the QI programs at CalOptima — including the CalOptima PACE QI Program — to the Board's Quality Assurance Committee (QAC), which performs the functions of CalOptima's 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 QAC is a subcommittee of the Board and consists of currently active Board members. The QAC reviews the quality and utilization data that are discussed during the PQIC reports. The QAC provides progress reports, reviews the annual PACE QI Plan and makes recommendations to the full Board regarding these items, which are ultimately approved by the Board.

PACE Quality Improvement Committee

Purpose
This committee provides oversight for the overall administrative and clinical operations of PACE and will meet, at a minimum, once a quarter. The PQIC will review all QI 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 that have been identified as critical to participants, families or staff. Potential areas for improvement will be identified through analysis of the data and through root cause analysis. This meeting will be chaired by the PACE Medical Director who will report its activities up to QIC, QAC, and the Board. The PACE Clinical Medical Director, PACE Program Director or PACE QI Manager may facilitate the meeting in the PACE Medical Director's absence. The PACE Clinical Medical Director, PACE Program Director or the PACE QI Manager may report up to QAC if the PACE Medical Director is not available.

Membership
Membership shall be comprised of the PACE Medical Director, PACE Program Director, PACE Clinical Medical Director, PACE Center Manager, PACE Clinical Operations Manager, PACE QI Manager, PACE Program Manager, PACE QI Coordinator, and PACE 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.

PACE Focused Review Committees

Purpose
These committees will be formed to respond to or to proactively address specific quality issues that 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.

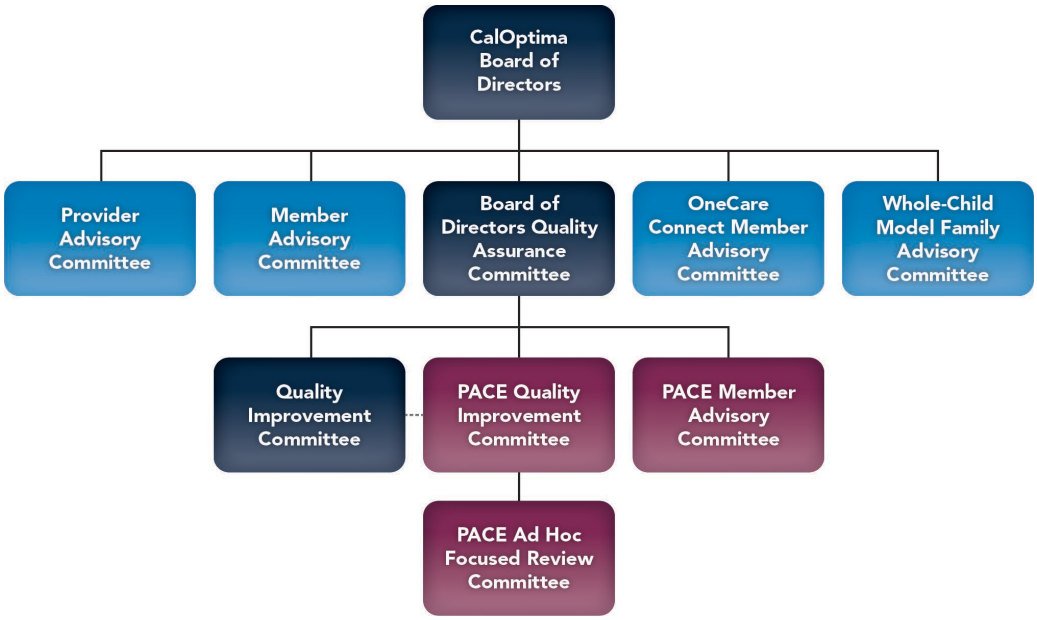
Membership
Membership will be flexible based on those with knowledge of the specific issues being addressed, but will consist of at least four members to include at least two of the following positions and/or functions: PACE Medical Director, PACE Clinical Medical Director, PACE QI Manager, PACE Program Director, PACE Center Manager, PACE Clinical Operations Manager, PACE Program Manager, PACE QI Coordinator, PACE Intake/Enrollment Manager or direct care staff. The Committee will be chaired by the PACE Medical Director, PACE Clinical Medical Director, PACE Director, PACE Manager or PACE QI Manager. 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.

PACE Member Advisory Committee

Purpose
PMAC 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 QAC, which then will be reported to the Board. The PACE Program Director or the PACE Center Manager shall report its activities to the PQIC.

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. The PACE Center Manager or PACE QI Manager may facilitate the meeting in the PACE Director's absence.

2020 Committee Organization Structure — Diagram



QUALITY AND PERFORMANCE IMPROVEMENT ACTIVITIES, OUTCOMES AND REPORTING

Quality Indicators and Opportunities for Improvement
Routine quality indicators appropriate to the PACE population are identified for analysis and trending. These indicators are related to the care and services provided at PACE. The indicators and opportunities for performance improvement are identified through:

Utilization of Services
- 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 overutilization and underutilization for areas of quality improvement.

Participant and Caregiver Satisfaction

- PACE shall survey the participants and their caregivers on at least an annual basis. Additionally, PACE will 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 PMAC shall provide direct feedback on satisfaction to both the PACE leadership staff and QAC.
- Grievance data is reviewed and analyzed quarterly for trends and opportunities for improvement.

Clinically Relevant HPMS Data

- Unusual Incidents
- Medication Errors
- Falls without Injury
- Clinical measures from the QI Work Plan elements which include:
    - Influenza and Pneumococcal Immunizations Rates (mandated by CMS)
    - Infection Control: Respiratory Infection Rates
    - Advanced Care Planning: POLST Completion
    - Functional Status Assessment Completion
    - Day Center Fall Rates
    - Opioids at High Dosage Monitoring
    - Medication Reconciliation Post Discharge
    - Diabetes Care: Annual Eye Exams
        - The following inclusion and exclusion criteria will be in place for this measure:
            - Inclusion criteria:
                - Enrolled for at least six months during measurement year
            - Exclusion criteria:
                - Participants who are end of life (less than six months)
                - Participants who are 76 years and older as of December 31, 2020
    - Diabetes Care: Nephropathy Monitoring and Blood Pressure Control
        - The following inclusion and exclusion criteria will be in place for this measure:
            - Inclusion criteria:
                - Enrolled for at least six months during 2020
            - Exclusion criteria:
                - Participants who are end of life (less than six months)
                - Participants who are 76 years and older as of December 31, 2020
                - Participants with End Stage Renal Disease
    - Potentially Harmful Drug-Disease Interactions in the Elderly: Dementia plus a tricyclic antidepressant or anticholinergic agent
        - The following inclusion and exclusion criteria will be in place for this measure:
            - Inclusion criteria:
                - Continuous enrollment throughout year
                - Participants who are 66 years and older as of December 31, 2020

- Exclusion criteria:
    - Participants who are end of life (less than six months)
    - Participants with Schizophrenia or Bipolar Disorder
- Potentially Harmful Drug-Disease Interactions in the Elderly: Chronic Kidney Disease plus Nonaspirin NSAIDS or Cox2 Selective NSAIDs
    - The following inclusion and exclusion criteria will be in place for this measure:
        - Inclusion criteria:
            - Continuous enrollment throughout year
            - Participants who are 66 years and older as of December 31, 2020
        - Exclusion criteria:
            - Participants who are end of life (less than six months)

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 (IDT) 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.
- Annual competency evaluations of PACE staff.
- PACE staff will monitor providers by methods such as review of providers' QI activities, medical record review, grievance investigations, observation of care and interviews.
- Unannounced visits to inpatient provider sites will be made by PACE staff as necessary.
- Oversight of contracted Alternative Care Sites (ACS), assuring compliance to PACE regulations (including, but not limited to participant rights, infection control, emergency preparedness, staff competencies) as well as CalOptima guidelines (e.g. HIPAA, FWA, licensing, etc.).

Non-Clinical Areas

- The PACE PQIC has oversight to all activities offered by PACE.
- Member grievances will be forwarded to the QI Coordinator and QI Manager for investigation, tracking, trending and data gathering. These results will be forwarded to the PACE Director for review and further direction on any corrective actions that may be implemented. Participants and caregivers will be informed of the results of the investigations, 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 QI Coordinator and QI Manager for tracking, trending and data gathering and the PACE Director or PACE Medical Director for review. The case will then be forwarded to a third-party with the appropriate licensure for review. The third-party reviewer's decision shall be reviewed by either the PACE Director or the PACE Medical Director and will be immediately shared with the IDT who will inform caregivers and participants of the decision and assist them with furtherment of the process as needed.
- Transportation services will continue to be monitored through monthly metrics and grievance trending. The monthly report generated by the transportation vendor will be reviewed at the monthly transportation leadership meeting and will be reported quarterly to the PQIC. The PACE QI department will monitor transportation services with periotic ride alongs. The times gathered during the ride alongs will be compared against the data in the transportation reports to ensure accuracy.
- Meal quality will be monitored through regular participant meal satisfaction surveys as well as comments solicited by the PMAC.
- 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, reviewed by the PACE Program Director, PACE Medical Director or the PACE QI Manager, and 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

- 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 PACE.

External Monitoring and Reporting

PACE will report both aggregate and individual-level data to CMS and SAA to allow them to monitor PACE performance. This includes certain Unusual Quality Incidents (previously referred to as Level II Events), 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 HPMS. The following data is reported to CMS via the HPMS on a quarterly basis:

- Grievances
- Appeals
- Unusual Incidents
- Medication Errors
- Immunizations
- Enrollment Data
- Denials of Prospective Enrollees
- Falls without Injury
- ER Visits

Unusual Quality Incidents

- When unusual incidents reach specified thresholds, PACE must notify CMS on a quarterly basis through HPMS. PACE must complete a Root Cause Analysis and present the results of the analysis on a conference call with both CMS and the Department of Health Care Services (DHCS) as well as internally at PQIC. The goal of this analysis is to identify systems failures and improvement opportunities. Examples of Unusual Quality Incidents include:
    - 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 injuries acquired while enrolled in PACE.
    - Traumatic injuries which result in death or hospitalization of five days or more or result in permanent loss of function.

    - Any elopement.
    - Adverse drug reactions
    - Foodborne outbreak
    - Burns 2nd degree or higher
- HOS-M
    - 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 Food and Drug Administration (FDA).
    - Any infectious disease outbreak will be reported to the Centers for Disease Control and Prevention (CDC) and the Orange County Health Care Agency.

Corrective Action Plans (CAP)

- When opportunities for improvement are identified, a corrective plan will be created.
- Each CAP will include an explanation of the problem, the individual who is responsible for implementing the CAP, the time frame for each step of the plan, and an evaluation process to determine effectiveness.
- CAPs from contracted providers will be requested by the QI Manager or another 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 PACE Medical Director and the PACE Director.
- The QI Manager or QI Coordinator will consult with relevant 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.

Quality Initiatives

- Quality Initiatives will be implemented as an adjunct to the PACE QI Plan. Quality Initiatives identify areas of improvement ultimately leading to enhanced clinical outcomes, appropriate changes in systems and overall participant satisfaction. PACE Quality Initiatives specify expected outcomes, strategies and measurable interventions to meet our goals. The status of PACE Quality Initiatives is presented to the PQIC on a quarterly basis.
- In 2020, a new advanced health care directive quality initiative will be added.

ANNUAL REVIEW OF PACE QI PLAN

- The PACE QI 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 QI Work Plan.
- The Board will review and approve the PACE QI Plan and direct the PACE Medical Director to revise the QI Plan, as necessary and appropriate, to assure organizational oversight and commitment.

APPENDIX A (SEE ATTACHMENT)

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PACE

CalOptima

A Public Agency

Better. Together.

2020 PACE Quality Improvement (QI) Plan Description

Board of Directors' Quality Assurance Committee Meeting

February 19, 2020

Miles Masatsugu, M.D., Medical Director

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2020 PACE QI Program Description

- Encompasses all clinical care, clinical services and organizational services provided to our participants
- Aligns with our vision and mission
- Focuses on optimal health outcomes for our participants
- Uses evidence-based guidelines, data and best practices tailored to our populations

2020 PACE QI Work Plan Goals

- Improve the Quality of Care for Participants
- Ensure the Safety of Clinical Care
- Ensure Appropriate Access and Availability
- Ensure Appropriate Use of Resources
- Improve Participant Experience

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2020 PACE QI Eliminated/Modified Work Plan Elements

- Eliminated one element
  - Advanced Care Planning: Designate decision maker on Physician's Orders for Life-Sustaining Treatment (POLST)
    - Adding an Advanced Health Care Directive QI Initiative in 2020
- Modify two elements
  - Qualified Lead to Enrollment Conversion
  - Added inclusion and exclusion criteria for diabetes and potentially harmful drug/disease interactions in the elderly
- Diabetes Care elements were unbundled into three separate elements
- Total of 26 QI Work Plan Elements in 2020

Recommended Action

- Recommend approval of the 2020 CalOptima Program of All-Inclusive Care for the Elderly (PACE) Quality Improvement Plan Description

CalOptima's Mission

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

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CalOptima's Mission

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

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Appendix A

2020 CalOptima PACE Quality Improvement (QI) Work Plan							
QAPI Item#	**Goal**	**Description**	**Objective**	**Activity**	**Reporting Frequency**	**Target completion**	**Responsible Person**
QI20.01	**Improve the Quality of Care for Participants**	**2019 PACE QAPI Plan and Work Plan Annual Evaluation**	2019 PACE QAPI Plan will be evaluated by March 1st, 2020	PACE QAPI Plan and Work Plan will be evaluated for effectiveness on an annual basis	Annually	3/1/2020	PACE Medical Director
QI20.02	**Improve the Quality of Care for Participants**	**2020 PACE QI Plan and Work Plan Annual Oversight**	PACE QI Plan and Work Plan will be updated, reviewed and approved by March 1st, 2020	QI Plan and QI Work Plan will be approved and adopted on an annual basis	Annually	3/1/2020	PACE Medical Director
QI20.03	**Improve the Quality of Care for Participants**	**Influenza Immunization Rates**	≥ 94% of eligible participants will have their annual influenza vaccination by December 31st, 2020	Improve compliance with influenza immunization recommendations	Q3 and Q4 2020	12/31/2020	PACE Clinical Operations Manager
QI20.04	**Improve the Quality of Care for Participants**	**Pneumococcal Immunization Rates**	≥ 94% of eligible participants will have had their pneumococcal vaccination by December 31st, 2020	Improve compliance with pneumococcal immunization recommendations.	Quarterly	12/31/2020	PACE Clinical Operations Manager
QI20.05	**Improve the Quality of Care for Participants**	**Infection Control**	In 2020, maintain respiratory infection rates of less than the national benchmarks of 0.1-2.4 respiratory infections/1000 participant days	Monitor and analyze the incidence of respiratory infections in the elderly at PACE and compare against national benchmark to find opportunities for quality improvement.	Quarterly	12/31/2020	PACE Clinical Operations Manager
QI20.06	**Improve the Quality of Care for Participants**	**Advanced Care Planning: Physician's Orders for Life-Sustaining Treatment**	≥ 95% of participants who have been enrolled in the PACE program for 6 months will have a POLST completed by December 31st, 2020	Ensure all PACE members are offered POLST upon enrollment and every six months until they have one completed in order to improve POLST utilization.	Quarterly	12/31/2020	PACE Center Manager

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QAPI Item#	Goal	Description	Objective	Activity	Reporting Frequency	Target completion	Responsible Person
QI20.07	**Improve the Quality of Care for Participants**	**Care for Older Adults (COA): Functional Status Assessment**	Ensure that 100% of PACE participants have a functional status assessment completed every 6 months by the disciplines required by CMS	Ensure all PACE participants have a functional status assessment completed by the required disciplines every 6 months.	Quarterly	12/31/2020	PACE Center Manager
QI20.08	**Improve the Quality of Care for Participants**	**Diabetes Care**	>81.50% of Diabetics will have a Blood Pressure of <140/90 (Comparable to the 2019 MEDICARE Quality Compass HEDIS 90th percentile, exclusions defined in QI Plan)*	PACE participants with diabetes will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams to develop strategies for improvement.	Quarterly	12/31/2020	PACE Clinical Medical Director
QI20.09	**Improve the Quality of Care for Participants**	**Diabetes Care**	> 85.33% of Diabetics will have an Annual Eye Exam (Comparable to the 2019 MEDICARE Quality Compass HEDIS 90th percentile, exclusions defined in QI Plan)*	PACE participants with diabetes will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams to develop strategies for improvement.	Quarterly	12/31/2020	PACE Clinical Medical Director
QI20.10	**Improve the Quality of Care for Participants**	**Diabetes Care**	>98.30% of Diabetics will have Nephropathy Monitoring (Comparable to the 2019 MEDICARE Quality Compass HEDIS 90th percentile, exclusions defined in QI Plan)*	PACE participants with diabetes will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams to develop strategies for improvement.	Quarterly	12/31/2020	PACE Clinical Medical Director
QI20.11	**Ensure the Safety of Clinical Care**	**Day Center Falls**	≤ 6.65 Falls per 1000 member months occurring at the PACE day centers (ACS and Garden Grove PACE)	Falls occurring at the Garden Grove PACE or ACS centers will be monitored by the PACE QI department who will work with the interdisciplinary teams, clinical teams and day center staff to develop strategies for improvement.	Quarterly	12/31/2020	PACE Center Manager

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QAPI Item#	Goal	Description	Objective	Activity	Reporting Frequency	Target completion	Responsible Person
QI20.12	**Improve the Quality of Care for Participants**	**Reduce Potentially Harmful Drug/Disease Interactions in the Elderly: Dementia + tricyclic antidepressant or anticholinergic agents**	<35.73% (Comparable to the 2019 MEDICARE Quality Compass HEDIS 90th percentile, exclusions defined in QI Plan)*	PACE participants with a diagnosis of Dementia will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams as well as the PACE pharmacist to develop strategies for improvement.	Quarterly	12/31/2020	PACE Clinical Medical Director
QI20.13	**Improve the Quality of Care for Participants**	**Reduce Potentially Harmful Drug/Disease Interactions in the Elderly: Chronic Renal Failure + Nonaspirin NSAIDS or Cox2 Selective NSAIDs**	<3.90% (Comparable to the 2019 MEDICARE Quality Compass HEDIS 90th percentile, exclusions defined in QI Plan)*	PACE participants with a diagnosis of Chronic Renal Failure will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams as well as the PACE pharmacist to develop strategies for improvement.	Quarterly	12/31/2020	PACE Clinical Medical Director
QI20.14	**Ensure the Safety of Clinical Care**	**Decrease the Use of Opioids at High Dosage (UOD)**	100% of members receiving opioids for 15 or more days at an average milligram morphine dose (MME) 120mg will be reevaluated monthly by their treating provider in 2020	The PACE QI department will monitor any participant who is receiving prescription opioids for >/= 15 days at an average milligram morphine dose (MME) >120mg	Quarterly	12/31/2020	PACE Clinical Medical Director
QI20.15	**Improve the Quality of Care for Participants**	**Medication Reconciliation Post Discharge (MRP)**	≥ 90% of participants will have their medications reconciled within 30 days of hospital discharge in 2020	The PACE QI department will work with the PACE Interdisciplinary Team, Pharmacist and Providers to develop strategies for improvement	Quarterly	12/31/2020	PACE Pharmacist
QI20.16	**Ensure Appropriate Access and Availability**	**Improve Access to Specialty Care**	≥ 80% of specialty care authorizations will be scheduled within 10 business days	Appointments for specialty care will be scheduled within 10 business days to improve access to specialty care for initial consultations	Quarterly	12/31/2020	PACE Clinical Operations Manager

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QAPI Item#	Goal	Description	Objective	Activity	Reporting Frequency	Target completion	Responsible Person
QI20.17	**Ensure Appropriate Use of Resources**	**Reduce Acute Hospital Day Utilization**	< 2,813 hospital days per 1000 per year (5% decrease from 2019)	PACE participants hospital days will be monitored and analyzed by the PACE QI department who will work with the PACE interdisciplinary and clinical teams to develop strategies to lower that rate through preventative care and education	Quarterly	12/31/2020	PACE Medical Director
QI20.18	**Ensure Appropriate Use of Resources**	**Reduce Emergency Room Utilization**	< 1,004 emergency room visits per 1000 per year (10% decrease from 2019)	ER utilization by PACE participants will be monitored and analyzed by the PACE QI department who will work with the PACE interdisciplinary and clinical teams to develop strategies to lower that rate through preventative care and education	Quarterly	12/31/2020	PACE Medical Director
QI20.19	**Ensure Appropriate Use of Resources**	**30-Day All Cause Readmission Rates**	<15% 30-day all cause readmission	30-day all cause readmission rates for hospitalized PACE participants will be monitored and analyzed by the PACE QI department who will work with PACE interdisciplinary and clinical teams to find opportunities for quality improvement	Quarterly	12/31/2020	PACE Medical Director
QI20.20	**Ensure Appropriate Use of Resources**	**Long Term Care Placement**	<3% of members (July 2019 CalPACE average) will reside in long term care	PACE participants placed in long term care will be monitored and analyzed by the PACE QI department who will work with the PACE interdisciplinary and clinical teams to develop strategies to lower that rate through preventative care and education	Quarterly	12/31/2020	PACE Center Manager

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QAPI Item#	Goal	Description	Objective	Activity	Reporting Frequency	Target completion	Responsible Person
QI20.21	**Improve Participant Experience**	**Enrollment/Disenrollment**	The percentage of participants who disenroll for controllable reasons from the PACE program within the first 90 days of enrollment will be less than 4%	Review and analyze the participants who disenrolled from PACE within 90 days of enrollment, excluding deaths and withdrawals, to develop strategies for improvement	Quarterly	12/31/2020	PACE Marketing and Enrollment Manager
QI20.22	**Improve Participant Experience**	**Enrollment/Disenrollment**	Increase the Qualified Lead to Enrollment conversion rate to 50% in 2020	Review and analyze the Qualified Lead to Enrollment conversion rate and develop strategies for improvement.	Quarterly	12/31/2020	PACE Marketing and Enrollment Manager
QI20.23	**Improve Participant Experience**	**Transportation**	I00% of transportation trips will be less than 60 minutes in 2020	Ensure all PACE participants are on the vehicle for less than 60 minutes per trip. Monitor and analyze one-hour violations, define areas for improvement and implement interventions to maintain compliance with regulation	Quarterly	12/31/2020	PACE Center Manager
QI20.24	**Improve Participant Experience**	**Transportation**	≥ 92% of all transportation rides will be on-time in 2019	Review and analyze transportation records to track transportation rides with a scheduled and actual trip time of ± 15 minutes. Validate reports with ride-along to ensure accuracy of reported times.	Quarterly	12/31/2020	PACE Center Manager
QI20.25	**Improve Participant Experience**	**Increase Participant Satisfaction with Meals**	≥ 71% on Satisfaction with Meals summary score (2019 PACE National Average) on the 2020 PACE Satisfaction Survey	Define areas for improvement and implement interventions to improve the participant and their families satisfaction with the meals within the PACE program.	Quarterly	12/31/2020	PACE Center Manager
QI20.26	**Improve Participant Experience**	**Increase Overall Participant Satisfaction**	≥ 89% on the Overall Satisfaction Weighted Average (2019 PACE National Average) on the 2020 PACE Satisfaction Survey	Review and analyze the annual satisfaction survey results, define areas for improvement and implement interventions to improve the participant and their families satisfaction with the PACE program	Annually	12/31/2020	PACE Director

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QAPI Item#	Goal	Description	Objective	Activity	Reporting Frequency	Target completion	Responsible Person

*There is not a PACE-specific benchmark for these measures. Because of this, we utilize the 2019 Medicare Quality Compass HEDIS as a comparable benchmark, even though the metrics do not have identical inclusion/exclusion criteria.

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 5, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

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

Contact

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

Recommended Actions

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

Background

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

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

Discussion

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

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

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

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

Fiscal Impact

The recommended action to amend Medi-Cal health network contracts to include disbursement of IGT 6 and 7 funds for WCM Assistance for Implementation and Development has no fiscal impact to CalOptima's operating budget. The Board authorized the allocation of $1.75 million from IGT 6 and 7 funds for this purpose at the August 1, 2019, meeting. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima members, and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

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

Concurrence

Gary Crockett, Chief Counsel

Attachments

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

/s/ Michael Schrader *02/26/2020*
Authorized Signature **Date**

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Attachment to March 5, 2020 Board of Directors Meeting – Agenda Item 14

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Health Network	Address	City	State	Zip Code
AMVI Medical Group	600 City Parkway West, #800	Orange	CA	92868
Arta Western Medical Group	1665 Scenic Ave Dr, #100	Costa Mesa	CA	92626
CalOptima Community Network	505 City Parkway West	Orange	CA	92868
CHOC Health Alliance	1120 West La Veta Ave, #450	Orange	CA	92868
Family Choice Medical Group	7631 Wyoming Street, #202	Westminster	CA	92683
Kaiser Permanente	393 E Walnut St	Pasadena	CA	91188
Monarch Medical Group	11 Technology Dr.	Irvine	CA	92618
Noble Mid-Orange County	5785 Corporate Ave	Cypress	CA	90630
Prospect Medical	600 City Parkway West, #800	Orange	CA	92868
HPN – Regal Medical Group	8510 Balboa Blvd, Suite #150	Northridge	CA	91325
Talbert Medical Group	1665 Scenic Ave Dr, Suite #100	Costa Mesa	CA	92626
United Care Medical Group	600 City Parkway West, #400	Orange	CA	92868
Orange County Health Care Agency	405 W. 5th St.	Santa Ana	CA	92701

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

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

Contact

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

Recommended Actions

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

Rev. 8/3/17

Background/Discussion

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

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

IGT 6 and 7 Proposed Expenditure Categories

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

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

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

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Prior IGT Funding Reallocations and Changes

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

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

Fiscal Impact

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

Rationale for Recommendation

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

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Concurrence
Gary Crockett, Chief Counsel

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

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

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

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

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

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

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

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

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

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

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

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

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

Community Grants

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

Internal Initiatives

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

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

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

Discussion

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

Community Grants

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

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

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

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

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

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

Concurrence
Gary Crockett, Chief Counsel

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

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

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IGT 6 and 7 Community Grant Award Recommendations

August 1, 2019

Candice Gomez
Executive Director, Program Implementation

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Background

- IGT process enables CalOptima to secure additional federal revenue to increase California's low Medi-Cal managed care capitation rates
  - IGTs 1–7: Funds must be used to deliver enhanced services for the Medi-Cal population
  - IGTs 8–9: Funds must be used for Medi-Cal covered services for the Medi-Cal population
- CalOptima Board of Directors approved IGT 6 and 7 priority areas for community-based funding opportunities
  - Children's Mental Health
  - Homeless Health
  - Opioid and Other Substance Overuse
  - Other Needs Identified by the Member Health Needs Assessment

Background (cont.)

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

RFP Evaluation Criteria

- Organizational capacity and financial condition
- Statement of need that describes the specific issue or problem and the proposed program/solution
- Impact on CalOptima members with outreach and education strategies
- Efficient and effective use of potential grant funds for proposed program/solution

Site Visits

- Subject matter experts and staff conducted site visits to finalist organizations
- Questions were asked to:
  - Better understand the organization, current services provided and the proposed project
  - Identify the organization's leadership capacity and skills to effectively provide the proposed services
  - Determine if there are any concerns with awarding a grant to the organization

RFP Summary

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

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

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

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

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

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

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

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

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

No Funding for RFPs 4 and 6

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

Internal Projects ($2.4 million)

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

Recommended Board Actions

- Approve the recommended allocations of IGT 6 and 7 funds in the amount of $19.1M for community grants and internal projects; and,
- Authorize the Chief Executive Officer with the assistance of Legal Counsel to execute grant contracts with the recommended community grantees.

CalOptima's Mission

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

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IGT Update & Proposed Funding Categories for IGT 6 & 7

Board of Directors Meeting

August 3, 2017

Cheryl Meronk

Director, Strategic Development

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Intergovernmental Transfers (IGT) Background

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

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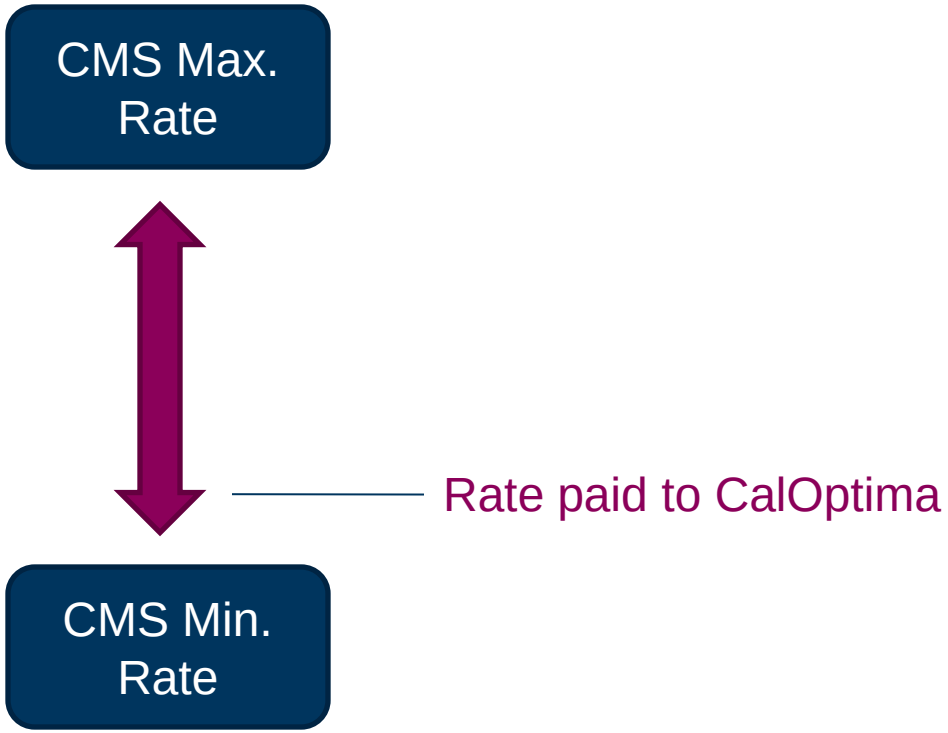
Low Medi-Cal Managed Care Rates

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



IGT Funds Availability and Process

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

CalOptima Share Totals To-Date

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

IGT 1 Status

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

As of 5/31/2017

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CalOptima A Public Agency Better. Together.

IGT 2 Status

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

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IGT 3 Status

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

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IGT 4 Status

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

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IGT 5

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

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

Member Health Needs Assessment (IGT 5)

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

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Member Health Needs Assessment (IGT 5)

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

Estimated IGT 6 and 7 Totals

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

Proposed IGT Funding Categories - IGT 6 and 7

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

Opioid/Other Substances Overuse

- Nationwide, 78 opioid overdose deaths per day
  - 45% of Rx drug overdose deaths are Medicaid beneficiaries
- In OC, 286 opioid-related drug overdose deaths in 2016
  - Opioid dependence second leading cause of substance-related hospitalizations in OC after alcohol dependence syndrome
- Potential solutions to be funded:
  - Expand access to pain management, addiction treatment and recovery services
  - Outreach and education
  - Technical assistance to community groups working to reduce opioid and other substance overuse

Children's Mental Health

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

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

Homeless Health

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

Competitive Community Grants

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

CalOptima Projects and Program Admin

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

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Next Steps

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

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CalOptima's Mission

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

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

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

Contact

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

Recommended Actions

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

Rev. 8/3/17

Background/Discussion

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

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

IGT 6 and 7 Proposed Expenditure Categories

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

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

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

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Prior IGT Funding Reallocations and Changes

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

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

Fiscal Impact

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

Rationale for Recommendation

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

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Concurrence
Gary Crockett, Chief Counsel

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

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

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

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

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

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

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

At the August 3, 2017 Board of Directors meeting, IGT 6 and 7 funds totaling approximately $22 million were approved to support community-based organizations through one-time competitive grants at the recommendation of the IGT Ad Hoc committee to address the following priority areas:
- Children's Mental Health
- Homeless Health
- Opioid and Other Substance Use Disorders
- Community Needs Identified by the CalOptima Member Needs Assessment

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

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

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

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

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

Discussion

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

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

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

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

Contact

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

Recommended Actions

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

Background

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

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

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

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

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

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

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

Discussion

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

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

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

Community Grants

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

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

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Internal Projects and Program Administration

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

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

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

Fiscal Impact

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

Rationale for Recommendation

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

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Concurrence
Gary Crockett, Chief Counsel

Attachment
PowerPoint Presentation: IGT 6 & 7 Expenditure Plan Allocation

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

8/29/2018 — **Date**

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IGT 6 & 7 Expenditure Plan Allocation

Board of Directors Meeting

September 6, 2018

Cheryl Meronk

Director, Strategic Development

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IGT 6 & 7 - Background

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

IGT 6 & 7 Funding

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

IGT 6 & 7 LOI Summary

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

Children's Mental Health – 2 RFPs

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

* Multiple awardees may be selected per RFP

RFP 1

Expand Access to Outpatient Children's Mental Health Services

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

RFP 2

Integrate Children's Mental Health Services into Primary Care Settings

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

Opioid & Other Substance Overuse – 1 RFP

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

*Multiple awardees may be selected per RFP

RFP 3

Increase access to Medication-Assisted Treatment

Funding Amount: $6.0 million

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

Community Needs Identified by MHNA: Food Access – 3 RFPs

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

*Multiple awardees may be selected per RFP

RFP 4

Expand Mobile Food Distribution Services

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

RFP 5

Expand Access and Food Distribution Services focused on Children and Families

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

RFP 6

Expand Access to Older Adult Meal Programs

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

Internal Projects/Program Admin.

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

Next Steps*

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

* Dates are subject to change based on Board approval

Homeless Health Care Delivery

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

Michael Schrader
Chief Executive Officer

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Agenda

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

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Current System of Care

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

**For Medi-Cal Members*

Current System of Care (Cont.)

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

Gaps in the Current System of Care

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

Immediate Response

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

Strengthened System of Care

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

Federal and State Guidance

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

Federal and State Guidance (Cont.)

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

Activities in Other Counties

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

Considerations

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

Additional Considerations

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

Recommended Actions

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

Recommended Actions (Cont.)

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

CalOptima's Mission

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 5, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item
15. Consider Actions Related to Homeless Health Care Pilot Initiatives

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

Recommended Actions
1. Regarding the Clinical Field Team Pilot Program (CFTPP):
   a. Extend the CFTPP through December 31, 2020 with operational changes as described herein;
   b. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to extend and amend contracts to implement the described operational changes with Federally Qualified Health Centers (FQHCs) and FQHC Look-alikes providing services under CFTPP; and
2. Regarding the Homeless Health Initiative (HHI):
   a. Extend the HHI FQHC Expansion pilot through December 31, 2020 and continue to allow for reimbursement to participating FQHCs and FQHC Look-alikes directly for services provided to CalOptima Members via mobile health care units, in fixed locations at shelters, and at identified homeless hotspots; and
   b. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to enter into contracts/contract amendments with FQHCs and FQHC Look-alikes as necessary to implement such payments.

Background
CalOptima has launched various initiatives to provide clinical care for CalOptima Medi-Cal Members (Members) experiencing homelessness through a series of actions approved by the CalOptima Board of Directors (Board). Specifically, the Board has approved or allocated funding for the following:

Date	Action(s)
February 22, 2019	• Authorized establishment of a CFTPP • Authorized reallocation of up to $1.6 million in Intergovernmental Transfers (IGT) 1 and IGT 6/7 funds for start-up costs for the CFTPP • Authorized eight unbudgeted FTEs and related costs in an amount not to exceed $1.2 million to service as part of CalOptima's Homeless Response Team • Directed staff to return to the Board with ratification request for further implementation details
April 4, 2019	Actions related to Delivery of Care for Homeless CalOptima Members • Approved the creation of a restricted Homeless Health Reserve in the amount of $100 million: $24 million in previously approved initiatives using IGT 1-7 funds, and $76

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	million in IGT 8 funds (approximately $43 million) with the balance from Fiscal Year (FY) 2018-19 operating funds • Stipulated that funds can only be used for homeless health Actions and contracts with FQHCs • Ratified the implementation plan for the Board authorized CFTPP • Ratified contracts with the following FQHCs to participate in the Clinical Field Team Pilot Program: Central City Community Health Center, Hurtt Family Health Clinic, Inc., Korean Community Services, Inc, dba Korean Community Services Health Center, and Serve the People Community Health Center • Authorized expenditures of up to $500,000 from existing reserves to fund the cost of services rendered to homeless CalOptima Medi-Cal members on a fee-for-service basis through June 30, 2019
August 1, 2019	Actions and contracts with FQHCs • Authorized expenditures of $135,000 from FY2019-20 Medi-Cal HHI from medical expenses to administrative expenses • Authorized the HHI FQHC Expansion pilot • Authorized contract amendments with FQHCs and FQHC Look-alikes to participate in the HHI FQHC Expansion Pilot • Ratified contract amendment with Families Together of Orange County to participate in the CFTPP Actions for development of CalOptima Homeless Clinical Access Program (HCAP) Authorized modification of the CalOptima Days quality improvement and incentive strategy to include HCAP for health care services in mobile units at, or in fixed clinical sites within, shelters or hotspots, including those FQHCs and FQHC Look-alikes participating in the CFTPP or HHI FQHC Expansion Pilot

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CalOptima has contracted with five FQHCs and/or FQHC Look-alikes, also referred to as community health centers, to provide CFTPP services.

- Central City Community Health Center
- Families Together of Orange County
- Hurtt Family Health Clinic, Inc.
- Korean Community Services, Inc, dba Korean Community Services Health Center
- Serve the People Community Health Center

The CFTPP was deployed on a phased in basis based on the community health centers' readiness. The community health centers currently provide on-call services in Orange County seven days a week. While capacity in the number of providers and on-call time availability has gradually increased since inception, collectively, between April and December 2019, through the CFTPP the following activity occurred:

- Receipt of 209 referrals from CalOptima Case Managers for outreach to Members expressing housing needs
- 1,302 face-to-face contacts with individuals experiencing homelessness
- Participation in five pre-enforcement engagements in Anaheim, Costa Mesa, Fullerton, Placentia and San Clemente
- 494 clinical field team dispatches
- 448 clinical field team visits conducted, of which 276 were CalOptima members
- 72 referrals to recuperative care

Additionally, through the HCAP, mobile services are regularly scheduled at shelters and other Orange County locations to provide primary and preventive services. To support additional participation in the HCAP, the HHI FQHC Expansion pilot was initiated. The HHI FQHC Expansion pilot allows new community health centers, in addition to those participating as CFTPPs, to seek reimbursement for services provided through a mobile unit, at a fixed shelter location, or identified homeless hotspot from CalOptima regardless of health network affiliation. The program has been operational for less than six months and outcome results are still being collected. Both the CFTPP and HHI FQHC Expansion pilot are set to end on March 31, 2020.

Discussion

Since the CFTPP was initiated in April 2019, modifications have been implemented in order to effectively operate the program and respond to Member needs. Because this has been a new pilot program, adjustments have been made as staff has gained more experience in coordinating services. For example, the following adjustments have been applied:

- Adding on-call services to facilitate documentation of recuperative care medical justification for recuperative care
- Referral sources for clinical field team services have been expanded. In addition, to the Orange County Health Care Agency Outreach & Engagement staff and CHAT-H nurses, referrals are also received from Homeless Emergency Assistance Program (HEAP) providers, shelter operators, city agencies, and other homeless service providers
- Mobile schedule shared with all community health centers to promote coordination among them, especially when referring a member to follow-up care

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- In collaboration with the community health centers, add more flexibility to the community health centers on-call schedules including on-call hours adjusted to 8:30 a.m. to 4:30 p.m. to better align with demand and mitigate safety issues

In 2019, CalOptima's Homeless Response Team dispatched the clinical field teams 494 times resulting in 448 clinical visits in the community. The Homeless Response Team also manages and maintains the community health centers schedule at shelters and hot spots to support the HCAP. Members experiencing homelessness are receiving health care services where they are located including shelters and hot spots. Because of claims lag, data regarding patient compliance, outcomes, inpatient, emergency department visits, and other utilization are still being evaluated. As such, CalOptima staff recommends extending both the CFTPP and FQHC Expansion pilots until December 31, 2020. Extending the pilots will allow for additional time to monitor outcomes and gain additional operational experience in developing sustainable programs. Furthermore, the California Department of Health Care Services released the Medi-Cal Healthier California for All proposal which includes a new Enhanced Care Management (ECM) benefit and availability of in lieu of services. ECM and in lieu of services become effective January 1, 2021 and have the potential to significantly impact services provided to Members experiencing homelessness.

In addition to recommending an extension of the CFTPP, CalOptima staff recommends modifying program requirements to adjust the on-call hours to 8:30 a.m. to 4:30 p.m. and other changes to align with administrative billing practices and actual services provided in the community. CalOptima staff also recommends removing the requirement to provide mobile services at two scheduled locations in four hour increments two days a week from the CFTPP. Providing services at set locations is now included in the HCAP and monitoring similar services through two separate programs is administratively duplicative for both the contracted CFTPP community health centers and CalOptima, especially as new community health centers begin to provide services through the HCAP.

CalOptima staff continues to work in collaboration with the community health centers and referring agencies and, based on feedback, is considering additional operational model changes to enhance the sustainability of the program which include:

- Modifying the on-call schedule based on current demand to allow for more flexibility for clinicians to see patients in the office and mobile units;
- Staggering provider hours to support scheduling in office appointments before or after CFT or mobile unit on-call shifts;
- Expanding outreach and education to existing and potential referring agencies regarding the program, deployment hours (including weekend availability) to continue building and refining the program to serve more individuals; and
- Considering an after-hour deployment fee for on-call services.

CalOptima staff will return to the Board regarding any additional recommended modifications to the pilot programs.

Fiscal Impact

The recommended actions to extend the terms of the CFTPP and the HHI FQHC Expansion pilot from April 1, 2020, through June 30, 2020, is budgeted under homeless related initiative expenditures in the

FY 2019-20 Operating Budget approved by the Board on June 6, 2019. Management plans to include expenses related to the period of July 1, 2020, through December 31, 2020, in the FY 2020-21 Operating Budget.

Rationale for Recommendation

Extension and modification of the pilots and contracts are recommended to continue this program to serve Members experiencing homelessness. The initiatives are consistent with the Board-approved Guiding Principles and Strategic Plan.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Entities Covered by this Recommended Board Action
2. Board Action dated February 22, 2019, Consider Authorizing Actions Related to Homeless Health Care Delivery Including, but not limited to, Funding and Provider Contracting
3. Board Action dated April 4, 2019, Consider Actions Related to Delivery of Care for Homeless CalOptima Members
4. Board Action dated April 4, 2019, Consider Ratifying Implementation of Actions and Contracts with Federally Qualified Health Centers for Board Authorized Clinical Field Team Pilot Program
5. Board Action dated June 27, 2019, Consider Funding Allocations Related to Supervisor Do's Homeless Healthcare Proposal
6. Board Action dated August 1, 2019, Consider Actions Related to Homeless Health Care Delivery
7. Board Action dated August 1, 2019 Consider Development of a CalOptima Homeless Clinic Access Program (HCAP) for Homeless Health Initiative
8. Board Action dated December 5, 2019, Consider Approval of Homeless Health Initiatives Guiding Principles

/s/ Michael Schrader *02/26/2020*
Authorized Signature **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip code
Central City Community Health Center	1000 San Gabriel Boulevard	Rosemead	CA	91770
Families Together of Orange County	661 W 1st St Suite G	Tustin	CA	92780
Hurtt Family Health Clinic, Inc.	One Hope Drive	Tustin	CA	92782
Korean Community Services, Inc. dba Korean Community Services Health Center	8633 Knott Ave	Buena Park	CA	90620
Serve the People Community Health Center	1206 E. 17th St., Ste 101	Santa Ana	CA	92701
Altamed Health Services Corporation	2040 Camfield Ave	Los Angeles	CA	90040
St Jude Neighborhood Health Centers	731 S Highland Ave	Fullerton	CA	92832
The Regents of the University of California, a California Constitutional Corp, UCI Family Medical Center	333 City Blvd West, Suite 200	Orange	CA	92868

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A Public Agency

CalOptima

Better. Together.

Homeless Health Care Delivery

Special Meeting of the CalOptima Board of Directors

February 22, 2019

Michael Schrader

Chief Executive Officer

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Agenda

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

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Current System of Care

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

**For Medi-Cal Members*

Current System of Care (Cont.)

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

Gaps in the Current System of Care

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

Immediate Response

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

Strengthened System of Care

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

Federal and State Guidance

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

Federal and State Guidance (Cont.)

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

Activities in Other Counties

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

Considerations

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

Additional Considerations

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

Recommended Actions

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

Recommended Actions (Cont.)

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

CalOptima's Mission

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

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Homeless Health Care Update

Board of Directors Meeting
April 4, 2019

Michael Schrader
Chief Executive Officer

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Impetus for Action in Orange County

- Address homeless crisis with urgency and commitment
- Address trend of homeless deaths
- Build a better system of care for members who are homeless that is long-lasting and becomes part of established delivery system
- Prioritize population health for this group

Homeless Deaths

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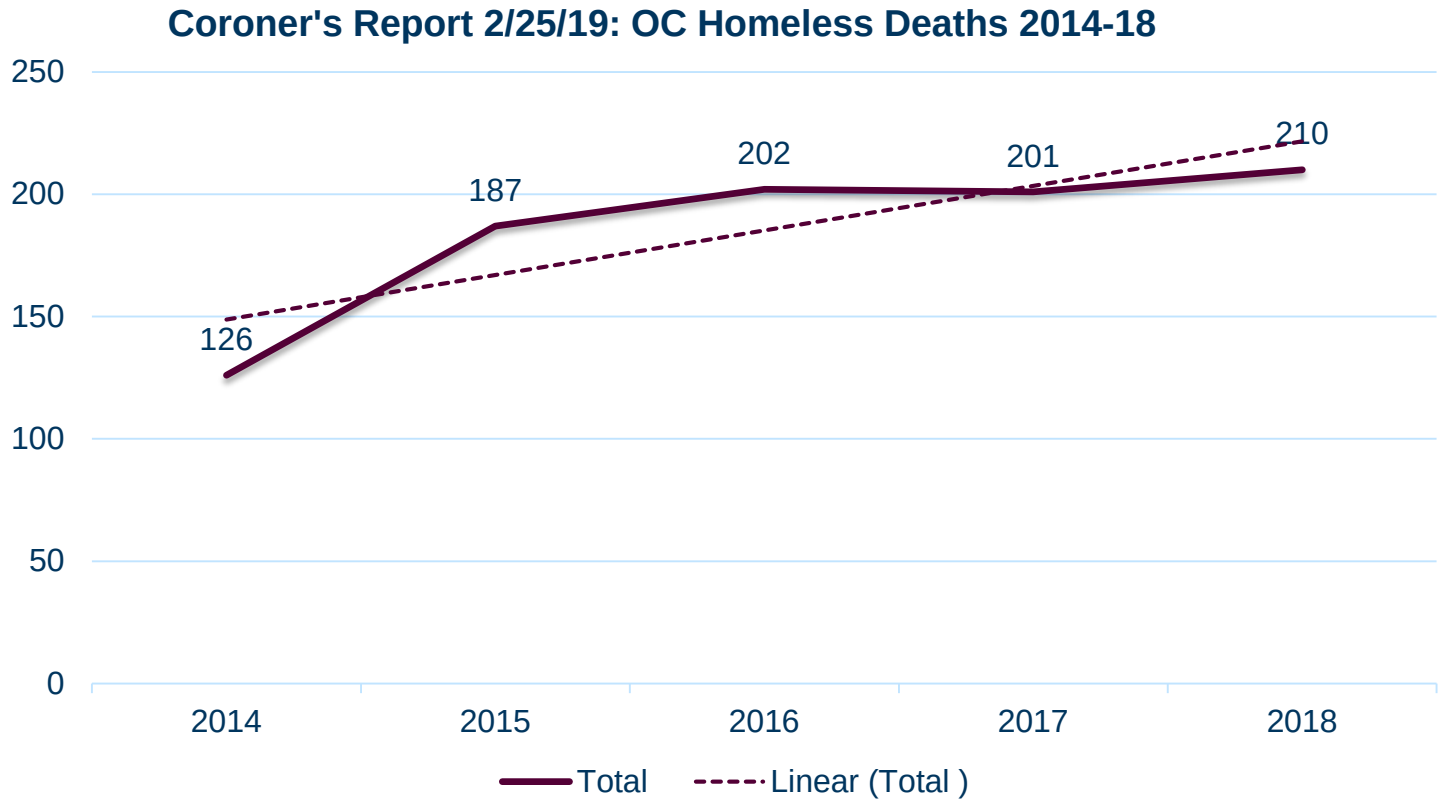
Coroner’s Report on Homeless Deaths



- Includes all homeless deaths in Orange County, not limited to CalOptima members
- Methodology of reporting and identification of homeless may vary by county
- Increased homeless death rates over the past five years reported in the media statewide

Coroner's Report on Homeless Deaths And Possible Interventions

- Natural causes (42% homeless v. 83% total OC population)
  - Clinical field teams (CalOptima)
  - CalOptima Homeless Response Team (CalOptima)
  - Recuperative care (County and CalOptima)
- Overdose (24% homeless v. 5% total OC population)
  - Opioid prescribing interventions (CalOptima)
  - Medication-assisted treatment (County and CalOptima)
  - Substance use disorder centers (County)
  - Medical detox (CalOptima)
  - Social model detox (County)
  - Naloxone (County and CalOptima)
  - Needle exchange (County)

Coroner's Report on Homeless Deaths And Possible Interventions (cont.)

- Traffic accidents (12% homeless v. 3% total OC population)
- Suicide (7% homeless v. 4% total OC population)
  - Moderate-severe behavioral health (County)
    - Crisis intervention
    - Post-acute transitions
    - Intensive outpatient treatment programs
  - Mild-moderate behavioral health (CalOptima)
    - Screening
    - Early treatment
- Homicide (6% homeless v. 1% total OC population)
- Other accidents (5% homeless v. 5% total OC population)
- Undetermined (3% homeless v. 1% total OC population)

Quality Assurance Committee
Further Clinical Analysis

- Deeper analysis into causes of deaths and interventions
- Case studies for each cause of homeless death
- Benchmarks and comparison with interventions and resources in other counties
- Presentations from partnering organizations

Better System of Care

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Ad Hoc Recommendations

- Take action to commit $100 million for homeless health
  - Create a restricted homeless health reserve
  - Stipulate that funds can only be used for homeless health

New Initiatives/Projects	BOD Approved	Pending BOD Approval	Funding Category
Be Well OC	$11.4 million		IGT 1–7 ($24 million total)
Recuperative Care	$11 million		
Clinical Field Team Startup	$1.6 million		
CalOptima Homeless Response Team ($1.2 million/year x 5 years)	$1.2 million	$4.8 million	IGT 8 and FY 2018–19 operating funds ($76 million total)
Homeless Coordination at Hospitals ($2 million/year x 5 years)		$10 million	
New Initiatives		$60 million	
Total Reserve: $100 million	**$25.2 million**	**$74.8 million**	

Clinical Field Team Structure

- Team Components
  - Includes clinical and support staff
  - Vehicle for transportation of staff and equipment
  - Internet connectivity and use of Whole-Person Care (WPC) Connect
- Clinical Services
  - Urgent care, wound care, vaccinations, health screening and point-of-care labs
  - Prescriptions and immediate dispensing of commonly used medications
  - Video consults, referrals, appointment scheduling and care transitions

Clinical Field Team Structure (cont.)

- Referrals and Coordination
  - Coordination with CalOptima Homeless Response Team
  - Coordination with providers
  - Referrals for behavioral health, substance abuse, recuperative care and social services
- Availability and Coverage
  - Regular hours at shelters/hot spots
  - Rotation for on-call services from 8 a.m.–9 p.m. seven days a week, with response time of less than 90 minutes

Clinical Field Team Partnerships

- Five FQHCs have received contract amendments
  - AltaMed
  - Central City Community Health Center*
  - Hurtt Family Health Clinic*
  - Korean Community Services*
  - Serve the People*
- Contract amendments to be authorized/ratified at April Board meeting, per Board direction
- Go-live
  - Deploy on a phased basis, based on FQHC readiness

** Signed contract amendment*

CalOptima Homeless Response Team

- Phone line and daily hours (8 a.m.–9 p.m.) established
  - Available to Blue Shirts and CHAT-H nurses
  - Primary point of contact at CalOptima for rapid response
- Coordinate and dispatch clinical field teams
- Serve as liaisons with regular field visits to shelters/hot spots in the county and recuperative care facilities
  - Establish working in-person relationships with collaborating partners
  - Assess and coordinate physical health needs for CalOptima members

Homeless Population in CalOptima Direct

- Pursue moving members who are homeless to CalOptima Direct, subject to regulatory approval
  - Maximum flexibility with access to any provider (no PCP assignment)
  - Fast-tracked authorization processing
  - Direct medical management in collaboration with clinical field teams, CalOptima Homeless Response Team, and County Blue Shirts and CHAT-H nurses
  - Connectivity with WPC Connect and CalOptima population health platform
- In the interim, move members identified in the field based on choice
- Obtain stakeholder input
  - County, PAC, MAC and health networks

Homeless Coordination at Hospitals

- COBAR in April
- Help hospitals meet SB 1152 requirements for homeless-specific discharge planning and care coordination, effective July 1, 2019
- Utilization by hospitals of data sharing technology to help facilitate coordination of services for CalOptima members who are homeless
- Proposing 2 percent increase to the inpatient Classic rates for Medi-Cal contracted hospitals
  - $2 million financial impact per year
  - Distributes funding based on volume of services provided to members

Medical Respite Program

- Recuperative care beyond 90 days
  - Reallocate $250,000 of the $10 million in IGT6/7 already allocated to the County's WPC program for recuperative care
  - Leverage existing process
    - County to coordinate and pay recuperative care vendor
    - CalOptima to reimburse County for 100 percent of cost
  - COBAR in April
  - Return to CalOptima Board for ratification of associated policy

WPC Connect

- Data-sharing tool for coordinating care used by the Whole-Person Care collaborative
  - Specifically used for homeless individuals
  - Includes social supports and referrals to services
  - Includes community partners (e.g., Illumination Foundation, 211, Lestonnac, Health Care Agency, Social Services Agency, hospitals, community clinics, health networks and CalOptima)
- WPC Connect workflow
  - Community partners can, with consent, add individuals into WPC Connect system once identified as homeless
  - WPC Connect sends an email notification and/or text message to identified care team for homeless individuals seen in ER, admitted to hospital or discharged

WPC Connect (cont.)

- CalOptima use of WPC Connect
  - Case management staff is trained and actively uses the system
    - Identify members enrolled in WPC
    - Coordinate with other partners caring for members
    - Access information from other partners

- Status of WPC Connect
  - Five hospitals are currently connected
  - COBAR to amend hospital contracts to support a discharge process for members experiencing homelessness, including the utilization by hospitals of data-sharing technology to help facilitate coordination of services with other providers and community partners

Better System of Care: Future Planning

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Evolving Strategy and Homeless Health Needs

- Propose and respond to changes
  - Regulatory and legislative
  - Available permanent supportive housing and shelters
  - State programs (e.g., expanded WPC funding and Housing for a Healthy California Program)
- Identify other potential uses for committed funds to optimize the delivery system, subject to Board consideration, for example:
  - Enrollment assistance
  - Enhanced data connectivity technology
  - Housing supportive services
  - Other physical health services
  - Rental assistance and shelter, if permissible

Recommended Actions

- Separate COBARs
  - Clinical field team implementation
  - Medical respite program
  - Homeless coordination at hospitals

- Additional action recommended by Board Ad Hoc
  - Create a restricted homeless health reserve in the amount of $100 million
    - $24 million – previously approved initiatives using IGT 1–7 funds
    - $76 million – all IGT 8 funds (approximately $43 million) with balance from FY 2018–19 operating funds
  - Stipulate that funds can only be used for homeless health

CalOptima's Mission

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

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 4, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

5. Consider Ratifying Implementation Actions and Contracts with Federally Qualified Health Centers for Board Authorized Clinical Field Team Pilot Program

Contact

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

Recommended Actions

1. Ratify implementation plan for Board authorized Clinical Field Team Pilot Program (CFTPP);
2. Ratify contracts with Federally Qualified Health Centers (FQHC) selected to participate in the CFTPP; and
3. Authorize expenditures of up to $500,000 from existing reserves to fund the cost of services rendered to homeless CalOptima Medi-Cal members on a fee-for-service (FFS) basis through June 30, 2019.

Background

CalOptima is responsible for arranging for the provision of physical health and mild to moderate behavioral health services to all CalOptima members. Among other things, the County of Orange is responsible for providing services related to Serious Mental Illness and Substance Use Disorder. The County of Orange also provides housing support services for the homeless through multiple programs. In combination, these services provide a continuum of care for CalOptima members.

The goal of the continuum of care is to coordinate physical and mental health, substance use disorder treatment and housing support. However, members who are identified as "homeless" based on the lack of permanent housing sometimes have unique challenges receiving healthcare services. These individuals sometimes have difficulty scheduling and keeping medical appointments and also sometimes face challenges with transportation to their medical providers. The County of Orange currently provides assistance in linking homeless individuals to mental health and substance use disorder treatment. In partnership with the County in these efforts, and as part of CalOptima's ongoing efforts to be responsive to stakeholder input and explore more effective means of delivering health care services to Medi-Cal beneficiaries, the CalOptima Board met at a special meeting on February 22, 2019 to consider the unique needs of the homeless population.

At the February 22, 2019 meeting, the CalOptima Board authorized the establishment of the CFTPP and allocated up to $1.6 million in IGT 6/7 dollars in support of this effort. The Board also authorized the establishment of a Homeless Response Team and directed staff to move forward with the program and return with a request for ratification of implementing details. As discussed at the February 22, 2019 meeting, the plan was for staff to move forward with amendments to contract with qualifying Federally Qualified Health Centers (FQHCs), which can receive federal funding as reimbursement for services provided to non-CalOptima members, as well payments from CalOptima for covered, medically necessary services provided to CalOptima Medi-Cal members.

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Discussion

Clinical Field Team Pilot Program (CFTPP)

The Clinical Field Team pilot program was designed with the intent to provide needed, urgent care type medical services to homeless members in Orange County, onsite where they are located. Services provided where the members are located is expected to help prevent avoidable medical complications, hospitalizations, re-hospitalizations, emergency department visits, adverse drug events, and progression of disease.

Services provided will be reimbursed based on the CalOptima Medi-Cal fee schedule directly by CalOptima regardless of the member's health network eligibility. As also indicated, under the CFTPP, CalOptima will establish a Homeless Response Team which will be dedicated to the homeless health initiative. Requests for physical health care services identified by County workers will be requested to and deployed by CalOptima's Homeless Response Team.

As indicated, at the February 22, 2019 meeting, the Board authorized reallocation of up to $1.6 million in designated but unused funds from IGT 1, IGT 6 and IGT 7 for start-up costs. As part of the CFTPP, CalOptima staff anticipates contracting with up to five FQHCs for services, resulting in $320,000 per FQHC for start-up funding. Specifically, Management recommends the following reallocations:

- $500,000 from IGT 1 – Depression Screenings;
- $100,000 from IGT 6 – IS and Infrastructure Projects;
- $500,000 from IGT 7 – Expand Mobile Food Distribution Services; and
- $500,000 from IGT 7 – Expand Access to Food Distribution Services for Older Adults.

In addition, CalOptima will provide payment to FQHCs for services rendered to CalOptima's Medi-Cal members on a FFS basis. Management recommends the Board authorize up to $500,000 from existing reserves to provide funding for these payments through June 30, 2019. Management plans to include additional funding for services provided as part of the CFTPP beyond this date in the FY2019-20 budget.

CalOptima staff has engaged FQHCs (and/or FQHC Look-alikes) to provide medical services because of their ability to provide (and be reimbursed for) services to both CalOptima members and non-CalOptima members; including those who are uninsured. Service reimbursement from CalOptima will only be provided for CalOptima members, and FQHCs are able to obtain alternate funding sources for services provided to individuals not enrolled with CalOptima. In order to select participating FQHCs for the pilot CalOptima requested that interested parties respond to questions regarding their experience providing clinical services to individuals experiencing homelessness, if similar services were already being provided in Orange County, if they were able to meet key requirements under the pilot, and if they were able to begin providing services on April 1, 2019. (number) responded to the questionnaire and the following five FQHCs were selected:

- AltaMed Health Services Corporation
- Central City Community Health Center
- Hurtt Family Health Clinic, Inc.
- Korean Community Services, Inc. dba Korean Community Services health Center
- Serve the People Community Health Center

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Once implemented, CFTPP program performance and results will be monitored and reported to the Board for further continuation or modification.

FQHC Contracts

CalOptima staff is in the process of amending contracts with the five identified FQHCs, whose mission and federal mandate are to deliver care to the most vulnerable individuals and families, including people experiencing homelessness in areas where economic, geographic, or cultural barriers limit access to affordable health care service. This ensures that homeless individuals, who are not currently CalOptima members, will also receive care as needed.

The contracted FQHCs will provide one or more clinical, field-based teams which will include clinical and support staff, point of care lab testing and frequently used medications to be disbursed to the homeless at their locations. Among the services to be provided by the field-based teams, Members will be able to receive wound care, vaccinations, health screenings and primary care and specialist referrals. Services will be available at extended hours and on-call. Services will be coordinated with CalOptima's Homeless Response Team, PCP, and Health Networks as appropriate.

Staff requests Board ratification of the existing agreements with the 5 FQHCs and the authority to contract with additional FQHCs as necessary to cover the scope of services under the pilot program.

Fiscal Impact

The recommended action to authorize expenditures to fund the cost of services rendered to CalOptima Medi-Cal members under the CFTPP program on a FFS basis is an unbudgeted item. A proposed allocation of up to $500,000 from existing reserves will fund this action through June 30, 2019. Management plans to include projected expenses associated with the CFTPP in the CalOptima Fiscal Year 2019-20 Operating Budget.

Rationale for Recommendation

Due to the unique access issues associated with receipt of healthcare services for individuals in the community who lack permanent housing, CalOptima staff recommends this action to ensure access by providing urgent health care services where these individuals are located.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. Board Presentation: Special Meeting of the CalOptima Board of Directors February 22, 2019, Homeless Health Care Delivery

/s/ Michael Schrader — *3/27/2019*

Authorized Signature — **Date**

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CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AltaMed Health Services Corporation	2040 Camfield Ave.	Commerce	CA	90040
Central City Community Health Center	1000 San Gabriel Boulevard	Rosemead	CA	91770
Hurtt Family Health Clinic, Inc.	One Hope Drive	Tustin	CA	92782
Korean Community Services, Inc. dba Korean Community Services Health Center	8633 Knott Ave	Buena Park	CA	90620
Serve the People Community Health Center	1206 E. 17th St., Ste 101	Santa Ana	CA	92701

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Homeless Health Care Delivery

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

Michael Schrader
Chief Executive Officer

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Agenda

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

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Current System of Care

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

**For Medi-Cal Members*

Current System of Care (Cont.)

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

Gaps in the Current System of Care

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

Immediate Response

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

Strengthened System of Care

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

Federal and State Guidance

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

Federal and State Guidance (Cont.)

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

Activities in Other Counties

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

Considerations

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

Additional Considerations

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

Recommended Actions

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

Recommended Actions (Cont.)

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

CalOptima's Mission

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

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SUPPLEMENTAL BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 27, 2019
Special Meeting of the CalOptima Board of Directors

Supplemental Report Item
S17a. Consider Funding Allocations Related to Supervisor Do's Homeless Healthcare Proposal

Recommended Actions
Authorize the $60 million identified for new homeless health initiatives as follows:
1. Clinic health care services in all homeless shelters – $10 million
2. Authorize mobile health team to respond to all homeless providers – $10 million
3. Residential support services and housing navigation – $20 million
4. Extend recuperative care for homeless individuals with chronic physical health issue – $20 million

Background
Supervisor Do is requesting consideration to allocate the $60 million identified at the February 22, 2019 Special Board of Directors meeting as follows:
1. Clinic health care services in all homeless shelters – $10 million
2. Authorize mobile health team to respond to all homeless providers – $10 million
3. Residential support services and housing navigation – $20 million
4. Extend recuperative care for homeless individuals with chronic physical health issue – $20 million

Attachments
1. May 29, 2019 Letter from Supervisor Do
2. June 5, 2019 Letter from Michael Schrader and the CalOptima Board Ad Hoc Committee on Homeless Health
3. June 6, 2019 Letter from Supervisor Do

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ANDREW DO
SUPERVISOR, FIRST DISTRICT

ORANGE COUNTY BOARD OF SUPERVISORS
333 W. SANTA ANA BLVD., P.O. BOX 687, SANTA ANA, CALIFORNIA 92702-0687
PHONE (714) 834-3110 FAX (714) 834-5754 andrew.do@ocgov.com

May 29, 2019

Mr. Michael Schrader
CalOptima
505 City Pkwy
Orange, CA 92868

SUBJECT: Request for June 14 Special Meeting on CalOptima's Response to Deaths of Homeless Members

Dear Mr. Schrader,

Given the information my office recently received from CalOptima, I am writing to reiterate my profound concerns regarding the agency's slow rate of progress for homeless services, particularly in light of the Board's Directives to establish homeless services since February 2019. I am also frustrated that out of the 210 homeless deaths last year, 153 were CalOptima members, despite my repeated requests for such services through all of last year. If ever, the time for action is now. We have had 25 more homeless deaths in the first two months of 2019 alone. To assist you and the Homeless Ad Hoc Committee, I am submitting four programs that CalOptima can implement immediately to provide care to our members who are living on the street.

A staggering 73 percent of those who died were enrolled in CalOptima services but were not provided adequate services. In the four months since the Board of Directors authorized my proposed Mobile Health Team, CalOptima has only served 47 individuals out of a population of almost 6,860 homeless residents countywide. Of those 47 patients, 36 were our members. While these feeble numbers should concern you as to the effectiveness of our outreach efforts, they clearly answer your question whether homeless individuals are CalOptima members. CalOptima is permitted to provide services to them using Medicaid funds.

Given such clear mandates, I don't understand your refusal to take referrals from providers other than the Orange County Health Care Agency's Outreach and Engagement Team. Many providers throughout the county interact with our county's homeless population. Such a restriction will necessarily limit the number of cases referred to CalOptima. It also flies in the face of the Board's repeated pledge that we are looking at every way legally possible to provide services.

Additionally, CalOptima's refusal to provide regularly scheduled clinics that led to the flawed decision to provide services solely on an on-call basis places the burden on the County to identify patients and wait with them in the field until CalOptima's contracted clinics show up. Not only is this a wasteful and inefficient model; but given that the wait is sometimes up to two hours, it's no wonder why so few homeless residents have taken up our services.

Finally, I don't understand why CalOptima refuses to provide and the Homeless Ad Hoc Committee has not recommended services at any of the multiple homeless shelters run by the County and Cities. Has CalOptima even done a cursory survey to see if the shelters, in fact, do not have CalOptima members? If you have not done so and, nevertheless, refuse to provide services, your

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choice is, at a minimum, harmful and negligent. With the data cited above showing actual CalOptima membership among the homeless, I would submit that CalOptima's continuing refusal is in wanton disregard of public health.

For two years, I have experienced consistent pushback to my demands for enhanced homeless health care from you, counsel and other Directors at CalOptima. I have been told repeatedly by CalOptima staff and counsel that CalOptima can only fund core health care services for CalOptima members, and these homeless individuals were not CalOptima members, therefore the agency was limited in what it can do.

Even after we were confronted in February in federal court with the number of homeless deaths, our Board's and CalOptima's staff response continued to be one of denial. After all this time we still needed research to confirm if any of these homeless who died were actually members of CalOptima. Now that the facts are overwhelmingly clear, the public will not wait for more feasibility studies or meetings to discuss what can be done.

In addition, $60 million for new unnamed homeless health initiatives has already been allocated by the Board. To date, no proposals are forthcoming for the June board meeting. Since the Board does not meet in July, it will be August, at the earliest, before any plans can be discussed by the Board.

Such a delay is unconscionable. Therefore, I am requesting a Special Board of Directors meeting to convene on June 14, where I will propose the following plan to immediately spend the $60 million allocated:

- **C**linic health care services in all homeless shelters - $10 million
- **A**uthorize mobile health team to respond to all homeless providers - $10 million
- **R**esidential support services and housing navigation - $20 million
- **E**xtend recuperative care for homeless individuals with chronic physical health issue-$20 million

The way I see things is our homeless residents are, by definition, indigent. They should receive the health care they need. This is especially true if they have gone through the process to enroll. It is CalOptima's responsibility to find ways to bring health care to them. If one CalOptima member is experiencing homelessness, that should be enough for this agency to spring into action. We can adopt, as a Board, a philosophy of finding a way to say yes, or we can continue to say no, while people are suffering and dying on the street.

My hope is that my request for a Special Board meeting will be met.

Sincerely,

ANDREW DO
Orange County Board of Supervisors
Supervisor, First District

AD/vc

cc: Members, CalOptima Board of Directors
Members, Orange County Board of Supervisors

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CalOptima
A Public Agency
Better. Together.

June 5, 2019

Supervisor Andrew Do
Orange County Board of Supervisors
333 W. Santa Ana Blvd., P.O. Box 687
Santa Ana, CA 92702

Dear Supervisor Do:

Thank you for your May 29 letter expressing concern about CalOptima members experiencing homelessness. We certainly share your interest in changing the course of the current homeless crisis in Orange County. CalOptima has demonstrated our significant commitment to having an impact on the health of this population through the investment of $100 million in financial resources and valuable, focused leadership from staff, executives and the Board.

It is unfortunate you will not be able to attend the June 6 meeting given the urgency you ascribe to this situation. Know that homeless health is a priority issue and that the CalOptima Board ad hoc committee formed to address this topic is actively discussing it on a weekly if not more frequent basis. An update on the homeless health initiatives is planned for the June 6 Board meeting, where you will hear that we are working diligently to find ways to improve the system of care for this population.

Removing yourself from that ad hoc committee may have distanced you from observing the progress that CalOptima is making. Please allow us to clarify a number of points from your letter to facilitate future collaboration, which is essential in addressing the challenges of homelessness. As we have stated before, homeless individuals who have Medi-Cal coverage are the mutual responsibility of CalOptima, and two County agencies, Health Care Agency (HCA) and Social Services Administration (SSA). CalOptima provides access to medical care, HCA provides access to moderate to severe mental health care and substance abuse services, and SSA determines eligibility and enrolls individuals into the Medi-Cal program. It's clear that medical care is only one dimension of the complex homelessness issue that extends to needs for housing, social services and economic support, all of which are overseen by the County. Again, because homeless individuals have needs of our organizations, optimal results can be achieved only if CalOptima and the County work together and are accountable for their respective responsibilities.

While we all are deeply saddened and frustrated by the high rate of homeless deaths in 2018, the incidence of CalOptima membership among this group has been widely discussed since the February 22, 2019, Special Meeting of the CalOptima Board. CalOptima staff is studying the causes of these deaths and considering your assertion that these members died because of a lack

of access to health care. However, whether an individual is a CalOptima member or not, the person can obtain primary care at a clinic, and if the person's need is urgent, obtain emergency care at any hospital emergency room (ER). Overall, approximately $100 million was spent on care for homeless CalOptima members in calendar year 2018. CalOptima data comparing homeless members with the general population CalOptima serves shows that homeless members average more than seven times as many hospital bed days, visit the ER five times more often, visit a specialist almost twice as often and see a primary care doctor 25 percent less. These statistics are telling and will inform the design of a model of care for the homeless that considers their specific challenges. Our goal is to remove barriers and deliver care more appropriately and cost-effectively, which is the reason we launched clinical field teams. Such teams are not intended to replace the care delivery system available to all CalOptima members but to make urgent care available in unique situations when a homeless individual with an urgent care need is unwilling or unable to access the system.

Your comments about the slow rate of progress are out of sync with the experience of the clinical field team launch. Our first team was in the field less than two months from Board approval, and CalOptima quickly ramped up to 48 hours/six days a week of coverage in the month after that. We now have five partner clinics dedicated to providing on-call care anywhere in the county. The totals served are higher than those in your letter. From April 10–May 30, 84 individuals received care, and 70 of them were CalOptima members. We appreciate and celebrate the mammoth effort of the clinics in launching this one-of-a-kind program that Orange County has never seen before. In fact, the genesis of our street medicine teams and how they are deployed was the result of a series of collaborative meetings in January and February between more than a dozen CalOptima and County leaders. This is why the County Outreach & Engagement Team is an essential component of the process in making referrals, building trust in CalOptima's services and ensuring a safe environment for the medical professionals providing the services. Calling the process into question as your letter does conflicts with the intentional design developed collaboratively by County, clinics and CalOptima representatives. At this initial stage, we are honoring the group's direction to coordinate deployment through the County. But we intend to refine the program over time and plan to eventually take referrals from other organizations.

Contrary to your assertion that CalOptima is refusing to offer clinic services at shelters, we are working to bring shelter operators and clinical field team leaders together to forge collaborative relationships that make sense for their facilities and teams. A meeting had been scheduled for May 31, but it was cancelled at the County's request due to County staff vacations. Still, these groups are excited about the prospects of working together, and there has been no "refusal" on our part to do this. We intend to encourage new mutually beneficial partnerships and continue to work to foster collaboration with our County and community partners.

The CalOptima Board homeless health ad hoc is keenly focused on homeless program development for the remaining Board-approved $60 million, seeking uses that are flexible and responsive. To meet that goal, the work of the ad hoc is increasingly inclusive, with the

committee prioritizing meetings with key stakeholders who have invaluable experience working directly with the homeless population. Your suggested CARE programs largely duplicate work already in progress or reflect a request that is outside of CalOptima's scope. We would like to detail this as follows:

- *Clinic health care services in all homeless shelters - $10 million*
  As stated above, we are encouraging clinics to work with shelters. They can choose to do this now and some are. When we are able to meet with clinics, County staff and shelters as a group, we can assess whether additional funding is needed and establish schedules and coverage to meet the health care needs.
- *Authorize mobile health team to respond to all homeless providers - $10 million*
  Your suggestion highlights a process change rather than a funding issue. CalOptima and our clinical field team partners can decide to revise the referral process, and services delivered to the member would be reimbursed regardless of the origin of the referral. CalOptima's homeless response team plans to expand its referral base and has budgeted sufficiently to accommodate growth. Further, there are reasons to keep the County Outreach & Engagement Team involved because oftentimes a member's need may be related to a County-covered services.
- *Residential support services and housing navigation - $20 million*
  The services that you suggest here are key elements of the Whole-Person Care (WPC) pilot, for which the County is the lead. CalOptima respectfully suggests that the County consider working with the state to add a housing pool to the WPC pilot program and also consider requesting additional money as part of its submission to the state for a portion of the governor's increased housing funds for WPC in the FY 2019–20 budget. If the County creates a housing pool under the WPC program, CalOptima could contribute money to the housing pool for housing supportive services. CalOptima staff looks forward to the possibility of partnering with the County on these initiatives within the parameters for which the use of CalOptima Medi-Cal funding is permissible.
- *Extend recuperative care for homeless individuals with chronic physical health issue - $20 million*
  CalOptima has twice allocated funds for recuperative care, bringing the total to $11 million. As you may recall, the CalOptima Board acted at its April meeting to lengthen the duration for recuperative care services beyond 90 days when medically indicated, and adequate funding remains available for these services.

Separately, the Board's ad hoc committee for IGT 6/7 on which you serve has an opportunity to approve grants that may positively impact the homeless community, such as the grants targeted for mental health and medication-assisted treatment. This adds yet another dimension to CalOptima's significant investment in responding to the homeless crisis.

In closing, please know that the homeless health ad hoc committee has received your program ideas for consideration. As indicated, the homeless health ad hoc and the CalOptima Board have already acted to address the "urgent" elements of your proposal. Collaboration and accountability are key CalOptima values that we share with stakeholders so that together we can authentically pursue our goal of better homeless health care services.

Sincerely,

Michael Schrader
CEO, CalOptima

CalOptima Board Ad Hoc Committee on Homeless Health
Paul Yost, M.D.
Lee Penrose
Ron DiLuigi
Alex Nguyen, M.D.

cc: Members, CalOptima Board of Directors
Members, Orange County Board of Supervisors

ANDREW DO
SUPERVISOR, FIRST DISTRICT

ORANGE COUNTY BOARD OF SUPERVISORS
333 W. SANTA ANA BLVD., P.O. BOX 687, SANTA ANA, CALIFORNIA 92702-0687
PHONE (714) 834-3110 FAX (714) 834-5754 andrew.do@ocgov.com

June 6, 2019

Mr. Michael Schrader
CalOptima
505 City Pkwy
Orange, CA 92868

Dear Mr. Schrader and CalOptima Board Ad Hoc Committee on Homeless Health:

I am in receipt of your letter dated June 5 in response to my May 29 letter. Your response letter demonstrates a clear lack of focus and concern for the issues I raised regarding the alarming number of deaths occurring among CalOptima members experiencing homelessness—a number I understand based on your letter, that the Ad hoc and CalOptima staff were aware of months ago and yet never shared with the Board until I posed the question on April 9. At that time I was informed related analysis is in the works in preparation for the upcoming Quality Assurance Committee meeting in May, which was cancelled. Subsequently, I followed up on May 21 and received the answer. If the Ad hoc has known this information for months, I am further concerned over the lack of transparency in sharing information with the Board of Directors on a crisis-level issue. I am also aware that CalOptima staff conducted analyses into the number of deaths and again, no results or informed recommendations were provided to the CalOptima Board.

As stated previously, there are no recommended actions on the June 6 agenda regarding the $60 million for new homeless health initiatives already allocated by the CalOptima Board. Whether I attend this meeting or not does not change this fact. An update on existing initiatives without recommendations for new actions to utilize the $60 million will not produce new results.

On the topic of homeless initiatives, it has come to my attention that a Board Action taken at the April 4 CalOptima Board meeting, Item 18 was portrayed and captured as part of CalOptima's homeless health initiatives to the tune of $10 million. At this same Board meeting, Item 4 described this pending action as part of CalOptima's current homeless health response contribution and yet I'm told there may not be is no reference to requiring homeless coordination as part of the hospital contracts attached to the approved Item 18. I want a copy of the contract to confirm these services are in fact directly related to the homeless initiatives as portrayed. The continued lack of transparency from CalOptima is alarming.

The statistics quoted in my letter were provided by CalOptima staff just last week, so if there are inconsistencies between those figures and the figures in your letter of June 5, I am unclear as to why that is. Even if 84 individuals were served between April 10 – May 30, that is fewer than two people per day over the 50-day period. It seems that five clinical field teams operating with

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the frequency you state are capable of handling significantly more service requests—why aren't they? The need is obvious.

There are nearly 3,000 homeless individuals in shelters in Orange County, and providing services "eventually" will not help them quickly enough. Referrals to the clinical field teams should be accepted from the shelters immediately. Again, this delayed response will not produce new results. County staff who have been working diligently on this issue continue to attempt to provide guidance to CalOptima staff on best practices and make connections; however, it seems to be taken for granted. In the meeting cancellation referenced in your letter, CalOptima staff were fully aware of County staff's availability in advance of the May 31 meeting date, yet the meeting was scheduled despite this knowledge.

I chose to remove myself from the ad hoc committee because my suggestions for improved services provided at the February 22 Special Board meeting were disregarded in favor of conducting more studies. We don't need studies to tell us that more services are needed on the streets and in the shelters. My CARE proposal was done in conjunction with the Health Care Agency. Your letter states the County Outreach and Engagement team is an essential component. I agree, which is why the team was consulted in my proposal.

We need a plan now, and I have provided a plan. The CalOptima Board of Directors must take action now, which is why I requested the June 14 special meeting. This ad hoc has been meeting, exploring, and fact gathering without a single recommendation to the Board for over 100 days. Waiting another two months to take action is simply unacceptable.

Sincerely,

ANDREW DO
Orange County Board of Supervisors
Supervisor, First District

AD/vc

cc: Members, CalOptima Board of Directors
Members, Orange County Board of Supervisors

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item
16. Consider Actions Related to Homeless Health Care Delivery

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

Recommended Actions
1. Authorize the Chief Executive Officer to implement the following operational changes to support homeless health initiatives;
    a. Reallocate $135,000 in Fiscal Year (FY) 2019-20 Medi-Cal budgeted funds under homeless health-related initiatives from medical expenses to administrative expenses;
    b. Implement a pilot program to reimburse Federally Qualified Health Centers (FQHC) and FQHC Look-alikes directly for services provided via mobile health care units or in a fixed shelter location for dates of service from August 1, 2019 through March 31, 2020, based on the CalOptima Medi-Cal fee schedule and for eligible CalOptima Members notwithstanding health network assignment and continuing capitation payments;
    c. With the assistance of Legal Counsel, enter into contract amendments with FQHCs and FQHC Look-alikes providing mobile health care unit services; and
2. Ratify contract amendment with Families Together of Orange County effective May 17, 2019 to participate in the CalOptima Clinical Field Team pilot program providing health care services for homeless members at their locations and provide start-up funding.

Background
CalOptima has launched various initiatives for its Members experiencing homelessness through a series of CalOptima Board of Directors' actions. Specifically, the Board has approved or allocated funding for the following:

Date	Action(s)
February 22, 2019	• Authorized establishment of a Clinical Field Team pilot program • Authorized reallocation of up to $1.6 million in Intergovernmental Transfers (IGT) 1 and IGT 6/7 funds for start-up costs for the Clinical Field Team pilot programs • Authorized eight unbudgeted FTEs and related costs in an amount not to exceed $1.2 million to service as part of CalOptima's Homeless Response Team • Directed staff to return to the Board with ratification request for further implementation details • Obtain legal opinion related to using Medi-Cal funding for housing related activities
April 4, 2019	Actions related to Delivery of Care for Homeless CalOptima Members

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	• Approved the creation of a restricted Homeless Health Reserve in the amount of $100 million: $24 million in previously approved initiatives using IGT 1-7 funds, and $76 million in IGT 8 funds (approximately $43 million) with the balance from Fiscal Year (FY) 2018-19 operating funds • Stipulated that funds can only be used for homeless health Actions and contracts with FQHCs • Ratified the implementation plan for the Board authorized Clinical Field Team Pilot Program • Ratified contracts with the following FQHCs to participate in the Clinical Field Team Pilot Program: Central City Community Health Center, Hurtt Family Health Clinic, Inc., Korean Community Services, Inc, dba Korean Community Services Health Center, and Service the People Community Health Center • Authorized expenditures of up to $500,000 from existing reserves to fund the cost of services rendered to homeless CalOptima Medi-Cal members on a fee-for-service basis through June 30, 2019
June 27, 2019	Authorized $60 million identified for new homeless health initiatives as follows: 1. Clinic health care services in all homeless shelters - $10 million 2. Authorize mobile health team to respond to all homeless providers - $10 million 3. Residential support services and housing navigation - $20 million 4. Extend recuperative care for homeless individuals with chronic physical health issue - $20 million

In addition to the above actions, a Board ad hoc committee focused on homeless health initiatives has engaged numerous community stakeholders, county agencies, providers, health networks, advocates, and other stakeholders to gather information regarding the needs of individuals experiencing homelessness and to make recommendations to the Board on how the health care needs of these members can best be met. The ad hoc's intent is to help develop a thoughtful, strategic approach to leveraging available CalOptima resources to meet the health care needs of homeless members. The overarching goal is to work collaboratively with community partners in developing a health care system that bridges individuals seeking urgently needed health care services where they are located to clinic and office-based settings, while utilizing the existing care management system.

Discussion

Operational changes to support homeless health initiatives

In order to implement the recommended actions, CalOptima staff will make the necessary operational changes and update policy and procedures and return to the Board for approval of any proposed changes to Board-approved policies. Additionally, authority is requested to add two unbudgeted FTE staffing resources, one Sr. Project Manager and one Sr. Program Manager, to support the operational

implementation and ongoing maintenance of homeless health initiatives in CalOptima's Case Management Department. Staff anticipates filling these proposed new positions in September 2019. The total estimated annual cost for the two impact is approximately $324,000, or $270,000 for the ten-month period from September 1, 2019, through June 30, 2020.

Implement pilot program for mobile health units and fixed clinic locations

Based on recent Board actions, CalOptima staff is in the process of expanding healthcare services options available to members experiencing homelessness, including access to preventive and primary services, at the shelter sites. CalOptima staff has also received stakeholder feedback that such services would be of value at other "hot spots," such as parks and soup kitchens. In a separate Board action, CalOptima staff is requesting consideration of modifying its quality improvement strategies, "CalOptima Days", to incentivize FQHCs and FQHC Look-alikes to provide health care services through their mobile units at shelters and other hotspots in the community. Additionally, some clinics are establishing fixed clinical sites within the four walls of the shelter. As proposed, the mobile clinics and fixed shelter locations will establish a regular schedule based on input from the shelters/hotspots, encourage CalOptima Members to seek services from their assigned CalOptima providers, and coordinate services with other medical and behavioral health care providers when appropriate. In order to better monitor utilization and coordination of services on a pilot basis, CalOptima staff recommends reimbursing the clinics for services provided in the mobile unit or fixed shelter location through CalOptima based on the CalOptima Medi-Cal fee schedule regardless of the Member's health network assignment for service rendered August 1, 2019 through March 31, 2020, to coincide with the Clinical Field Team pilot program. Through this process reimbursement will only be provided for Members eligible with CalOptima at the time services are rendered.

Ratify contract amendment with Families Together of Orange County

The Clinical Field Team pilot program is making available urgent care type medical services to Orange County's homeless Members onsite where they are located. This delivery model is designed to reduce delays in care that some homeless Members may experience, whether caused by unwillingness to access services in a typical office-based care setting, challenges with transportation or appointment scheduling, or other factors. Services provided at the Member's location also help prevent or reduce avoidable medical complications such as hospitalizations, re-hospitalizations, emergency department visits, adverse drug events, and progression of disease. For the pilot program, CalOptima has engaged FQHCs (and FQHC Look-alikes) to provide medical services because they provide services to both CalOptima Members and non-CalOptima members; including those who are uninsured. Four community clinics were initially engaged to provide services under the Clinical Field Team pilot program. As indicated, on February 22, 2019, the Board allocated funds for start-up costs for the Clinical Field Team pilot program, resulting in approximately $320,000 in start up funding available per clinic for up to five clinics. Families Together of Orange County was contracted as the fifth provider effective May 17, 2019 and has been provided with start-up funding.

CalOptima staff recommends the Board authorize up to $300,000 from the $10 million allocated on June 27, 2019 towards "Clinic health care services in all homeless shelters" to provide funding for these payments through June 30, 2019. Similar to the Clinical Field Team pilot program, CalOptima will contract with FQHCs and FQHC Look-alikes operating mobile units to provide medical services to CalOptima Members. Reimbursement provided by CalOptima for services provided through the mobile units will apply to CalOptima members as FQHCs are able to obtain alternate funding sources for services provided to individuals not eligible with CalOptima. To be eligible to contract with

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CalOptima, the mobile unit must meet Health Resources and Services Administration (HRSA) and CalOptima requirements.

Fiscal Impact

The recommended action to reimburse FQHCs and FQHC look-alikes for services provided in a mobile until for the period August 1, 2019, through March 31, 2020, is a budgeted item. Expenses of up to $300,000 for claims payments and up to $270,000 for staffing expenditures for two new positions is budgeted under homeless health related initiatives in the FY 2019-20 Operating Budget approved by the Board on June 6, 2019, and will be funded from the "Clinic health care services in all homeless shelters" category approved by the Board on June 27, 2019.

The recommended action to reallocate $135,000 in budgeted funds within the Medi-Cal line of business from medical expenses to administrative expenses for the Sr. Project Manager position is budget neutral. Staff will monitor the claims volume. To the extent there is an additional fiscal impact, such impact will be addressed in separate Board actions.

Rationale for Recommendation

Due to the unique access issues associated with receipt of healthcare services for CalOptima Members experiencing homelessness, CalOptima staff recommends these actions to facilitate increased access to services and ongoing operational and clinical support of the initiatives.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated February 22, 2019, Consider Actions Related to Homeless Health Care Delivery Including, but not limited to, Funding and Provider Contracting
2. Board Presentation dated March 7, 2019, Homeless Health Update
3. Board Action dated April 4, 2019, Consider Actions Related to Delivery of Care for Homeless CalOptima Members
4. Board Action dated April 4, 2019, Consider Ratifying Implementation of Actions and Contracts with Federally Qualified Health Centers for Board Authorized Clinical Field Team Pilot Program
5. CEO Report to the CalOptima Board of Directors dated May 2, 2019
6. Board Action dated June 27, 2019, Consider Funding Allocations Related to Supervisor Do's Homeless Healthcare Proposal

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

Authorized Signature **Date**

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Attachment to August 1, 2019 Board of Directors Meeting – Agenda Item 16

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Altamed Health Services Corporation	2040 Camfield Ave	Los Angeles	CA	90040
APLA Health & Wellness	611 S Kingsley Dr	Los Angeles	CA	90005
Benevolence Industries Inc dba Benevolence Health Centers	1010 Crenshaw Blvd	Torrance	CA	90501
Camino Health Center	30300 Camino Capistrano	San Juan Capistrano	CA	92675
Central City Community Health Center	1000 San Gabriel Blvd., Suite 200	Rosemead	CA	91770
Families Together of Orange County	661 W 1st St Suite G	Tustin	CA	92780
Friends of Family Health Center	501 S Idaho St Suite 260	La Habra	CA	90631
Hurtt Family Health Clinic, Inc	1 Hope Dr	Tustin	CA	92782
Korean Community Services Inc	8633 Knott Ave	Buena Park	CA	90620
Laguna Beach Community Clinic	362 3rd St	Laguna Beach	CA	92651
Livingstone Community Development Corpration dba Livingstone Community Health Clinic	12362 Beach Blvd, Suite 10	Stanton	CA	90680
Mission City Community Network Inc	8527 Sepulveda Blvd.	North Hills	CA	91343
Nhan Hoa Comprehensive Health Care Clinic	7761 Garden Grove Blvd	Garden Grove	CA	92841
North Orange County Regional Health Foundation	901 W Orangethorpe Ave	Fullerton	CA	92832
The Regents of the University of California, a California Constitutional Corp, UCI Family Medical Center	333 City Blvd West, Suite 200	Orange	CA	92868
Serve the People, Inc. dba Serve the People Community Health Center	1206 E 17th St, Suite 101	Santa Ana	CA	92701

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Share our Selves Corporation	1550 Superior Ave	Costa Mesa	CA	92627
Southland Integrated Services Inc dba Southland Health Center	1618 W 1st St	Santa Ana	CA	92703
St Jude Neighborhood Health Centers	731 S Highland Ave	Fullerton	CA	92832
Vista Community Clinic dba VCC The Gary Center	1000 Vale Terrace Dr	Vista	CA	92084

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Homeless Health Care Delivery

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

Michael Schrader
Chief Executive Officer

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Agenda

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

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Current System of Care

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

**For Medi-Cal Members*

Current System of Care (Cont.)

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

Gaps in the Current System of Care

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

Immediate Response

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

Strengthened System of Care

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

Federal and State Guidance

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

Federal and State Guidance (Cont.)

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

Activities in Other Counties

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

Considerations

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

Additional Considerations

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

Recommended Actions

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

Recommended Actions (Cont.)

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

CalOptima's Mission

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

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Homeless Health Care Delivery

Board of Directors Meeting
March 7, 2019

Michael Schrader
Chief Executive Officer

Back to Agenda

Agenda

- Clinical field team pilot
- CalOptima Homeless Response Team
- Other expanded service options under consideration

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Clinical Field Team Pilot

- Board approved up to $1.6 million in IGT 6/7 dollars for startup funding for a clinical field team (CFT) pilot of up to 1 year with Federally Qualified Health Centers (FQHCs)
- Develop parameters and structure for pilot program
  - Partner with up to five interested FQHCs that will:
    - Establish regular hours at high-volume shelters
    - Deploy to community locations on short notice
    - Coordinate to arrange for coverage with extended hours
    - Deliver urgent-care-type services to homeless individuals in need
      - Bill CalOptima for current CalOptima members
      - FQHCs to seek federal funding as payment for non-CalOptima members
- Staff working to complete contract amendments with FQHCs

Homeless Response Team

- Board authorized CalOptima Homeless Response Team
  - Eight new positions in Case Management department
  - Primary point of contact at CalOptima for homeless health services for CalOptima members
    - Dedicated phone line
    - Extended hours
  - Coordinate scheduling and dispatch of CFTs
  - Work closely with County, shelters and providers
    - Make regular field visits to shelters and recuperative care facilities providing services to CalOptima members
- Recruiting to fill positions

Expanded Service Options Under Consideration

- Embedded clinics at shelters
  - FQHCs to consider establishing regular hours for CFTs at selected high-volume shelters with deployment to other community locations on demand
- Whole-Person Care (WPC) hospital navigators
  - Increase per-diem and APR-DRG reimbursement to contracted hospitals for integrating into the WPC program
- Increased access to skilled nursing services
  - Deliver skilled services (e.g., home health nursing, physical therapy or IV antibiotics, etc.) at recuperative care facilities in lieu of skilled nursing facility placement

Expanded Service Options Under Consideration (cont.)

- Recuperative care beyond 90 days
  - Set up a post-WPC recuperative care program
  - Reallocate part of $10 million in IGT6/7 already allocated to the County's WPC program for recuperative care
    - From WPC recuperative care funds
    - To develop post-WPC recuperative care program
- Recuperative care with behavioral health focus
  - Coordinate with County to explore possibilities of:
    - Existing recuperative care facilities dedicating space for CalOptima members with underlying Serious Mental Illness (SMI)
    - Contracting with recuperative care vendor for a dedicated facility with behavioral health focus

Expanded Service Options Under Consideration (cont.)

- Housing supportive services
  - CalOptima could contribute Medi-Cal funding toward housing supportive services (not including rent) for certain CalOptima members under an 1115 waiver program
    - WPC
      - Link clients to other programs that provide housing supportive services
      - Amend County contract with the State to include a funding pool that CalOptima can contribute to for housing supportive services
    - Health Homes Program
      - For members with multiple chronic conditions who also meet acuity criteria (multiple ER visits, inpatient stays or chronic homelessness)
      - Members must elect to participate
      - Care management includes housing navigation

Expanded Service Options Under Consideration (cont.)

- Housing development and rental assistance
  - Obtaining legal opinion
  - Seeking guidance from the Department of Health Care Services

Next Steps

- Conduct further study on expanded service options under consideration, get feedback from stakeholders and return to Board for authority as appropriate on the following possibilities:
  - WPC hospital navigators
  - Increased access to skilled nursing services
  - Recuperative care beyond 90 days
  - Recuperative care with behavioral health focus
  - Housing supportive services
  - Housing development and rental assistance

CalOptima's Mission

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

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Homeless Health Care Update

Board of Directors Meeting
April 4, 2019

Michael Schrader
Chief Executive Officer

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Impetus for Action in Orange County

- Address homeless crisis with urgency and commitment
- Address trend of homeless deaths
- Build a better system of care for members who are homeless that is long-lasting and becomes part of established delivery system
- Prioritize population health for this group

Homeless Deaths

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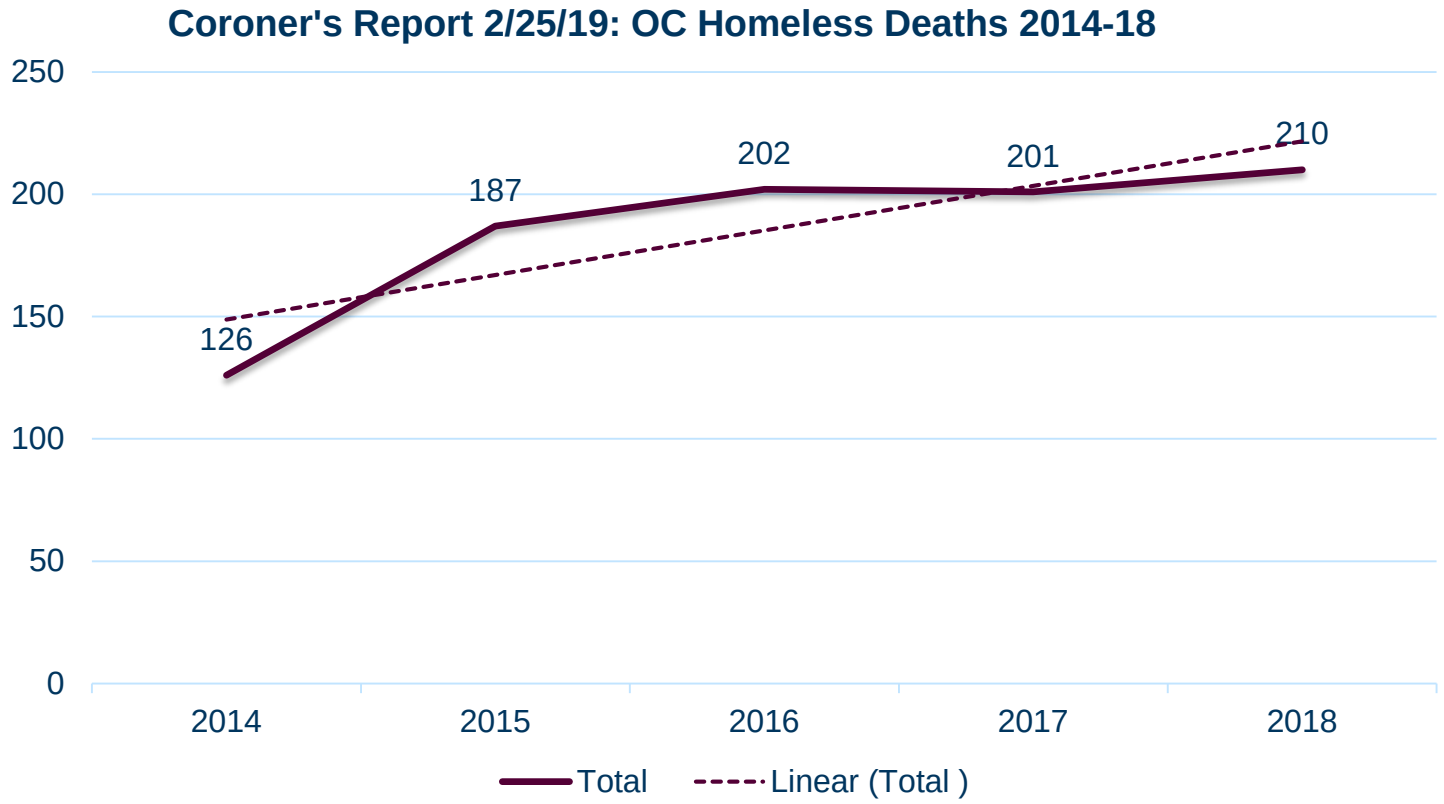
Coroner’s Report on Homeless Deaths



- Includes all homeless deaths in Orange County, not limited to CalOptima members
- Methodology of reporting and identification of homeless may vary by county
- Increased homeless death rates over the past five years reported in the media statewide

Coroner's Report on Homeless Deaths And Possible Interventions

- Natural causes (42% homeless v. 83% total OC population)
  - Clinical field teams (CalOptima)
  - CalOptima Homeless Response Team (CalOptima)
  - Recuperative care (County and CalOptima)
- Overdose (24% homeless v. 5% total OC population)
  - Opioid prescribing interventions (CalOptima)
  - Medication-assisted treatment (County and CalOptima)
  - Substance use disorder centers (County)
  - Medical detox (CalOptima)
  - Social model detox (County)
  - Naloxone (County and CalOptima)
  - Needle exchange (County)

Coroner's Report on Homeless Deaths And Possible Interventions (cont.)

- Traffic accidents (12% homeless v. 3% total OC population)
- Suicide (7% homeless v. 4% total OC population)
  - Moderate-severe behavioral health (County)
    - Crisis intervention
    - Post-acute transitions
    - Intensive outpatient treatment programs
  - Mild-moderate behavioral health (CalOptima)
    - Screening
    - Early treatment
- Homicide (6% homeless v. 1% total OC population)
- Other accidents (5% homeless v. 5% total OC population)
- Undetermined (3% homeless v. 1% total OC population)

Quality Assurance Committee
Further Clinical Analysis

- Deeper analysis into causes of deaths and interventions
- Case studies for each cause of homeless death
- Benchmarks and comparison with interventions and resources in other counties
- Presentations from partnering organizations

Better System of Care

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Ad Hoc Recommendations

- Take action to commit $100 million for homeless health
  - Create a restricted homeless health reserve
  - Stipulate that funds can only be used for homeless health

New Initiatives/Projects	BOD Approved	Pending BOD Approval	Funding Category
Be Well OC	$11.4 million		IGT 1–7 ($24 million total)
Recuperative Care	$11 million		
Clinical Field Team Startup	$1.6 million		
CalOptima Homeless Response Team ($1.2 million/year x 5 years)	$1.2 million	$4.8 million	IGT 8 and FY 2018–19 operating funds ($76 million total)
Homeless Coordination at Hospitals ($2 million/year x 5 years)		$10 million	
New Initiatives		$60 million	
Total Reserve: $100 million	**$25.2 million**	**$74.8 million**	

Clinical Field Team Structure

- Team Components
  - Includes clinical and support staff
  - Vehicle for transportation of staff and equipment
  - Internet connectivity and use of Whole-Person Care (WPC) Connect
- Clinical Services
  - Urgent care, wound care, vaccinations, health screening and point-of-care labs
  - Prescriptions and immediate dispensing of commonly used medications
  - Video consults, referrals, appointment scheduling and care transitions

Clinical Field Team Structure (cont.)

- Referrals and Coordination
  - Coordination with CalOptima Homeless Response Team
  - Coordination with providers
  - Referrals for behavioral health, substance abuse, recuperative care and social services
- Availability and Coverage
  - Regular hours at shelters/hot spots
  - Rotation for on-call services from 8 a.m.–9 p.m. seven days a week, with response time of less than 90 minutes

Clinical Field Team Partnerships

- Five FQHCs have received contract amendments
  - AltaMed
  - Central City Community Health Center*
  - Hurtt Family Health Clinic*
  - Korean Community Services*
  - Serve the People*
- Contract amendments to be authorized/ratified at April Board meeting, per Board direction
- Go-live
  - Deploy on a phased basis, based on FQHC readiness

** Signed contract amendment*

CalOptima Homeless Response Team

- Phone line and daily hours (8 a.m.–9 p.m.) established
  - Available to Blue Shirts and CHAT-H nurses
  - Primary point of contact at CalOptima for rapid response
- Coordinate and dispatch clinical field teams
- Serve as liaisons with regular field visits to shelters/hot spots in the county and recuperative care facilities
  - Establish working in-person relationships with collaborating partners
  - Assess and coordinate physical health needs for CalOptima members

Homeless Population in CalOptima Direct

- Pursue moving members who are homeless to CalOptima Direct, subject to regulatory approval
  - Maximum flexibility with access to any provider (no PCP assignment)
  - Fast-tracked authorization processing
  - Direct medical management in collaboration with clinical field teams, CalOptima Homeless Response Team, and County Blue Shirts and CHAT-H nurses
  - Connectivity with WPC Connect and CalOptima population health platform
- In the interim, move members identified in the field based on choice
- Obtain stakeholder input
  - County, PAC, MAC and health networks

Homeless Coordination at Hospitals

- COBAR in April
- Help hospitals meet SB 1152 requirements for homeless-specific discharge planning and care coordination, effective July 1, 2019
- Utilization by hospitals of data sharing technology to help facilitate coordination of services for CalOptima members who are homeless
- Proposing 2 percent increase to the inpatient Classic rates for Medi-Cal contracted hospitals
  - $2 million financial impact per year
  - Distributes funding based on volume of services provided to members

Medical Respite Program

- Recuperative care beyond 90 days
  - Reallocate $250,000 of the $10 million in IGT6/7 already allocated to the County's WPC program for recuperative care
  - Leverage existing process
    - County to coordinate and pay recuperative care vendor
    - CalOptima to reimburse County for 100 percent of cost
  - COBAR in April
  - Return to CalOptima Board for ratification of associated policy

WPC Connect

- Data-sharing tool for coordinating care used by the Whole-Person Care collaborative
  - Specifically used for homeless individuals
  - Includes social supports and referrals to services
  - Includes community partners (e.g., Illumination Foundation, 211, Lestonnac, Health Care Agency, Social Services Agency, hospitals, community clinics, health networks and CalOptima)
- WPC Connect workflow
  - Community partners can, with consent, add individuals into WPC Connect system once identified as homeless
  - WPC Connect sends an email notification and/or text message to identified care team for homeless individuals seen in ER, admitted to hospital or discharged

WPC Connect (cont.)

- CalOptima use of WPC Connect
  - Case management staff is trained and actively uses the system
    - Identify members enrolled in WPC
    - Coordinate with other partners caring for members
    - Access information from other partners

- Status of WPC Connect
  - Five hospitals are currently connected
  - COBAR to amend hospital contracts to support a discharge process for members experiencing homelessness, including the utilization by hospitals of data-sharing technology to help facilitate coordination of services with other providers and community partners

Better System of Care: Future Planning

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Evolving Strategy and Homeless Health Needs

- Propose and respond to changes
  - Regulatory and legislative
  - Available permanent supportive housing and shelters
  - State programs (e.g., expanded WPC funding and Housing for a Healthy California Program)
- Identify other potential uses for committed funds to optimize the delivery system, subject to Board consideration, for example:
  - Enrollment assistance
  - Enhanced data connectivity technology
  - Housing supportive services
  - Other physical health services
  - Rental assistance and shelter, if permissible

Recommended Actions

- Separate COBARs
  - Clinical field team implementation
  - Medical respite program
  - Homeless coordination at hospitals

- Additional action recommended by Board Ad Hoc
  - Create a restricted homeless health reserve in the amount of $100 million
    - $24 million – previously approved initiatives using IGT 1–7 funds
    - $76 million – all IGT 8 funds (approximately $43 million) with balance from FY 2018–19 operating funds
  - Stipulate that funds can only be used for homeless health

CalOptima's Mission

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

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 4, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

5. Consider Ratifying Implementation Actions and Contracts with Federally Qualified Health Centers for Board Authorized Clinical Field Team Pilot Program

Contact

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

Recommended Actions

1. Ratify implementation plan for Board authorized Clinical Field Team Pilot Program (CFTPP);
2. Ratify contracts with Federally Qualified Health Centers (FQHC) selected to participate in the CFTPP; and
3. Authorize expenditures of up to $500,000 from existing reserves to fund the cost of services rendered to homeless CalOptima Medi-Cal members on a fee-for-service (FFS) basis through June 30, 2019.

Background

CalOptima is responsible for arranging for the provision of physical health and mild to moderate behavioral health services to all CalOptima members. Among other things, the County of Orange is responsible for providing services related to Serious Mental Illness and Substance Use Disorder. The County of Orange also provides housing support services for the homeless through multiple programs. In combination, these services provide a continuum of care for CalOptima members.

The goal of the continuum of care is to coordinate physical and mental health, substance use disorder treatment and housing support. However, members who are identified as "homeless" based on the lack of permanent housing sometimes have unique challenges receiving healthcare services. These individuals sometimes have difficulty scheduling and keeping medical appointments and also sometimes face challenges with transportation to their medical providers. The County of Orange currently provides assistance in linking homeless individuals to mental health and substance use disorder treatment. In partnership with the County in these efforts, and as part of CalOptima's ongoing efforts to be responsive to stakeholder input and explore more effective means of delivering health care services to Medi-Cal beneficiaries, the CalOptima Board met at a special meeting on February 22, 2019 to consider the unique needs of the homeless population.

At the February 22, 2019 meeting, the CalOptima Board authorized the establishment of the CFTPP and allocated up to $1.6 million in IGT 6/7 dollars in support of this effort. The Board also authorized the establishment of a Homeless Response Team and directed staff to move forward with the program and return with a request for ratification of implementing details. As discussed at the February 22, 2019 meeting, the plan was for staff to move forward with amendments to contract with qualifying Federally Qualified Health Centers (FQHCs), which can receive federal funding as reimbursement for services provided to non-CalOptima members, as well payments from CalOptima for covered, medically necessary services provided to CalOptima Medi-Cal members.

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Discussion

Clinical Field Team Pilot Program (CFTPP)

The Clinical Field Team pilot program was designed with the intent to provide needed, urgent care type medical services to homeless members in Orange County, onsite where they are located. Services provided where the members are located is expected to help prevent avoidable medical complications, hospitalizations, re-hospitalizations, emergency department visits, adverse drug events, and progression of disease.

Services provided will be reimbursed based on the CalOptima Medi-Cal fee schedule directly by CalOptima regardless of the member's health network eligibility. As also indicated, under the CFTPP, CalOptima will establish a Homeless Response Team which will be dedicated to the homeless health initiative. Requests for physical health care services identified by County workers will be requested to and deployed by CalOptima's Homeless Response Team.

As indicated, at the February 22, 2019 meeting, the Board authorized reallocation of up to $1.6 million in designated but unused funds from IGT 1, IGT 6 and IGT 7 for start-up costs. As part of the CFTPP, CalOptima staff anticipates contracting with up to five FQHCs for services, resulting in $320,000 per FQHC for start-up funding. Specifically, Management recommends the following reallocations:

- $500,000 from IGT 1 – Depression Screenings;
- $100,000 from IGT 6 – IS and Infrastructure Projects;
- $500,000 from IGT 7 – Expand Mobile Food Distribution Services; and
- $500,000 from IGT 7 – Expand Access to Food Distribution Services for Older Adults.

In addition, CalOptima will provide payment to FQHCs for services rendered to CalOptima's Medi-Cal members on a FFS basis. Management recommends the Board authorize up to $500,000 from existing reserves to provide funding for these payments through June 30, 2019. Management plans to include additional funding for services provided as part of the CFTPP beyond this date in the FY2019-20 budget.

CalOptima staff has engaged FQHCs (and/or FQHC Look-alikes) to provide medical services because of their ability to provide (and be reimbursed for) services to both CalOptima members and non-CalOptima members; including those who are uninsured. Service reimbursement from CalOptima will only be provided for CalOptima members, and FQHCs are able to obtain alternate funding sources for services provided to individuals not enrolled with CalOptima. In order to select participating FQHCs for the pilot CalOptima requested that interested parties respond to questions regarding their experience providing clinical services to individuals experiencing homelessness, if similar services were already being provided in Orange County, if they were able to meet key requirements under the pilot, and if they were able to begin providing services on April 1, 2019. (number) responded to the questionnaire and the following five FQHCs were selected:

- AltaMed Health Services Corporation
- Central City Community Health Center
- Hurtt Family Health Clinic, Inc.
- Korean Community Services, Inc. dba Korean Community Services health Center
- Serve the People Community Health Center

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Once implemented, CFTPP program performance and results will be monitored and reported to the Board for further continuation or modification.

FQHC Contracts

CalOptima staff is in the process of amending contracts with the five identified FQHCs, whose mission and federal mandate are to deliver care to the most vulnerable individuals and families, including people experiencing homelessness in areas where economic, geographic, or cultural barriers limit access to affordable health care service. This ensures that homeless individuals, who are not currently CalOptima members, will also receive care as needed.

The contracted FQHCs will provide one or more clinical, field-based teams which will include clinical and support staff, point of care lab testing and frequently used medications to be disbursed to the homeless at their locations. Among the services to be provided by the field-based teams, Members will be able to receive wound care, vaccinations, health screenings and primary care and specialist referrals. Services will be available at extended hours and on-call. Services will be coordinated with CalOptima's Homeless Response Team, PCP, and Health Networks as appropriate.

Staff requests Board ratification of the existing agreements with the 5 FQHCs and the authority to contract with additional FQHCs as necessary to cover the scope of services under the pilot program.

Fiscal Impact

The recommended action to authorize expenditures to fund the cost of services rendered to CalOptima Medi-Cal members under the CFTPP program on a FFS basis is an unbudgeted item. A proposed allocation of up to $500,000 from existing reserves will fund this action through June 30, 2019. Management plans to include projected expenses associated with the CFTPP in the CalOptima Fiscal Year 2019-20 Operating Budget.

Rationale for Recommendation

Due to the unique access issues associated with receipt of healthcare services for individuals in the community who lack permanent housing, CalOptima staff recommends this action to ensure access by providing urgent health care services where these individuals are located.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. Board Presentation: Special Meeting of the CalOptima Board of Directors February 22, 2019, Homeless Health Care Delivery

/s/ Michael Schrader — *3/27/2019*

Authorized Signature — **Date**

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CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AltaMed Health Services Corporation	2040 Camfield Ave.	Commerce	CA	90040
Central City Community Health Center	1000 San Gabriel Boulevard	Rosemead	CA	91770
Hurtt Family Health Clinic, Inc.	One Hope Drive	Tustin	CA	92782
Korean Community Services, Inc. dba Korean Community Services Health Center	8633 Knott Ave	Buena Park	CA	90620
Serve the People Community Health Center	1206 E. 17th St., Ste 101	Santa Ana	CA	92701

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Homeless Health Care Delivery

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

Michael Schrader
Chief Executive Officer

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Agenda

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

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Current System of Care

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

**For Medi-Cal Members*

Current System of Care (Cont.)

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

Gaps in the Current System of Care

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

Immediate Response

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

Strengthened System of Care

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

Federal and State Guidance

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

Federal and State Guidance (Cont.)

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

Activities in Other Counties

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

Considerations

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

Additional Considerations

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

Recommended Actions

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

Recommended Actions (Cont.)

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

CalOptima's Mission

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

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MEMORANDUM

DATE:	May 2, 2019
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; and Whole-Child Model Family Advisory Committee

Homeless Health Initiatives Underway; Clinical Field Teams Launched in April
CalOptima moved our $100 million commitment to homeless health from concept into action this past month in several ways, most notably with the launch of clinical field teams. Guided by your Board's ad hoc committee, which is meeting weekly to spearhead the effort, selected initiatives are summarized below.

- Clinical Field Teams: Launched on time on April 10, CalOptima's first clinical field team conducted its first medical visit with a member at a Santa Ana park. Following a newly established process, the Orange County Health Care Agency's Outreach and Engagement team contacted our internal Homeless Response Team, which then dispatched a Central City Community Health Center (CCCHC) field team, consisting of a physician assistant and medical assistant. The field team treated a member needing care for a sizable open wound. CalOptima and CCCHC agree the initial experience was successful and instructive. Since that time, three other Federally Qualified Health Center (FQHC) partners have begun their programs, including Korean Community Services on April 17, Hurtt Family Health Clinic on April 18 and Serve the People on April 23. We are communicating with other FQHCs, directly and through the Coalition of Orange County Community Health Centers, about their potential participation in the clinical field team program. As we develop a better understanding of the population, its needs and the best methods for serving them, we will continue expanding our coverage.
- Anaheim Encampment: Reflecting our commitment to meeting the healthcare needs of members experiencing homelessness, CalOptima recently participated in a collaborative effort to clear a homeless encampment of approximately 70 people in 40 tents along a stretch of railroad tracks located in Anaheim. The group included the County's Outreach and Engagement team, the City of Anaheim, public health nurses, and other service providers. CalOptima arranged FQHC mobile clinics to work alongside the group to address any medical needs of the homeless. In addition, CalOptima had a case manager on site to make referrals.
- Use of Funds: Approximately $60 million of CalOptima's homeless health commitment is for new initiatives not yet identified. CalOptima is obligated to follow statutory, regulatory, and contractual requirements in determining the type of initiatives that are permissible. To that end, CalOptima has publicly shared the "Use of CalOptima Funds" document that follows this report. The information about the agency's framework and

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allowable use of funds will ensure the community is aware of the principles guiding your Board's decision making regarding homeless health.

- Stakeholder Input: The Board ad hoc committee will be seeking additional input to our homeless health initiatives through meetings with stakeholders. CalOptima is in the process of identifying people and/or organizations to engage and will begin setting up those meetings. Recently, the ad hoc committee met with Former Santa Ana City Councilwoman Michele Martinez, Illumination Foundation CEO Paul Leon and Pastor Donald Dermit, from The Rock Church in Anaheim.
- State Programs and Legislation: Efforts to end the homeless crisis are ongoing statewide, and CalOptima is tracking a variety of bills and programs that have potential to positively impact Orange County. One example is the Housing for a Healthy California Program, which is a new source of funds for supportive housing through the Department of Housing and Community Development (DHCD). The program provides supportive housing for Medi-Cal members to reduce financial burdens related to medical and public services overutilization. DHCD is expected to open applications to supportive housing owners and developers for grants that total $36 million statewide. Orange County Health Care Agency intends to work with owners and developers to explore this funding opportunity. Separately, Assembly Bill 563 is state legislation that would grant the North Orange County Public Safety Task Force $16 million in funding to set up comprehensive crisis intervention infrastructure. The aim is to mitigate the local mental health and homeless crisis by expanding and coordinating the many available services, potentially through the Be Well OC Regional Mental Health and Wellness Campus. The bill is currently in the early stages of the legislative process.

Impact of New Knox-Keene Licensure Regulation Will Be Mitigated by Exemptions

With an effective date of July 1, 2019, a new Department of Managed Health Care (DMHC) global risk regulation will substantially expand the number of health care organizations required to have a Knox-Keene license. Fortunately, CalOptima was able to mitigate local concerns that the rule applied to our delegated health networks, which operate under three models — Health Maintenance Organizations (HMOs), Physician-Hospital Consortia (PHCs) and Shared-Risk Groups (SRGs). DHMC has now confirmed that CalOptima's limited Knox-Keene licensed HMO health networks may continue their current contractual arrangements with CalOptima, and the regulator has reached out to our partners to update their licenses. With regard to PHCs and SRGs, the DMHC has reviewed CalOptima's template contracts and believes that these limited risk-sharing arrangements will qualify for exemptions from the new licensure requirement. Contracts that renew or are amended after July 1, 2019, will need to be submitted to the DMHC for a review and exemption process that is anticipated to take no longer than 30 days. CalOptima staff has informed our health network partners about this latest positive development.

California Children's Services (CCS) Advisory Group Meeting Focuses on CalOptima Readiness for Transition

Implementation of the Whole-Child Model (WCM) for CCS in Orange County is now only two months away. Given our impending transition, CalOptima was the focus of an April 10 meeting of the CCS Advisory Group, a highly engaged Department of Health Care Services (DHCS)-appointed panel of medical experts and member advocates who are dedicated to ensuring the WCM effectively serves children with complex CCS conditions. CalOptima Chief Medical Officer David Ramirez, M.D., Executive Director of Clinical Operations Tracy Hitzeman and

Thanh-Tam Nguyen, M.D., our medical director for WCM, shared detailed information about our authorization process, provider panel, delegated delivery system and more, all from the member's perspective. Our WCM Family Advisory Committee Representative Kristen Rogers also spoke. The meeting was an important opportunity to instill confidence about our ability to effectively integrate the CCS program, and we successfully demonstrated CalOptima's careful preparations for WCM. Feedback from the advisory group and DHCS leaders was supportive.

Future Medi-Cal Expansion (MCE) Rates Face Likely Reduction as State Regulator Examines CalOptima Reimbursement

Following a trend established across the past few years, DHCS is signaling a likely reduction in CalOptima's MCE capitation rates for FY 2019–20. Staff was notified in April that a significant adjustment may be ahead, based on the fact that CalOptima's reimbursement for the MCE population is a noticeable outlier. Specifically, DHCS identified that CalOptima's provider capitation and risk pool incentive payouts are significantly higher than those paid by other managed care plans in California. Staff has been in close communication with state officials who will soon share our draft rates. Importantly, we are continuing to communicate with our provider partners so they can plan ahead for a possible reduction. As more information becomes available, staff will look to your Board's Finance and Audit Committee for guidance on any adjustments to provider reimbursement.

CalOptima Welcomes New Executive Director, Human Resources

This past month, Brigette Gibb joined CalOptima as Executive Director, Human Resources. She has more than 35 years of public-sector experience. Most recently, Ms. Gibb worked as the human resources director for the Orange County Fire Authority (OFCA), where she led and directed the administration, coordination and evaluation of all human resources and risk management functions. She has established and maintained effective working relationships with the OCFA Board of Directors, city managers, executive team members and labor group representatives. She holds a master's degree in public administration, with a concentration in human resources, from California State University, Fullerton.

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SUPPLEMENTAL BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 27, 2019
Special Meeting of the CalOptima Board of Directors

Supplemental Report Item
S17a. Consider Funding Allocations Related to Supervisor Do's Homeless Healthcare Proposal

Recommended Actions
Authorize the $60 million identified for new homeless health initiatives as follows:
1. Clinic health care services in all homeless shelters – $10 million
2. Authorize mobile health team to respond to all homeless providers – $10 million
3. Residential support services and housing navigation – $20 million
4. Extend recuperative care for homeless individuals with chronic physical health issue – $20 million

Background
Supervisor Do is requesting consideration to allocate the $60 million identified at the February 22, 2019 Special Board of Directors meeting as follows:
1. Clinic health care services in all homeless shelters – $10 million
2. Authorize mobile health team to respond to all homeless providers – $10 million
3. Residential support services and housing navigation – $20 million
4. Extend recuperative care for homeless individuals with chronic physical health issue – $20 million

Attachments
1. May 29, 2019 Letter from Supervisor Do
2. June 5, 2019 Letter from Michael Schrader and the CalOptima Board Ad Hoc Committee on Homeless Health
3. June 6, 2019 Letter from Supervisor Do

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ANDREW DO
SUPERVISOR, FIRST DISTRICT

ORANGE COUNTY BOARD OF SUPERVISORS
333 W. SANTA ANA BLVD., P.O. BOX 687, SANTA ANA, CALIFORNIA 92702-0687
PHONE (714) 834-3110 FAX (714) 834-5754 andrew.do@ocgov.com

May 29, 2019

Mr. Michael Schrader
CalOptima
505 City Pkwy
Orange, CA 92868

SUBJECT: Request for June 14 Special Meeting on CalOptima's Response to Deaths of Homeless Members

Dear Mr. Schrader,

Given the information my office recently received from CalOptima, I am writing to reiterate my profound concerns regarding the agency's slow rate of progress for homeless services, particularly in light of the Board's Directives to establish homeless services since February 2019. I am also frustrated that out of the 210 homeless deaths last year, 153 were CalOptima members, despite my repeated requests for such services through all of last year. If ever, the time for action is now. We have had 25 more homeless deaths in the first two months of 2019 alone. To assist you and the Homeless Ad Hoc Committee, I am submitting four programs that CalOptima can implement immediately to provide care to our members who are living on the street.

A staggering 73 percent of those who died were enrolled in CalOptima services but were not provided adequate services. In the four months since the Board of Directors authorized my proposed Mobile Health Team, CalOptima has only served 47 individuals out of a population of almost 6,860 homeless residents countywide. Of those 47 patients, 36 were our members. While these feeble numbers should concern you as to the effectiveness of our outreach efforts, they clearly answer your question whether homeless individuals are CalOptima members. CalOptima is permitted to provide services to them using Medicaid funds.

Given such clear mandates, I don't understand your refusal to take referrals from providers other than the Orange County Health Care Agency's Outreach and Engagement Team. Many providers throughout the county interact with our county's homeless population. Such a restriction will necessarily limit the number of cases referred to CalOptima. It also flies in the face of the Board's repeated pledge that we are looking at every way legally possible to provide services.

Additionally, CalOptima's refusal to provide regularly scheduled clinics that led to the flawed decision to provide services solely on an on-call basis places the burden on the County to identify patients and wait with them in the field until CalOptima's contracted clinics show up. Not only is this a wasteful and inefficient model; but given that the wait is sometimes up to two hours, it's no wonder why so few homeless residents have taken up our services.

Finally, I don't understand why CalOptima refuses to provide and the Homeless Ad Hoc Committee has not recommended services at any of the multiple homeless shelters run by the County and Cities. Has CalOptima even done a cursory survey to see if the shelters, in fact, do not have CalOptima members? If you have not done so and, nevertheless, refuse to provide services, your

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choice is, at a minimum, harmful and negligent. With the data cited above showing actual CalOptima membership among the homeless, I would submit that CalOptima's continuing refusal is in wanton disregard of public health.

For two years, I have experienced consistent pushback to my demands for enhanced homeless health care from you, counsel and other Directors at CalOptima. I have been told repeatedly by CalOptima staff and counsel that CalOptima can only fund core health care services for CalOptima members, and these homeless individuals were not CalOptima members, therefore the agency was limited in what it can do.

Even after we were confronted in February in federal court with the number of homeless deaths, our Board's and CalOptima's staff response continued to be one of denial. After all this time we still needed research to confirm if any of these homeless who died were actually members of CalOptima. Now that the facts are overwhelmingly clear, the public will not wait for more feasibility studies or meetings to discuss what can be done.

In addition, $60 million for new unnamed homeless health initiatives has already been allocated by the Board. To date, no proposals are forthcoming for the June board meeting. Since the Board does not meet in July, it will be August, at the earliest, before any plans can be discussed by the Board.

Such a delay is unconscionable. Therefore, I am requesting a Special Board of Directors meeting to convene on June 14, where I will propose the following plan to immediately spend the $60 million allocated:

- **C**linic health care services in all homeless shelters - $10 million
- **A**uthorize mobile health team to respond to all homeless providers - $10 million
- **R**esidential support services and housing navigation - $20 million
- **E**xtend recuperative care for homeless individuals with chronic physical health issue-$20 million

The way I see things is our homeless residents are, by definition, indigent. They should receive the health care they need. This is especially true if they have gone through the process to enroll. It is CalOptima's responsibility to find ways to bring health care to them. If one CalOptima member is experiencing homelessness, that should be enough for this agency to spring into action. We can adopt, as a Board, a philosophy of finding a way to say yes, or we can continue to say no, while people are suffering and dying on the street.

My hope is that my request for a Special Board meeting will be met.

Sincerely,

ANDREW DO
Orange County Board of Supervisors
Supervisor, First District

AD/vc

cc: Members, CalOptima Board of Directors
Members, Orange County Board of Supervisors

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CalOptima
A Public Agency
Better. Together.

June 5, 2019

Supervisor Andrew Do
Orange County Board of Supervisors
333 W. Santa Ana Blvd., P.O. Box 687
Santa Ana, CA 92702

Dear Supervisor Do:

Thank you for your May 29 letter expressing concern about CalOptima members experiencing homelessness. We certainly share your interest in changing the course of the current homeless crisis in Orange County. CalOptima has demonstrated our significant commitment to having an impact on the health of this population through the investment of $100 million in financial resources and valuable, focused leadership from staff, executives and the Board.

It is unfortunate you will not be able to attend the June 6 meeting given the urgency you ascribe to this situation. Know that homeless health is a priority issue and that the CalOptima Board ad hoc committee formed to address this topic is actively discussing it on a weekly if not more frequent basis. An update on the homeless health initiatives is planned for the June 6 Board meeting, where you will hear that we are working diligently to find ways to improve the system of care for this population.

Removing yourself from that ad hoc committee may have distanced you from observing the progress that CalOptima is making. Please allow us to clarify a number of points from your letter to facilitate future collaboration, which is essential in addressing the challenges of homelessness. As we have stated before, homeless individuals who have Medi-Cal coverage are the mutual responsibility of CalOptima, and two County agencies, Health Care Agency (HCA) and Social Services Administration (SSA). CalOptima provides access to medical care, HCA provides access to moderate to severe mental health care and substance abuse services, and SSA determines eligibility and enrolls individuals into the Medi-Cal program. It's clear that medical care is only one dimension of the complex homelessness issue that extends to needs for housing, social services and economic support, all of which are overseen by the County. Again, because homeless individuals have needs of our organizations, optimal results can be achieved only if CalOptima and the County work together and are accountable for their respective responsibilities.

While we all are deeply saddened and frustrated by the high rate of homeless deaths in 2018, the incidence of CalOptima membership among this group has been widely discussed since the February 22, 2019, Special Meeting of the CalOptima Board. CalOptima staff is studying the causes of these deaths and considering your assertion that these members died because of a lack

of access to health care. However, whether an individual is a CalOptima member or not, the person can obtain primary care at a clinic, and if the person's need is urgent, obtain emergency care at any hospital emergency room (ER). Overall, approximately $100 million was spent on care for homeless CalOptima members in calendar year 2018. CalOptima data comparing homeless members with the general population CalOptima serves shows that homeless members average more than seven times as many hospital bed days, visit the ER five times more often, visit a specialist almost twice as often and see a primary care doctor 25 percent less. These statistics are telling and will inform the design of a model of care for the homeless that considers their specific challenges. Our goal is to remove barriers and deliver care more appropriately and cost-effectively, which is the reason we launched clinical field teams. Such teams are not intended to replace the care delivery system available to all CalOptima members but to make urgent care available in unique situations when a homeless individual with an urgent care need is unwilling or unable to access the system.

Your comments about the slow rate of progress are out of sync with the experience of the clinical field team launch. Our first team was in the field less than two months from Board approval, and CalOptima quickly ramped up to 48 hours/six days a week of coverage in the month after that. We now have five partner clinics dedicated to providing on-call care anywhere in the county. The totals served are higher than those in your letter. From April 10–May 30, 84 individuals received care, and 70 of them were CalOptima members. We appreciate and celebrate the mammoth effort of the clinics in launching this one-of-a-kind program that Orange County has never seen before. In fact, the genesis of our street medicine teams and how they are deployed was the result of a series of collaborative meetings in January and February between more than a dozen CalOptima and County leaders. This is why the County Outreach & Engagement Team is an essential component of the process in making referrals, building trust in CalOptima's services and ensuring a safe environment for the medical professionals providing the services. Calling the process into question as your letter does conflicts with the intentional design developed collaboratively by County, clinics and CalOptima representatives. At this initial stage, we are honoring the group's direction to coordinate deployment through the County. But we intend to refine the program over time and plan to eventually take referrals from other organizations.

Contrary to your assertion that CalOptima is refusing to offer clinic services at shelters, we are working to bring shelter operators and clinical field team leaders together to forge collaborative relationships that make sense for their facilities and teams. A meeting had been scheduled for May 31, but it was cancelled at the County's request due to County staff vacations. Still, these groups are excited about the prospects of working together, and there has been no "refusal" on our part to do this. We intend to encourage new mutually beneficial partnerships and continue to work to foster collaboration with our County and community partners.

The CalOptima Board homeless health ad hoc is keenly focused on homeless program development for the remaining Board-approved $60 million, seeking uses that are flexible and responsive. To meet that goal, the work of the ad hoc is increasingly inclusive, with the

committee prioritizing meetings with key stakeholders who have invaluable experience working directly with the homeless population. Your suggested CARE programs largely duplicate work already in progress or reflect a request that is outside of CalOptima's scope. We would like to detail this as follows:

- *Clinic health care services in all homeless shelters - $10 million*
  As stated above, we are encouraging clinics to work with shelters. They can choose to do this now and some are. When we are able to meet with clinics, County staff and shelters as a group, we can assess whether additional funding is needed and establish schedules and coverage to meet the health care needs.
- *Authorize mobile health team to respond to all homeless providers - $10 million*
  Your suggestion highlights a process change rather than a funding issue. CalOptima and our clinical field team partners can decide to revise the referral process, and services delivered to the member would be reimbursed regardless of the origin of the referral. CalOptima's homeless response team plans to expand its referral base and has budgeted sufficiently to accommodate growth. Further, there are reasons to keep the County Outreach & Engagement Team involved because oftentimes a member's need may be related to a County-covered services.
- *Residential support services and housing navigation - $20 million*
  The services that you suggest here are key elements of the Whole-Person Care (WPC) pilot, for which the County is the lead. CalOptima respectfully suggests that the County consider working with the state to add a housing pool to the WPC pilot program and also consider requesting additional money as part of its submission to the state for a portion of the governor's increased housing funds for WPC in the FY 2019–20 budget. If the County creates a housing pool under the WPC program, CalOptima could contribute money to the housing pool for housing supportive services. CalOptima staff looks forward to the possibility of partnering with the County on these initiatives within the parameters for which the use of CalOptima Medi-Cal funding is permissible.
- *Extend recuperative care for homeless individuals with chronic physical health issue - $20 million*
  CalOptima has twice allocated funds for recuperative care, bringing the total to $11 million. As you may recall, the CalOptima Board acted at its April meeting to lengthen the duration for recuperative care services beyond 90 days when medically indicated, and adequate funding remains available for these services.

Separately, the Board's ad hoc committee for IGT 6/7 on which you serve has an opportunity to approve grants that may positively impact the homeless community, such as the grants targeted for mental health and medication-assisted treatment. This adds yet another dimension to CalOptima's significant investment in responding to the homeless crisis.

In closing, please know that the homeless health ad hoc committee has received your program ideas for consideration. As indicated, the homeless health ad hoc and the CalOptima Board have already acted to address the "urgent" elements of your proposal. Collaboration and accountability are key CalOptima values that we share with stakeholders so that together we can authentically pursue our goal of better homeless health care services.

Sincerely,

Michael Schrader
CEO, CalOptima

CalOptima Board Ad Hoc Committee on Homeless Health
Paul Yost, M.D.
Lee Penrose
Ron DiLuigi
Alex Nguyen, M.D.

cc: Members, CalOptima Board of Directors
Members, Orange County Board of Supervisors

ANDREW DO
SUPERVISOR, FIRST DISTRICT

ORANGE COUNTY BOARD OF SUPERVISORS
333 W. SANTA ANA BLVD., P.O. BOX 687, SANTA ANA, CALIFORNIA 92702-0687
PHONE (714) 834-3110 FAX (714) 834-5754 andrew.do@ocgov.com

June 6, 2019

Mr. Michael Schrader
CalOptima
505 City Pkwy
Orange, CA 92868

Dear Mr. Schrader and CalOptima Board Ad Hoc Committee on Homeless Health:

I am in receipt of your letter dated June 5 in response to my May 29 letter. Your response letter demonstrates a clear lack of focus and concern for the issues I raised regarding the alarming number of deaths occurring among CalOptima members experiencing homelessness—a number I understand based on your letter, that the Ad hoc and CalOptima staff were aware of months ago and yet never shared with the Board until I posed the question on April 9. At that time I was informed related analysis is in the works in preparation for the upcoming Quality Assurance Committee meeting in May, which was cancelled. Subsequently, I followed up on May 21 and received the answer. If the Ad hoc has known this information for months, I am further concerned over the lack of transparency in sharing information with the Board of Directors on a crisis-level issue. I am also aware that CalOptima staff conducted analyses into the number of deaths and again, no results or informed recommendations were provided to the CalOptima Board.

As stated previously, there are no recommended actions on the June 6 agenda regarding the $60 million for new homeless health initiatives already allocated by the CalOptima Board. Whether I attend this meeting or not does not change this fact. An update on existing initiatives without recommendations for new actions to utilize the $60 million will not produce new results.

On the topic of homeless initiatives, it has come to my attention that a Board Action taken at the April 4 CalOptima Board meeting, Item 18 was portrayed and captured as part of CalOptima's homeless health initiatives to the tune of $10 million. At this same Board meeting, Item 4 described this pending action as part of CalOptima's current homeless health response contribution and yet I'm told there may not be is no reference to requiring homeless coordination as part of the hospital contracts attached to the approved Item 18. I want a copy of the contract to confirm these services are in fact directly related to the homeless initiatives as portrayed. The continued lack of transparency from CalOptima is alarming.

The statistics quoted in my letter were provided by CalOptima staff just last week, so if there are inconsistencies between those figures and the figures in your letter of June 5, I am unclear as to why that is. Even if 84 individuals were served between April 10 – May 30, that is fewer than two people per day over the 50-day period. It seems that five clinical field teams operating with

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the frequency you state are capable of handling significantly more service requests—why aren't they? The need is obvious.

There are nearly 3,000 homeless individuals in shelters in Orange County, and providing services "eventually" will not help them quickly enough. Referrals to the clinical field teams should be accepted from the shelters immediately. Again, this delayed response will not produce new results. County staff who have been working diligently on this issue continue to attempt to provide guidance to CalOptima staff on best practices and make connections; however, it seems to be taken for granted. In the meeting cancellation referenced in your letter, CalOptima staff were fully aware of County staff's availability in advance of the May 31 meeting date, yet the meeting was scheduled despite this knowledge.

I chose to remove myself from the ad hoc committee because my suggestions for improved services provided at the February 22 Special Board meeting were disregarded in favor of conducting more studies. We don't need studies to tell us that more services are needed on the streets and in the shelters. My CARE proposal was done in conjunction with the Health Care Agency. Your letter states the County Outreach and Engagement team is an essential component. I agree, which is why the team was consulted in my proposal.

We need a plan now, and I have provided a plan. The CalOptima Board of Directors must take action now, which is why I requested the June 14 special meeting. This ad hoc has been meeting, exploring, and fact gathering without a single recommendation to the Board for over 100 days. Waiting another two months to take action is simply unacceptable.

Sincerely,

ANDREW DO
Orange County Board of Supervisors
Supervisor, First District

AD/vc

cc: Members, CalOptima Board of Directors
Members, Orange County Board of Supervisors

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

17. Consider Development of a CalOptima Homeless Clinic Access Program (HCAP) for Homeless Health Initiative.

Contact

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

Recommended Actions

1. Authorize modification of the existing "CalOptima Day" Quality Improvement and incentive strategy to include a CalOptima Homeless Clinic Access Program (HCAP) that includes primary and preventive care services at Orange County homeless shelters and other locations in collaboration with Community Health Centers;
2. Authorize the expenditure of up to $1 million in provider incentives consistent with this proposed expansion of CalOptima Day quality improvement and incentive strategy; and
3. Authorize the hiring of two additional staff at an annual cost not to exceed $231,087 in support of this expansion of the CalOptima Day quality incentive program.

Background

"CalOptima Day" is one of the Quality Improvement and incentive strategies approved by the Board on December 1, 2016 as part Medi-Cal Quality Improvement Accreditation Activities During CalOptima Fiscal Year (FY) 2016-17, Including Contracting and Contract Amendments with Consultant(s), Member and Provider Incentives, and Expenditure of Unbudgeted Funds of up to $1.1Millon. CalOptima Day aims to increase access to care, enhance the member experience, and improve quality outcomes in collaboration with health networks and CalOptima Community Network provider offices. CalOptima Days are half- or full-day health and wellness events for high-volume provider offices or clinics chosen by health networks. Staff works with the provider office/clinic to schedule members to receive necessary preventive services on CalOptima Day. The provider office/clinic earns incentives for each completed preventive health visit, as evidenced by billing/encounter reporting using codes in accordance to the Healthcare Effectiveness Data and Information Set (HEDIS) specifications. The intent of these initiatives is to increase access to care and provide CalOptima members with immunizations, well-care visits and/or other services tied to quality measures. CalOptima Days have proven to be an impactful quality activity since they began in 2016. Due to the many benefits linked to CalOptima Days, they are now part of an ongoing quality strategy to improve access to preventive care and performance on quality measures.

During the February, April and June 2019 CalOptima Board meetings, the Board approved various homeless health initiatives, including an implementation plan for the Clinical Field Team Pilot Program (CFTPP) and contracts with Federally Qualified Health Centers (FQHC) and FQHC Look-Alikes (jointly Community Health Centers) selected to participate in the CFTPP.

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As part of the CFTPP, CalOptima amended its contracts with five Community Health Centers to provide on-call services at hot spots throughout the county such as parks, encampments and shelters to address urgent clinical needs of individuals experiencing homelessness.

Further, the Board requested that CalOptima staff focus on significantly expanding preventive and primary care services at homeless shelter sites. CalOptima also received stakeholder feedback that such services would also be valuable at other hot spots, such as soup kitchens. CalOptima staff proposes expansion of the CalOptima Day model to provide greater access to preventive and primary care services at these locations in collaboration with interested Community Health Centers, whether they participate in CFTPP or not.

At its June 27, 2019 special meeting, the Board approved funding allocations for $60 million in new Homeless Health Initiatives. As part of this action, the Board allocated $10 million to "Clinic health care services in all homeless shelters."

Discussion

Staff recognizes the need for members experiencing homelessness to have reliable access to preventive and primary care in shelters and at other settings. Many shelters already have established relationships with community providers to provide those services via either an on-site or mobile clinic; however, hours may be limited. These services are sometimes not be billed, even when a provider is rendering services to a CalOptima member. This may occur, for example, if the provider is not contracted with the member's assigned health network or is not the member's assigned primary care provider (PCP). Further, some Community Health Centers have advised that set up and tear down of mobile clinics is time consuming and may not be cost-effective, even if the clinic is able to bill for the visit. These factors may contribute to limited access to care at shelters and other hot spots.

To address these concerns, CalOptima staff proposes partnering with any interested Community Health Centers to provide preventive and primary health care services at shelters and other hot spots. This may include locations that do not have established schedules with community providers, as well as those that may benefit from expanded schedules. These Community Health Centers will be required to create a regular schedule based on input from the shelters/hot spots, and those schedules will be informed by need, which may include bed count, frequency of resident turnover, other individuals served at the location, existing service schedules, and proximity to community providers. Additionally, the Community Health Centers will be expected to encourage CalOptima members to seek services from their assigned CalOptima providers and coordinate services with other medical and behavioral health care providers.

As proposed, and similar to the CalOptima Day tiered incentive payment model, clinics maintaining a presence at the shelter or hot spot will be compensated up to $1 million annually in total for all participating providers, excluding CalOptima staff resources, based on expanded hours and services completed for CalOptima members, as well as claims submission.

CalOptima staff proposes to offer eligible providers with a monetary incentive for participating in the HCAP according to two (2) tiers:

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- Tier 1: An eligible provider will receive a Tier 1 provider incentive for event participation for a half day (4 hours) or a full day (8 hours).

- Tier 2: An eligible provider may receive a Tier 2 provider incentive, in addition to the Tier 1 provider incentive, if the following levels of services are provided:
    - Eligible provider completes 10 appointments during a half day (4 hours). Appointments may be any combination of well-care or vaccine-only visit.
    - Eligible provider completes 20 appointments during a full day (8 hours). Appointments may be any combination of well-care or vaccine-only visit.

Provider Incentive	Half Day (4 hours)	Full Day (8 hours)
Tier 1	$800	$1,600
Tier 2	$400	$800

Staff estimates that CalOptima will schedule a combination of 10 half day or full day HCAP events per week, with an average of 15 appointments completed during each event.

CalOptima staff will leverage the coordination and incentive mechanisms already established by the current CalOptima Day strategy. The effectiveness of CalOptima Days is measured by lead measures such as numbers of members accessing services, numbers of CalOptima Days with expanded hours, and lag measures such as HEDIS. A similar program measurement and evaluation discipline will apply to the HCAP.

In addition, management requests additional staffing to coordinate HCAP. Staff recommends the addition of two full-time equivalent positions: a Program Manager and a Quality Analyst. The total estimated annual impact of the addition of the two staff positions is approximately $231,087.

Fiscal Impact

The recommended action to develop HCAP by modifying the existing CalOptima Day Quality Improvement and incentive strategy is a Homeless Health Initiative budgeted item. Expenses of up to $1 million annually for provider incentives and $231,087 annually for staffing expenditures are budgeted under homeless health-related initiatives in the Fiscal Year 2019–20 Operating Budget approved by the Board on June 6, 2019 and will be funded from the "clinic health care services in all homeless shelters" category approved by the Board on June 27, 2019.

Rationale for Recommendation

CalOptima members experiencing homelessness sometimes face unique challenges in accessing the care they need. By partnering with shelters, other hot spots and Community Health Centers to implement the HCAP will help provide members with access to preventive and primary health services that this population segment may not otherwise seek. Early intervention while the members reside in shelters could also help them reacclimate to receiving scheduled care by appointment, hopefully helping to reintroduce them to obtaining health care in a more traditional and cost-effective setting.

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Concurrence
Gary Crockett, Chief Counsel

Attachments
1. CalOptima Homeless Clinic Access Program Presentation
2. Board approval of Medi-Cal Quality Improvement Accreditation Activities During CalOptima Fiscal Year (FY) 2016-17, Including Contracting and Contract Amendments with Consultant(s), Member and Provider Incentives, and Expenditure of Unbudgeted Funds of up to $1.1Millon. on December 1, 2016
3. CalOptima Day Fact Sheet

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

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CalOptima Homeless Clinic Access Program

David Ramirez, M.D.
Chief Medical Officer

Betsy Ha, R.N., M.S., LSSMBB
Executive Director, Quality & Population Health Management

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Building a Better System of Care

- In response to the homelessness crisis in Orange County, CalOptima has approved the following:
  - Homeless Response Team to coordinate care
  - Deployed the Clinical Field Team in collaboration with Federally Qualified Health Centers (FQHC) to provide urgent care for those unable or unwilling to access the traditional care system
  - Help hospitals meet SB 1152 requirements for homeless-specific discharge planning and care coordination
  - Increased Recuperative Care funding and creation of a Medical Respite Program
- These initiatives focus on the urgent and clinical needs of members unsheltered.

Bridging to Existing System

Nontraditional Settings

- Clinical Field Teams (CFTs)
- Mobile Clinics
- Telehealth

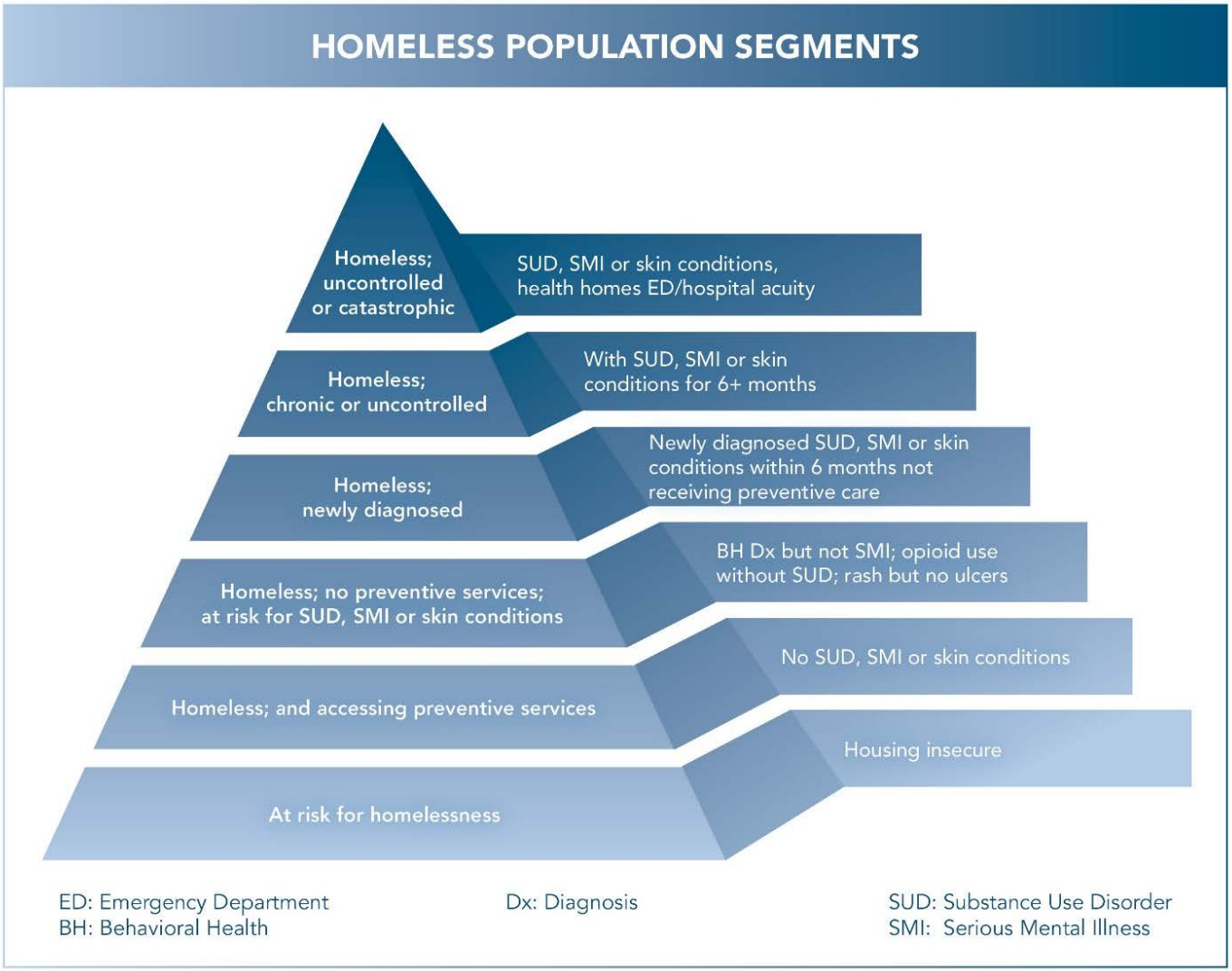
Transitional Settings

- Clinics in Shelters
- On-Site Supportive Services

Existing System

- Clinics
- Office-Based Providers
- Telephonic Case Management

A Population Health Approach



Clinic Health Care Services

- In response to the June 27, 2019, special meeting, the Board approved funding allocations of $60 million for new homeless health initiatives.
- As part of this action, the Board allocated $10 million to “Clinic health care services in all homeless shelters.”
- Staff recognizes the need to establish reliable, recurring, preventive and primary care schedules for members experiencing homelessness who are staying in shelters.
- Currently, most shelters in Orange County have inadequate physical health services available either on-site or through mobile clinics

Leveraging Quality Incentives

Modify the “CalOptima Day” Quality Improvement and incentive strategy for Homeless Health Initiative

Develop a CalOptima Homeless Clinic Access Program (HCAP)

Provide CalOptima Homeless Clinic Access Program (HCAP) at Orange County homeless shelters and other appropriate locations

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What is CalOptima Day?

- A practice site-based Quality Improvement and incentive strategy used by CalOptima since 2016 to improve member access to care and HEDIS performance results
  - A half or full-day health and wellness event that is co-hosted by CalOptima, a health network, and a clinic or provider office, offering immunizations and well-care visits to our Medi-Cal members.
  - Clinic/providers offices' to only schedule appointments for CalOptima members assigned to the participating health network and clinic/provider office designated CalOptima Days.
  - Providers are incentivized to host the event and can receive up to $2,400 per CalOptima Day.
  - Members are incentivized with a $25 gift card for completing a visit.

2018 CalOptima Day Focused Measures

- Well-Care Measures
  - Well-Child Visits in the First 15 Months of Life (W15)
  - Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)
  - Adolescent Well-Care Visits (AWC)
- Immunization Measures
  - Childhood Immunization Status (CIS)
    - Combo 10
  - Immunizations for Adolescents (AWC)
    - Combo 2

CalOptima Homeless Clinic Access Program (HCAP)

- Increase the availability of preventive and routine health care services at Orange County shelters to create regular clinic schedules informed by need.
- Provide care transition support and encourage CalOptima members to seek services from their assigned CalOptima providers.
- Coordinate services with other medical and behavioral health care providers when needed.

Proposed Quality Measures

- Preventive services, screenings and chronic care HEDIS measures may include but not be limited to:
  - Access to Ambulatory and Preventive Care Services (AAP)
  - Adult BMI Assessment (ABA)
  - Chlamydia Screening (CHL)
  - Cervical Cancer Screening (CCS)
  - Adult Immunization Status (AIS)
  - Comprehensive Diabetes Care (CDC)
    - HbA1C
    - Retinal Eye Exam
    - Blood Pressure

Proposed Provider Incentives

- CalOptima will offer eligible providers a monetary incentive for participating in the CalOptima Homeless Clinic Access Program (HCAP) events according to two (2) tiers:
  - Tier 1: Eligible provider receives a Tier 1 incentive for event participation for a half (4 hours) or full day (8 hours)
  - Tier 2: Eligible provider may receive a Tier 2 provider incentive, in addition to Tier 1, if the following levels or service are provided;
    - Eligible provider completes 10 appointments during half day (4 hours)
    - Eligible provider completes 20 appointments during a full day (8 hours)

Provider Incentive	Half Day (4 Hours)	Full Day (8 Hours)
Tier 1 Incentive	$800	$1,600
Tier 2 Incentive	$400	$800

Fiscal Impact

- Expenses of up to $1 million annually for provider incentives and $231,087 annually for staffing expenditures
- Budgeted under homeless health-related initiatives in the Fiscal Year 2019–20 Operating Budget
- Approved by the Board on June 6, 2019
- Will fund from the “Clinic health care services in all homeless shelters” category approved by the Board on June 27, 2019

Staffing Expenditure

- Hire Program Manager and Quality Analyst
- Perform incentive program management
- Facilitate scheduling
- Provide care transition support
- Monitor quality and access to primary care
- Coordination with internal and external partners
- Quality performance measurement, analysis and reporting

Recommended Action

- Authorize modification of the existing “CalOptima Day” Quality Improvement and incentive strategy to include a CalOptima Homeless Clinic Access Program (HCAP) that includes primary and preventive care services at Orange County homeless shelters and other locations in collaboration with Community Health Centers;
- Authorize the expenditure of up to $1 million in provider incentives consistent with this proposed expansion of CalOptima Day quality improvement and incentive strategy; and
- Authorize the hiring of two additional staff at an annual cost not to exceed $231,087 in support of this expansion of the CalOptima Day quality incentive program.

CalOptima's Mission

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

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Consent Calendar

5. Consider Approval of Medi-Cal Quality Improvement and Accreditation Activities During CalOptima Fiscal Year (FY) 2016-17, Including Contracts and Contract Amendments with Consultant(s), Member and Provider Incentives, and Expenditures of Unbudgeted Funds of up to $1.1 Million

Contact

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

Recommended Actions

1. Approve the Quality Improvement activities listed on Attachment 1;
2. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to contract with new vendors and amend existing vendor contracts, as appropriate, for quality improvement-related services, including NCQA consulting and provider coaching services, incentive distribution and tracking services, PSA development services, survey implementation services, and material and print services selected consistent with CalOptima's Board-approved procurement process;
3. Direct staff to develop Member and Provider incentive programs in the amounts listed on Attachment 1., subject to applicable regulatory approval and guidelines, and final approval by the CalOptima Board prior to implementation; and
4. Authorize unbudgeted expenditures not to exceed $1.1 million to implement these initiatives.

Background

In CalOptima's 2013-2016 Strategic Plan, one of the strategic priorities was related to Quality Programs and Services. As a part of this strategic priority, CalOptima has worked diligently to provide members with access to quality health care services and ensure optimal health outcomes for all our members.

One of the areas of focus within Quality Programs and Services is CalOptima's performance in the National Committee for Quality Assurance (NCQA) accreditation and ratings. The evaluation criterion for the NCQA health plan ratings consists of three dimensions: Prevention, Treatment and Member Satisfaction. According to the most recent NCQA Health Plan Ratings, (NCQA's Medicaid Health Insurance Plan Ratings 2015-2016) CalOptima scored 4 out of 5 on Prevention, 3.5 out of 5 on Treatment, and 2.5 out of 5 in Customer Service. Health Plans are rated on a 5 point scale. CalOptima achieved an overall rating of 4 out of 5. CalOptima has the distinction of being the top rated Medicaid Health plan in California for the past three years. CalOptima is proud to be the only California Medicaid health plan accredited at the "commendable" level by NCQA. Additionally, CalOptima has achieved a 3.5 out of 5.0 "STAR" rating for Medicare by the Centers for Medicare & Medicaid Services (CMS).

Although CalOptima has achieved much success in our quality programs, we have also identified two measures that were below the minimum performance level (MPL) established by the California

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Department of Health Care Services (DHCS), and we have prospectively identified other quality measures on the decline that are required for NCQA accreditation and health plan ratings. In order to maintain or exceed our quality performance levels, it is imperative to consider additional interventions which are necessary to achieve these goals, as referenced in our 2016 QI Program Description (Clinical Data Warehouse section, pg 41). These include utilizing multiple levers (direct-to-member, direct-to-provider, incentives, communication strategies, etc.) and programs planned as ongoing strategies throughout the calendar year.

In preparing the CalOptima FY 2016-17 Operating Budget, staff applied the regular budgeting methodology which used the past year's actual run-rate assumptions to allocate funds to various categories, units and lines of business. Upon further review, it became clear that additional funding was necessary to meet existing program commitments for Medi-Cal quality monitoring, reporting and improvement as well as new and expanded quality programs.

Discussion

Maintaining CalOptima's "commendable" accreditation status and rating by NCQA as a top Medicaid plan in California requires ongoing investment in innovative quality initiatives focused on underperforming measures as well as measures aligned with NCQA accreditation, health plan ratings, as well as DHCS and CMS requirements. Funding is also requested to maintain current vendor contracts utilized for quality reporting and to support annually required trainings for quality staff.

Expenditures requested are classified as:

• Budget augmentation for current quality initiatives:	$ 457,740
• New requests for quality initiatives:	$ 605,839
Total Request	$1,063,579

Attachment 1: Summary of Expenditures for Medi-Cal Quality Improvement and Accreditation Activities provides additional detail on the quality related programs, initiatives and proposed incentives. Member and provider incentive programs will be established by CalOptima. Member incentives will follow the guidelines in CalOptima Policy AA.1208 – Non-Monetary Member Incentives. All member and provider incentive programs will be fully developed and returned for Board approval prior to implementation, as well as regulatory approval, as applicable.

Fiscal Impact

The recommended action to appropriate and authorize expenditures of up to $1.1 million for Medi-Cal quality improvement and accreditation activities is an unbudgeted item. Management is requesting Board approval to authorize an additional amount of up to $1.1 million in medical expenses to fund the cost of the quality improvement activities.

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Rationale for Recommendation

CalOptima staff believes that by partnering with our Health Network and provider community, targeted, impactful interventions will result in improvements in our quality scores, to maintain our NCQA Commendable status.

Concurrence

Gary Crockett, Chief Counsel
Chet Uma, Chief Financial Officer
Board of Directors' Quality Assurance Committee
Board of Directors' Finance and Audit Committee

Attachments

- Attachment 1: Summary of Expenditures for Medi-Cal Quality Improvement and Accreditation Activities
- PowerPoint Presentation: Quality Analytics Budget

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

11/22/2016 — **Date**

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Attachment 1: Summary of Expenditures for Medi-Cal Quality Improvement and Accreditation Activities

A. Budget Augmentation for Current Quality Initiatives

Item	Detail	Amount (Not to Exceed)
Surveys & NCQA Fees	• Addition of CG CAHPs - Adult & Child • Fee increases for regular CAHPS • Implement SPD CAHPS • Additional record retrieval for Medical Record Review • Increase in NCQA required fees • Timely Access Survey	$252,937
NCQA Consultant	• RFP results did not produce viable option; completed bid exception for known entity due to timeframe	$17,375
Quality Initiatives in Flight	• Flu/pneumococcal shot reminders • Preventive care visits • Pharyngitis kits • Readmissions project (CMS QIP) • Member & provider communications (more non-adherent members; more measures to move) •	$138,793
	• Member and provider incentives	$12,380
Required Training	• Annual Inovalon & HEDIS Best Practices training • CME expenses for physician training • Provider education activities • New hire equipment	$28,480
Miscellaneous		$7,775
Total		**$457,740**

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Attachment 1: Summary of Expenditures for Medi-Cal Quality Improvement and Accreditation Activities

B. New Request for Quality Initiatives

Item	Detail	Amount (Not to Exceed)
Member Programs	• Prenatal/postpartum incentive (Increase volume of outreach; $10,887 • Breast cancer screening -Downward trend Reminder mailing & incentive; $99,900 • Cervical cancer screening -Below MPL Reminder mailing & incentive; $149,900	$260,687
Provider Programs	• Physician office extended hours pilot project - MPL measures ($10,000) • Prenatal/postpartum provider office incentive ($5,000) • PCP office staff incentives for well women visits/screenings ($75,000) • Physician office extended hours initiative mailing ($2,500)	$92,500
Member Experience Initiatives	• Member focus groups, supplemental survey, provider CME ($72,525) • Practice coaches for member experience ($18,840)	$91,365
Provider Toolkits	• AWARE toolkit on antibiotic use ($5,000) • Provider Outreach/Education on AAB Measure (Below MPL; $1,500)	$6,500
Outreach Projects	• PSA for well women visits (Feb & May) - Culturally-specific radio stations ($99,900) • Child & Adolescent Outreach and Events for Childhood Immunizations (13% decrease; $44,887) • Educational posters/print ads for physician offices for Women's Wellness Campaign ($10,000)	$154,787
Total		**$605,839**

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Quality Analytics Budget

Board of Directors' Quality Assurance Committee Meeting
November 16, 2016

Board of Directors' Finance and Audit Committee Meeting
November 17, 2016

Richard Bock, MD, Deputy CMO
Caryn Ireland, Executive Director, Quality

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FY 2016-2017 Budget

- Budget augmentation for current quality initiatives: $457,740
  - Surveys & NCQA Fees
  - NCQA Consultant
  - Quality Initiatives in Flight
  - Required Training
  - Miscellaneous

- New requests for quality initiatives: $605,839
  - Member Programs
  - Provider Programs
  - Member Experience Initiatives
  - Provider Toolkits
  - Outreach Projects

Budget Augmentation for Current Quality Initiatives: $457,740

- Surveys & NCQA Fees: $252,937
  - Addition of CG CAHPS – Adult & Child
  - Fee increases for regular CAHPS
  - Implement SPD CAHPS
  - Additional record retrieval for Medical Record Review
  - Increase in NCQA required fees
  - Timely Access Survey
- NCQA Consultant: $17,375
  - RFP results did not produce viable option; completed bid exception for known entity due to timeframe
- Quality Initiatives in Flight: $151,173
  - Flu/pneumococcal shot reminders
  - Preventive care visits
  - Pharyngitis kits
  - Readmissions project (CMS QIP)
  - Member communications (more non-adherent members; more measures to move)
  - Member and provider incentives

Budget Augmentation for Current Quality Initiatives (cont.)

- Required Training $28,480
  - Annual Inovalon & HEDIS Best Practices training
  - CME expenses for physician training
  - Provider education activities
  - New hire equipment

- Miscellaneous $7,775

Funding for Additional Program: $605,839

- **Member Programs** — $260,687
  - Prenatal/postpartum incentive (Increase volume of outreach)
  - Breast Cancer Screening (Downward trend)
  - Cervical Cancer Screening (Below MPL)
- **Provider Programs** — $92,500
  - Physician office extended hours pilot project – MPL measures
  - Prenatal/postpartum provider office incentive
  - PCP office staff incentives for well women visits/screenings
  - Physician office extended hours initiative mailing
- **Member Experience Initiatives** — $91,365
  - Member focus groups, supplemental survey, provider CME
  - Practice coaches for member experience
- **Provider Toolkits** — $6,500
  - AWARE toolkit on antibiotic use
  - Provider outreach/education on AAB Measure (Below MPL)
- **Outreach Projects:** — $154,787
  - PSA for well women visits (Feb & May) – Culturally-specific radio stations
  - Child & adolescent outreach and events for childhood immunizations (13% decrease)
  - Educational posters/print ads for physician offices for Women's Wellness Campaign

Description of Additional Programs	Amount
Member Programs	$260,687
Prenatal/postpartum incentive (Increase volume of outreach)	$10,887
Breast cancer screening (Downward trend)	$99,900
Cervical cancer screening (Below MPL) - Reminder mailing and member incentives	$149,900
Provider Programs	$92,500
Physician office extended hours pilot project – MPL measures	$10,000
Prenatal/postpartum provider office incentive	$5,000
PCP office staff incentives for well women visits/screenings	$75,000
Physician office extended hours initiative mailing	$2,500
Member Experience	$91,365
Member focus groups ($50K), supplemental survey ($20,475), provider CME ($7K)	$72,525
Practice coaches for member experience	$18,840
Provider Tool Kits	$6,500
AWARE Toolkit on antibiotic use	$5,000
Provider outreach/education on AAB Measure (Below MPL)	$1,500
Outreach Projects	$154,787
PSA for well women visits (Feb & May) – Culturally-specific radio stations	$99,900
Child & adolescent outreach and events for childhood immunizations (13% decrease)	$44,887
Educational posters/print ads for physician offices for Women's Wellness Campaign	$10,000
Total	**$605,839**

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CalOptima's Mission

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

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QUALITY INITIATIVES

"CalOptima Day"
Child and Adolescent Health and Wellness Event

CalOptima strives to provide quality care for our members. This means finding new ways to better serve them. CalOptima is looking for health networks to host CalOptima Day, a one-day health and wellness event at one high-volume provider office or clinic of their choice, offering immunizations and well-care visits to children and adolescent Medi-Cal members.

Criteria for Participation:

- Health networks and the selected provider office or clinic will help market the event as "CalOptima Day."
- Voluntary participation of one provider office or clinic per health network that serves a high volume of targeted CalOptima Medi-Cal members in Orange County
- Provider office or clinic must be in good standing with CalOptima and have no sanctions or corrective action plans in place at the time of participation.
- Health networks and provider office/ clinic are expected to host a wellness event targeting any or all the measures listed: W15, W34, AWC, CIS and IMA.
- Provider offices and clinics are expected to conduct member outreach efforts including outbound calling, scheduling appointments and record keeping.
- Provider offices/ clinics and the health network are expected to properly code the office visit in accordance to the HEDIS specifications and provide validation to CalOptima this occurred.
- The participating provider or clinic shall provide feedback and a summary report of all vaccinations and well-child visits completed at the event.
- CalOptima will provide gift cards to members as incentives for receiving a recommended immunization(s) during the CalOptima Day event.
- CalOptima will offer participating provider offices or clinics a monetary incentive for hosting the health and wellness event of $300/hr. for each health event, up to $2,400/event. Depending on budget, a primary care provider (PCP)/clinic site may conduct more than one event at the discretion of CalOptima.

For more information, email questions to QI_Initiatives@CalOptima.org.

Please note: A limited number of provider offices and/or clinics will be eligible to participate in the Child and Adolescent Health and Wellness Event. Be on the lookout for more opportunities to participate in a CalOptima incentive program.

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item
13. Consider Approval of Homeless Health Initiatives Guiding Principles

Contact
Michael Schrader, Chief Executive Officer (714) 246-8400

Recommended Action
Approve Homeless Health Initiatives Guiding Principles and Crosswalk as a framework for future funding allocations.

Background
On April 4, 2019, the CalOptima Board of Directors committed expenditures of $100 million for Homeless Health Initiatives within a three-year period. At that time, $40 million was directed to a range of specific initiatives, including enhanced Medi-Cal services at the Be Well OC Regional Mental Health and Wellness Campus; recuperative care; clinical field team startup costs; CalOptima Homeless Response Team; and homeless coordination at hospitals. An additional $60 million was appropriated for future initiatives. At the special Board meeting on June 27, 2019, a proposal with funding allocations for the $60 million was approved. The funding allocations covered four areas: clinic health care services in all homeless shelters; authorize mobile health team to respond to all homeless providers; residential support services and housing navigation; and extend recuperative care for homeless individuals with chronic physical health issues. On September 5, 2019, staff received Board direction to develop Guiding Principles related to the $60 million allocation and to solicit input from Board members and providers on those principles.

The draft Homeless Health Initiatives Guiding Principles were shared with the Board on September 20, 2019, and a crosswalk of the Guiding Principles and funding categories was later integrated. Both documents were developed in coordination with the Board's ad hoc committee on homeless health. The draft Guiding Principles were also shared with the Orange County Medical Association, the Hospital Association of Southern California and CalOptima health networks. At the October 3, 2019, Board meeting, staff again received direction to bring the Guiding Principles to the full Board for consideration. On October 28, 2019, the California Department of Health Care Services released California Advancing and Innovating Medi-Cal (CalAIM), a proposal with the potential to significantly impact the future Medi-Cal delivery system framework, starting in 2021. Although the proposal is not yet finalized or approved by state and federal regulators, some tenets of CalAIM are designed to enhance services for high-needs populations, including homeless individuals. On November 7, 2019, the Board requested that staff consider the impact of CalAIM on the Guiding Principles, update the document if needed and present the information to the full Board.

Discussion
The Board recognizes that the approved $60 million allocation for the Homeless Health Initiatives allows room for flexibility to execute the new initiatives that are most impactful and relevant to our

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members experiencing homelessness. The staff developed the Homeless Health Initiatives Guiding Principles to refine the decision-making process, ensure investment in the most appropriate programs and to address provider concerns. Proposals consistent with the principles will be brought forward for consideration by the Board; proposals that are inconsistent will face revision or rejection. Proposals may also change depending on the status of CalAIM. Ultimately, the Board has full discretion on the allocation of funds. However, internal and external stakeholders will be able to use the Guiding Principles to support initiatives that unify the community around the shared goal of better serving Orange County's homeless population.

Fiscal Impact

The recommended action is budget neutral. The $60 million allocation has already been approved by the Board. The recommended action has the effect of distributing funds to various as yet undetermined initiatives, but the amount will not exceed $60 million.

Rationale for Recommendation

The above recommendation serves to guide funding allocations for CalOptima's Homeless Health Initiatives to ensure expenditures meet strategic priorities and have the most positive impact for members.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Homeless Health Initiatives: Guiding Principles presentation
2. Homeless Health Initiatives Guiding Principles
3. Crosswalk: Guiding Principles and Homeless Health Funding Categories
4. CalAIM Appendix D

/s/ Michael Schrader *11/26/2019*
Authorized Signature Date

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CalOptima
A Public Agency
Better. Together.

Homeless Health Initiatives: Guiding Principles

Board of Directors Meeting
December 5, 2019

Michael Schrader, Chief Executive Officer
TC Roady, Director, Regulatory Affairs and Compliance
Candice Gomez, Executive Director, Program Implementation

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- Current initiatives and Board direction
- California Advancing and Innovating Medi-Cal (CalAIM)
- Homeless Health allocation in light of CalAIM

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Current Initiatives

Board-Approved Programs With $100 Million Homeless Health Reserve	Funding
Be Well OC Regional Mental Health and Wellness Hub	$11.4 million
Recuperative Care	$10.75 million
Respite Care	$250,000
Clinical Field Team Startup	$1.6 million
CalOptima Homeless Response Team	$6 million
Homeless Coordination at Hospitals	$10 million
CalOptima Day and Quality Improvement Program	$1.2 million
Federally Qualified Health Centers Expansion	$.6 million
Total Allocated	**$41.8 million**
Remaining Funding Available	**$58.2 million**

- Other Board-Approved Programs Supporting Homeless Health
  - Medication-Assisted Treatment: $6 million (IGT funds)
- Other Programs Pending Board Approval
  - Housing Supportive Services: $2.5 million (reallocated from reserve)

Board Actions and Directives on Homeless Health

- In June, the Board adopted a $60 million allocation for homeless health spending in four categories
  - Clinic health care services in all homeless shelters
  - Mobile health team response to all homeless providers
  - Residential support services and housing navigation
  - Recuperative care for those with chronic physical health issues
- Working with the Board's ad hoc committee, staff developed Guiding Principles and crosswalk to provide the Board with a tool to guide funding decisions
- CalAIM has the potential to affect homeless health spending in the future
  - Consider CalAIM's impact on Guiding Principles

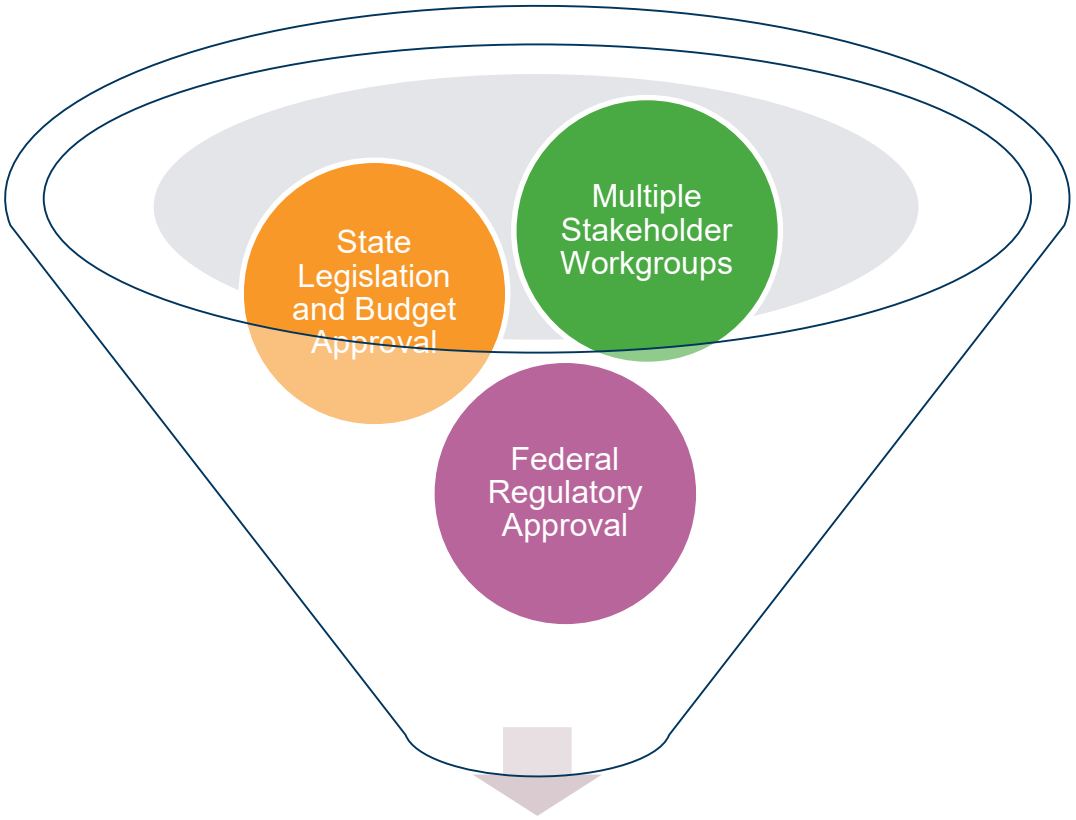
CalAIM Background

- On October 28, the Department of Health Care Services (DHCS) released CalAIM, a proposal with the potential to significantly impact the future Medi-Cal delivery system framework
  - Spans a five-year period from 2021 to 2025
  - Contains more than 20 core initiatives
  - Expands Medi-Cal managed care plans' responsibilities

- The proposal represents the start of a process that will include stakeholder engagement, and multiple federal and state approvals

CalAIM Process

- CalAIM is in the early stages of development
- CalAIM will evolve before reaching a final form for implementation starting January 1, 2021
  - ➢ Many layers of input will undoubtedly change the proposal



Final CalAIM Document

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Five CalAIM Workgroups

Population Health/ Annual Enrollment	• Requires managed care plans to develop and maintain population health management strategies
Enhanced Care Management	• Explores implementation of an enhanced care management benefit and in lieu of services
Behavioral Health	• Considers integration of county-level mental health and substance use disorder programs
NCQA Accreditation	• Provides input on a proposal to require Medi-Cal managed care plans to obtain accreditation
Full Integration Plans	• Discusses full integration of physical health, behavioral health and oral health under one entity

Future CalAIM Implementation

- The various proposals have different effective dates, ranging from January 2021 to January 2025
  - Understanding the rules and regulations before and after implementation will be challenging

- With regard to CalOptima's Homeless Health Initiatives, three proposals (in their current form) have the most potential impact in the near term
  - Population Health Management
  - Enhanced Care Management
  - In Lieu of Services

Current State, Before CalAIM

- Programs that “bridge” to CalAIM
  - Health Homes Program (HHP)
    - Enhanced care management
    - Housing supportive services
  - Whole-Person Care (WPC)
    - Recuperative care
- Intergovernmental Transfer (IGT) 1–7 dollars
  - Enhanced services for Medi-Cal members
    - Reallocating funds toward housing supportive services
- IGT 8 dollars
  - Medi-Cal-covered services for Medi-Cal members
    - Enhanced hospital discharge planning
    - Transitions of care (under development with stakeholder group)

Future Possibilities, After CalAIM*

- Population Health Management (PHM)
  - Develop and maintain PHM programs compliant with NCQA requirements, and update and file annually with DHCS
  - Risk stratify populations (low-, medium- and high-risk) and have defined actions and programs to address population needs
  - Conduct initial member assessments and then reassessments on an annual basis
  - Offer basic, complex and enhanced care management

**Subject to stakeholder input and CMS and DHCS approval*

Future Possibilities, After CalAIM* (Cont.)

- Enhanced Care Management (ECM) and In Lieu of Services (ILOS)
  - Statewide health plan benefit replacing HHP and WPC by January 1, 2021
  - Holistic, interdisciplinary approach to clinical and non-clinical needs of target populations
    - Individuals experiencing homelessness are specifically included as a target population
  - By July 2020, plans must submit transition plan moving from HHP and WPC to the ECM/ILOS model of care

**Subject to stakeholder input and CMS and DHCS approval*

Future Possibilities, After CalAIM* (Cont.)

- ILOS can only be covered if:
  - State determines that the service is a medically appropriate and cost-effective substitute for a typical service
  - The service is optional (beneficiaries are not required to use ILOS)
  - The service is authorized and identified in the state's Medi-Cal managed care plan contract

Menu of In Lieu of Services Options**
Housing transition navigation services
Housing deposits
Housing tenancy
Short-term post-hospitalization housing
Nursing facility transition/diversion
Recuperative care
Personal care and homemaker services
Respite care
Day habilitation programs
Home modifications
Meals/medically tailored meals
Sobering centers

***See CalAIM Appendix D for a detailed description of what is allowed under each of the above ILOS*

* *Subject to stakeholder input and CMS and DHCS approval*

CalAIM Advocacy

- California Association of Health Plans and Local Health Plans of California are actively participating in the CalAIM process
  - Managed care plans, including CalOptima, will be integral in shaping the eventual final CalAIM document
  - Managed care plans are generally very supportive of the direction CalAIM is headed

- Responding to the needs of Orange County's homeless population would be enhanced through adoption of certain current CalAIM proposals
  - CalOptima will advocate to this effect and pursue opportunities as available

Recommended Action

- Approve homeless health initiatives Guiding Principles and crosswalk as a framework for future funding allocations

HOMELESS HEALTH INITIATIVES GUIDING PRINCIPLES
December 5, 2019

Organizations across Orange County are actively responding to the local homeless crisis. CalOptima is participating by making improvements to the health care delivery system for homeless individuals. On April 4, 2019, the Board of Directors voted to commit $100 million in a restricted homeless health reserve. At that time, $40 million was directed to a range of specific initiatives, and $60 million was for unidentified new initiatives:

Projects *(as of April 4, 2019)*	**Allocated**	**Unallocated**	**Funding Category**
Enhanced Medi-Cal Services at the Be Well OC Regional Mental Health and Wellness Campus	$11.4 million		IGT 1–7 ($24 million total)
Recuperative Care	$11 million		
Clinical Field Team Startup Costs	$1.6 million		
CalOptima Homeless Response Team ($1.2 million/year x 5 years)	$6 million		IGT 8 and FY 2018–19 operating funds ($76 million total)
Homeless Coordination at Hospitals ($2 million/year x 5 years)	$10 million		
New Initiatives		$60 million	
Total Reserve: $100 million	**$40 million**	**$60 million**	

In the months since, CalOptima has continued to consider program options, in part by welcoming input from community organizations and providers serving homeless individuals. On June 27, 2019, at a special Board meeting, the Board approved a proposal outlining $60 million in funding allocations for new homeless health initiatives as follows:

1. Clinic health care services in all homeless shelters – $10 million
2. Authorize mobile health team to respond to all homeless providers –$10 million
3. Residential support services and housing navigation – $20 million
4. Extend recuperative care for homeless individuals with chronic physical health issue – $20 million

The Board recognizes that the approved allocations allow room for interpretation and the possibility of executing new initiatives in various ways. Further, a recent state proposal, known as California Advancing and Innovating Medi-Cal (CalAIM), suggests significant changes to the Medi-Cal managed care landscape starting in 2021. Although the proposal is not yet finalized or approved by state and federal regulators, some tenets of CalAIM are designed to enhance services for high-needs populations, including homeless individuals. To move forward with effective funding allocations in this dynamic environment, staff have developed Guiding

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Principles to refine decision making, ensure investment in the most appropriate programs and respond to provider concerns. Proposals consistent with the principles would be brought forward for consideration by the Board; proposals that are inconsistent would face revision or rejection. Proposals may also change depending on the status of CalAIM. Ultimately, the Board has full discretion, but internal and external audiences can use the principles to support initiatives that unify the community around our shared goal of better serving Orange County's homeless population.

GUIDING PRINCIPLES

Transparent and Inclusive

Inherent in CalOptima's response to the homeless crisis is a commitment to engage the community. Since beginning this effort and across several months, we have collaborated with Orange County Health Care Agency leaders, homeless advocates, community health center staff, provider representatives and countless others. CalOptima staff have and will continue to host meetings and forums, most recently adding a provider and hospital meeting series. Our interest in establishing these Guiding Principles starts from this place of inclusiveness.

- *CalOptima shall foster transparency in homeless health spending by regularly engaging stakeholders to gather ideas and feedback.*

Compliant and Sustainable

CalOptima has invested considerable time and money in understanding the legal and regulatory spending parameters related to health care delivery system enhancements for members who are homeless. In this environment, there are clear distinctions between funding sources that must be maintained. Intergovernmental Transfer (IGT) 1–7 dollars were permitted for enhancements to Medi-Cal services, but new IGT 8 dollars must be used according to different guidelines that restrict the spending to Medi-Cal-covered services. Furthermore, use of FY 2018–19 operating funds is similarly restricted to Medi-Cal-covered services for members, so expenditure of these dollars will be incorporated into CalOptima's rate development process. This would create sustainable funding for ongoing homeless health programs even after depletion of the Board-established homeless health reserve. However, the CalAIM proposal has the potential to expand Medi-Cal-covered benefits, which could broaden what CalOptima is permitted to fund for homeless health. This opportunity is under development, so until CalAIM is finalized, CalOptima must adhere to current rules. In any event, financial stewardship is one of CalOptima's core values, and our commitment is to spend on new homeless health initiatives in a fashion that complies with all applicable rules and appropriately builds our rates.

- *CalOptima shall spend the $60 million on allowable uses only, with the strict rule that IGT 8 and FY 2018–19 funds must be used for Medi-Cal-covered services for Medi-Cal members.*

Strategic and Integrated

CalOptima's effort to better serve members who are homeless is aligned with the strategic direction of state and federal regulators as well as industry trends. Population health initiatives recognize that certain populations need targeted interventions, and these programs can be integrated within the existing delivery system. For example, CalOptima's clinical field team program is designed to reconnect members with their medical homes not replace them. We appreciate the essential role of our hospital and health network partners and will purposefully seek ways to ensure new homeless health initiatives are integrated.

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- *CalOptima shall support programs that honor the unique needs of the homeless population while integrating into the existing delivery system.*

Defined and Accountable

CalOptima is in new territory exploring ways to respond to the needs of homeless members. But our commitment to longstanding principles of quality and accountability has not changed. As we move forward, new programs will be carefully defined through Board-approved actions and subject to appropriate oversight and performance metrics. The CalOptima Board will hold itself accountable to ensure the implemented programs provide value and perform as anticipated, which may include establishing incentives for provider partners.

- *CalOptima shall identify measures of success and develop incentives to boost accountability in any new homeless health initiative.*

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CROSSWALK: HOMELESS HEALTH INITIATIVES GUIDING PRINCIPLES AND FUNDING CATEGORIES

December 5, 2019

		Homeless Health Funding Categories			
		Clinic health care services in all homeless shelters	**Authorize mobile health team to respond to all homeless providers**	**Residential support services and housing navigation**	**Extend recuperative care for homeless individuals with chronic physical health issue**
Guiding Principles	**Transparent and Inclusive*** *Transparent planning that includes providers and other key stakeholders*	Consistent: Specific initiatives in this category could be designed and developed in collaboration with providers and other stakeholders.	Consistent: Specific initiatives in this category could be designed and developed in collaboration with providers and other stakeholders.	Consistent: CalOptima and our health networks transparently and inclusively provide Medi-Cal members with case management and care coordination as appropriate. In addition, health networks will serve as CB-CMEs for HHP, with Illumination Foundation as an available vendor for housing navigation. However, the CalAIM proposal would sunset HHP and transition housing navigation to another program. Separately, the IHSS, MSSP and PACE programs provide services in the member's home.	Consistent: Today, recuperative care is not currently a Medi-Cal benefit, apart from the WPC pilot to which CalOptima previously allocated funds for recuperative care. However, CalOptima is planning to advocate with providers and stakeholders through the CalAIM process for the state to make recuperative care a Medi-Cal benefit in 2021, upon the completion of the WPC pilot.
		*Assumes continued coordination of input from biweekly health network/hospital meetings with CalOptima Board Homeless Health Ad Hoc.			
	Compliant and Sustainable *Sustained Medi-Cal funding for CalOptima from DHCS*	Consistent: Continuing to pay for clinic services (Medi-Cal-covered services) for CalOptima Medi-Cal members at shelters would be sustainable in terms	Consistent: Continuing to pay for clinical field team services (Medi-Cal-covered services) for CalOptima Medi-Cal members would be sustainable in	Consistent: Case management and care coordination are covered benefits under the basic Medi-Cal program, and housing navigation is a	Inconsistent: Inconsistent today because recuperative care is not a Medi-Cal-covered service, except through the WPC pilot. Consequently, there

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		of ongoing state funding.	terms of ongoing state funding.	covered benefit under HHP. However, the CalAIM proposal would sunset HHP and transition housing navigation to another program. Consequently, there is sustainable funding within these parameters.	is no source of sustainable funding currently. However, the CalAIM process has the potential to broaden Medi-Cal-covered services to include recuperative care.
	Strategic and Integrated *Integration with CalOptima's contracted health care delivery system*	Consistent: Clinic services in homeless shelters should reconnect members with their medical homes (i.e., health networks and PCPs).	Consistent: Clinical field teams should reconnect members with their medical homes (i.e., health networks and PCPs).	Consistent: Case management and care coordination services are integrated into CalOptima's contracted health care delivery system. HHP CB-CMEs will also be integrated through health networks. The CalAIM proposal would sunset HHP and transition housing navigation to another program, which would also be integrated into the CalOptima system.	Consistent: If recuperative care becomes a Medi-Cal benefit following completion of the WPC pilot and/or implementation of CalAIM, CalOptima would integrate the benefit with our contracted delivery system of health networks and hospitals.
	Defined and Accountable *Specific deliverables and measures of success*	Consistent: Specific initiatives in this category could be designed and developed with identified deliverables and measures of success.	Consistent: Specific initiatives in this category could be designed and developed with identified deliverables and measures of success.	Consistent: There is definition and accountability for health networks related to case management, care coordination and HHP CB-CME housing services. However, the CalAIM proposal would sunset HHP and transition housing navigation to another program, which would also be defined and accountable.	Consistent: If recuperative care becomes a Medi-Cal benefit, we will continue what the WPC pilot successfully started, including to have specific deliverables and measures of success (e.g., transitions to PSH).

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Acronyms:
CalAIM = California Advancing and Innovating Medi-Cal
CB-CME = Community-Based Care Management Entity
HHP = Health Homes Program
IHSS = In-Home Supportive Services
MSSP = Multipurpose Senior Services Program
PACE = Program of All-Inclusive Care for the Elderly
PCP = Primary Care Physician
PSH = Permanent Supportive Housing
WPC = Whole-Person Care

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 5, 2020
Regular Meeting of the CalOptima Board of Directors

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

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

Recommended Action
Authorize Procurement and Renewal of Insurance Policies for Policy Year (PY) 2020-21 at a premium cost not to exceed $2,850,000

Background/Discussion
CalOptima's business insurance coverage, except employee group health insurance and benefits, expires on April 7 of each year. Staff recommends renewing the same coverage categories included during PY 2019-20. As reference, the following table provides brief descriptions for the proposed insurance policies included for PY 2020-21:

Coverage Type	Description
Property	Provides coverage in the event of property or personal property damage to the 505 Building, the PACE center, and the Server location, not due to an Earthquake. Property, General Liability, and Commercial Auto are collectively known as Commercial Package coverage.
General Liability (GL)	Provides coverage to third parties for bodily injury or property damage.
Commercial Auto	Provides coverage for bodily injury and property damage caused by CalOptima's company-owned van, as well as collision and comprehensive coverage for the van itself; provides excess liability for employees using personal vehicles for company business.
Workers' Compensation (WC)/ Employers Liability (EL)	Provides coverage for medical care and temporary disability benefits to employees for on-the-job injuries or illnesses.
Umbrella	Provides excess limits for general liability and commercial auto coverage over and above the respective policies.
Excess Liability	Provides excess limits over and above the Umbrella policy.
Earthquake	Provides coverage in the event of property or personal property damage to the 505 Building, the PACE center, and the Server location, only due to an Earthquake.
Cyber – primary and excess	Provides coverage for claims related to or arising from cyber incidents, such as a data breach (coverage includes, but is not

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	limited to, regulatory fines and penalties, business interruption, credit monitoring, notice requirements, etc.) or network extortion (e.g., ransomware).
Directors and Officers (D&O) – primary and excess	Provides coverage for claims that are a result of an act, error, or breach of duty by a CalOptima employee or Board member when acting within his/her official capacity.
Employment Practices Liability (EPL) – primary and excess	Provides coverage for claims brought by any past, present or prospective employee against CalOptima or a CalOptima employee (acting within the scope of his/her employment) alleging, for example, employment discrimination, harassment, or wrongful termination.
Crime	Provides coverage for claims related to employee theft or forgery of money, securities, or other property, and computer and funds transfer fraud.
Managed Care Errors and Omissions (E&O) – primary and excess	Provides coverage for claims that are a result of an act, error, or omission in the performance of CalOptima's managed care activities (e.g., provider contracting, utilization review, implementation of clinical guidelines).
Medical Malpractice	Provides coverage for CalOptima employed physicians and certain other medical staff (i.e., CalOptima employed physician and therapists at the PACE center) in the event of a medical malpractice claim.
Pollution	Provides coverage for bodily injury, remediation expenses and property damages to third parties and remediation expenses to CalOptima in the event of a pollution incident, such as stored paint leaching into the ground water supply.
Wage and Hour	Provides coverage for actual or alleged violations of the Fair Labor Standards Act or any similar federal, state, or local laws governing or related to the payment of wages.
Fiduciary	Provides coverage for actual or alleged mismanagement of CalOptima's employee benefit and retirement plans.

The following table provides information on the coverage limits and deductibles for each type of insurance coverage:

Coverage	Limit	Deductible
Property	Building: $65,853,951	$25,000
	Business Personal Property: $26,422,520	$25,000
	Business Interruption & Extra Expense: $40,235,777	24 Hours

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Coverage	Limit	Deductible
GL	GL: $1,000,000/$2,000,000 Employee Benefits Liability: $1,000,000	$0/$1,000
Commercial Auto	Auto Liability: $1,000,000 CSL	$0 Liability $1,000/$1,000 Damage
WC/ EL	WC: Statutory EL: $1,000,000/$1,000,000/$1,000,000	$0 (Guaranteed Cost)
Umbrella	$10,000,000	Primary limits for GL, Auto and EL
Excess Liability	$25,000,000	$10,000,000
Earthquake	$75,000,000	EQ 5% subject to $50,000 minimum per occurrence
Cyber	$10,000,000	$250,000
Excess Cyber	$10,000,000	Primary limit for Cyber
D&O/EPL	$5,000,000 (Shared Limit)	$500,000
Crime	$5,000,000	$100,000
Excess D&O/EPL	$15,000,000	Primary limit for D&O/EPL
Managed Care E&O	$10,000,000	$150,000
Excess Managed Care E&O	$10,000,000	Primary limit for Managed Care E&O
Medical Malpractice (PACE)	$1,000,000/$3,000,000	$5,000
Pollution (3-year Policy Term)	$2,000,000/$4,000,000	$25,000
Wage and Hour	$10,000,000	$750,000
Fiduciary	$5,000,000	$10,000

On February 5, 2020, and February 24, 2020, Woodruff Sawyer, CalOptima's insurance broker, provided quotations for existing coverage. Staff has reviewed and evaluated the options. Overall, CalOptima's insurance policy renewals for PY 2020-21 are approximately 11% or $279,860 higher than the previous year. Staff recommends the following renewals at a total estimated premium not to exceed $2,850,000:

Coverage	2019-20 Premium	2020-21 Premium	$ Difference from Prior Year	% Difference from Prior Year
Renewal Premiums				
Commercial Package*	$73,278	$75,229	$1,951	3%

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WC/ EL*	$1,104,671	$1,237,392	$132,721	12%
Umbrella*	$10,080	$10,890	$810	8%
Excess Liability	$20,000	$21,463	$1,463	7%
Earthquake	$181,257	$200,322	$19,065	11%
Cyber	$110,250	$110,313	$63	0%
Excess Cyber	$85,000	$70,550	($14,450)	-17%
D&O/EPL*, Crime*	$146,640 (all three)	$174,735 (D&O/EPL), $23,450 (Crime)	$51,545	35%
Excess D&O/EPL*	$112,200	$175,713	$63,513	57%
Managed Care E&O*	$233,730	$247,100	$13,370	6%
Excess Managed Care E&O*	$130,205	$137,655	$7,450	6%
Medical Malpractice (PACE)	$33,866	$29,914	($3,952)	-12%
Pollution (3-year Policy Term)	$5,292	$5,295	$3	0%
Wage and Hour	$259,140	$261,725	$2,585	1%
Fiduciary*	$23,616	$27,339	$3,723	16%
Total: Renewal Premiums	**$2,529,225**	**$2,809,085**	**$279,860**	**11%**

*Estimated Premium; coverage still under negotiation

Due to CalOptima's use of an insurance broker and the inherent competitive quotation process, premium negotiations may often continue up to the day before policy expiration. As of February 25, 2020, the following insurance coverage policy terms are still being negotiated: Commercial Package, WC/EL, Umbrella, D&O/EPL – primary and excess, Crime, Managed Care E&O – primary and excess, and Fiduciary.

Explanation of significant cost increases:

- **Workers' Compensation:** CalOptima's premium increased by 12% or $132,721 from the previous year, under the quotation provided by the incumbent carrier. The primary factor is due to a 10% estimated increase in payroll, which is the main driver of premium growth. In addition, CalOptima continues to experience a high frequency of ergonomic injuries, such as strains. The experience modifier increased 26 basis points year-over-year, from 178 to 204. Woodruff Sawyer marketed the coverage, and in addition to the incumbent carrier, received a quotation from another carrier, for a savings of 22% or $238,000 from CalOptima's current premium.

  Staff recommends binding coverage with the new carrier for the following reasons:

  1. The new carrier has better claims management services and outcomes than the incumbent;

2. The new carrier is committed to building a strong relationship with CalOptima and to working with CalOptima to provide training to Management and Staff on claims mitigation, ergonomics, and other programs to lessen the frequency and severity of claims; and
3. This commitment from the new carrier, along with internal staff resources, would position CalOptima very favorably in the next one to two years to bind a deductible plan, resulting in significant premium savings.

If negotiations with the new carrier fail, CalOptima will bind with the incumbent. Also note, the Commercial Package coverage is dependent on the Workers' Compensation coverage, and the insurer that CalOptima elects to bind for Workers' Compensation coverage will also provide coverage for the Commercial Package.

- **Earthquake**: CalOptima's premium increased by 11% or $19,065 from the previous year. CalOptima continues to experience increased property values, which equate to higher premiums to insure against catastrophic events, like earthquakes. Also, there is a lower threshold for risk by carriers in the market in general, particularly as carriers try to recover from losses sustained globally.

- **D&O/EPL (primary and excess) and Crime:** CalOptima's primary D&O/EPL and Crime premium increased by 35% or $51,545 from the previous year. The incumbent carrier exited the managed care industry for all coverage lines in August 2019. At that time, another carrier bought the book of business, and quoted CalOptima's renewal for D&O/EPL only, as the carrier does not offer Crime coverage. Although the carrier is increasing the D&O/EPL deductible from $125,000 to $500,000, this is the most viable option for coverage, as other carriers declined to quote or proposed higher deductibles and/or higher premiums. This is the current trend in the EPL market, particularly in California and notably in Southern California. Carriers are limiting their risk exposure by increasing premiums, increasing retention, lowering coverage limits, or implementing a combination of these actions. CalOptima will explore with the broker the option to self-insure in the next one to two years.

  As stated above, the Crime coverage needed to be separately marketed. Two carriers provided quotations, one with a deductible of $250,000 and another with a deductible of $100,000 and a lower premium. CalOptima recommends binding the coverage with carrier offering the lower deductible and premium.

  As the excess coverage follows the primary coverage, the excess coverage market is facing the same trends, the excess coverage premium similarly increased.

- **Fiduciary:** CalOptima's premium increased by 16% or $3,723 from the previous year, under the quotation provided by the incumbent carrier. This is due to an increase in aggregate plan assets. Another carrier provided a competitively priced option, for a savings of 15% or $3,630 from CalOptima's current premium. Woodruff Sawyer is still negotiating terms to ensure the same or better coverage as the incumbent coverage. If negotiations with the other carrier fail, CalOptima will bind with the incumbent.

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Fiscal Impact

The fiscal impact of the annual insurance policy renewals and new coverages related to the period of April 7, 2020, through June 30, 2020, is a budgeted item under the Fiscal Year (FY) 2019-20 Operating Budget approved by the Board on June 6, 2019. Management plans to include funding for the remaining policy period of July 1, 2020, through April 7, 2021, and projected expenditures through fiscal year end in the CalOptima FY 2020-21 Operating Budget.

Rationale for Recommendation

The continued procurement of business insurance, without a lapse in coverage, ensures that CalOptima's risk and exposure to claims is mitigated as much as possible.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Board Action

/s/ Michael Schrader *02/26/2020*
Authorized Signature **Date**

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Attachment to March 5, 2020 Board of Directors Meeting – Agenda Item 16

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Woodruff-Sawyer & Co.	50 California Street, Floor 12	San Francisco	CA	94111
CNA	151 North Franklin St	Chicago	IL	
Travelers	One Tower Square	Hartford	CT	06183
AWAC	199 Water St, 25th Floor	New York	NY	10038
XL	100 Constitution Plaza #15	Hartford	CT	06103
TDCSU	29 Mill Street	Unionville	CT	06085
Navigators/Hartford	83 Wooster Heights Road	Danbury	CT	06810
Ironshore	28 Liberty St, 5th Floor	New York	NY	10005
Argo Re	110 Pitts Bay Rd	Pembroke HM 08	Bermuda	
RT Specialty	180 N Stetson Ave, Ste 4600	Chicago	IL	60601
Beazley US /Lloyds	30 Batterson Park Rd	Farmington	CT	06032

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 5, 2020
Regular Meeting of the CalOptima Board of Directors

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

Contact
Nora Onishi, Director, Information Services 714 246-8400
Belinda Abeyta, Executive Director, Operations, 714 246-8400

Recommended Actions
Authorize the Chief Executive Officer (CEO) to:

1. Extend the contracts with the following vendors as listed below through the dates indicated in the attached Tables 1 and 2:
    a. Office Ally, Inc. (Claims Clearinghouse)
    b. Change Healthcare Technologies, LLC (Claims Clearinghouse)
    c. Health Management Systems, Inc. (HMS) (Medi-Cal Cost Containment)
    d. Medecision, Inc. (CalOptima Link)
    e. Star Medical Therapy Management (MTM), LLC (Clinical Support Services)
2. Authorize payment of maintenance and support fees to these vendors through the dates and up to the amounts indicated in the attached Tables 1 and 2.

Background
CalOptima contracts with many vendors that provide a variety of software solutions to support the overall business model. Two core systems (medical data management and claims processing) are central to this infrastructure, while many other supporting solutions surround the core systems.

Within the managed care industry, this is standard practice, as no commercially available single solution can meet the demands of the industry for all functions. The trend over the past 10 or more years has been to utilize this approach by using the core for what those systems handle best, and to use specialty solutions to surround the core. CalOptima, the other 15 local health plans of California, and virtually all health plans, use this approach.

Supporting Systems include:

a. Office Ally – Claims clearinghouse. Providers in the community interact with Office Ally systems to submit claims to CalOptima for payment consideration. The Office Ally clearinghouse provides these services to the majority of California providers. Office Ally also provides electronic health record and practice management solutions at no additional cost to provider offices, including hundreds of CalOptima-contracted provider offices.

b. Change Healthcare Technologies – Claims clearinghouse. Providers in the community interact with Change Healthcare systems to submit Long Term Care claims for payment to CalOptima. In addition, Change Healthcare is responsible for printing CalOptima provider remittance advices (RA) biweekly. The RA provides a notice and explanation of reasons for payment, adjustment,

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and denial of charges on a medical claim.

c. HMS – HMS is a coordination of benefits recovery cost containment service vendor. For CalOptima, as well as the California Department of Health Care Services (DHCS). HMS is a contingency contract to identify and recover overpayments for improper Medi-Cal payments related to coordination of benefits. HMS' mission is to help protect the integrity of government-sponsored health and human services programs. HMS provides similar services to 23 states, including 41 state Medicaid programs.
d. Medecision Aerial Care Coordination – This solution is the current CalOptima provider portal, more commonly known to CalOptima provider partners as CalOptima Link. This portal enables thousands of provider office users to verify eligibility, review claims status, view patient rosters, and submit service authorization requests. This will ultimately be replaced by the internal development of our new CalOptima Provider Portal.
e. Star MTM Clinical Support Services – This vendor provides the system and services to support the Pharmacy Medication Therapy Management Program (MTMP) required by the Centers for Medicare & Medicaid Services (CMS) for both the OneCare and OneCare Connect programs. This highly regulated program is integrated within the overall administration of CalOptima's pharmacy benefit. Since initial contracting, the vendor was acquired by Star MTMP, resulting in much needed enhancements that have directly benefited CalOptima members and have led to a more efficient workflow. Given the strength and success of the MTMP in CalOptima's annual CMS data validation audits, staff recommends extending the current contract by two years with a re-evaluation for RFP scheduled during Fiscal Year (FY) 2022-23. With the upcoming plan for a PBM RFP, this extension will also help support the resources to focus on one major Pharmacy RFP at a time.

Discussion

The vendors listed in the attached tables represent the solutions described above with contracts expiring in 2020 and 2022. Replacing any of these solutions would require substantial additional investment, time commitment, and significant disruption to operations.

Many of these solutions are tightly embedded/integrated into either Facets and/or Altruista (the core systems) – see Table 1. Unless Facets or Altruista were replaced, changing these tightly integrated solutions is infeasible without substantial investment and significant disruption to CalOptima's operations. Some also represent the most viable solution considering CalOptima's operating environment. See Table 2. Staff recommends that those falling into this category will have their contracts extended without going through the competitive bidding process at this time.

Fiscal Impact

The CalOptima FY 2019-20 Operating Budget includes the annual fees for the listed contracted vendors related to CalOptima's core and supporting systems through June 30, 2020. Management plans to include expenses for the recommended contract extension periods on or after July 1, 2020, in future CalOptima Operating Budgets.

Rationale for Recommendation

Staff recommends extension of the contracts for the referenced systems to ensure that there is no disruption to the services provided by each of the solutions and to allow for continuity of operations throughout the organization and CalOptima's member and provider communities.

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Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Contracted Entities Covered by this Recommended Board Action
2. Proposed Contract Extensions – Tables 1 and 2

/s/ Michael Schrader *02/26/2020*
Authorized Signature **Date**

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Attachment 1 to the March 20, 2020 Board of Directors Meeting – Agenda Item 17

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Office Alley	1300 SE Cardinal Court Suite 190	Vancouver	WA	98683
Change Healthcare Technologies, LLC	3055 Lebanon Pike Street	Nashville	TN	37214
HMS	401 Park Avenue South	New York	NY	91803
Medecision, Inc.	550 E. Swedesford Road	Wayne	PA	19087
Star Medical Therapy Management (MTM), LLC	701 Seneca Street	Buffalo	NY	14210

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Attachment - Proposed Contract Extensions

Table 1 — Solutions tightly integrated with core Facets (claims processing) and/or Altruista (medical data management) systems

Number from List, Vendor, Solution Name (if applicable)	Description of Service	Original Contract Start Date	Current Contract Expires	Recommend Contract Extension Through:	Competitive Bid Initiation (approximate):	Annual Cost Based on Fiscal Year 2019–20 Budget
d. Medecision	Provider Portal	3/23/2011	12/31/2020	12/31/2021	N/A	$1,560,000
a. e. Star MTM	Pharmacy	11/1/2014	3/21/2022	3/21/2024	N/A	$156,000

Table 2 — Solutions defined as “most viable” based on market standard, lack of competition or related to state consistency

Number from List, Vendor, Solution Name (if applicable)	Description of Service	Original Contract Start Date	Current Contract Expires	Recommend Contract Extension Through:	Competitive Bid Initiation (approximate):	Annual Cost Based on Fiscal Year 2019–20 Budget
a. Office Alley	Claims Clearinghouse	7/1/2004	12/31/2020	12/31/2023	N/A	$685,000
b. Change Healthcare	Claims Clearinghouse	10/12/2000	12/31/2020	12/31/2023	N/A	$17,000
c. HMS	Coordination of Benefits Recovery	5/15/2008	5/14/2020	5/14/2023	N/A	$1,425,000

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No Action Taken

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 5, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

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

Contact

Michael Schrader, Chief Executive Officer, (714) 246-8400
Brigette Gibb, Executive Director, Human Resources, (714) 246-8400

Recommended Actions

1. Receive Report from Grant Thornton on compensation and benefits benchmarking and analysis with Appendix: Custom Peer Groups;
2. Adopt Resolution approving CalOptima's updated Human Resources Policies GA.8057: Compensation Program and GA.8058: Salary Schedule, with a proposed implementation date for the Salary Schedule of March 1, 2020;
3. Authorize the Chief Executive Officer to administer CalOptima compensation practices in accordance with CalOptima policies and Grant Thornton recommendations; and
4. Direct staff to research deferred compensation plan options and return to the Board with recommendations.

Background/Discussion

On November 1, 1994, the Board of Directors delegated authority to the Chief Executive Officer (CEO) to promulgate employee policies and procedures, and to amend these policies from time to time, subject to annual presentation of the policies and procedures, with specific emphasis on any changes thereto, to the Board or a committee appointed by the Board for that purpose. On December 6, 1994, the Board adopted CalOptima's Bylaws, which requires, pursuant to section 13.1, that the Board adopt by resolution, and from time to time amend, procedures, practices and policies for, among other things, hiring employees and managing personnel.

On August 1, 2013, the Board adopted the CalOptima Compensation Philosophy, which established the objectives of the compensation program to include base salary, incentive, and benefit levels competitive with the median range of CalOptima's labor market.

On March 6, 2014, the Board approved revisions to CalOptima's Compensation Administration Guidelines (Guidelines), which is a document that defines the principles upon which CalOptima's compensation practices are managed, the procedural aspects of how compensation is administered, and how the overall compensation administration function responds to changing market conditions and business demands to compete for and retain talent. The approved Guidelines reflect the results of an independent review of CalOptima's total compensation and related administration practices and established pay rates based on the market fiftieth percentile.

According to the Guidelines, CalOptima's salary structure should be reviewed on a regular basis, either annually or every other year, to continue to reflect market competitiveness. As provided

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in the Guidelines, market adjustments are to be applied to the salary schedule as needed, at least every two years. Following approval of the salary structure and salary schedule in the first half of 2014, on December 3, 2015, the Board approved an adjustment to CalOptima's salary schedule pay ranges up by 4% to keep pace with the then current market rates.

Consistent with the Guidelines, staff requested authorization and appropriation on May 18, 2017 for a compensation study as part of the fiscal year (FY) 2017-18 operating budget to review CalOptima's salary structure. However, the Finance and Audit Committee directed staff to remove the compensation study from the FY 2017-18 budget in order to mitigate the then anticipated reductions from the state in Medi-Cal Classic and Medi-Cal Expansion provider rates.

Since the most recent employee compensation study was completed in 2014, CalOptima has experienced significant change and growth in terms of the number of members served, as well as a more than doubling in terms of revenue and number of employees. CalOptima has also seen significant expansion of its programs, bringing certain functions in-house, along with new programs and initiatives. In addition, the general labor market is experiencing historically low unemployment rates, leading to competition for qualified applicants and employees.

At the Board's May 3, 2018 meeting, staff received direction to look into conducting periodic salary surveys and include implementation funds in the budget.

At its June 7, 2018 meeting, the Board authorized and appropriated funds in the FY 2018-19 Operating Budget, which included $300,000 in professional fees to conduct an independent compensation study, and Grant Thornton was engaged to perform a study of CalOptima's total compensation and related administration practices. The goal of the review by Grant Thornton was to determine CalOptima's competitiveness with other organizations for human capital recruitment and retention, and to make recommendations.

At the Board's May 2, 2019 meeting, Chair Yost appointed Directors DiLuigi and Penrose to review the work of Grant Thornton, the compensation consultant.

At its June 6, 2019 meeting, the Board approved the FY 2019-20 Operating Budget, which includes $1.5 million for compensation market adjustments and an additional $50,000 in professional fees to complete the compensation study-related tasks.

In alignment with CalOptima's Compensation Philosophy, and building on the framework that was established by the Board for the compensation program, Grant Thornton evaluated CalOptima's total compensation and has made recommendations based on current market data to update CalOptima's current pay practices to reflect market competitiveness, including, but not limited to, base pay, incentive pay, benefits, and other supplemental pay practices.

As reflected in the Board-approved Guidelines, periodic review of CalOptima's salary structure is necessary to obtain current market compensation data as a key element in an effective recruitment and retention strategy. Grant Thornton has made recommendations to support both

recruitment and retention efforts. As provided in the Guidelines, any adjustment to the salary schedule structure requires that the CEO take the recommendations to the Board for final approval. Based on the Compensation Philosophy, Guidelines, and Grant Thornton's recommendations, the following proposal is presented for Board approval and has been incorporated in the proposed revised policy:

- Adjust CalOptima's salary structure and salary schedule with an implementation date of March 1, 2020, to keep pace with the current market rates, taking into account internal evaluation of job responsibilities. March 1, 2020 is the first day of the pay period and selected as the implementation date for ease of administration.

At the February 6, 2020 Board Meeting, the Board reviewed this item and there was a request for additional information from Grant Thornton for further review and to return this item to the March 5, 2020 Board Meeting. The requested information on the custom peer groups is included in the Report.

Upon Board authorization, the CEO, will complete the phased in implementation of CalOptima compensation practices in accordance with recommendations by Grant Thornton in FY 2019-20 and FY 2020-21.

Additionally, consistent with Grant Thornton's report, it is recommended that the Board direct staff to explore options for long-term deferred compensation in order to bring total compensation into alignment with CalOptima's compensation philosophy.

Pursuant to the California Code of Regulations, Title 2, Section 570.5, CalOptima is required to adopt a publicly available pay schedule that meets the requirements set forth by the California Public Employees' Retirement System (CalPERS) to reflect recent changes, including the addition or deletion of positions and revisions to wage grades for certain positions.

The following table lists the Human Resources policies that have been updated and are being presented for review and approval:

	Policy No./Name	**Summary of Changes**	**Reason for Change**
1.	GA.8057 Compensation Program Attachment A – Compensation Guidelines	• Deleted language to comply with the California Equal Pay Act requirements. • Minor language and formatting changes to the Policy. • Attachment A – Compensation Guidelines updated	• Revised Policy to comply with California Equal Pay Act, Labor Code section 1197.5 and Labor Code section 432.3 • Clarifying language provided for ease of comprehension and consistent application

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	Policy No./Name	Summary of Changes	Reason for Change
		with: • Minor language and formatting changes; • Revised merit pay calculation methodology to coincide with fiscal year; • Provide clarifying language and modifications to reflect current operational processes and practices; • Clarify the method for calculating salary for promotions, demotions and transfers.	and to reflect current compensation practices
2.	GA.8058 – Salary Schedule Attachment A- Salary Schedule	• This policy focuses solely on CalOptima's Salary Schedule and requirements under CalPERS regulations. • Minor language and formatting changes to the Policy • Attachment A – Salary Schedule has been revised in order to reflect changes to the salary structure based on Grant Thornton's compensation study and internal evaluation of job responsibilities. Changes include the proposed addition of new positions and the	• Pursuant to CalPERS requirement, 2 CCR §570.5, CalOptima must update the salary schedule to reflect current job titles and pay rates for each job position. • Attachment A changes include the addition of new positions and deletion of positions which are no longer being used. Revisions to wage grades and salary ranges are made as a result of the Grant Thornton Compensation Study and internal evaluation

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	Policy No./Name	Summary of Changes	Reason for Change
		deletion of positions that are no longer in use. A summary of the changes to the Salary Schedule is included for reference. • Since the February 6, 2020 Board Meeting, three (3) new titles have been added to the proposed Salary Schedule, three (3) pay grades have been decreased, and one (1) pay grade has been increased as noted in the Summary of Changes to Salary Schedule. • The proposed implementation date of the Salary Schedule updates is March 1, 2020.	of job responsibilities. • New Positions: Creation of new Job Titles are typically due to a change in the scope of a current position or the addition of a new level in a job family. • Implementing changes to the salary schedule with an implementation date of March 1, 2020, will coincide with the start of the pay period for ease of administration.

Fiscal Impact

The proposed implementation date for the updated Salary Schedule is March 1, 2020. The fiscal impact of the recommended actions to implement the initial phase of salary adjustments pursuant to recommendations by Grant Thornton is $1.7 million through June 30, 2020. Compensation market adjustments and unspent budgeted funds for salaries and benefits included in the FY 2019-20 Operating Budget approved by the Board on June 6, 2019, will fund the recommended actions. The estimated annual cost for the recommended actions is approximately $9 million, which would result in a 5.5% increase in payroll expenses. Upon approval, Management will include updated expenses in future operating budgets.

Rationale for Recommendation

The independent review of CalOptima's compensation structure and program will ensure that CalOptima's compensation practices are clear, consistent, and competitive. The revised policies will also address the need to respond to changing market conditions and business demands for talent in a manner that is consistent with CalOptima's status as a public agency and the Board-approved Compensation Guidelines.

Concurrence

Gary Crockett, Chief Counsel

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No Action Taken

Attachments

1. Grant Thornton Compensation and Benefits Benchmarking and Analysis Report
2. Resolution No. 20-0305-01, Approve Updated Human Resources Policies
3. Revised CalOptima Policies:
   a. GA. 8057: Compensation Program (redlined and clean copies) with revised Attachment A (redlined and clean copies)
   b. GA. 8058: Salary Schedule (redlined and clean copies) with revised Attachment A (redlined and clean copies.
4. Summary of Changes to Salary Schedule

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

02/26/2020 — **Date**

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Grant Thornton

CalOptima

Compensation and Benefits Benchmarking and Analysis

March 5, 2020

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Prepared by:

Grant Thornton LLP

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General Overview

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General Overview – About Grant Thornton

Grant Thornton LLP is the U.S. member firm of Grant Thornton International Ltd., one of the world's leading organizations of independent assurance, tax, and advisory firms. Proactive teams led by approachable partners in these firms use insights, experience and instinct to understand complex issues for not-for-profit, public sector, privately owned and publicly listed clients and help them to find solutions.

Our human capital services professionals are a senior team that possess the right mix of experience, technical skills, industry knowledge, and personal commitment to help you achieve your desired results. Not only do we know competitive benchmarking from the executive to staff level and short and long-term incentive design, but we also have the support and bench strength of national benefits and tax specialists to provide assessments on other compensation topics if needed.

We have extensive experience serving health plans similar to CalOptima. We conduct assessments of competitive compensation levels, deferred compensation and other benefits/perquisite programs using proven methodologies and relevant resources. Our ability to design and implement value-added strategies is grounded in our understanding of your business goals and value drives, as well as risk factors.

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General Overview

A successful total compensation program is one that promotes the ability of an organization to recruit, retain and motivate qualified employees to help the organization achieve its mission and goals. The objective for this Compensation and Benefits Study is to assess the competitiveness of CalOptima's total compensation program, measured against similar organizations from which CalOptima competes for labor. Our review includes base salary and incentive compensation, where applicable. As well as, employee benefits that are an essential component of an employee's overall compensation such as retirement, health insurance, life insurance, pension, sick leave, vacation time, etc.

In an effort to have a program that is fair, equitable, and competitive, CalOptima has undertaken an internal review on the following key items:

- **Job descriptions.** Updated and accurate job descriptions that describe what employees are doing within their respective roles
- **Relevant markets**. Revised comparison markets by functional area and classification that more accurately captures the compensation paid at organizations from which CalOptima recruits employees
- **Market-based structure.** Salary structure that is based on a balance between defined, specific comparison markets and internal factors
- **Revised pay guidelines.** Key principles that help Human Resources administer compensation in a disciplined way to ensure that compensation of employees is managed fairly and consistently

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Scope of Work
Overview of Project

Grant Thornton was engaged to perform a Compensation Study (Salary and Benefits) to evaluate CalOptima's pay practices for human capital recruitment and retention as compared to other local, regional, and national organizations of similar size and operations i.e., hospitals (public agencies, non-profit and private), health plans (public agencies and private), health networks, and other employers (public agencies and private entities).

We reviewed and made recommendations on the appropriateness and competitiveness of CalOptima's current pay practices (Salary and Benefits) in order to remain competitive in the market, taking into account CalOptima's organization as a public agency and its obligation to remain fiscally prudent. We focused on skilled employees to fill and retain leadership roles and key positions essential to fulfilling the agency's strategic plan and operational goals.

The study included base pay, incentive pay, and other supplemental pay practices, along with all benefits offered to CalOptima employees (i.e. paid time off, employer share of health benefits, retirement benefits (CalPERS and PARS), life insurance, etc.) We benchmarked positions against internal CalOptima positions, where appropriate, to ensure fairness in its pay practices and to avoid pay compression. Some job titles with similar job functions and responsibilities were benchmarked against other CalOptima positions.

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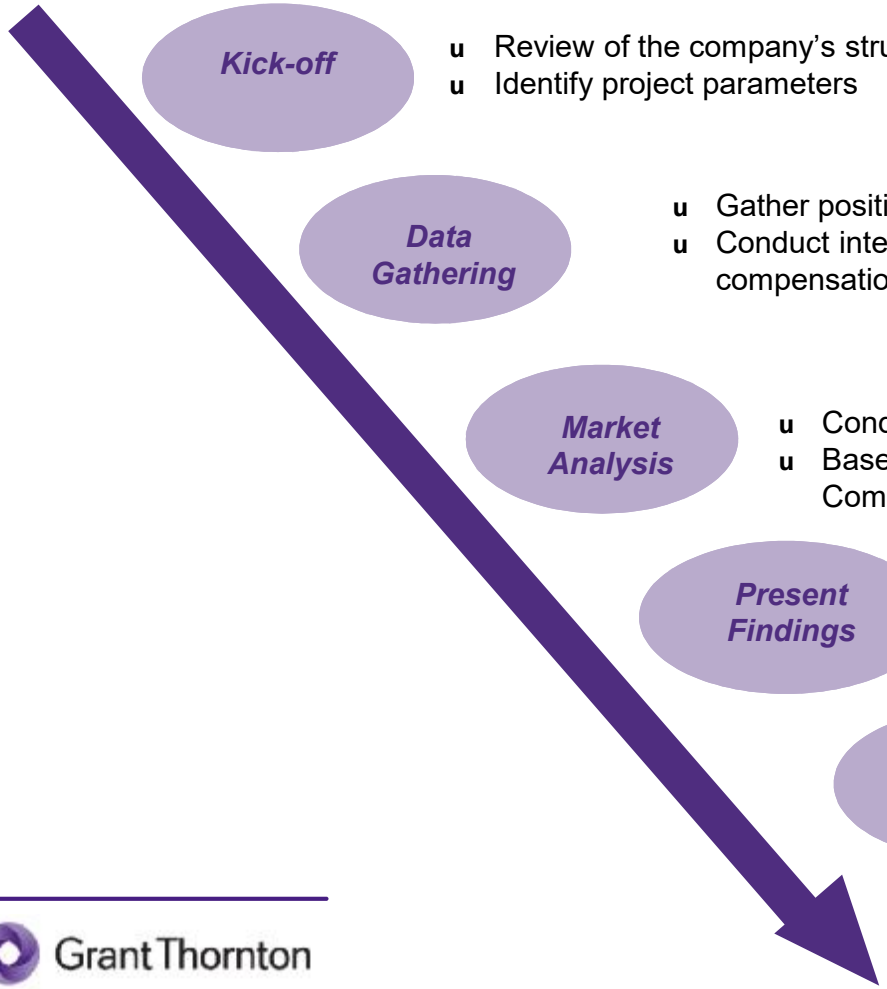
Scope of Work
Grant Thornton's Engagement Approach



Kick-off

- Review of the company's structure, goals, and objectives
- Identify project parameters

Data Gathering

- Gather position information, pay information, and benefit program summaries
- Conduct interviews with key stakeholders regarding issues relevant to compensation philosophy and executive pay

Market Analysis

- Conduct assessment and market comparisons:
- Base Salary, Total Cash Compensation, Total Direct Compensation, and Benefit Programs

Present Findings

- Prepare and present initial report
- Collaborate with compensation study workgroup

Next Steps

- Finalize report and any recommendations
- Implementation support as needed

Grant Thornton

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Scope of Work
Peer Groups

CalOptima recruits and retains talent in the Southern California competitive job market for all positions, and broader regions - even national - for senior level management positions. Our peer groups have been customized to reflect the geographic pool for talent for these different positions.

Despite being a government agency, CalOptima competes with like health plan organizations, whether government, tax-exempt, or for-profit. Therefore, Grant Thornton (GT) conducted the competitive market analysis using a combined peer group of blended data from the following sectors of health plans on an equally blended basis:

- Government Peers
- Not-for-Profit Peers
- For-Profit Peers

Examples: An Accounts Payable Clerk was benchmarked using like positions, with equal weight on government, not-for-profit, and for-profit organizations regionally since this represents the labor pool. Alternatively, a senior executive position is benchmarked relative to the same peers, but looking at comparable organizations nationally.

Scope of Work
Peer Groups/Market Data Sources

- GT used the following peer groups and compensation surveys to assess competitive market levels:

Data Source	Description
Government Health Plan Peer Group	§ Contains government health plan organizations of similar size and business focus to CalOptima, including LA Care and Inland Empire § GT kept the same constituents of CalOptima's prior government health plan peer group (used in GT's 2017 CEO/CLO report) § Used for comparison to CalOptima's executive team
Tax Exempt Health Plan Peer Group	§ Contains tax exempt health plan organizations of similar size and business focus to CalOptima § GT kept the same constituents of CalOptima's prior tax exempt health plan peer group (used in GT's 2017 CEO/CLO report) § Used for comparison to CalOptima's executive team
For-Profit Health Plan Peer Group	§ Contains for-profit health plan organizations of similar size and business focus to CalOptima § GT kept the same constituents of CalOptima's prior public health plan peer group (used in GT's 2017 CEO/CLO report) § Used for comparison to CalOptima's executive team

Scope of Work
Peer Groups/Market Data Sources

- GT used the following peer groups and compensation surveys to assess competitive market levels:

Data Source	Description
ERI	§ Economic Research Institute ("ERI") is a nationally recognized for profit regression based survey § We have pulled compensation data for the "Medical, Dental, & Disability Plans" sector for organizations with $700M in assets § Used for comparison to CalOptima's executive team, directors, managers, and staff level positions
Health Plan Survey	§ Lastly, we have used a confidential health plan survey that has compensation information for executives, directors, managers, and staff in tax exempt and public health plans. § Used for comparison to CalOptima's executive team, directors, managers, and staff level positions

Grant Thornton

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Executive Summary

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Executive Summary
Current Total Rewards Environment

CalOptima reviewed their total rewards program in 2013. To provide context on the current market, we highlighted the following total rewards trends for the last five years:

- Salaries
  - 3% to 4% annual salary increase in market, totaling an average market movement of 15% to 20% over the last five years
- Annual Incentives
  - Almost universal use of incentives in the health plan market, across all ownership types, with payouts often averaging above target or expected levels
- Long-Term Incentives
  - Universal use with for-profit health plans, and majority practice for large health plans
- Total Compensation (Inclusive of Benefits)
  - Increases at a rate consistent with salaries, since benefits and incentive values are typically expressed/provided as a percent of salary
  - Generally, benefit cost increases are shared partially employees/participants
- The market's total compensation increases are above the standard levels described above for growing job levels, considering that market total compensation increases by 5% to 20% for every doubling in organizational size (e.g., $3B health plan pay levels would tend to be 5% to 20% higher then $1.5B health plan)
  - Leadership position pay values are more sensitive to organizational size than staff levels
- The current labor market is an employees market due to the historically low unemployment rate

Executive Summary
Compensation Program

- Base Salary
  - On average:
    - Executives are positioned 13% below market median
    - Directors are positioned 13% below market median
    - Managers are positioned 6% below market median
    - Staff are positioned 4% below market median
- Total Cash Compensation (Base Salary + Annual Incentives)
  - On average:
    - Executives are positioned 30% below market median
    - Directors are positioned 24% below market median
    - Managers are positioned 13% below market median
    - Staff are positioned 7% below market median
    - Disparities are due to the limited incentive compensation offered
- Total Direct Compensation (Base Salary + Annual Incentives + Long-Term Incentives)
  - On average, executives are positioned 43% below market median
  - Disparity is due to the lack of a long-term incentive plan at CalOptima

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Executive Summary
Compensation Program

- While we used a blend of data from government, tax exempt, and for-profit health plans in our study, we wanted to show how CalOptima pay compares against only government health plan pay data.
- We looked at the median market base salaries of 5 executives, 5 managers, and 5 staff positions to see how the government data compared against the blended data and CalOptima's midpoints. The charts below and on the next slide outline our findings:

Base Salary

Title	CalOptima Base Salary Midpoint	Blended Peer Group P50	Government Peer Group P50	% Difference
Chief Financial Officer	$320,216	$397,000	$351,640	-11%
Chief Operating Officer	$320,216	$335,000	$284,380	-15%
Chief Medical Officer	$320,216	$380,000	$374,060	-2%
Chief Information Officer	$266,968	$299,000	$260,000	-13%
Chief Counsel	$266,968	$343,000	$293,800	-14%
			Average	**-11%**

Total Cash

Title	CalOptima Total Cash Midpoint	Blended Peer Group P50	Government Peer Group P50	% Difference
Chief Financial Officer	$352,238	$520,000	$393,900	-24%
Chief Operating Officer	$352,238	$444,000	$318,500	-28%
Chief Medical Officer	$352,238	$453,000	$421,260	-7%
Chief Information Officer	$293,665	$370,000	$262,600	-29%
Chief Counsel	$293,665	$494,000	$382,200	-23%
			Average	**-22%**

Total Direct

Title	CalOptima Total Direct Midpoint	Blended Peer Group P50	Government Peer Group P50	% Difference
Chief Financial Officer	$352,238	$663,000	$439,400	-34%
Chief Operating Officer	$352,238	$480,000	$352,300	-27%
Chief Medical Officer	$352,238	$619,000	$456,660	-26%
Chief Information Officer	$293,665	$392,000	$330,200	-16%
Chief Counsel	$293,665	$500,000	$442,500	-12%
			Average	**-23%**

- On average, the government peer group data is 11% lower than the blended peer group data for executive base salaries.
- On average, the government peer group data is 22% lower than the blended peer group data for executive total cash compensation.
- On average, the government peer group data is 23% lower than the blended peer group data for executive total direct compensation.

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Executive Summary
Compensation Program

Title	CalOptima Base Salary Midpoint	Blended Peer Group P50	Government Peer Group P50	% Difference
Manager Accounting	$93,184	$120,000	$119,800	0%
Manager Communications	$93,184	$100,000	$95,000	-5%
Manager Customer Service	$93,184	$85,000	$83,500	-2%
Manager Facilities	$93,184	$89,000	$82,200	-8%
Manager Finance	$93,184	$117,000	$114,000	-3%
			Average	**-3%**

Title	CalOptima Base Salary Midpoint	Blended Peer Group P50	Government Peer Group P50	% Difference
Actuary	$107,328	$126,000	$110,000	-13%
Accountant Intermediate	$70,512	$73,000	$70,000	-4%
Accounting Clerk	$46,384	$42,000	$45,000	7%
Payroll Specialist	$53,352	$53,000	$52,000	-2%
Buyer Intermediate	$61,360	$69,000	$65,000	-6%
			Average	**-3%**

- On average, the government peer group data is 3% lower than the blended peer group data for manager and staff base salaries.
- While government health plans tend to have lower pay levels, it is important to consider organizational size and complexity when analyzing pay levels. Due to CalOptima's expansion of programs and members, which has resulted in increased complexity and more than doubling in size since 2014, we looked at data for labor markets for bigger organizations, including a blend of government, tax exempt, and for-profit health plans, comparable in size and revenue, in our analysis.
- With the increased complexity and size, CalOptima should expect to see a significant impact in salary for employees in management positions and above to account for growth and greater responsibilities.

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Executive Summary
Benefits Program

- Health and Welfare Programs
  - Offering four medical plans allow employees more choice and flexibility
  - The health plans offered by CalOptima offer a high level of benefits
  - HMO plans have much lower employee contributions and slightly better cost-sharing than market
  - HDHP and PPO plans have average employee contributions and cost-sharing compared to market
  - Prescription drug, dental, vision, life, LTD, and STD benefits are competitive or above market
- Retirement Programs
  - Participants receive employer contributions in both the defined contribution (PARS) and a defined benefit plan (CalPERS)
- Vacation/Paid Time-Off Programs
  - Offers more time-off than the composite benchmark, but less than other public agencies

This analysis was based on composite benchmarks of organizations of similar size, geography, and industry

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Executive Summary
Benefits Program

- CalOptima is above market from a total benefits program perspective
- Time-off programs are above market but less than other public agencies
- The strongest benefit is the CalPERS defined benefit plan, though CalOptima adopted one of the lowest benefit formulas as compared to other public agency peers

Market Competitiveness*	
Retirement Benefits	Above Market
Medical Benefits	Above Market
Dental Benefits	Above Market
Vision Benefits	At Market
Disability Benefits	At Market
Life Insurance Benefits	At Market
Time-Off Programs	Above Market
Total Benefits Program	**Above Market**

* This analysis was based on composite benchmarks of organizations of similar size, geography, and industry.

Executive Summary
Total Compensation

- By group, with compensation generally being below median and benefits being above median, average total compensation is as follows:
  - Executives and Directors are well below median
    - Driven primarily by aggressive incentive practices in peers
    - Compensation gap is not closed by above market benefits
  - Managers are moderately below median
    - Compensation gap is moderated based on above market benefits
  - Staff are positioned close to median
    - Compensation gap is made up due to highly competitive benefits

Recommendations

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Compensation Recommendations
Total Compensation Philosophy

The following are principles that can be used as the foundation of CalOptima's total compensation program:

- To reinforce the mission of the organization
- To achieve balance between the needs and concerns of CalOptima employees, and the communities it serves
- To attract and retain outstanding employees
- To motivate and reward outstanding performance
- To link compensation to consistent merit principles, including both individual and organizational performance
- To base decisions on appropriate comparability data provided by independent sources
- To ensure that compensation and benefits programs comply with all pertinent laws and regulations
- To maintain consistency and fairness, to the extent possible, without violating other principles
- To provide benefits in a manner that allows employees to participate in determining how best to meet their needs and those of their families

Compensation Recommendations
Total Rewards Competitive Positioning

- CalOptima wishes to recruit, retain, and motivate staff in order to accomplish organizational mission, vison, and strategic objectives. With this goal in mind, CalOptima intends to provide a total compensation program that is competitive with organizations that represent the competitive labor market for CalOptima's various staff positions.
- To achieve competitiveness, total compensation will be positioned at the:
  - 50th percentile for executives
  - 50th percentile for directors and managers
  - 50th percentile for most staff positions
  - Approximately the 62.5 percentile (between the 50th and 75th) for hard to fill staff positions, i.e. nursing, legal, and accounting staff.
- Base salaries, limited incentives and recognition and rewards, targeted at market median.
- Benefits targeted above market median.
- Pay for performance provides flexibility to position pay 10% to 20% above market for sustained outstanding performance.

Compensation Recommendations

Overall, CalOptima compensation is positioned below market, with the executives and directors most significantly lagging the market due to a combination of low salaries and low or no incentives. Our conceptual considerations are as follows:

- Base Salary
  - Implement CalOptima's compensation philosophy with market-based salary ranges, with market adjustments for those that are below market positioning and that have performed at a "meets expectations" level for a period of years.
  - With benefits above market, target base salary as follows:
    - 10% below 50th percentile total cash executives
    - 50th percentile total cash for directors and managers
    - 50th percentile total cash for most staff
    - For hard to recruit positions, we recommend positioning between the 50th and 75th percentile (62.5 percentile)

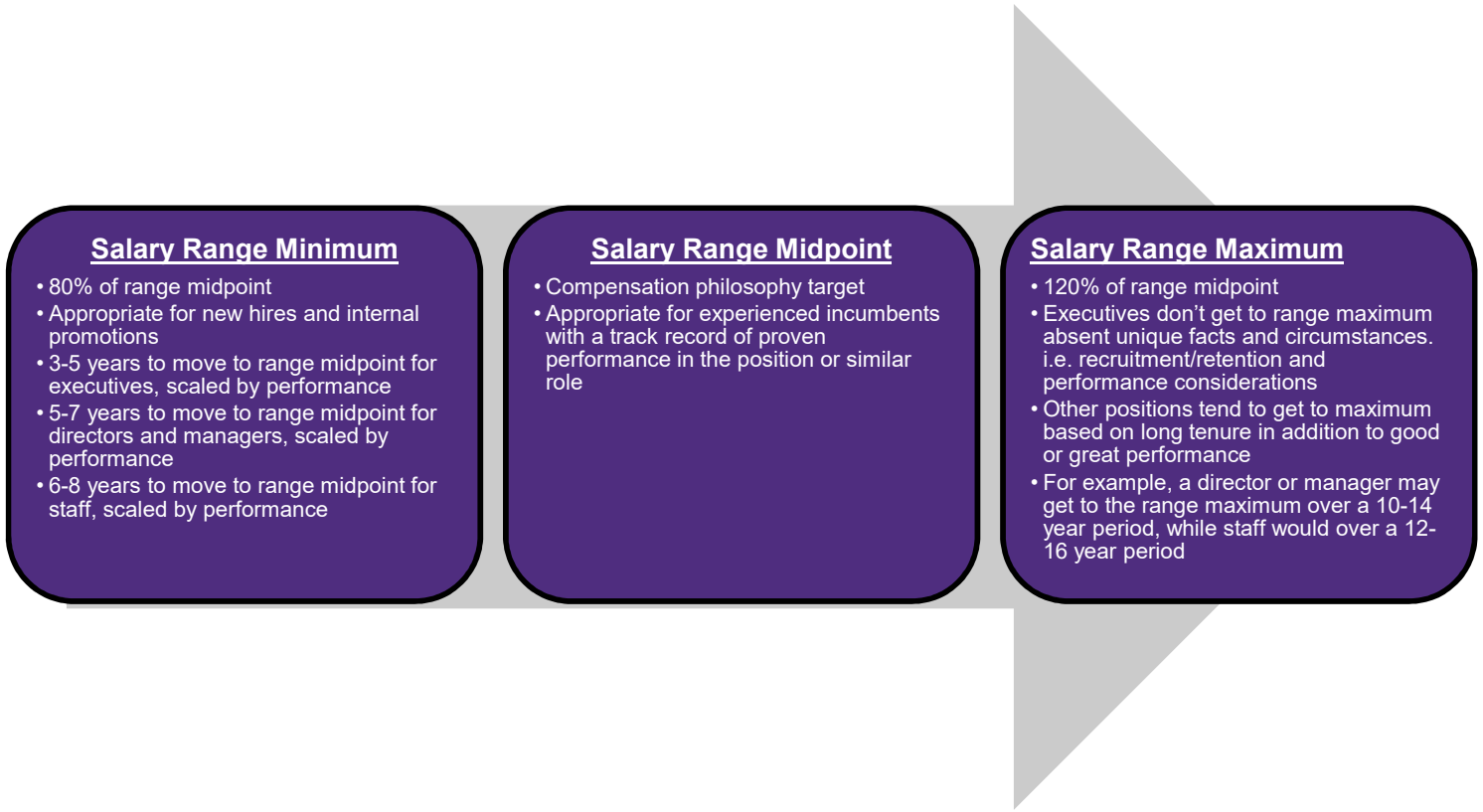
Compensation Recommendations

- Annual Incentive Compensation
  - Maintain existing annual incentive plan structure, with 10% target incentives, which would position target pay at the 50th percentile total cash
  - However, potentially add Directors and Managers to the annual incentive plan over the next two years

- Other Incentives
  - No additional incentives, for the time being, given the administrative difficulty on introducing higher incentives, either on an annual or long-term incentive basis

Compensation Recommendations
Base Salary Administration Guidelines

- The following is an example of competitive salary administration guidelines to help manage salaries around market-based compensation philosophy



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Compensation Recommendations

- Adjustments for FY 2019-20:
  - Move employees who are below proposed salary range minimum to the minimum (as required by CalPERS reporting)
  - Move employees with a track record of proven performance in the same level or position at CalOptima to midpoint based on methodology identified on the previous slide

- Ongoing for FY 2020-21:
  - Increase the aggregate merit pool from 3% to 5%
  - Apply market adjustments per current policy if necessary

- ***Methodology will deal with internal equity and compression issues inherently within each job, and amongst like jobs***

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Other Compensation Recommendations

- Upon implementation of 50th percentile total cash salary ranges, total compensation will still lag market for the executives and some directors
- We would suggest addressing a portion of this gap by implementing a non-qualified deferred compensation plan for executives and other select leadership positions, structured either as
  - A mid-term retention plan, whereby anywhere from 5% to 20% of salary is set aside per year, subject to a three to five year cliff vest (i.e., the dollars set aside are only earned and paid out to the extent the leader is employed by the organization at the end of the vesting period, or
  - Supplemental executive retirement plan, whereby a certain amount is set aside at the same value as the qualified retirement plan for those earnings above and beyond the qualified plan limits (i.e., restoration plan)
- The above strategy would still result in leadership pay being below market – but would assist in having incentives to retain key talent

Recommended Salary Structure

Grade Level	Minimum	Midpoint	Maximum
X	$ 347,000	$ 434,000	$ 521,000
W	$ 295,000	$ 369,000	$ 443,000
V	$ 251,000	$ 314,000	$ 377,000
U	$ 214,000	$ 267,000	$ 320,000
T	$ 182,000	$ 227,000	$ 272,000
S	$ 154,000	$ 193,000	$ 232,000
R	$ 144,000	$ 174,000	$ 204,000
Q	$ 130,000	$ 157,000	$ 184,000
P	$ 117,000	$ 141,000	$ 165,000
O	$ 105,000	$ 127,000	$ 149,000
N	$ 95,000	$ 114,000	$ 133,000
M	$ 85,000	$ 103,000	$ 121,000

Grade Level	Minimum	Midpoint	Maximum
L	$ 77,000	$ 93,000	$ 109,000
K	$ 70,000	$ 84,000	$ 98,000
J	$ 65,000	$ 78,000	$ 91,000
I	$ 61,000	$ 73,000	$ 85,000
H	$ 59,000	$ 68,000	$ 77,000
G	$ 55,000	$ 63,000	$ 71,000
F	$ 51,000	$ 59,000	$ 67,000
E	$ 48,000	$ 55,000	$ 62,000
D	$ 44,000	$ 51,000	$ 58,000
C	$ 41,000	$ 47,000	$ 53,000
B	$ 38,000	$ 44,000	$ 50,000
A	$ 36,000	$ 41,000	$ 46,000

*Please note that recommendation for CEO pay range is not included as part of this study

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Benefits Recommendations
General Overview

- Annual Strategic Analysis
  - Develop a formalized annual review process to review the goals and strategies of CalOptima's benefits program
    - Develop broad strategies and goals for CalOptima's compensation and benefits programs
    - Develop the general framework of the programs and how they will support the needs of employees and the financial constraints
    - Determine the employee's value of the benefit offerings versus the cost and, if appropriate, shift resources to items that employees value
  - Prepare a written benefit program philosophy that can create guiding principles to make benefit program decisions such as plan design changes. (For example, employees should pay low medical premiums, but have higher cost sharing.)
- Financial Modeling and Projections
  - Analyze the relative costing information for each alternative to understand financial implications of the benefit program decisions
  - Analyze advantages and disadvantages of each alternative, including the financial implications, and document them
  - Prepare a cost/benefit analysis to assess the benefits as well as the employer and employee costs. (For example, reinstituting the employer HSA contributions can increase participant enrollment and save both the employee and employer money.)

Benefits Recommendations
Program Issues

Overall, CalOptima benefits are positioned above market. The benefits recommendations below would not significantly change CalOptima's position in the market.

- Medical/Health Insurance
  - CalOptima offers medical plans with above market benefit levels and high employer cost share. CalOptima should consider reviewing its benefit strategy in order to reduce total plan costs, such as
    - Plan designs changes to encourage in-network utilization
    - Promote participant consumerism and cost-effective decisions
- Prescription Drug Programs
  - Consider pharmacy cost-saving measures, such as:
    - Excluding certain drugs with lower cost alternatives
    - Encouraging participation in the mail-order program
    - Implementing step-therapy for certain high-cost drugs
- Life and Disability Insurance Programs
  - Consider increasing the basic life insurance maximum to $500,000 to give an increased benefit to highly paid employees
  - Consider a cost/benefit analysis to join the California Short-Term Disability Insurance
- Retirement Programs
  - Consider consolidating the 457(b) Plan and 401(a) PARS Plan to a single vendor in order to reduce administrative and investment fees that will benefit participants by increasing their investment returns

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Financial Impact

(Estimated costs include benefits)

Recommendations	Financial Impact (12 months)
Bring employees up to minimum	3,180,000
Adjustments based on GT methodology	1,840,000
Merit pool increase from 3% to 5%	3,620,000
Market adjustments as needed	400,000
Total:	**$ 9,040,000**

% of Total Salary	5.5%
Impact to ALR	0.2%

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Appendix
Custom Peer Groups – Government Peer Group (like CalOptima)

Government Peer Organization	Industry	Total Revenues Most Recent Year (000,000)	Most Recent Year Total Assets (000,000)
Affinity Health Plan	Health-General & Financing	$1,418,105,612	$376,092,562
Boston Medical Center Health Plan	Health-General & Financing	$1,640,398,973	$429,520,379
CareOregon	Health-General & Financing	$971,484,613	$425,539,455
CareSource	Health-General & Financing	$6,531,587,542	$1,831,803,361
Commonwealth Care Alliance	Health-General & Financing	$809,417,329	$175,417,209
Community Health Choice	Health-General & Financing	$851,462,290	$239,892,454
Driscoll Childrens Health Plan	Health-General & Financing	$438,714,445	$83,473,281
ElderPlan Inc	Health-General & Financing	$904,056,324	$199,305,781
Inland Empire Health Plan*	Health-General & Financing	$4,302,922,597	$1,782,242,790
LA Care Health Plan	Health-General & Financing	$8,304,109,805	$459,986,900
Neighborhood Health Plan Inc	Health-General & Financing	$2,536,658,776	$456,299,895
Virginia Premier Health Plan	Health-General & Financing	$1,063,725,747	$386,298,189

CalOptima	$3,800,000,000	$1,800,000,000
Minimum	$438,714,445	$83,473,281
25th Percentile	$890,907,816	$229,745,786
Average	$2,481,053,671	$570,489,355
Median	$1,240,915,680	$405,918,822
75th Percentile	$2,978,224,731	$457,221,646
90th Percentile	$6,308,721,048	$1,650,017,201
Maximum	$8,304,109,805	$1,831,803,361

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Appendix
Custom Peer Groups – NFP Peer Group

NFP Peer Organization	Industry	Total Revenues Most Recent Year (000,000)	Most Recent Year Total Assets (000,000)
Blue Cross Blue Shield	Health-General & Financing	$512,533,419	$650,271,510
Capital Health Plan Inc	Health-General & Financing	$939,178,501	$480,125,384
Care Wisconsin Health Plan	Health-General & Financing	$123,315,773	$34,840,468
Geisinger Health Plan	Health-General & Financing	$2,109,272,521	$535,769,375
Group Health Cooperative	Health-General & Financing	$416,836,322	$119,242,329
Harvard Pilgrim Health Care	Health-General & Financing	$1,979,581,176	$958,882,498
HealthFirst Health Plan	Health-General & Financing	$2,028,384,559	$652,104,450
Medica Health Plans	Health-General & Financing	$2,108,568,644	$896,765,075
Tufts Associated HMO	Health-General & Financing	$2,995,230	$1,126,552,016

.

CalOptima	$3,800,000,000	$1,800,000,000
Minimum	$2,995,230	$34,840,468
25th Percentile	$416,836,322	$480,125,384
Average	$1,135,629,572	$606,061,456
Median	$939,178,501	$650,271,510
75th Percentile	$2,028,384,559	$896,765,075
90th Percentile	$2,108,709,419	$992,416,402
Maximum	$2,109,272,521	$1,126,552,016

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Appendix
Custom Peer Groups – For-Profit Peer Group

For-Profit Peer Organization	Industry	Total Revenues Most Recent Year (000,000)	Most Recent Year Total Assets (000,000)
CNO Financial Group Inc	Life & Health Insurance	$3,992,400,000	$31,975,200,000
Envision Healthcare Corp	Health Care Services	$3,696,000,000	$16,708,900,000
Health Net Inc	Managed Health Care	$16,243,587,000	$6,397,646,000
Healthequity Inc	Managed Health Care	$178,370,000	$279,136,000
Magellan Health Inc	Managed Health Care	$4,836,884,000	$2,443,687,000
Mednax Inc	Health Care Services	$3,183,159,000	$5,339,400,000
Stancorp Financial Group Inc	Life & Health Insurance	$2,902,400,000	$23,174,400,000
Team Health Holdings Inc	Health Care Services	$3,597,247,000	$4,060,842,000
Triple-S Management Corp	Managed Health Care	$2,984,806,000	$2,218,999,000
Universal American Corp	Managed Health Care	$1,379,646,000	$785,583,000
Wellcare Health Plans Inc	Managed Health Care	$14,237,100,000	$6,152,800,000

.

CalOptima	$3,800,000,000	$1,800,000,000
Minimum	$178,370,000	$279,136,000
25th Percentile	$2,943,603,000	$2,331,343,000
Average	$5,202,872,636	$9,048,781,182
Median	$3,597,247,000	$5,339,400,000
75th Percentile	$4,414,642,000	$11,553,273,000
90th Percentile	$14,237,100,000	$23,174,400,000
Maximum	$16,243,587,000	$31,975,200,000

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Disclosure

Our review was limited to the documents provided by CalOptima and did not include the underlying plan documents and summary plan descriptions. Our findings were based on the documents provided including employment agreements, policies, and summaries.

Our conclusions relate only to our understanding of the facts provided by CalOptima which are stated in this analysis. We have not independently verified these facts, and if any of these facts prove to be in error, the conclusions reached in this memorandum do not apply. Our conclusions are based on the Department of Labor, Internal Revenue Code, regulations and interpretations thereunder in their form as of the date of this analysis. We are under no obligation to update our conclusions for future changes in these authorities. Our conclusions are based on our interpretation of the tax law. Another party, such as the Internal Revenue Service or a court, hearing the same facts may reach different conclusions.

In accordance with applicable professional regulations, please understand that, unless expressly stated otherwise, any written advice contained in, forwarded with, or attached to this document is not intended or written by Grant Thornton LLP to be used, and cannot be used, by any person for the purpose of avoiding any penalties that may be imposed under the Internal Revenue Code.

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RESOLUTION NO. 20-0305-01

RESOLUTION OF THE BOARD OF DIRECTORS ORANGE COUNTY HEALTH AUTHORITY
d.b.a. CalOptima

APPROVE UPDATED HUMAN RESOURCES POLICIES

WHEREAS, section 13.1 of the Bylaws of the Orange County Health Authority, dba CalOptima, provide that the Board of Directors shall adopt by resolution, and may from time to time amend, procedures, practices and policies for, inter alia, hiring employees, and managing personnel; and

WHEREAS, in 1994, the Board of Directors designated the Chief Executive Officer as the Appointing Authority with full power to hire and terminate CalOptima employees at will, to set compensation within the boundaries of the budget limits set by the Board, to promulgate employee policies and procedures, and to amend said policies and procedures from time to time, subject to annual review by the Board of Directors, or a committee appointed by the Board for that purpose; and

WHEREAS, California Code of Regulations, Title 2, Section 570.5, requires CalOptima to adopt a publicly available pay schedule that identifies the position title and pay rate for every employee position, and CalOptima regularly reviews CalOptima's salary schedule accordingly.

NOW, THEREFORE, BE IT RESOLVED:

Section 1. That the Board of Directors hereby approves and adopts the attached updated Human Resources Policies: GA.8057 Compensation Program and GA.8058 Salary Schedule.

Section 2. That the Chief Executive Officer is authorized to implement the revised Salary Schedule effective March 1, 2020.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a., CalOptima this March 5, 2020.

AYES:
NOES:
ABSENT:
ABSTAIN:

/s/_____
Title: Chair, Board of Directors
Printed Name and Title: Paul Yost M.D., Chair, CalOptima Board of Directors

Attest:
/s/_____
Sharon Dwiers, Clerk of the Board

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Policy ~~#~~:	GA.8057
Title:	**Compensation Program**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	Michael Schrader
Effective Date:	05/01/2014
~~Last Review Date:~~	~~07/18~~
Revised Date:	03/05/2020~~06/ 07/18~~

I. PURPOSE

This policy establishes a compensation program for CalOptima job classifications within clearly defined guidelines that promote consistent, competitive and equitable pay practices.

II. POLICY

A. CalOptima's compensation program is intended to:

1. Provide fair compensation based on organization and individual performance;
2. Attract, retain, and motivate employees;
3. Balance internal equity and market competitiveness to recruit and retain qualified employees; and
4. Be mindful of CalOptima's status as a public agency.

B. The Chief Executive Officer (CEO), in conjunction with the Executive Director of Human Resources, is directed to administer the compensation program consistent with the attached Compensation Administration Guidelines, which ~~is a document that~~ defines the principles upon which CalOptima's compensation practices will be managed, procedural aspects of how the compensation ~~administration~~ procedures will be administered, and how the overall compensation administration function will respond to changing market conditions and business demands. Some of these guidelines include, but are not limited to:

1. Establishing pay rates based on the market 50th percentile.

~~2.~~ Determining appropriate pay rates within the pay range for a position by assessing an employee's or applicant's knowledge, skills, experience, and ~~current pay level, as well as~~the pay rates currently being paid to similarly situated incumbents. Employees may be paid anywhere within the pay range based on proficiency levels. The following criteria shall be considered:

Minimum (Min)	The rate paid to an individual possessing the minimum job qualifications & meeting minimum job performance expectations
Midpoint (Mid) aka: 50th percentile	The rate paid to individuals that are fully proficient in all aspects of the job's requirements & performance expectations
Maximum (Max)	The maximum rate paid to individuals who possess qualifications significantly above market norms & consistently deliver superior performance

~~4.~~3. All new hires and employees should have a pay rate equal to or greater than the pay range minimum, unless the minimum job requirements are not met, then a training rate equal to ten percent (10%) below the salary grade minimum may be used for six (6) months.

~~5.~~4. Base pay for all employees shall be capped at the pay range maximum, and once an employee reaches the base pay maximum, the employee will not be eligible for future base pay increases. However, in lieu of future base pay increases, these employees may be eligible for merit pay delivered as a lump sum bonus provided that the employee's performance warrants this additional compensation.

C. The ~~Chief Executive Officer (~~CEO~~)~~ is authorized and directed to take all steps necessary and proper to implement the CalOptima compensation program and the Compensation Administration ~~Guideline~~Guidelines not inconsistent therewith.

III. PROCEDURE

Not Applicable

IV. ATTACHMENT(S)

A. Compensation Administration Guidelines

V. REFERENCE(S)

Not Applicable

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
05/01/2014	Regular Meeting of the CalOptima Board of Directors
08/07/2014	Regular Meeting of the CalOptima Board of Directors
11/06/2014	Regular Meeting of the CalOptima Board of Directors
12/04/2014	Regular Meeting of the CalOptima Board of Directors
03/05/2015	Regular Meeting of the CalOptima Board of Directors
06/04/2015	Regular Meeting of the CalOptima Board of Directors
06/07/2018	Regular Meeting of the CalOptima Board of Directors
TBD	Regular Meeting of the CalOptima Board of Directors

~~A. 06/07/18: Regular Meeting of the CalOptima Board of Directors~~
~~B. 06/04/15: Regular Meeting of the CalOptima Board of Directors~~
~~C. 03/05/15: Regular Meeting of the CalOptima Board of Directors~~
~~D. 12/04/14: Regular Meeting of the CalOptima Board of Directors~~
~~E. 11/06/14: Regular Meeting of the CalOptima Board of Directors~~
~~F. 08/07/14: Regular Meeting of the CalOptima Board of Directors~~
~~G. 05/01/14: Regular Meeting of the CalOptima Board of Directors~~

VIII. ~~REVIEW/~~REVISION HISTORY

~~Version~~Action	Date	Policy ~~Number~~	Policy Title	~~Line(s) of Business~~Program(s)
Effective	05/01/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	08/07/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	11/06/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	12/04/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	06/04/2015	GA.8057	Compensation Program	Administrative
Revised	06/07/2018	GA.8057	Compensation Program	Administrative
Revised	03/05/2020~~TBD~~	GA.8057	Compensation Program	Administrative

IX. GLOSSARY

Not Applicable

Policy:	GA.8057
Title:	**Compensation Program**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	Michael Schrader
Effective Date:	05/01/2014
Revised Date:	03/05/2020

I. PURPOSE

This policy establishes a compensation program for CalOptima job classifications within clearly defined guidelines that promote consistent, competitive and equitable pay practices.

II. POLICY

A. CalOptima's compensation program is intended to:

1. Provide fair compensation based on organization and individual performance;
2. Attract, retain, and motivate employees;
3. Balance internal equity and market competitiveness to recruit and retain qualified employees; and
4. Be mindful of CalOptima's status as a public agency.

B. The Chief Executive Officer (CEO), in conjunction with the Executive Director of Human Resources, is directed to administer the compensation program consistent with the attached Compensation Administration Guidelines, which defines the principles upon which CalOptima's compensation practices will be managed, procedural aspects of how the compensation procedures will be administered, and how the overall compensation administration function will respond to changing market conditions and business demands. Some of these guidelines include, but are not limited to:

1. Establishing pay rates based on the market 50th percentile.
2. Determining appropriate pay rates within the pay range for a position by assessing an employee's or applicant's knowledge, skills, experience, and the pay rates currently being paid to similarly situated incumbents. Employees may be paid anywhere within the pay range based on proficiency levels. The following criteria shall be considered:

Minimum (Min)	The rate paid to an individual possessing the minimum job qualifications & meeting minimum job performance expectations
Midpoint (Mid) aka: 50th percentile	The rate paid to individuals that are fully proficient in all aspects of the job's requirements & performance expectations

Maximum (Max)	The maximum rate paid to individuals who possess qualifications significantly above market norms & consistently deliver superior performance

3. All new hires and employees should have a pay rate equal to or greater than the pay range minimum, unless the minimum job requirements are not met, then a training rate equal to ten percent (10%) below the salary grade minimum may be used for six (6) months.

4. Base pay for all employees shall be capped at the pay range maximum, and once an employee reaches the base pay maximum, the employee will not be eligible for future base pay increases. However, in lieu of future base pay increases, these employees may be eligible for merit pay delivered as a lump sum bonus provided that the employee's performance warrants this additional compensation.

C. The CEO is authorized and directed to take all steps necessary and proper to implement the CalOptima compensation program and the Compensation Administration Guidelines not inconsistent therewith.

III. PROCEDURE

Not Applicable

IV. ATTACHMENT(S)

A. Compensation Administration Guidelines

V. REFERENCE(S)

Not Applicable

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
05/01/2014	Regular Meeting of the CalOptima Board of Directors
08/07/2014	Regular Meeting of the CalOptima Board of Directors
11/06/2014	Regular Meeting of the CalOptima Board of Directors
12/04/2014	Regular Meeting of the CalOptima Board of Directors
03/05/2015	Regular Meeting of the CalOptima Board of Directors
06/04/2015	Regular Meeting of the CalOptima Board of Directors
06/07/2018	Regular Meeting of the CalOptima Board of Directors
TBD	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	05/01/2014	GA.8057	Compensation Program and Salary Schedule	Administrative

Action	Date	Policy	Policy Title	Program(s)
Revised	08/07/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	11/06/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	12/04/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	06/04/2015	GA.8057	Compensation Program	Administrative
Revised	06/07/2018	GA.8057	Compensation Program	Administrative
Revised	03/05/2020	GA.8057	Compensation Program	Administrative

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IX. GLOSSARY

Not Applicable

Compensation Administration Guidelines

~~Pay administration guidelines~~

Revised March 05, 2020

Contents

Pay Administration Guidelines

Common pay administration guidelines for CalOptima are detailed in this section. These ~~guidelines:~~

- ~~Help~~*Guidelines help maintain the integrity of the base pay program by introducing a common set of standards*

~~Assist~~ *and assist managers in ongoing compensation program administration.*

In addition, note the following administration of the Guidelines:

- Chief Executive Officer (CEO) compensation will be established by the Board of Directors.
- Chief and Executive Director compensation will be established by the CEO within ~~proposed guidelines~~the Guidelines.
- The Board will be informed of all Chief and Executive Director hires and compensation changes.

Proposed Pay Administration Guidelines

~~***Pay ranges and pay levels***~~

- ~~Pay range targets~~
- ~~Range minimums and maximums~~

Pay ranges and pay levels

- ~~Pay range thirds~~
- ~~Pay range halves~~
- ~~Compa-ratio~~

~~***Periodic pay adjustments/increases***~~

- ~~New hire/Rehire~~
- ~~Promotion~~

Pay range target Range minimums and maximums Pay above range maximums Pay range thirds Pay range halves Compa-ratio

- ~~Demotion~~
- ~~Temporary assignment~~
- ~~Secondary job~~

Periodic pay adjustments/increases	New hire/Rehire Promotion Lateral Transfer Demotion Temporary Assignment Secondary job Job Re-evaluation Appeal Process Register/Certified Status Base pay program maintenance Salary structure adjustment Annual competitive assessment Market sensitive jobs
Annual pay adjustments/increases	Market Adjustment Merit pay Step increase
Special one-time pay considerations	Recruitment incentive

- ~~Market adjustment~~
- ~~Merit pay~~
- ~~Step increase~~
- ~~Base pay program maintenance~~
  - ~~Salary structure adjustment~~
  - ~~Annual competitive assessment~~
  - ~~Market sensitive jobs~~

Annual pay adjustments/increases

- Register/Certified status

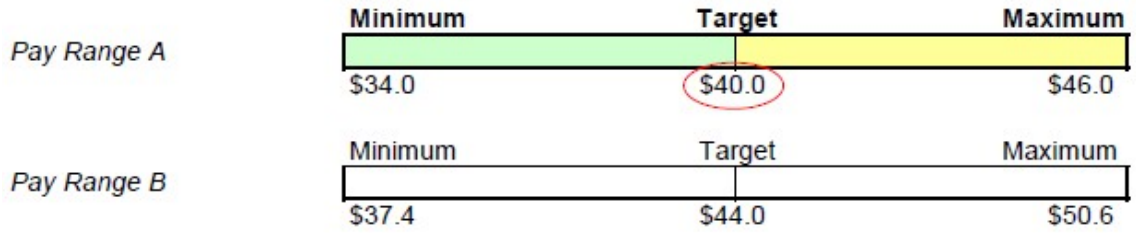
Special one-time pay considerations

- Recruitment incentive

Pay Ranges and Pay Levels

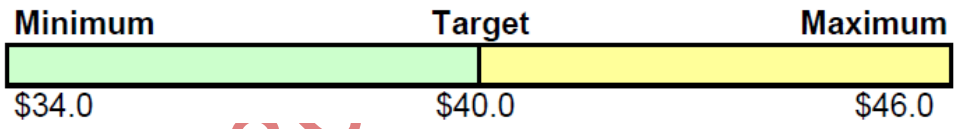
Range Target: internal "going market rate" for the job (50th percentile); represents the rate paid to individuals that are fully proficient in all aspects of the job's requirements and performance expectations.

- For benchmark jobs, the pay range (i.e. pay grade) is determined based on the comparability of values between market median base pay rates and the pay range targets.



Range Target $40.0 is Closest to Market Median of $41.5; job is assigned to Pay Range A

- For non-benchmark jobs, the pay range is determined based on comparability of the job to benchmark jobs within the same job family or other internal positions in terms of knowledge, skills, complexity and organizational impact.



Range Minimum: represents the rate paid to individuals possessing the minimum job qualifications and meeting minimum job performance expectations.

- All employees should have a pay rate equal to or greater than the pay range minimum.
- If the minimum job requirements are not met, a training rate equal to ten percent (10~~%~~%) below the salary grade minimum may be used for six (6) months while a new incumbent is learning the skills to become proficient in the new role.

Range Maximum: represents the maximum rate paid to individuals who ~~posses~~possess qualifications significantly above market norms and consistently deliver superior performance.

- Base pay growth is capped at the pay range maximum.

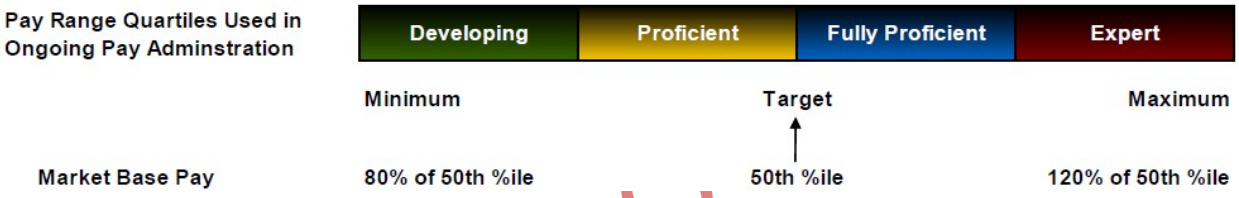
Pay Above Range Maximum: ~~as a rule, employees~~ Employees are not ~~to be~~ paid above the range maximum.

- Employees ~~paid~~whose current pay becomes above the pay range maximum will have their base pay frozen and will not be eligible for future base pay increases until such time as their base pay falls below the pay range maximum.

- In lieu of future base pay increases, these ~~individuals~~employees may be eligible for merit pay delivered as a lump sum bonus providing their performance warrants this additional compensation.

- As the pay structures and pay ranges move ~~(~~every twelve (12~~—~~) – thirty-six (36) months or as necessary~~)~~, the employees paid above the pay range maximum will eventually be paid below the pay range maximum and will then be eligible to receive base pay increases, as appropriate.

Pay Range: Employees may be paid anywhere within the open pay range; the pay range is divided into equal quartiles to assist in achieving competitive, equitable, and appropriate pay levels



- Developing Area – Below market pay; this area is used for employees possessing minimum job requirements and/or for those having significant learning curves to become fully proficient in the job's duties, responsibilities and performance expectations.

- Proficient/Fully Proficient Area – Market competitive pay; this area is used for employees possessing preferred job requirements and consistently demonstrate one hundred percent (100~~%~~%) proficiency in all aspects of the job's duties, responsibilities and performance expectations.

- Expert Area – Above market pay; this area is used for employees possessing unique knowledge, skills, or abilities that far surpass the market's typical requirements and consistently demonstrate superior performance in all aspects of the job's duties, responsibilities, and performance expectations.

Compa-Ratio: In addition to pay range quartiles, this is a metric also used to communicate pay competitiveness.

- Compa-Ratio: A compa-ratio is calculated by taking the employee's base pay divided by his/her pay range target.

- Compa-Ratio of 100%: This ratio indicates the employee's base pay equals the pay range target, or the market rate.

- Compa-Ratio <100%: This ratio indicates the employee's base pay is less than the pay range target.

- Compa-Ratio >100%: This ratio indicates the employee's base pay is greater than the pay range target.

Illustrative Range Shown Below:

	Minimum	Target	Maximum
Compa-Ratio RNs	87.5%	100.0%	117.0%
Compa-Ratio Non-Exempt	88.0%	100.0%	117.0%
Compa-Ratio Exempt	83.0%	100.0%	118.0%

Note: *Range minimums and maximums will be based on the developed salary range spreads.*

	Minimum	Target	Maximum
Compa-Ratio RNs	87.5%	100.0%	117.0%
Compa-Ratio Non-Exempt	88.0%	100.0%	117.0%
Compa-Ratio Exempt	83.0%	100.0%	118.0%

Annual Pay Adjustments/Increases

Market Adjustment: A market adjustment is an increase or decrease to pay range ~~rates~~grades based on market pay practices.

- A market adjustment ~~results~~may result in base pay increases for full-time, part-time, and some as- needed and limited term staff paid at or below the pay range target (there is no base pay increase between target and maximum for non-market sensitive jobs unless compression exists at the target~~)~~).
    - For some market-sensitive jobs, a market adjustment may also be granted to full- time, part-time, and some as-needed and limited term staff paid above the pay range target but below the pay range maximum to maintain competitiveness and minimize pay compression.
- A market adjustment may result in a base pay increase to some staff to ensure employees are paid a base pay rate at least equal to the new pay range minimum.
    - If a market adjustment is made, employees paid below the new range minimum receive an increase to their base pay to ensure it is at least equal to the pay range minimum before any merit pay is awarded (cap at 10~~%~~)%).

~~**Market Adjustment:**~~

- The appropriateness of a market adjustment is determined based on:
    1. A competitive assessment of the pay range target versus market base pay practices;
    2. Market trends and practices relative to average base pay and pay range increases; and
    3. Current recruiting and retention issues.
- ~~Market adjustments are made prior to determining merit pay~~

- .

- Newly hired employees will be eligible for any market adjustments granted at the annual pay increase date if the employee is paid at or below the pay range target.

Base Pay Adjustment: All employees who achieve a satisfactory level of performance will be eligible for a merit pay adjustment.

- Merit Pay: Merit pay is variable pay that typically affects ~~individuals'~~employees' base pay; it recognizes ~~individuals'~~employees' job proficiency and performance of job duties.

  - Merit pay is applicable to full-time and part-time employees paid below, at, or above the pay range target; Per diem employees are not eligible for merit pay.

  - To be eligible for merit pay, the employee must have started work on or before March ~~31st~~31 to be eligible for a merit increase in July of the same year and have successfully completed the introductory period [three (3) months for transfers and new hires~~)~~] prior to the annual pay adjustment date.

  - Merit pay will typically be an increase to base pay; however, it may also be delivered as a ~~onetime~~one-time lump sum bonus for individuals paid above the pay range maximum.

  - The budgeted amount for merit pay, if any, is based on~~:~~ 1) the organization's financial status; 2) market trends relative to average base pay increases; 3) competitiveness of current base pay practices; and, 4) recruiting and retention issues.

Merit Pay – Staff Paid At and Above Pay Range Target

- The combination of an individual's performance rating, the position of his/her pay within the pay range, the number of months he/she has been working, and the salary earned during those months determines the individual's merit pay opportunity.

  - Merit pay is typically calculated as a percent of base pay in effect on March 31, prorated to reflect the number of months an employee worked ~~and the salary earned~~ during ~~those months~~the twelve (12)-month period starting from the first pay period in the fiscal year and ending with the last pay period of that same fiscal year.

  - Managers have the discretion to determine the actual increase amount within the published ~~guidelines~~Guidelines; the appropriate merit pay amount will reflect the manager's internal equity, pay competitiveness, and performance recognition objectives.

  - Adjustments to employees' base pay are capped at the pay range maximums; therefore, some employees may receive a portion of their merit pay as a base pay increase up to the pay range maximum and also receive a lump sum amount for the remaining portion of the merit pay. Employees paid over the pay range maximum may be eligible to receive merit pay as a lump sum payment paid out in two (2) incremental amounts- the first half when merit pay is normally distributed; and the second half six (6) months later.

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- Merit pay may be held altogether or delayed for ninety (90) days if employees do not achieve a satisfactory level of performance or if a written warning or suspension/final written warning is active in their record.
- Merit pay is typically awarded once a year at a specific time.
- Full-time and part-time employees may receive both a market adjustment and a merit pay adjustment at the same time.
- Executive Directors and Chief's must approve merit pay increases for all areas for which they are responsible ~~for~~ before submitting to HR.
- HR has final approval of all merit increases.

A Merit Pay Grid similar to the one shown below ~~([~~assumes a three percent (3~~%~~%) merit increase budget~~)~~] is often used to provide managers with a guideline as to what merit pay increase may be appropriate based upon performance and to reflect:**

1. The organization's financial status;
2. Market trends relative to average base pay increases;
3. Competitiveness of current base practices; and~~,~~
4. Recruiting and retention issues.

	Pay Range Position				
Performance Rating	1st Quartile	2nd Quartile	3rd Quartile	4th Quartile	Above Max
Highly Effective	6% - 5%	5% - 4%	4% - 3%	3% - 2%	3% - 2%
Effective	5% - 4%	4% - 3%	3% - 2%	3% - 2%	0%
Needs Improvement	0%	0%	0%	0%	0%

Above Max = Lump Sum Bonus

** ** *The Merit Pay Grid is a sample only. Actual merit increase percentages will depend upon the salary distribution across the salary structure.*

- Employees who do not achieve a satisfactory level of performance at the time of their annual pay increase will not receive any type of pay increase – market adjustment, or merit pay.
- The increase may be ~~held all together~~withheld altogether or delayed ninety (90) days until the written performance improvement plan is complete and performance is judged to be acceptable by the manager; the pay increase will be effective at the time performance is judged to be acceptable (beginning of applicable pay period) and will not be ~~retro-active~~retroactive; the manager is responsible for informing the employee in this situation and is responsible for notifying HR to initiate the increase.
- Employees on any type of leave of absence who are eligible for a market adjustment, and/or merit pay, may receive these adjustments upon their return to active status with a completed performance appraisal that is competent or above.

Special One-time Pay Considerations

Recruitment Incentive

- Recruitment incentives up to fifteen percent (15%%) of an employee's base pay may be provided on an exception basis to entice an employee to join CalOptima.
    - Recruitment incentives require the approval of the CEO.
    - Board approval is required for recruitment incentives offered to Executive Director and above positions.
    - Incentives are provided with a "pay-back" provision if the employee terminates within twenty-four (24) months of hire.

New Hires/Rehires

- A new hire's pay level ~~should correspond~~corresponds to the appropriate pay range ~~but~~quartile and typically should not exceed the pay range target~~; offers~~. Offers above the pay range target require the approval of the ~~Compensation Analyst in consultation with the~~ Executive Director of Human Resources~~,~~ and the CEO, when necessary.

- Factors to be considered in determining an appropriate pay level for a new hire include:

    - Job-related experience: ~~what~~What is the estimated learning curve given the individual's prior work experience? How many years of experience does the individual have in the same or equivalent classification?

    - Market conditions: ~~what~~What is the going rate of pay in the external market for the individual's skills and knowledge?

    - Internal equity: ~~is~~Is the proposed pay level lower, higher or in line with the pay levels of current employees having comparable skill and experience levels?

- At hire, external service is typically valued comparable to internal service.

    - For example, an RN having three (3) years of prior job experience is viewed comparably to an RN having three (3) years of job experience at CalOptima.

- Internal equity (how this position and compensation compares relative to existing employees) must be considered when making hiring decisions.

Process for Determining a New Hire Starting Pay Rate

HR determines applicable pay rate:

- Starting pay rate is at or near the minimum of the pay range for a candidate who only meets the job's minimum qualifications.

- Starting pay rate cannot be below the minimum of the pay range (unless it is viewed as a training rate~~)~~).

- Determine appropriate pay rate by assessing candidate's knowledge, skills, and experience, ~~current pay level,~~ as well as pay rates currently being paid to similarly situated incumbents.

- Candidates with superior knowledge, skills, and experience can be paid above the pay range midpoint~~; starting~~. Starting pay rates above the pay range midpoint must have approval of the ~~appropriate Compensation Analyst,~~ Executive Director of Human Resources~~,~~ and CEO ~~approval~~, when necessary.

- There are certain positions that will usually be placed near the salary grade minimum (all entry level service and clerical~~)~~).

- Pay rates for all ~~management~~ positions ~~must be~~are reviewed with the Compensation ~~Analyst~~Unit before an offer is made. The Compensation ~~Analyst~~Unit will review internal

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equity across the system to ensure that the appropriate offer is made.

- ~~Any questions or concerns about new hire offers should be directed to the Compensation Analyst or Executive Director of Human Resources. The Compensation Analyst will review any concerns with the Executive Director of Human Resources as necessary~~

- Rehires to the same ~~position~~classification should be paid at least the same amount they earned prior to termination, with adjustments and/or credit for recent additional career experience or education earned while away from CalOptima.
- The above policy applies to the current organization structure.
- Additional positions at the level of Chief or Executive Director require Board approval.

Promotion

~~Promotion:~~ An employee receives a promotion when ~~he/she~~the employee applies for and is selected for a job with a higher pay range target.

- An employee will receive a promotional increase to at least the pay range minimum of ~~his/her~~the new pay range.
- The amount of a promotional increase will ~~vary and the actual amount will~~ be determined based on the incumbent's qualifications, performance, and ~~the~~ internal pay practices ~~of other similarly-situated employees.~~. The typical promotional increase for a promotion without external competition is ~~4%~~up to ~~5% of~~five percent (5%) of the employee's base pay ~~for~~per one (1) pay grade increase.
- Typically, the promotional increase should not exceed the pay range target.
- When an employee moves from non-exempt to exempt, the loss of overtime pay will be considered. However, the realization that overtime is not guaranteed must also be considered.
- The pay rate adjustment will be effective on the first day of the pay period in which the job change takes effect.
- Employees who are promoted after March 31, but prior to receiving their merit increase, will have their merit increase, if any, included in the base pay used to calculate their promotional pay. If the employee's performance evaluation rating and therefore merit increase amount is not known at the time the promotional pay is being calculated, a merit increase equivalent to "Fully Meets Expectations" will be included in the base pay used to calculate their promotional pay.
- The next merit pay adjustment after a promotion may be pro-rated based on the amount of time the employee has spent in the job.

Lateral Transfer

~~Lateral transfer:~~ It is considered a lateral transfer if an employee moves to a job having the same pay range target.

- Lateral job changes will not typically result in a base pay increase or adjustment unless otherwise approved by the ~~Compensation Analyst and~~ Executive Director of Human Resources.

- Employees who are laterally transferred after March 31, but prior to receiving their merit increase, will typically have their merit pay calculated as a percent of their base pay in effect on March 31.

Demotion

~~Demotion:~~ An employee is classified as having been demoted if ~~he/she~~the employee moves to a job with a lower pay range target.

- ~~An~~The pay of an employee demoted due to an organizational restructure, ~~no pay decrease~~ will not be ~~given~~decreased unless the employee is above the maximum on the new pay range; if so, the employee will be reduced to the maximum of the new pay range.
    - ~~An~~For an involuntary demotion, due to performance ~~will follow the guidelines below~~, or for ~~reducing base pay~~
    - ~~A~~a voluntary demotion ~~based on an application for an open position will typically result in a pay decrease between 0 – 4% for each salary~~, the pay grade of the demoted
- ~~The demoted~~ employee will be assigned to the pay grade of the employee's new classification. The employee's base pay will typically be reduced ~~to the next lower pay grade. Target, or~~ up to five percent (5%) for each pay grade ~~maximum, whichever is appropriate using the 0 – 4% guideline above~~demoted.
- The pay rate adjustment will be effective on the first day of the pay period in which the job change takes effect.
- Future merit increases and market adjustments will not be affected by a demotion unless competent performance is not achieved.
- Employees who are demoted after March 31, but prior to receiving their merit increase, will typically have their merit pay calculated as a percent of their base pay in effect on March 31.

Temporary Assignment

~~Temporary assignment:~~ An employee who is asked to assume a full-time temporary assignment in a job having a higher pay range target is eligible for a temporary base pay increase. The employee must assume some or all of the responsibilities of the new job to qualify for a temporary assignment increase.

- The employee's base pay rate prior to the assignment will be maintained and the higher temporary assignment rate will be added as a secondary job title and pay rate.
- This increased secondary pay rate is eliminated when the temporary assignment ends.
- The amount of the temporary assignment increase should be consistent with the promotion policy.

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Job Re-Evaluations

~~Job Re-Evaluations:~~ Job re-evaluations will be reviewed in the following priority order:

1. New Positions.
2. Change of thirty-five percent (35~~%~~%) or more of duties ~~{~~[any change in responsibilities less than thirty-five percent (35~~%~~%) will not be considered~~}~~].
    - Enhancements must require a higher level of skills, abilities, scope of authority, autonomy, and/or education to qualify for a re-classification.

- Additional duties that do not require the above will not be considered for reclassification.
- All requests for job re-classification must be documented, signed by the department manager and submitted to the Compensation ~~Analyst~~Unit.
- In the case of management positions being re-classified, the appropriate Chief must sign the documentation.
- The request must include the incumbent's current job description and revised job description with enhancements highlighted.
- The request must also include justification that the re-classification supports a business need.

If the job is determined to be a priority, the Compensation ~~Analyst~~Unit will analyze the job according to:

1. The job's scope against other jobs in the same discipline.
2. Available market data.
3. ~~2.~~ Appropriate title identification. The Compensation ~~Analyst~~Unit will determine if the title fits within the hierarchy; if not, a benchmark title will be recommended.
4. ~~3.~~ Job family.
5. ~~4.~~ Fair Labor Standards Act (FLSA) status.
6. ~~5.~~ Appropriate pay grade – the job will be fit into one (1) of the pay grades that currently exists~~- there will be no~~. No new pay grades created.
7. ~~6.~~ A pay rate will be determined.
8. ~~7.~~ A recommendation will be made to the Executive Director of Human Resources for approval, and the decision will be communicated to the appropriate manager.

- If a job is reassigned to a higher grade, the change will be effective on the first day of the pay period following the evaluation. The pay increase is not retroactive to any earlier date
- . The manager will be informed of the decision to move the job to a higher pay grade by the Compensation ~~Analyst~~
- Unit. The amount of the pay increase should follow the guidelines in the ~~promotion~~Promotion section

. If the upgrade and a pay change ~~occurs~~occur less than six (6) months before the annual pay increase date, the employee's next merit pay adjustment may be pro-rated.

If the job is not reassigned to a higher pay grade, the manager will be notified. If dissatisfied with the decision, the manager may file an appeal with the Executive Director

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of Human Resources.

If a job is reassigned to a lower pay grade as a result of a job re-evaluation due to available market data, without a change in job responsibilities, the involuntary demotion due to organizational restructuring protocol will be followed.

If a job is reassigned to a lower pay grade due to a job evaluation and change in job responsibilities, the voluntary demotion protocol will be followed.

Job evaluations and re-evaluations will occur throughout the year; all priority jobs will be evaluated within one (1) month of the request.

If a job is not a priority or does not meet the guidelines, the manager will be notified.

Base Pay Program Maintenance

Salary Structure Adjustment

- The salary structure should be reviewed on a regular basis either annually or every other year to continue to reflect market competitiveness.
- The salary structure updates are designed to relieve any upward pressure on range minimums, midpoints and maximums that may impede the ability to attract, motivate, and retain the workforce.
- The salary structure is dynamic; it needs to be revised at regular intervals based upon market conditions to maintain market competitiveness. The goal is to keep the structure's market rates on track with market data.
- Market adjustments will be applied to the salary schedule as needed at least every two (2) years, using surveyed salary structure adjustment percentages.
- The salary structure adjustment approval process includes:
  - The Executive Director of Human Resources makes a recommendation to the CEO for approval.
  - CEO takes the recommendation to the Board for final approval.

Annual Competitive Assessment

- On ~~an annual~~a regular basis either annually or every other year, HR will identify the current competitiveness of CalOptima's pay practices by comparing: 1) current pay levels to market practices; 2) current pay levels to pay range targets; and, 3) current pay range targets to market practices.
  - CalOptima will on a regular basis either annually or every other year spot check benchmark jobs to determine market fluctuations in benchmark jobs' pay rates.
  - Based on market findings, the pay grade and ranges will be updated.
  - Any jobs in which reasonable benchmark data is not available can be slotted into the salary structure based on internal equity considerations.
- The results of these analyses, along with CalOptima's current financial performance and economic situation, will determine the appropriate market adjustments (i.e., pay range adjustments) and merit pay budgets.
- The following criteria is typically used to determine which jobs to market price each year:
  - Review job-level turnover statistics for jobs with above-average separation rates to identify jobs with potential retention issues~~;~~.
  - Review the time-to-fill metrics for jobs requiring above-average recruiting efforts and

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expenses to identify jobs with potential recruiting issues~~;~~.

- Review the applicant tracking reports (if available) for jobs with a high level of initial/ subsequent offer rejections to identify additional potential recruiting issues~~;~~.

- Review jobs with pay-to-pay range target compa-ratios in excess of 110% or below 90%%.
- Review jobs with market-to-pay range target compa-ratios in excess of 110% or below 90%%.
- Review all market-sensitive jobs and those on the "watch list"."
- Review top ten (10) highest populated jobs on an annual basis.
- Jobs are ranked by degree of severity for each of the preceding criteria; the jobs that are most frequently identified across all criteria are typically market priced.
- It is recommended that at least two (2) jobs be selected from every pay range.

Market Adjustments (Structure and Pay Range Adjustments): Market adjustments to specific pay ranges or the entire pay structure may be made on an annual or as needed basis to reflect current competitiveness or market trends.

- Each yearOn a regular basis either annually or every other year, the pay range targets are compared to the external market base pay practices and necessary adjustments are made to ensure alignment including job grade changes and range rate adjustments.
- Employees falling below the range minimum of the adjusted structures are typically brought to the pay range minimum, assuming the employee has a satisfactory level of performance; any pay compression resulting from structure adjustments should be addressed as part of the annual pay increase process.
  - Adjustments to pay range minimums occur prior to merit pay calculations.

Process for Making Market Adjustments

- HR performs an annual, on a regular basis either annually or every other year, a review of compensation surveys to calculate the average market adjustment to pay structures; HR also analyzes the competitiveness of the current pay range targets to market practices for benchmarked jobs.
- HR reviews CalOptima's financial operating conditions and quantifies any recruiting/ retention issues.
- HR determines if an adjustment is appropriate (minor variations in the market may be recognized in the following year) and recommends the amount.
- HR multiplies the current pay range target of each grade by the necessary adjustment percentage; then HR recalculates the pay range minimum and maximum based on the existing structure design (i.e., pay range minimums = 80% of the new pay range target; pay range maximums = 120% of the new pay range target, etc.).).
- HR identifies the cost implications for the market adjustment by identifying the difference between: 1) current pay rates and new pay range minimums, and, 2) current pay rates.

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- The market adjustment approval process will work as follows:
    - The Executive Director of Human Resources recommends an adjustment to the CEO for approval.
    - If the CEO agrees, the CEO will seek Board approval, unless the market adjustment is within the approved pay range for the ~~position~~classification as designated in the Board-approved salary schedule. In such case(s), the CEO may approve the market adjustment and inform the Board of such change(s).

Market-Sensitive Jobs: Market sensitive jobs are those for which market conditions make recruiting and retention challenging.

- Premium pay is built into the pay range targets for these jobs.
    - Prospectively, the pay range and grade selected for these jobs will reflect the desired market target rate (i.e., 60th or 75th percentile of base pay practices) based on business need.
    - The desired market target rate is established on a job-by-job basis to reflect specific market conditions.
- Criteria used to determine if a job is classified as market-sensitive typically includes two (2) or more of the following:
    - Time to fill the position – statistics will suggest the average amount of time required to fill a requisition for a market-sensitive position will be significantly higher than the historical norm for this position or similar positions.
    - Job offer rejections – statistics will illustrate an increase in the number of employment offers rejected due to low starting rates.
    - Turnover – statistics will suggest a higher than typical amount of turnover for the position within the last three (3) to six (6) months; turnover for the job will be compared to historical results for the same job and to other similarly-situated jobs.
    - Market Changes – market-sensitive jobs may experience an excessively large increase in competitive pay rates over the previous year's results; specifically, jobs considered to be market-sensitive may have:
        - a year-to-year increase significantly greater than the average year-to-year increase for other jobs analyzed,
        - a competitive market rate significantly higher ~~(~~[approximately ten percent (10~~%)~~%)] than its current pay range target, or
        - a competitive market rate with significantly higher pay practices ~~(~~[approximately ten percent (10~~%)~~%)] in the labor market than the average of current internal pay practices.
- When a job is classified as market-sensitive, typically some form of adjustment is made to employees' base pay rates and is typically referred to as a market adjustment and the pay increase policies noted under the market adjustment section apply.
- Jobs classified as market-sensitive are reviewed annually to determine if this status still applies.
    - Once a job is classified as market-sensitive, it typically remains as such until the recruiting and retention challenges subside and/or the market pay rates adjust themselves – typically not less than one (1) year.
    - When a job is no longer considered market-sensitive, the job's pay range and grade

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is reassigned to reflect a market median base pay rate target; no changes are typically made to the employees' base pay rates at this time.

- Throughout the year, jobs that are not yet considered market sensitive, but are showing signs of becoming so are placed on a "watch list" and monitored.

  - If necessary, these jobs will be moved to the market-sensitive category and handled accordingly.

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Compensation Administration Guidelines

Revised March 05, 2020

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Contents

Pay Administration Guidelines

Common pay administration guidelines for CalOptima are detailed in this section. These Guidelines help maintain the integrity of the base pay program by introducing a common set of standards and assist managers in ongoing compensation program administration.

In addition, note the following administration of the Guidelines:

- Chief Executive Officer (CEO) compensation will be established by the Board of Directors.
- Chief and Executive Director compensation will be established by the CEO within the Guidelines.
- The Board will be informed of all Chief and Executive Director hires and compensation changes.

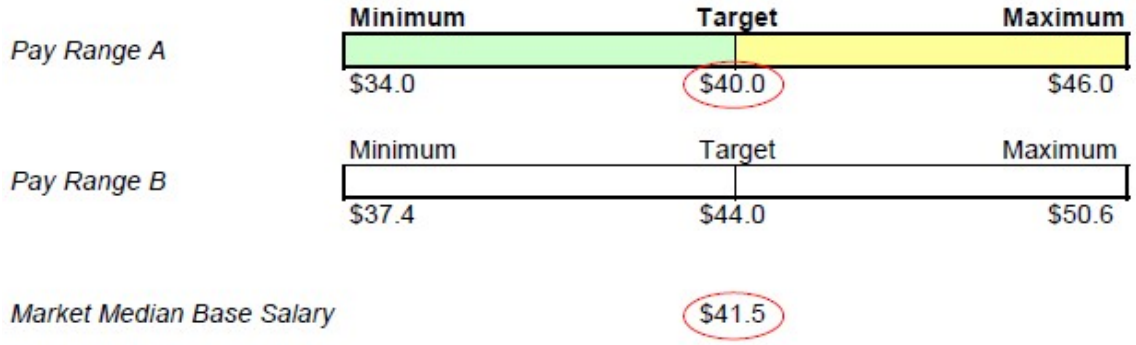
Proposed Pay Administration Guidelines

Pay ranges and pay levels	Pay range target Range minimums and maximums Pay above range maximums Pay range thirds Pay range halves Compa-ratio
Periodic pay adjustments/increases	New hire/Rehire Promotion Lateral Transfer Demotion Temporary Assignment Secondary job Job Re-evaluation Appeal Process Register/Certified Status Base pay program maintenance Salary structure adjustment Annual competitive assessment Market sensitive jobs
Annual pay adjustments/increases	Market Adjustment Merit pay Step increase
Special one-time pay considerations	Recruitment incentive

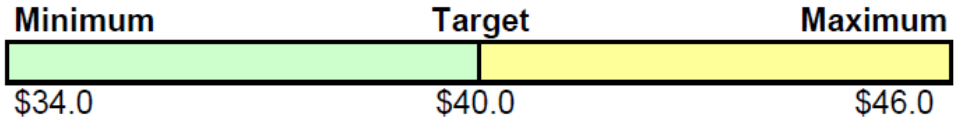
Pay Ranges and Pay Levels

Range Target: internal "going market rate" for the job (50th percentile); represents the rate paid to individuals that are fully proficient in all aspects of the job's requirements and performance expectations.

- For benchmark jobs, the pay range (i.e. pay grade) is determined based on the comparability of values between market median base pay rates and the pay range targets.



- For non-benchmark jobs, the pay range is determined based on comparability of the job to benchmark jobs within the same job family or other internal positions in terms of knowledge, skills, complexity and organizational impact.



Range Minimum: represents the rate paid to individuals possessing the minimum job qualifications and meeting minimum job performance expectations.

- All employees should have a pay rate equal to or greater than the pay range minimum.
- If the minimum job requirements are not met, a training rate equal to ten percent (10%) below the salary grade minimum may be used for six (6) months while a new incumbent is learning the skills to become proficient in the new role.

Range Maximum: represents the maximum rate paid to individuals who possess qualifications significantly above market norms and consistently deliver superior performance.

- Base pay growth is capped at the pay range maximum.

Pay Above Range Maximum: Employees are not paid above the range maximum.

- Employees whose current pay becomes above the pay range maximum will have their base pay frozen and will not be eligible for future base pay increases until such time as their base pay falls below the pay range maximum.

- In lieu of future base pay increases, these employees may be eligible for merit pay delivered as a lump sum bonus providing their performance warrants this additional compensation.

- As the pay structures and pay ranges move every twelve (12) – thirty-six (36) months or as necessary, the employees paid above the pay range maximum will eventually be paid below the pay range maximum and will then be eligible to receive base pay increases, as appropriate.

Pay Range: Employees may be paid anywhere within the open pay range; the pay range is divided into equal quartiles to assist in achieving competitive, equitable, and appropriate pay levels

- Developing Area – Below market pay; this area is used for employees possessing minimum job requirements and/or for those having significant learning curves to become fully proficient in the job's duties, responsibilities and performance expectations.

- Proficient/Fully Proficient Area – Market competitive pay; this area is used for employees possessing preferred job requirements and consistently demonstrate one hundred percent (100%) proficiency in all aspects of the job's duties, responsibilities and performance expectations.

- Expert Area – Above market pay; this area is used for employees possessing unique knowledge, skills, or abilities that far surpass the market's typical requirements and consistently demonstrate superior performance in all aspects of the job's duties, responsibilities, and performance expectations.

Compa-Ratio: In addition to pay range quartiles, this is a metric also used to communicate pay competitiveness.

- Compa-Ratio: A compa-ratio is calculated by taking the employee's base pay divided by his/her pay range target.

- Compa-Ratio of 100%: This ratio indicates the employee's base pay equals the pay range target, or the market rate.

- Compa-Ratio <100%: This ratio indicates the employee's base pay is less than the pay range target.

- Compa-Ratio >100%: This ratio indicates the employee's base pay is greater than the pay range target.

Illustrative Range Shown Below:

	Minimum	Target	Maximum
Compa-Ratio RNs	87.5%	100.0%	117.0%
Compa-Ratio Non-Exempt	88.0%	100.0%	117.0%
Compa-Ratio Exempt	83.0%	100.0%	118.0%

Note: *Range minimums and maximums will be based on the developed salary range spreads.*

Annual Pay Adjustments/Increases

Market Adjustment: A market adjustment is an increase or decrease to pay range grades based on market pay practices.

- A market adjustment may result in base pay increases for full-time, part-time, and some as-needed and limited term staff paid at or below the pay range target (there is no base pay increase between target and maximum for non-market sensitive jobs unless compression exists at the target).
    - For some market-sensitive jobs, a market adjustment may also be granted to full- time, part-time, and some as-needed and limited term staff paid above the pay range target but below the pay range maximum to maintain competitiveness and minimize pay compression.
- A market adjustment may result in a base pay increase to some staff to ensure employees are paid a base pay rate at least equal to the new pay range minimum.
    - If a market adjustment is made, employees paid below the new range minimum receive an increase to their base pay to ensure it is at least equal to the pay range minimum before any merit pay is awarded (cap at 10%).
- The appropriateness of a market adjustment is determined based on:
    1. A competitive assessment of the pay range target versus market base pay practices;
    2. Market trends and practices relative to average base pay and pay range increases; and
    3. Current recruiting and retention issues.
- Market adjustments are made prior to determining merit pay.
- Newly hired employees will be eligible for any market adjustments granted at the annual pay increase date if the employee is paid at or below the pay range target.

Base Pay Adjustment: All employees who achieve a satisfactory level of performance will be eligible for a merit pay adjustment.

- Merit Pay: Merit pay is variable pay that typically affects employees' base pay; it recognizes employees' job proficiency and performance of job duties.
    - Merit pay is applicable to full-time and part-time employees paid below, at, or above the pay range target; Per diem employees are not eligible for merit pay.
    - To be eligible for merit pay, the employee must have started work on or before March 31 to be eligible for a merit increase in July of the same year and have successfully completed the introductory period [three (3) months for transfers and new hires] prior to the annual pay adjustment date.
    - Merit pay will typically be an increase to base pay; however, it may also be delivered

as a one-time lump sum bonus for individuals paid above the pay range maximum.

- The budgeted amount for merit pay, if any, is based on 1) the organization's financial status; 2) market trends relative to average base pay increases; 3) competitiveness of current base pay practices; and, 4) recruiting and retention issues.

Merit Pay – Staff Paid At and Above Pay Range Target

- The combination of an individual's performance rating, the position of his/her pay within the pay range, the number of months he/she has been working, and the salary earned during those months determines the individual's merit pay opportunity.
  - Merit pay is typically calculated as a percent of base pay in effect on March 31, prorated to reflect the number of months an employee worked during the twelve (12)-month period starting from the first pay period in the fiscal year and ending with the last pay period of that same fiscal year.
  - Managers have the discretion to determine the actual increase amount within the published Guidelines; the appropriate merit pay amount will reflect the manager's internal equity, pay competitiveness, and performance recognition objectives.
  - Adjustments to employees' base pay are capped at the pay range maximums; therefore, some employees may receive a portion of their merit pay as a base pay increase up to the pay range maximum and also receive a lump sum amount for the remaining portion of the merit pay. Employees paid over the pay range maximum may be eligible to receive merit pay as a lump sum payment paid out in two (2) incremental amounts- the first half when merit pay is normally distributed; and the second half six (6) months later.
  - Merit pay may be held altogether or delayed for ninety (90) days if employees do not achieve a satisfactory level of performance or if a written warning or suspension/final written warning is active in their record.
  - Merit pay is typically awarded once a year at a specific time.
  - Full-time and part-time employees may receive both a market adjustment and a merit pay adjustment at the same time.
  - Executive Directors and Chief's must approve merit pay increases for all areas for which they are responsible before submitting to HR.
  - HR has final approval of all merit increases.

A Merit Pay Grid similar to the one shown below [assumes a three percent (3%) merit increase budget] is often used to provide managers with a guideline as to what merit pay increase may be appropriate based upon performance and to reflect:**

1. The organization's financial status;
2. Market trends relative to average base pay increases;
3. Competitiveness of current base practices; and

4. Recruiting and retention issues.

	Pay Range Position				
Performance Rating	1st Quartile	2nd Quartile	3rd Quartile	4th Quartile	Above Max
Highly Effective	6% - 5%	5% - 4%	4% - 3%	3% - 2%	3% - 2%
Effective	5% - 4%	4% - 3%	3% - 2%	3% - 2%	0%
Needs Improvement	0%	0%	0%	0%	0%

Above Max = Lump Sum Bonus

***The Merit Pay Grid is a sample only. Actual merit increase percentages will depend upon the salary distribution across the salary structure.*

- Employees who do not achieve a satisfactory level of performance at the time of their annual pay increase will not receive any type of pay increase – market adjustment, or merit pay.

- The increase may be withheld altogether or delayed ninety (90) days until the written performance improvement plan is complete and performance is judged to be acceptable by the manager; the pay increase will be effective at the time performance is judged to be acceptable (beginning of applicable pay period) and will not be retroactive; the manager is responsible for informing the employee in this situation and is responsible for notifying HR to initiate the increase.

- Employees on any type of leave of absence who are eligible for a market adjustment, and/or merit pay, may receive these adjustments upon their return to active status with a completed performance appraisal that is competent or above.

Special One-time Pay Considerations

Recruitment Incentive

- Recruitment incentives up to fifteen percent (15%) of an employee's base pay may be provided on an exception basis to entice an employee to join CalOptima.
    - Recruitment incentives require the approval of the CEO.
    - Board approval is required for recruitment incentives offered to Executive Director and above positions.

Incentives are provided with a "pay-back" provision if the employee terminates within twenty-four (24) months of hire.

New Hires/Rehires

- A new hire's pay level corresponds to the appropriate pay range quartile and typically should not exceed the pay range target. Offers above the pay range target require the approval of the Executive Director of Human Resources and the CEO, when necessary.

- Factors to be considered in determining an appropriate pay level for a new hire include:

    - Job-related experience: What is the estimated learning curve given the individual's prior work experience? How many years of experience does the individual have in the same or equivalent classification?

    - Market conditions: What is the going rate of pay in the external market for the individual's skills and knowledge?

    - Internal equity: Is the proposed pay level lower, higher or in line with the pay levels of current employees having comparable skill and experience levels?

- At hire, external service is typically valued comparable to internal service.

    - For example, an RN having three (3) years of prior job experience is viewed comparably to an RN having three (3) years of job experience at CalOptima.

- Internal equity (how this position and compensation compares relative to existing employees) must be considered when making hiring decisions.

Process for Determining a New Hire Starting Pay Rate

HR determines applicable pay rate:

- Starting pay rate is at or near the minimum of the pay range for a candidate who only meets the job's minimum qualifications.

- Starting pay rate cannot be below the minimum of the pay range (unless it is viewed as a training rate).

- Determine appropriate pay rate by assessing candidate's knowledge, skills, and experience, as well as pay rates currently being paid to similarly situated incumbents.

- Candidates with superior knowledge, skills, and experience can be paid above the pay range midpoint. Starting pay rates above the pay range midpoint must have approval of the Executive Director of Human Resources and CEO, when necessary.

- There are certain positions that will usually be placed near the salary grade minimum (all entry level service and clerical).

- Pay rates for all positions are reviewed with the Compensation Unit before an offer is made. The Compensation Unit will review internal equity across the system to ensure that the appropriate offer is made.

- Rehires to the same classification should be paid at least the same amount they earned prior to termination, with adjustments and/or credit for recent additional career experience or

education earned while away from CalOptima.

- The above policy applies to the current organization structure.
- Additional positions at the level of Chief or Executive Director require Board approval.

Promotion

An employee receives a promotion when the employee applies for and is selected for a job with a higher pay range target.

- An employee will receive a promotional increase to at least the pay range minimum of the new pay range.
- The amount of a promotional increase will be determined based on the incumbent's qualifications, performance, and internal pay practices. The typical promotional increase for a promotion without external competition is up to five percent (5%) of the employee's base pay per one (1) pay grade increase.
- Typically, the promotional increase should not exceed the pay range target.
- When an employee moves from non-exempt to exempt, the loss of overtime pay will be considered. However, the realization that overtime is not guaranteed must also be considered.
- The pay rate adjustment will be effective on the first day of the pay period in which the job change takes effect.
- Employees who are promoted after March 31, but prior to receiving their merit increase, will have their merit increase, if any, included in the base pay used to calculate their promotional pay. If the employee's performance evaluation rating and therefore merit increase amount is not known at the time the promotional pay is being calculated, a merit increase equivalent to "Fully Meets Expectations" will be included in the base pay used to calculate their promotional pay.
- The next merit pay adjustment after a promotion may be pro-rated based on the amount of time the employee has spent in the job.

Lateral Transfer

It is considered a lateral transfer if an employee moves to a job having the same pay range target.

- Lateral job changes will not typically result in a base pay increase or adjustment unless otherwise approved by the Executive Director of Human Resources.
- Employees who are laterally transferred after March 31, but prior to receiving their merit increase, will typically have their merit pay calculated as a percent of their base pay in effect on March 31.

Demotion

An employee is classified as having been demoted if the employee moves to a job with a lower pay range target.

- The pay of an employee demoted due to an organizational restructure, will not be

decreased unless the employee is above the maximum on the new pay range; if so, the employee will be reduced to the maximum of the new pay range.

- For an involuntary demotion, due to performance, or for a voluntary demotion, the pay grade of the demoted employee will be assigned to the pay grade of the employee's new classification. The employee's base pay will typically be reduced up to five percent (5%) for each pay grade demoted.

- The pay rate adjustment will be effective on the first day of the pay period in which the job change takes effect.

- Future merit increases and market adjustments will not be affected by a demotion unless competent performance is not achieved.

- Employees who are demoted after March 31, but prior to receiving their merit increase, will typically have their merit pay calculated as a percent of their base pay in effect on March 31.

Temporary Assignment

An employee who is asked to assume a full-time temporary assignment in a job having a higher pay range target is eligible for a temporary base pay increase. The employee must assume some or all of the responsibilities of the new job to qualify for a temporary assignment increase.

- The employee's base pay rate prior to the assignment will be maintained and the higher temporary assignment rate will be added as a secondary job title and pay rate.

- This increased secondary pay rate is eliminated when the temporary assignment ends.

- The amount of the temporary assignment increase should be consistent with the promotion policy.

Job Re-Evaluations

Job re-evaluations will be reviewed in the following priority order:

1. New Positions.

2. Change of thirty-five percent (35%) or more of duties [any change in responsibilities less than thirty-five percent (35%) will not be considered].

   - Enhancements must require a higher level of skills, abilities, scope of authority, autonomy, and/or education to qualify for a re-classification.

   - Additional duties that do not require the above will not be considered for reclassification.

   - All requests for job re-classification must be documented, signed by the department manager and submitted to the Compensation Unit.

   - In the case of management positions being re-classified, the appropriate Chief must sign the documentation.

   - The request must include the incumbent's current job description and revised job description with enhancements highlighted.

   - The request must also include justification that the re-classification supports a business need.

If the job is determined to be a priority, the Compensation Unit will analyze the job according to:

1. The job's scope against other jobs in the same discipline.

2. Available market data.

3. Appropriate title identification. The Compensation Unit will determine if the title fits within the hierarchy; if not, a benchmark title will be recommended.

4. Job family.

5. Fair Labor Standards Act (FLSA) status.

6. Appropriate pay grade – the job will be fit into one (1) of the pay grades that currently exists. No new pay grades created.

7. A pay rate will be determined.

8. A recommendation will be made to the Executive Director of Human Resources for approval, and the decision will be communicated to the appropriate manager.

If a job is reassigned to a higher grade, the change will be effective on the first day of the pay period following the evaluation. The pay increase is not retroactive to any earlier date.

The manager will be informed of the decision to move the job to a higher pay grade by the Compensation Unit. The amount of the pay increase should follow the guidelines in the Promotion section. If the upgrade and a pay change occur less than six (6) months before the annual pay increase date, the employee's next merit pay adjustment may be pro-rated.

If the job is not reassigned to a higher pay grade, the manager will be notified. If dissatisfied with the decision, the manager may file an appeal with the Executive Director of Human Resources.

If a job is reassigned to a lower pay grade as a result of a job re-evaluation due to available market data, without a change in job responsibilities, the involuntary demotion due to organizational restructuring protocol will be followed.

If a job is reassigned to a lower pay grade due to a job evaluation and change in job responsibilities, the voluntary demotion protocol will be followed.

Job evaluations and re-evaluations will occur throughout the year; all priority jobs will be evaluated within one (1) month of the request.

If a job is not a priority or does not meet the guidelines, the manager will be notified.

Base Pay Program Maintenance

Salary Structure Adjustment

- The salary structure should be reviewed on a regular basis either annually or every other year to continue to reflect market competitiveness.
- The salary structure updates are designed to relieve any upward pressure on range minimums, midpoints and maximums that may impede the ability to attract, motivate, and retain the workforce.
- The salary structure is dynamic; it needs to be revised at regular intervals based upon market conditions to maintain market competitiveness. The goal is to keep the structure's market rates on track with market data.
- Market adjustments will be applied to the salary schedule as needed at least every two (2) years, using surveyed salary structure adjustment percentages.
- The salary structure adjustment approval process includes:
    - The Executive Director of Human Resources makes a recommendation to the CEO for approval.
    - CEO takes the recommendation to the Board for final approval.

Annual Competitive Assessment

- On a regular basis either annually or every other year, HR will identify the current competitiveness of CalOptima's pay practices by comparing: 1) current pay levels to market practices; 2) current pay levels to pay range targets; and, 3) current pay range targets to market practices.
    - CalOptima will on a regular basis either annually or every other year spot check benchmark jobs to determine market fluctuations in benchmark jobs' pay rates.
    - Based on market findings, the pay grade and ranges will be updated.
    - Any jobs in which reasonable benchmark data is not available can be slotted into the salary structure based on internal equity considerations.
- The results of these analyses, along with CalOptima's current financial performance and economic situation, will determine the appropriate market adjustments (i.e., pay range adjustments) and merit pay budgets.
- The following criteria is typically used to determine which jobs to market price each year:
    - Review job-level turnover statistics for jobs with above-average separation rates to identify jobs with potential retention issues.
    - Review the time-to-fill metrics for jobs requiring above-average recruiting efforts and

expenses to identify jobs with potential recruiting issues.

- Review the applicant tracking reports (if available) for jobs with a high level of initial/ subsequent offer rejections to identify additional potential recruiting issues.
- Review jobs with pay-to-pay range target compa-ratios in excess of 110% or below 90%.
- Review jobs with market-to-pay range target compa-ratios in excess of 110% or below 90%.
- Review all market-sensitive jobs and those on the "watch list."
- Review top ten (10) highest populated jobs on an annual basis.
- Jobs are ranked by degree of severity for each of the preceding criteria; the jobs that are most frequently identified across all criteria are typically market priced.
- It is recommended that at least two (2) jobs be selected from every pay range.

Market Adjustments (Structure and Pay Range Adjustments): Market adjustments to specific pay ranges or the entire pay structure may be made on an annual or as needed basis to reflect current competitiveness or market trends.

- On a regular basis either annually or every other year, the pay range targets are compared to the external market base pay practices and necessary adjustments are made to ensure alignment including job grade changes and range rate adjustments.
- Employees falling below the range minimum of the adjusted structures are typically brought to the pay range minimum, assuming the employee has a satisfactory level of performance; any pay compression resulting from structure adjustments should be addressed as part of the annual pay increase process.
    - Adjustments to pay range minimums occur prior to merit pay calculations.

Process for Making Market Adjustments

- HR performs, on a regular basis either annually or every other year, a review of compensation surveys to calculate the average market adjustment to pay structures; HR also analyzes the competitiveness of the current pay range targets to market practices for benchmarked jobs.
- HR reviews CalOptima's financial operating conditions and quantifies any recruiting/ retention issues.
- HR determines if an adjustment is appropriate (minor variations in the market may be recognized in the following year) and recommends the amount.
- HR multiplies the current pay range target of each grade by the necessary adjustment percentage; then HR recalculates the pay range minimum and maximum based on the existing structure design (i.e., pay range minimums = 80% of the new pay range target; pay range maximums = 120% of the new pay range target, etc.).

- HR identifies the cost implications for the market adjustment by identifying the difference between 1) current pay rates and new pay range minimums, and, 2) current pay rates.

- The market adjustment approval process will work as follows:

    - The Executive Director of Human Resources recommends an adjustment to the CEO for approval.

    - If the CEO agrees, the CEO will seek Board approval, unless the market adjustment is within the approved pay range for the classification as designated in the Board-approved salary schedule. In such case(s), the CEO may approve the market adjustment and inform the Board of such change(s).

Market-Sensitive Jobs: Market sensitive jobs are those for which market conditions make recruiting and retention challenging.

- Premium pay is built into the pay range targets for these jobs.

    - Prospectively, the pay range and grade selected for these jobs will reflect the desired market target rate (i.e., 60th or 75th percentile of base pay practices) based on business need.

    - The desired market target rate is established on a job-by-job basis to reflect specific market conditions.

- Criteria used to determine if a job is classified as market-sensitive typically includes two (2) or more of the following:

    - Time to fill the position – statistics will suggest the average amount of time required to fill a requisition for a market-sensitive position will be significantly higher than the historical norm for this position or similar positions.

    - Job offer rejections – statistics will illustrate an increase in the number of employment offers rejected due to low starting rates.

    - Turnover – statistics will suggest a higher than typical amount of turnover for the position within the last three (3) to six (6) months; turnover for the job will be compared to historical results for the same job and to other similarly-situated jobs.

    - Market Changes – market-sensitive jobs may experience an excessively large increase in competitive pay rates over the previous year's results; specifically, jobs considered to be market-sensitive may have:

        - a year-to-year increase significantly greater than the average year-to-year increase for other jobs analyzed,

        - a competitive market rate significantly higher [approximately ten percent (10%)] than its current pay range target, or

        - a competitive market rate with significantly higher pay practices [approximately ten percent (10%)] in the labor market than the average of current internal pay practices.

- When a job is classified as market-sensitive, typically some form of adjustment is made to employees' base pay rates and is typically referred to as a market adjustment and the pay increase policies noted under the market adjustment section apply.

- Jobs classified as market-sensitive are reviewed annually to determine if this status still applies.

    - Once a job is classified as market-sensitive, it typically remains as such until the recruiting and retention challenges subside and/or the market pay rates adjust themselves – typically not less than one (1) year.

    - When a job is no longer considered market-sensitive, the job's pay range and grade is reassigned to reflect a market median base pay rate target; no changes are typically made to the employees' base pay rates at this time.

- Throughout the year, jobs that are not yet considered market sensitive, but are showing signs of becoming so are placed on a "watch list" and monitored.

If necessary, these jobs will be moved to the market-sensitive category and handled accordingly.

Policy ~~#~~:	GA.8058
Title:	**Salary Schedule**
Department:	CalOptima Administrative
Section:	Human Resources
CEO Approval:	~~*Michael Schrader*~~
Effective Date:	05/01/2014
Revised Date:	~~08/01/2019~~03/05/2020

~~*Board Approved Policy*~~

I. PURPOSE

A. This policy maintains a CalOptima Salary Schedule that lists all active job classifications including job title, salary grade, and salary ranges (minimum, midpoint, and maximum pay rate amounts).

B. This policy ensures the salary schedule is publicly available pursuant to the requirements of Title 2, California Code of Regulations (CCR) §570.5 so that employees who are members of the California Public Employees Retirement System (CalPERS) have their compensation considered qualified for pension calculation under CalPERS regulations.

II. POLICY

A. Pursuant to the requirements under Title 2, California Code of Regulations (CCR) §570.5, CalOptima has established the attached salary schedule for each CalOptima job position. In order for CalPERS member's pay rates to be credited by CalPERS, the Human Resources Department (HR) shall maintain a salary schedule that meets the following eight (8) separate criteria:

1. Approval and adoption by the governing body in accordance with requirements applicable to public meetings laws;

2. Identification of position titles for every employee position;

3. Listing of pay rate for each identified position, which may be stated as a single amount or as multiple amounts with a range;

4. Specifies the time base, including, but not limited to, whether the time base is hourly, daily, bi-weekly, monthly, bi-monthly, or annually;

5. Posted at the employer's office or immediately accessible and available for public review from the employer during normal business hours or posted on the employer's internet website;

6. Indicates the effective date and date of any revisions;

7. Retained by the employer and available for public inspection for not less than five (5) years; and

8. Does not reference another document in lieu of disclosing the pay rate.

B. The Chief Executive Officer (CEO) is authorized and directed to take all steps necessary and proper

to implement the salary schedule for all other employees not inconsistent therewith.

III. PROCEDURE

A. The Human Resources Department (HR) will ensure that the salary schedule~~,~~ meet~~s~~ing the requirements above and is~~, are~~ available at CalOptima's offices and immediately accessible for public review during normal business hours or posted on CalOptima's internet website.

B. HR shall retain the salary schedule for not less than five (5) years.

C. HR shall review the salary schedule and provide recommendations to maintain the competitiveness of the salary schedule to market pay levels.

D. Any adjustments to the salary schedule requires that the Executive Director of HR make a recommendation to the CEO for approval, with the CEO taking the recommendation to the CalOptima Board of Directors for final approval. No changes to the salary schedule, or CEO compensation, shall be effective unless and until approved by the CalOptima Board of Directors.

IV. ATTACHMENT(S)

A. CalOptima - Salary Schedule (Revised as of ~~08/01/2019~~03/05/2020)

V. REFERENCES

A. Title 2, California Code of Regulations, §570.5

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
05/01/2014	Regular Meeting of the CalOptima Board of Directors
08/07/2014	Regular Meeting of the CalOptima Board of Directors
11/06/2014	Regular Meeting of the CalOptima Board of Directors
12/04/2014	Regular Meeting of the CalOptima Board of Directors
03/05/2015	Regular Meeting of the CalOptima Board of Directors
06/04/2015	Regular Meeting of the CalOptima Board of Directors
10/01/2015	Regular Meeting of the CalOptima Board of Directors
12/03/2015	Regular Meeting of the CalOptima Board of Directors
03/03/2016	Regular Meeting of the CalOptima Board of Directors
06/02/2016	Regular Meeting of the CalOptima Board of Directors
08/04/2016	Regular Meeting of the CalOptima Board of Directors
09/01/2016	Regular Meeting of the CalOptima Board of Directors
10/06/2016	Regular Meeting of the CalOptima Board of Directors
11/03/2016	Regular Meeting of the CalOptima Board of Directors
12/01/2016	Regular Meeting of the CalOptima Board of Directors
03/02/2017	Regular Meeting of the CalOptima Board of Directors
05/04/2017	Regular Meeting of the CalOptima Board of Directors
06/01/2017	Regular Meeting of the CalOptima Board of Directors

Date	Meeting
08/03/2017	Regular Meeting of the CalOptima Board of Directors
09/07/2017	Regular Meeting of the CalOptima Board of Directors
11/02/2017	Regular Meeting of the CalOptima Board of Directors
02/01/2018	Regular Meeting of the CalOptima Board of Directors
09/06/2018	Regular Meeting of the CalOptima Board of Directors
10/04/2018	Regular Meeting of the CalOptima Board of Directors
02/07/2019	Regular Meeting of the CalOptima Board of Directors
08/01/2019	Regular Meeting of the CalOptima Board of Directors
03/05/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy ~~#~~	Policy Title	Program(s)
Effective	05/01/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	08/07/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	11/06/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	12/04/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	03/05/2015	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	06/04/2015	GA.8058	Salary Schedule	Administrative
Revised	10/01/2015	GA.8058	Salary Schedule	Administrative
Revised	12/03/2015	GA.8058	Salary Schedule	Administrative
Revised	03/03/2016	GA.8058	Salary Schedule	Administrative
Revised	06/02/2016	GA.8058	Salary Schedule	Administrative
Revised	08/04/2016	GA.8058	Salary Schedule	Administrative
Revised	09/01/2016	GA.8058	Salary Schedule	Administrative
Revised	10/06/2016	GA.8058	Salary Schedule	Administrative
Revised	11/03/2016	GA.8058	Salary Schedule	Administrative
Revised	12/01/2016	GA.8058	Salary Schedule	Administrative
Revised	03/02/2017	GA.8058	Salary Schedule	Administrative
Revised	05/04/2017	GA.8058	Salary Schedule	Administrative
Revised	06/01/2017	GA.8058	Salary Schedule	Administrative
Revised	08/03/2017	GA.8058	Salary Schedule	Administrative
Revised	09/07/2017	GA.8058	Salary Schedule	Administrative
Revised	11/02/2017	GA.8058	Salary Schedule	Administrative
Revised	02/01/2018	GA.8058	Salary Schedule	Administrative
Revised	09/06/2018	GA.8058	Salary Schedule	Administrative
Revised	10/04/2018	GA.8058	Salary Schedule	Administrative
Revised	02/07/2019	GA.8058	Salary Schedule	Administrative
Revised	08/01/2019	GA.8058	Salary Schedule	Administrative
Revised	03/05/2020	GA.8058	Salary Schedule	Administrative

IX. GLOSSARY

Not Applicable

Policy:	GA.8058
Title:	**Salary Schedule**
Department:	CalOptima Administrative
Section:	Human Resources
CEO Approval:	
Effective Date:	05/01/2014
Revised Date:	03/05/2020

I. PURPOSE

A. This policy maintains a CalOptima Salary Schedule that lists all active job classifications including job title, salary grade, and salary ranges (minimum, midpoint, and maximum pay rate amounts).

B. This policy ensures the salary schedule is publicly available pursuant to the requirements of Title 2, California Code of Regulations (CCR) §570.5 so that employees who are members of the California Public Employees Retirement System (CalPERS) have their compensation considered qualified for pension calculation under CalPERS regulations.

II. POLICY

A. Pursuant to the requirements under Title 2, California Code of Regulations (CCR) §570.5, CalOptima has established the attached salary schedule for each CalOptima job position. In order for CalPERS member's pay rates to be credited by CalPERS, the Human Resources Department (HR) shall maintain a salary schedule that meets the following eight (8) separate criteria:

1. Approval and adoption by the governing body in accordance with requirements applicable to public meetings laws;

2. Identification of position titles for every employee position;

3. Listing of pay rate for each identified position, which may be stated as a single amount or as multiple amounts with a range;

4. Specifies the time base, including, but not limited to, whether the time base is hourly, daily, bi-weekly, monthly, bi-monthly, or annually;

5. Posted at the employer's office or immediately accessible and available for public review from the employer during normal business hours or posted on the employer's internet website;

6. Indicates the effective date and date of any revisions;

7. Retained by the employer and available for public inspection for not less than five (5) years; and

8. Does not reference another document in lieu of disclosing the pay rate.

B. The Chief Executive Officer (CEO) is authorized and directed to take all steps necessary and proper

to implement the salary schedule for all other employees not inconsistent therewith.

III. PROCEDURE

A. The Human Resources Department (HR) will ensure that the salary schedule meets the requirements above and is available at CalOptima's offices and immediately accessible for public review during normal business hours or posted on CalOptima's internet website.

B. HR shall retain the salary schedule for not less than five (5) years.

C. HR shall review the salary schedule and provide recommendations to maintain the competitiveness of the salary schedule to market pay levels.

D. Any adjustments to the salary schedule requires that the Executive Director of HR make a recommendation to the CEO for approval, with the CEO taking the recommendation to the CalOptima Board of Directors for final approval. No changes to the salary schedule, or CEO compensation, shall be effective unless and until approved by the CalOptima Board of Directors.

IV. ATTACHMENT(S)

A. CalOptima - Salary Schedule (Revised as of03/05/2020)

V. REFERENCES

A. Title 2, California Code of Regulations, §570.5

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
05/01/2014	Regular Meeting of the CalOptima Board of Directors
08/07/2014	Regular Meeting of the CalOptima Board of Directors
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Date	Meeting
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03/05/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	05/01/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	08/07/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
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Revised	12/04/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	03/05/2015	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	06/04/2015	GA.8058	Salary Schedule	Administrative
Revised	10/01/2015	GA.8058	Salary Schedule	Administrative
Revised	12/03/2015	GA.8058	Salary Schedule	Administrative
Revised	03/03/2016	GA.8058	Salary Schedule	Administrative
Revised	06/02/2016	GA.8058	Salary Schedule	Administrative
Revised	08/04/2016	GA.8058	Salary Schedule	Administrative
Revised	09/01/2016	GA.8058	Salary Schedule	Administrative
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Revised	11/03/2016	GA.8058	Salary Schedule	Administrative
Revised	12/01/2016	GA.8058	Salary Schedule	Administrative
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Revised	05/04/2017	GA.8058	Salary Schedule	Administrative
Revised	06/01/2017	GA.8058	Salary Schedule	Administrative
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Revised	09/07/2017	GA.8058	Salary Schedule	Administrative
Revised	11/02/2017	GA.8058	Salary Schedule	Administrative
Revised	02/01/2018	GA.8058	Salary Schedule	Administrative
Revised	09/06/2018	GA.8058	Salary Schedule	Administrative
Revised	10/04/2018	GA.8058	Salary Schedule	Administrative
Revised	02/07/2019	GA.8058	Salary Schedule	Administrative
Revised	08/01/2019	GA.8058	Salary Schedule	Administrative
Revised	03/05/2020	GA.8058	Salary Schedule	Administrative

IX. GLOSSARY

Not Applicable

CalOptima - Annual Base Salary Schedule - Revised March 5, 2020,
to be implemented March 1, 2020
Effective as of May 1, 2014

Job Title	Pay Grade	Job Code	Min***	Mid	Max	For Approval
Accountant	H	39	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Accountant Int	I	634	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Accountant Sr	K	68	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Accounting Clerk	D	334	$44,000	$51,000	$58,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Accounting Clerk Sr	E	TBD	$48,000	$55,000	$62,000	New Position
Activity Coordinator (PACE)	E	TBD	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Actuarial Analyst	I	558	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Actuarial Analyst Sr	L	559	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Actuary	O	357	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Administrative Assistant	D	19	$44,000	$51,000	$58,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Analyst	H	562	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Analyst Int	I	563	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Analyst Sr	J	564	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Applications Analyst	H	232	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Applications Analyst Int	I	233	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Applications Analyst Sr	K	298	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Assistant Director	P	TBD	$117,000	$141,000	$165,000	New Position
~~Associate Director Customer Service~~	~~O~~	~~593~~	~~$82,576~~	~~$107,328~~	~~$131,976~~	Remove Position
Associate Director Information Services	Q	557	$130,000	$157,000	$184,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
~~Associate Director Provider Network~~	~~O~~	~~647~~	~~$82,576~~	~~$107,328~~	~~$131,976~~	Remove Position
Auditor	I	565	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Auditor Sr	J	566	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Behavioral Health Manager	M	383	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Biostatistics Manager	M	418	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Board Services Specialist	E	435	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Business Analyst	J	40	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Business Analyst Sr	L	611	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Business Systems Analyst Sr	K	69	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.

CalOptima - Annual Base Salary Schedule - Revised March 5, 2020,
to be implemented March 1, 2020
Effective as of May 1, 2014

Job Title	Pay Grade	Job Code	Min***	Mid	Max	For Approval
Buyer	G	29	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Buyer Int	H	49	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Buyer Sr	I	67	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Care Manager	K	657	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Care Transition Intervention Coach (RN)	L	417	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Certified Coder	H	399	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Certified Coding Specialist	H	639	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Certified Coding Specialist Sr	J	640	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Change Control Administrator	I	499	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Change Control Administrator Int	J	500	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
~~Change Management Analyst Sr~~	~~N~~	~~465~~	~~$71,760~~	~~$93,184~~	~~$114,712~~	Remove Position
** Chief Counsel	X	132	$347,000	$434,000	$521,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
** Chief Executive Officer	Z	138	$319,740	$431,600	$543,600	Wage grade letter adjustment based on Grant Thornton revised salary structure, but no changes to pay range.
** Chief Financial Officer	X	134	$347,000	$434,000	$521,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
** Chief Information Officer	W	131	$295,000	$369,000	$443,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
** Chief Medical Officer	X	137	$347,000	$434,000	$521,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
** Chief Operating Officer	X	136	$347,000	$434,000	$521,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Claims - Lead	G	574	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Claims Examiner	C	9	$41,000	$47,000	$53,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Claims Examiner - Lead	F	236	$51,000	$59,000	$67,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Claims Examiner Sr	E	20	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Claims QA Analyst	E	28	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Claims QA Analyst Sr.	F	540	$51,000	$59,000	$67,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Claims Recovery Specialist	F	283	$51,000	$59,000	$67,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Claims Resolution Specialist	F	262	$51,000	$59,000	$67,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Clerk of the Board	O	59	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.

CalOptima - Annual Base Salary Schedule - Revised March 5, 2020,
to be implemented March 1, 2020
Effective as of May 1, 2014

Job Title	Pay Grade	Job Code	Min***	Mid	Max	For Approval
Clinical Auditor	L	567	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Clinical Auditor Sr	M	568	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Clinical Documentation Specialist (RN)	M	641	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Clinical Pharmacist	P	297	$117,000	$141,000	$165,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Clinical Systems Administrator	K	607	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Clinician (Behavioral Health)	K	513	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Communications Specialist	G	188	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Community Partner	G	575	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Community Partner Sr	H	612	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Community Relations Specialist	G	288	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Community Relations Specialist Sr	I	646	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Compliance Claims Auditor	G	222	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Compliance Claims Auditor Sr	H	279	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Contract Administrator	K	385	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Contracts Manager	M	207	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Contracts Manager, Sr.	N	TBD	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Contracts Specialist	I	257	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Contracts Specialist Int	J	469	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Contracts Specialist Sr	K	331	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
* Controller	T	464	$182,000	$227,000	$272,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Credentialing Coordinator	E	41	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Credentialing Coordinator - Lead	F	510	$51,000	$59,000	$67,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Customer Service Coordinator	E	182	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Customer Service Rep	C	5	$41,000	$47,000	$53,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Customer Service Rep - Lead	E	482	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.

CalOptima - Annual Base Salary Schedule - Revised March 5, 2020,
to be implemented March 1, 2020
Effective as of May 1, 2014

	Job Title	Pay Grade	Job Code	Min***	Mid	Max	For Approval
	Customer Service Rep Sr	D	481	$44,000	$51,000	$58,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Data Analyst	I	337	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Data Analyst Int	J	341	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Data Analyst Sr	K	342	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Data and Reporting Analyst - Lead	M	654	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Data Entry Tech	A	3	$36,000	$41,000	$46,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Data Warehouse Architect	N	363	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Data Warehouse Programmer/Analyst	N	364	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	~~Data Warehouse Project Manager~~	~~O~~	~~362~~	~~$82,576~~	~~$107,328~~	~~$131,976~~	Remove Position
	Data Warehouse Reporting Analyst	M	412	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Data Warehouse Reporting Analyst Sr	N	522	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Database Administrator	L	90	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Database Administrator Sr	N	179	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
**	Deputy Chief Counsel	W	160	$295,000	$369,000	$443,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
**	Deputy Chief Medical Officer	W	561	$295,000	$369,000	$443,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Deputy Clerk of the Board	J	TBD	$65,000	$78,000	$91,000	New Position
*	~~Director Accounting~~	~~P~~	~~122~~	~~$95,264~~	~~$128,752~~	~~$162,032~~	Remove Position
*	~~Director Applications Management~~	~~R~~	~~170~~	~~$137,280~~	~~$185,328~~	~~$233,376~~	Remove Position
*	Director Audit & Oversight	R	546	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Director Behavioral Health Services	Q	392	$130,000	$157,000	$184,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Director Budget and Procurement	S	527	$154,000	$193,000	$232,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	~~Director Business Development~~	~~P~~	~~351~~	~~$95,264~~	~~$128,752~~	~~$162,032~~	Remove Position
*	~~Director Business Integration~~	~~Q~~	~~543~~	~~$114,400~~	~~$154,440~~	~~$194,480~~	Remove Position
*	Director Case Management	S	318	$154,000	$193,000	$232,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Director Claims Administration	R	112	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	~~Director Clinical Outcomes~~	~~Q~~	~~602~~	~~$114,400~~	~~$154,440~~	~~$194,480~~	Remove Position
*	Director Clinical Pharmacy	T	129	$182,000	$227,000	$272,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Director Coding Initiatives	S	375	$154,000	$193,000	$232,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Director Communications	R	361	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	~~Director Community Relations~~	~~P~~	~~292~~	~~$95,264~~	~~$128,752~~	~~$162,032~~	Remove Position

CalOptima - Annual Base Salary Schedule - Revised March 5, 2020,
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Effective as of May 1, 2014

Job Title	Pay Grade	Job Code	Min***	Mid	Max	For Approval
* ~~Director Configuration & Coding~~	~~Q~~	~~596~~	~~$114,400~~	~~$154,440~~	~~$194,480~~	Remove Position
* Director Contracting	R	184	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
* ~~Director COREC~~	~~Q~~	~~369~~	~~$114,400~~	~~$154,440~~	~~$194,480~~	Remove Position
* Director Customer Service	R	118	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
* ~~Director Electronic Business~~	~~P~~	~~358~~	~~$95,264~~	~~$128,752~~	~~$162,032~~	Remove Position
* Director Enterprise Analytics	R	520	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
* Director Facilities	Q	428	$130,000	$157,000	$184,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
* ~~Director Finance & Procurement~~	~~P~~	~~157~~	~~$95,264~~	~~$128,752~~	~~$162,032~~	Remove Position
* Director Financial Analysis	T	374	$182,000	$227,000	$272,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
* Director Financial Compliance	R	460	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
* Director Fraud Waste & Abuse and Privacy	R	581	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
* ~~Director Government Affairs~~	~~P~~	~~277~~	~~$95,264~~	~~$128,752~~	~~$162,032~~	Remove Position
* Director Grievance & Appeals	R	528	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
* ~~Director Health Services~~	~~Q~~	~~328~~	~~$114,400~~	~~$154,440~~	~~$194,480~~	Remove Position
* Director Human Resources	R	322	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
* Director Information Services	T	547	$182,000	$227,000	$272,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
* Director Long Term Support Services	S	128	$154,000	$193,000	$232,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
* ~~Director Medi-Cal Plan Operations~~	~~P~~	~~370~~	~~$95,264~~	~~$128,752~~	~~$162,032~~	Remove Position
* Director Network Management	R	125	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
* ~~Director OneCare Operations~~	~~P~~	~~425~~	~~$95,264~~	~~$128,752~~	~~$162,032~~	Remove Position
* ~~Director Organizational Training & Education~~	~~P~~	~~579~~	~~$95,264~~	~~$128,752~~	~~$162,032~~	Remove Position
* Director PACE Program	S	449	$154,000	$193,000	$232,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
* Director Population Health Management	Q	675	$130,000	$157,000	$184,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
* Director Program and Process Management	R	447	$144,000	$174,000	$204,000	Revised Position title and pay range adjustment based on Grant Thornton and internal alignment of job responsibilities.
* Director Program Implementation	R	489	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
* ~~Director Project Management~~	~~Q~~	~~447~~	~~$114,400~~	~~$154,440~~	~~$194,480~~	Remove Position
* Director Provider Data Management Services	Q	655	$130,000	$157,000	$184,000	Revised Position title and pay range adjustment based on Grant Thornton and internal alignment of job responsibilities.
* ~~Director Provider Services~~	~~P~~	~~597~~	~~$95,264~~	~~$128,752~~	~~$162,032~~	Remove Position
* ~~Director Public Policy~~	~~P~~	~~459~~	~~$95,264~~	~~$128,752~~	~~$162,032~~	Remove Position
* Director Purchasing	Q	TBD	$130,000	$157,000	$184,000	New Position
* ~~Director Quality (LTSS)~~	~~Q~~	~~613~~	~~$114,400~~	~~$154,440~~	~~$194,480~~	Remove Position
* Director Quality Analytics	R	591	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
* Director Quality Improvement	R	172	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.

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	Job Title	Pay Grade	Job Code	Min***	Mid	Max	For Approval
*	Director Regulatory Affairs and Compliance	R	625	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Director Strategic Development	R	121	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	~~Director Systems Development~~	~~R~~	~~169~~	~~$137,280~~	~~$185,328~~	~~$233,376~~	Remove Position
*	Director Utilization Management	S	265	$154,000	$193,000	$232,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	~~Disease Management Coordinator~~	~~M~~	~~70~~	~~$62,400~~	~~$81,120~~	~~$99,840~~	Remove Position
	~~Disease Management Coordinator - Lead~~	~~M~~	~~472~~	~~$62,400~~	~~$81,120~~	~~$99,840~~	Remove Position
	~~EDI Project Manager~~	~~O~~	~~403~~	~~$82,576~~	~~$107,328~~	~~$131,976~~	Remove Position
	Enrollment Coordinator (PACE)	F	441	$51,000	$59,000	$67,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Enterprise Analytics Manager	O	582	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Executive Administrative Services Manager	J	661	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Executive Assistant	G	339	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Executive Assistant to CEO	I	TBD	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
**	Executive Director Clinical Operations	V	501	$251,000	$314,000	$377,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
**	Executive Director Compliance	V	493	$251,000	$314,000	$377,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
**	Executive Director Human Resources	V	494	$251,000	$314,000	$377,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
**	Executive Director Network Operations	V	632	$251,000	$314,000	$377,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
**	Executive Director Operations	V	276	$251,000	$314,000	$377,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
**	Executive Director Program Implementation	V	490	$251,000	$314,000	$377,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
**	Executive Director Public Affairs	V	290	$251,000	$314,000	$377,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
**	Executive Director Quality & Population Health Management	V	676	$251,000	$314,000	$377,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
**	Executive Director, Behavioral Health Integration	V	614	$251,000	$314,000	$377,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Facilities & Support Services Coord - Lead	G	631	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Facilities & Support Services Coordinator	E	10	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Facilities & Support Services Coordinator, Sr.	F	TBD	$51,000	$59,000	$67,000	New Position
	Facilities Coordinator	E	438	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Financial Analyst	J	51	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Financial Analyst Sr	L	84	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Financial Reporting Analyst	I	475	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	~~Gerontology Resource Coordinator~~	~~M~~	~~204~~	~~$62,400~~	~~$81,120~~	~~$99,840~~	Remove Position

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Graphic Designer	K	387	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Grievance & Appeals Nurse Specialist	M	226	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Grievance Resolution Specialist	F	42	$51,000	$59,000	$67,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Grievance Resolution Specialist - Lead	I	590	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Grievance Resolution Specialist Sr	H	589	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Health Coach	K	556	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Health Educator	H	47	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Health Educator Sr	I	355	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Health Network Liaison Specialist (RN)	L	524	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Health Network Oversight Specialist	K	323	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
HEDIS Case Manager	M	443	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
~~HEDIS Case Manager (LVN)~~	~~M~~	~~552~~	~~$62,400~~	~~$81,120~~	~~$99,840~~	Remove Position
Help Desk Technician	E	571	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Help Desk Technician Sr	F	573	$51,000	$59,000	$67,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
HR Assistant	D	181	$44,000	$51,000	$58,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
HR Business Partner	M	584	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
~~HR Compensation Specialist Sr~~	~~N~~	~~663~~	~~$71,760~~	~~$93,184~~	~~$114,712~~	Remove Position
HR Coordinator	F	316	$51,000	$59,000	$67,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
HR Representative	J	278	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
HR Representative Sr	L	350	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
HR Specialist	G	505	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
HR Specialist Sr	H	608	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
~~HRIS Analyst Sr~~	~~M~~	~~468~~	~~$62,400~~	~~$81,120~~	~~$99,840~~	Remove Position
~~ICD-10 Project Manager~~	~~O~~	~~411~~	~~$82,576~~	~~$107,328~~	~~$131,976~~	Remove Position
Infrastructure Systems Administrator	F	541	$51,000	$59,000	$67,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Infrastructure Systems Administrator Int	G	542	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Inpatient Quality Coding Auditor	I	642	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Intern	A	237	$36,000	$41,000	$46,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.

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Investigator Sr	I	553	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
IS Coordinator	E	365	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
IS Project Manager	N	424	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
IS Project Manager Sr	O	509	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
IS Project Specialist	K	549	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
IS Project Specialist Sr	L	550	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Kitchen Assistant	A	585	$36,000	$41,000	$46,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
~~Legislative Program Manager~~	~~N~~	~~330~~	~~$71,760~~	~~$93,184~~	~~$114,712~~	Remove Position
Licensed Clinical Social Worker	J	598	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Litigation Support Specialist	K	588	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
LVN (PACE)	K	533	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
LVN Specialist	K	TBD	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Mailroom Clerk	A	1	$36,000	$41,000	$46,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Manager Accounting	O	98	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Manager Actuary	Q	453	$130,000	$157,000	$184,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
~~Manager Applications Management~~	~~P~~	~~271~~	~~$95,264~~	~~$128,752~~	~~$162,032~~	Remove Position
Manager Audit & Oversight	O	539	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Manager Behavioral Health	O	633	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Manager Business Integration	O	544	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Manager Case Management	P	270	$117,000	$141,000	$165,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Manager Claims	O	92	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Manager Clinic Operations	N	551	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Manager Clinical Pharmacist	R	296	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Manager Coding Quality	N	382	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Manager Communications	N	398	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Manager Community Relations	N	384	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Manager Contracting	O	329	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.

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Job Title	Pay Grade	Job Code	Min***	Mid	Max	For Approval
Manager Creative Branding	M	430	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Manager Cultural & Linguistic	M	349	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Manager Customer Service	M	94	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
~~Manager Decision Support~~	~~O~~	~~454~~	~~$82,576~~	~~$107,328~~	~~$131,976~~	Remove Position
Manager Electronic Business	N	422	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
~~Manager Employment Services~~	~~N~~	~~420~~	~~$71,760~~	~~$93,184~~	~~$114,712~~	Remove Position
Manager Encounters	M	516	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Manager Environmental Health & Safety	N	495	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
~~Manager Facilities~~	~~N~~	~~209~~	~~$71,760~~	~~$93,184~~	~~$114,712~~	Remove Position
Manager Finance	O	148	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Manager Financial Analysis	P	356	$117,000	$141,000	$165,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
~~Manager Government Affairs~~	~~N~~	~~437~~	~~$71,760~~	~~$93,184~~	~~$114,712~~	Remove Position
Manager Grievance & Appeals	O	426	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
~~Manager Health Education~~	~~N~~	~~173~~	~~$71,760~~	~~$93,184~~	~~$114,712~~	Remove Position
~~Manager HEDIS~~	~~O~~	~~427~~	~~$82,576~~	~~$107,328~~	~~$131,976~~	Remove Position
Manager Human Resources	O	526	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Manager Information Services	P	560	$117,000	$141,000	$165,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
~~Manager Information Technology~~	~~P~~	~~110~~	~~$95,264~~	~~$128,752~~	~~$162,032~~	Remove Position
~~Manager Integration Government Liaison~~	~~N~~	~~455~~	~~$71,760~~	~~$93,184~~	~~$114,712~~	Remove Position
Manager Long Term Support Services	O	200	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Manager Marketing & Enrollment (PACE)	N	414	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Manager Marketing & Outreach	M	477	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
~~Manager Medical Data Management~~	~~O~~	~~519~~	~~$82,576~~	~~$107,328~~	~~$131,976~~	Remove Position
~~Manager Medi-Cal Program Operations~~	~~N~~	~~483~~	~~$71,760~~	~~$93,184~~	~~$114,712~~	Remove Position
Manager Member Liaison Program	M	354	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Manager Member Outreach & Education	M	616	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
~~Manager Member Outreach Education & Provider Relations~~	~~O~~	~~576~~	~~$82,576~~	~~$107,328~~	~~$131,976~~	Remove Position
Manager MSSP	O	393	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Manager OneCare Clinical	P	359	$117,000	$141,000	$165,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Manager OneCare Customer Service	M	429	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
~~Manager OneCare Regulatory~~	~~N~~	~~197~~	~~$71,760~~	~~$93,184~~	~~$114,712~~	Remove Position
~~Manager OneCare Sales~~	~~O~~	~~248~~	~~$82,576~~	~~$107,328~~	~~$131,976~~	Remove Position
~~Manager Outreach & Enrollment~~	~~N~~	~~477~~	~~$71,760~~	~~$93,184~~	~~$114,712~~	Remove Position

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Manager PACE Center	N	432	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Manager Population Health Management	N	674	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Manager Process Excellence	O	622	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Manager Program Implementation	N	488	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
~~Manager Project Management~~	~~O~~	~~532~~	~~$82,576~~	~~$107,328~~	~~$131,976~~	Remove Position
Manager Provider Data Management Services	M	653	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Manager Provider Network	O	191	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Manager Provider Relations	M	171	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
~~Manager Provider Services~~	~~O~~	~~656~~	~~$82,576~~	~~$107,328~~	~~$131,976~~	Remove Position
Manager Purchasing	O	275	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Manager QI Initiatives	M	433	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Manager Quality Analytics	N	617	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Manager Quality Improvement	N	104	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Manager Regulatory Affairs and Compliance	O	626	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Manager Reporting & Financial Compliance	O	572	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Manager Strategic Development	O	603	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
~~Manager Strategic Operations~~	~~N~~	~~446~~	~~$71,760~~	~~$93,184~~	~~$114,712~~	Remove Position
~~Manager Systems Development~~	~~P~~	~~515~~	~~$95,264~~	~~$128,752~~	~~$162,032~~	Remove Position
Manager Utilization Management	P	250	$117,000	$141,000	$165,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Marketing and Outreach Specialist	F	496	$51,000	$59,000	$67,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Medical Assistant	C	535	$41,000	$47,000	$53,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Medical Authorization Asst	C	11	$41,000	$47,000	$53,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Medical Case Manager	L	72	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Medical Case Manager (LVN)	K	444	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
* Medical Director	V	306	$251,000	$314,000	$377,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Medical Records & Health Plan Assistant	B	548	$38,000	$44,000	$50,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Medical Records Clerk	B	523	$38,000	$44,000	$50,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Medical Services Case Manager	G	54	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.

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Member Liaison Specialist	C	353	$41,000	$47,000	$53,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
MMS Program Coordinator	G	360	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Nurse Practitioner (PACE)	O	635	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Occupational Therapist	L	531	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Occupational Therapist Assistant	H	623	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Office Clerk	A	335	$36,000	$41,000	$46,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
OneCare Operations Manager	N	461	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
OneCare Partner - Sales	F	230	$51,000	$59,000	$67,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
OneCare Partner - Sales (Lead)	G	537	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
OneCare Partner - Service	C	231	$41,000	$47,000	$53,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
OneCare Partner (Inside Sales)	E	371	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Outreach Specialist	C	218	$41,000	$47,000	$53,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Paralegal/Legal Secretary	I	376	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Payroll Specialist	E	554	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Payroll Specialist, Sr.	G	TBD	$55,000	$63,000	$71,000	New Position
Performance Analyst	I	538	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Personal Care Attendant	A	485	$36,000	$41,000	$46,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Personal Care Attendant - Lead	B	498	$38,000	$44,000	$50,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Personal Care Coordinator	C	525	$41,000	$47,000	$53,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Personal Care Coordinator, Sr.	D	TBD	$44,000	$51,000	$58,000	New Position
Pharmacy Resident	G	379	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Pharmacy Services Specialist	C	23	$41,000	$47,000	$53,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Pharmacy Services Specialist Int	D	35	$44,000	$51,000	$58,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Pharmacy Services Specialist Sr	E	507	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Physical Therapist	L	530	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Physical Therapist Assistant	H	624	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Policy Advisor Sr	M	580	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.

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Privacy Manager	N	536	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Privacy Officer	O	648	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Process Excellence Manager	N	529	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Program Assistant	C	24	$41,000	$47,000	$53,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Program Coordinator	C	284	$41,000	$47,000	$53,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
~~Program Development Analyst Sr~~	~~M~~	~~492~~	~~$62,400~~	~~$81,120~~	~~$99,840~~	Remove Position
Program Manager	L	421	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Program Manager Sr	M	594	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Program Specialist	E	36	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Program Specialist Int	G	61	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Program Specialist Sr	I	508	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Program/Policy Analyst	I	56	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Program/Policy Analyst Sr	K	85	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Programmer	K	43	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Programmer Int	M	74	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Programmer Sr	N	80	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Project Manager	L	81	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Project Manager - Lead	M	467	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Project Manager Sr	N	105	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Project Specialist	E	291	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Project Specialist Sr	I	503	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Projects Analyst	G	254	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Provider Data Management Services Coordinator	D	12	$44,000	$51,000	$58,000	Revised position title and pay range adjustment based on internal alignment and equity analysis
Provider Data Management Services Coordinator, Sr	F	586	$51,000	$59,000	$67,000	Revised position title and pay range adjustment based on internal alignment and equity analysis
Provider Enrollment Manager	G	190	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Provider Network Rep Sr	I	391	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.

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	Provider Network Specialist	H	44	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Provider Network Specialist Sr	J	595	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Provider Office Education Manager	I	300	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Provider Relations Rep	G	205	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Provider Relations Rep Sr	I	285	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Publications Coordinator	G	293	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	QA Analyst	I	486	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	QA Analyst Sr	L	380	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	QI Nurse Specialist	M	82	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	QI Nurse Specialist (LVN)	L	445	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Receptionist	B	140	$38,000	$44,000	$50,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Records Manager	P	TBD	$117,000	$141,000	$165,000	New Position
	Recreational Therapist	H	487	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	~~Recruiter~~	~~L~~	~~406~~	~~$54,288~~	~~$70,512~~	~~$86,736~~	Remove Position
	~~Recruiter Sr~~	~~M~~	~~497~~	~~$62,400~~	~~$81,120~~	~~$99,840~~	Remove Position
	Registered Dietitian	I	57	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Regulatory Affairs and Compliance Analyst	I	628	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Regulatory Affairs and Compliance Analyst Sr	K	629	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Regulatory Affairs and Compliance Lead	L	630	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	RN (PACE)	M	480	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Security Analyst Int	M	534	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Security Analyst Sr	N	TBD	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Security Officer	B	311	$38,000	$44,000	$50,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	SharePoint Developer/Administrator Sr	N	397	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Social Worker	J	463	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Social Worker, Sr.	K	TBD	$70,000	$84,000	$98,000	New Position
*	Special Counsel	T	317	$182,000	$227,000	$272,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	~~Sr Director Regulatory Affairs and Compliance~~	~~R~~	~~658~~	~~$137,280~~	~~$185,328~~	~~$233,376~~	Remove Position

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Sr Manager Financial Analysis	Q	660	$130,000	$157,000	$184,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
~~Sr Manager Government Affairs~~	~~O~~	~~451~~	~~$82,576~~	~~$107,328~~	~~$131,976~~	Remove Position
~~Sr Manager Human Resources~~	~~P~~	~~649~~	~~$95,264~~	~~$128,752~~	~~$162,032~~	Remove Position
Sr Manager Information Services	Q	650	$130,000	$157,000	$184,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
~~Sr Manager Provider Network~~	~~O~~	~~651~~	~~$82,576~~	~~$107,328~~	~~$131,976~~	Remove Position
Staff Attorney	P	195	$117,000	$141,000	$165,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Staff Attorney, Sr	R	TBD	$144,000	$174,000	$204,000	New Position
Supervisor Accounting	M	434	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Supervisor Audit and Oversight	M	618	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Supervisor Behavioral Health	M	659	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Supervisor Budgeting	N	466	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Supervisor Case Management	M	86	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Supervisor Claims	I	219	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Supervisor Coding Initiatives	M	502	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Supervisor Credentialing	I	671	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Supervisor Customer Service	I	34	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Supervisor Data Entry	H	192	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Supervisor Day Center (PACE)	H	619	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Supervisor Dietary Services (PACE)	J	643	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Supervisor Encounters	I	253	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Supervisor Facilities	J	162	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Supervisor Finance	M	419	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Supervisor Grievance and Appeals	L	620	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
~~Supervisor Health Education~~	~~M~~	~~381~~	~~$62,400~~	~~$81,120~~	~~$99,840~~	Remove Position
Supervisor Information Services	N	457	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Supervisor Long Term Support Services	M	587	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Supervisor Member Outreach and Education	K	TBD	$70,000	$84,000	$98,000	New Position
Supervisor MSSP	M	348	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Supervisor Nursing Services (PACE)	M	662	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.

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Supervisor OneCare Customer Service	I	408	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Supervisor Payroll	M	517	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Supervisor Pharmacist	Q	610	$130,000	$157,000	$184,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Supervisor Population Health Management	M	673	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Supervisor Provider Data Management Services	K	439	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Supervisor Provider Relations	L	652	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Supervisor Quality Analytics	M	609	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Supervisor Quality Improvement	M	600	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Supervisor Regulatory Affairs and Compliance	M	627	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Supervisor Social Work (PACE)	J	636	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
~~Supervisor Systems Development~~	~~O~~	~~456~~	~~$82,576~~	~~$107,328~~	~~$131,976~~	Remove Position
Supervisor Therapy Services (PACE)	M	645	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Supervisor Utilization Management	M	637	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
~~Systems Manager~~	~~N~~	~~512~~	~~$71,760~~	~~$93,184~~	~~$114,712~~	Remove Position
Systems Network Administrator Int	L	63	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Systems Network Administrator Sr	M	89	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Systems Operations Analyst	F	32	$51,000	$59,000	$67,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Systems Operations Analyst Int	G	45	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Technical Analyst Int	I	64	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Technical Analyst Sr	K	75	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Technical Writer	H	247	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Technical Writer Sr	J	470	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Therapy Aide	E	521	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Training Administrator	I	621	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Training Program Coordinator	H	471	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Translation Specialist	B	241	$38,000	$44,000	$50,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Web Architect	N	366	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.

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* These positions are identified for the purposes of CalOptima Policy GA. 8042: Supplemental Compensation as Director level and above positions for which eligible employees may qualify for Employer-Paid Member Contribution.

** These positions are identified for the purposes of CalOptima Policy GA. 8042: Supplemental Compensation as Director level and above positions for which eligible employees may qualify for Employer-Paid Member Contribution and are also Chief or Executive Director level positions.

*** A training rate of 10% below the minimum applies to all grades.

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Accountant	H	39	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Accountant Int	I	634	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Accountant Sr	K	68	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Accounting Clerk	D	334	$44,000	$51,000	$58,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Accounting Clerk Sr	E	TBD	$48,000	$55,000	$62,000	New Position
Activity Coordinator (PACE)	E	TBD	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Actuarial Analyst	I	558	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Actuarial Analyst Sr	L	559	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Actuary	O	357	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Administrative Assistant	D	19	$44,000	$51,000	$58,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Analyst	H	562	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Analyst Int	I	563	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Analyst Sr	J	564	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Applications Analyst	H	232	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Applications Analyst Int	I	233	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Applications Analyst Sr	K	298	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Assistant Director	P	TBD	$117,000	$141,000	$165,000	New Position
Associate Director Information Services	Q	557	$130,000	$157,000	$184,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Auditor	I	565	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Auditor Sr	J	566	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Behavioral Health Manager	M	383	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Biostatistics Manager	M	418	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Board Services Specialist	E	435	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Business Analyst	J	40	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Business Analyst Sr	L	611	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Business Systems Analyst Sr	K	69	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Buyer	G	29	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.

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Buyer Int	H	49	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Buyer Sr	I	67	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Care Manager	K	657	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Care Transition Intervention Coach (RN)	L	417	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Certified Coder	H	399	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Certified Coding Specialist	H	639	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Certified Coding Specialist Sr	J	640	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Change Control Administrator	I	499	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Change Control Administrator Int	J	500	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
** Chief Counsel	X	132	$347,000	$434,000	$521,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
** Chief Executive Officer	Z	138	$319,740	$431,600	$543,600	Wage grade letter adjustment based on Grant Thornton revised salary structure, but no changes to pay range.
** Chief Financial Officer	X	134	$347,000	$434,000	$521,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
** Chief Information Officer	W	131	$295,000	$369,000	$443,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
** Chief Medical Officer	X	137	$347,000	$434,000	$521,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
** Chief Operating Officer	X	136	$347,000	$434,000	$521,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Claims - Lead	G	574	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Claims Examiner	C	9	$41,000	$47,000	$53,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Claims Examiner - Lead	F	236	$51,000	$59,000	$67,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Claims Examiner Sr	E	20	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Claims QA Analyst	E	28	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Claims QA Analyst Sr.	F	540	$51,000	$59,000	$67,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Claims Recovery Specialist	F	283	$51,000	$59,000	$67,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Claims Resolution Specialist	F	262	$51,000	$59,000	$67,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Clerk of the Board	O	59	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Clinical Auditor	L	567	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.

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Clinical Auditor Sr	M	568	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Clinical Documentation Specialist (RN)	M	641	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Clinical Pharmacist	P	297	$117,000	$141,000	$165,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Clinical Systems Administrator	K	607	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Clinician (Behavioral Health)	K	513	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Communications Specialist	G	188	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Community Partner	G	575	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Community Partner Sr	H	612	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Community Relations Specialist	G	288	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Community Relations Specialist Sr	I	646	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Compliance Claims Auditor	G	222	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Compliance Claims Auditor Sr	H	279	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Contract Administrator	K	385	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Contracts Manager	M	207	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Contracts Manager, Sr.	N	TBD	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Contracts Specialist	I	257	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Contracts Specialist Int	J	469	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Contracts Specialist Sr	K	331	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
* Controller	T	464	$182,000	$227,000	$272,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Credentialing Coordinator	E	41	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Credentialing Coordinator - Lead	F	510	$51,000	$59,000	$67,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Customer Service Coordinator	E	182	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Customer Service Rep	C	5	$41,000	$47,000	$53,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Customer Service Rep - Lead	E	482	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Customer Service Rep Sr	D	481	$44,000	$51,000	$58,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.

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	Data Analyst	I	337	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Data Analyst Int	J	341	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Data Analyst Sr	K	342	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Data and Reporting Analyst - Lead	M	654	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Data Entry Tech	A	3	$36,000	$41,000	$46,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Data Warehouse Architect	N	363	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Data Warehouse Programmer/Analyst	N	364	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Data Warehouse Reporting Analyst	M	412	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Data Warehouse Reporting Analyst Sr	N	522	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Database Administrator	L	90	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Database Administrator Sr	N	179	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
**	Deputy Chief Counsel	W	160	$295,000	$369,000	$443,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
**	Deputy Chief Medical Officer	W	561	$295,000	$369,000	$443,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Deputy Clerk of the Board	J	TBD	$65,000	$78,000	$91,000	New Position
*	Director Audit & Oversight	R	546	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Director Behavioral Health Services	Q	392	$130,000	$157,000	$184,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Director Budget and Procurement	S	527	$154,000	$193,000	$232,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Director Case Management	S	318	$154,000	$193,000	$232,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Director Claims Administration	R	112	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Director Clinical Pharmacy	T	129	$182,000	$227,000	$272,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Director Coding Initiatives	S	375	$154,000	$193,000	$232,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Director Communications	R	361	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Director Contracting	R	184	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Director Customer Service	R	118	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Director Enterprise Analytics	R	520	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Director Facilities	Q	428	$130,000	$157,000	$184,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.

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* Director Financial Analysis	T	374	$182,000	$227,000	$272,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
* Director Financial Compliance	R	460	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
* Director Fraud Waste & Abuse and Privacy	R	581	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
* Director Grievance & Appeals	R	528	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
* Director Human Resources	R	322	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
* Director Information Services	T	547	$182,000	$227,000	$272,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
* Director Long Term Support Services	S	128	$154,000	$193,000	$232,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
* Director Network Management	R	125	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
* Director PACE Program	S	449	$154,000	$193,000	$232,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
* Director Population Health Management	Q	675	$130,000	$157,000	$184,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
* Director Program and Process Management	R	447	$144,000	$174,000	$204,000	Revised Position title and pay range adjustment based on Grant Thornton and internal alignment of job responsibilities.
* Director Program Implementation	R	489	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
* Director Provider Data Management Services	Q	655	$130,000	$157,000	$184,000	Revised Position title and pay range adjustment based on Grant Thornton and internal alignment of job responsibilities.
* Director Purchasing	Q	TBD	$130,000	$157,000	$184,000	New Position
* Director Quality Analytics	R	591	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
* Director Quality Improvement	R	172	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
* Director Regulatory Affairs and Compliance	R	625	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
* Director Strategic Development	R	121	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
* Director Utilization Management	S	265	$154,000	$193,000	$232,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Enrollment Coordinator (PACE)	F	441	$51,000	$59,000	$67,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Enterprise Analytics Manager	O	582	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Executive Administrative Services Manager	J	661	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Executive Assistant	G	339	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Executive Assistant to CEO	I	TBD	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
** Executive Director Clinical Operations	V	501	$251,000	$314,000	$377,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
** Executive Director Compliance	V	493	$251,000	$314,000	$377,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.

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** Executive Director Human Resources	V	494	$251,000	$314,000	$377,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
** Executive Director Network Operations	V	632	$251,000	$314,000	$377,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
** Executive Director Operations	V	276	$251,000	$314,000	$377,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
** Executive Director Program Implementation	V	490	$251,000	$314,000	$377,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
** Executive Director Public Affairs	V	290	$251,000	$314,000	$377,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
** Executive Director Quality & Population Health Management	V	676	$251,000	$314,000	$377,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
** Executive Director, Behavioral Health Integration	V	614	$251,000	$314,000	$377,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Facilities & Support Services Coord - Lead	G	631	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Facilities & Support Services Coordinator	E	10	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Facilities & Support Services Coordinator, Sr.	F	TBD	$51,000	$59,000	$67,000	New Position
Facilities Coordinator	E	438	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Financial Analyst	J	51	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Financial Analyst Sr	L	84	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Financial Reporting Analyst	I	475	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Graphic Designer	K	387	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Grievance & Appeals Nurse Specialist	M	226	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Grievance Resolution Specialist	F	42	$51,000	$59,000	$67,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Grievance Resolution Specialist - Lead	I	590	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Grievance Resolution Specialist Sr	H	589	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Health Coach	K	556	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Health Educator	H	47	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Health Educator Sr	I	355	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Health Network Liaison Specialist (RN)	L	524	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Health Network Oversight Specialist	K	323	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
HEDIS Case Manager	M	443	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Help Desk Technician	E	571	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.

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Help Desk Technician Sr	F	573	$51,000	$59,000	$67,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
HR Assistant	D	181	$44,000	$51,000	$58,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
HR Business Partner	M	584	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
HR Coordinator	F	316	$51,000	$59,000	$67,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
HR Representative	J	278	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
HR Representative Sr	L	350	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
HR Specialist	G	505	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
HR Specialist Sr	H	608	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Infrastructure Systems Administrator	F	541	$51,000	$59,000	$67,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Infrastructure Systems Administrator Int	G	542	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Inpatient Quality Coding Auditor	I	642	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Intern	A	237	$36,000	$41,000	$46,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Investigator Sr	I	553	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
IS Coordinator	E	365	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
IS Project Manager	N	424	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
IS Project Manager Sr	O	509	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
IS Project Specialist	K	549	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
IS Project Specialist Sr	L	550	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Kitchen Assistant	A	585	$36,000	$41,000	$46,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Licensed Clinical Social Worker	J	598	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Litigation Support Specialist	K	588	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
LVN (PACE)	K	533	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
LVN Specialist	K	TBD	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Mailroom Clerk	A	1	$36,000	$41,000	$46,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Manager Accounting	O	98	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.

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Manager Actuary	Q	453	$130,000	$157,000	$184,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Manager Audit & Oversight	O	539	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Manager Behavioral Health	O	633	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Manager Business Integration	O	544	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Manager Case Management	P	270	$117,000	$141,000	$165,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Manager Claims	O	92	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Manager Clinic Operations	N	551	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Manager Clinical Pharmacist	R	296	$144,000	$174,000	$204,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Manager Coding Quality	N	382	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Manager Communications	N	398	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Manager Community Relations	N	384	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Manager Contracting	O	329	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Manager Creative Branding	M	430	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Manager Cultural & Linguistic	M	349	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Manager Customer Service	M	94	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Manager Electronic Business	N	422	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Manager Encounters	M	516	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Manager Environmental Health & Safety	N	495	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Manager Finance	O	148	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Manager Financial Analysis	P	356	$117,000	$141,000	$165,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Manager Grievance & Appeals	O	426	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Manager Human Resources	O	526	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Manager Information Services	P	560	$117,000	$141,000	$165,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Manager Long Term Support Services	O	200	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Manager Marketing & Enrollment (PACE)	N	414	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.

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Manager Marketing & Outreach	M	477	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Manager Member Liaison Program	M	354	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Manager Member Outreach & Education	M	616	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Manager MSSP	O	393	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Manager OneCare Clinical	P	359	$117,000	$141,000	$165,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Manager OneCare Customer Service	M	429	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Manager PACE Center	N	432	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Manager Population Health Management	N	674	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Manager Process Excellence	O	622	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Manager Program Implementation	N	488	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Manager Provider Data Management Services	M	653	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Manager Provider Network	O	191	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Manager Provider Relations	M	171	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Manager Purchasing	O	275	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Manager QI Initiatives	M	433	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Manager Quality Analytics	N	617	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Manager Quality Improvement	N	104	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Manager Regulatory Affairs and Compliance	O	626	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Manager Reporting & Financial Compliance	O	572	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Manager Strategic Development	O	603	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Manager Utilization Management	P	250	$117,000	$141,000	$165,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Marketing and Outreach Specialist	F	496	$51,000	$59,000	$67,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Medical Assistant	C	535	$41,000	$47,000	$53,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Medical Authorization Asst	C	11	$41,000	$47,000	$53,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Medical Case Manager	L	72	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.

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	Medical Case Manager (LVN)	K	444	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
*	Medical Director	V	306	$251,000	$314,000	$377,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Medical Records & Health Plan Assistant	B	548	$38,000	$44,000	$50,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Medical Records Clerk	B	523	$38,000	$44,000	$50,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Medical Services Case Manager	G	54	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Member Liaison Specialist	C	353	$41,000	$47,000	$53,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	MMS Program Coordinator	G	360	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Nurse Practitioner (PACE)	O	635	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Occupational Therapist	L	531	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Occupational Therapist Assistant	H	623	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Office Clerk	A	335	$36,000	$41,000	$46,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	OneCare Operations Manager	N	461	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	OneCare Partner - Sales	F	230	$51,000	$59,000	$67,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	OneCare Partner - Sales (Lead)	G	537	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	OneCare Partner - Service	C	231	$41,000	$47,000	$53,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	OneCare Partner (Inside Sales)	E	371	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Outreach Specialist	C	218	$41,000	$47,000	$53,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Paralegal/Legal Secretary	I	376	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Payroll Specialist	E	554	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Payroll Specialist, Sr.	G	TBD	$55,000	$63,000	$71,000	New Position
	Performance Analyst	I	538	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Personal Care Attendant	A	485	$36,000	$41,000	$46,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Personal Care Attendant - Lead	B	498	$38,000	$44,000	$50,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Personal Care Coordinator	C	525	$41,000	$47,000	$53,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Personal Care Coordinator, Sr.	D	TBD	$44,000	$51,000	$58,000	New Position
	Pharmacy Resident	G	379	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Pharmacy Services Specialist	C	23	$41,000	$47,000	$53,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.

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Pharmacy Services Specialist Int	D	35	$44,000	$51,000	$58,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Pharmacy Services Specialist Sr	E	507	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Physical Therapist	L	530	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Physical Therapist Assistant	H	624	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Policy Advisor Sr	M	580	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Privacy Manager	N	536	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Privacy Officer	O	648	$105,000	$127,000	$149,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Process Excellence Manager	N	529	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Program Assistant	C	24	$41,000	$47,000	$53,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Program Coordinator	C	284	$41,000	$47,000	$53,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Program Manager	L	421	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Program Manager Sr	M	594	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Program Specialist	E	36	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Program Specialist Int	G	61	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Program Specialist Sr	I	508	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Program/Policy Analyst	I	56	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Program/Policy Analyst Sr	K	85	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Programmer	K	43	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Programmer Int	M	74	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Programmer Sr	N	80	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Project Manager	L	81	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Project Manager - Lead	M	467	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Project Manager Sr	N	105	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Project Specialist	E	291	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Project Specialist Sr	I	503	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.

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Projects Analyst	G	254	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Provider Data Management Services Coordinator	D	12	$44,000	$51,000	$58,000	Revised position title and pay range adjustment based on internal alignment and equity analysis
Provider Data Management Services Coordinator, Sr	F	586	$51,000	$59,000	$67,000	Revised position title and pay range adjustment based on internal alignment and equity analysis
Provider Enrollment Manager	G	190	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Provider Network Rep Sr	I	391	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Provider Network Specialist	H	44	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Provider Network Specialist Sr	J	595	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Provider Office Education Manager	I	300	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Provider Relations Rep	G	205	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Provider Relations Rep Sr	I	285	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Publications Coordinator	G	293	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
QA Analyst	I	486	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
QA Analyst Sr	L	380	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
QI Nurse Specialist	M	82	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
QI Nurse Specialist (LVN)	L	445	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Receptionist	B	140	$38,000	$44,000	$50,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Records Manager	P	TBD	$117,000	$141,000	$165,000	New Position
Recreational Therapist	H	487	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Registered Dietitian	I	57	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Regulatory Affairs and Compliance Analyst	I	628	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Regulatory Affairs and Compliance Analyst Sr	K	629	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Regulatory Affairs and Compliance Lead	L	630	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
RN (PACE)	M	480	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Security Analyst Int	M	534	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Security Analyst Sr	N	TBD	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Security Officer	B	311	$38,000	$44,000	$50,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.

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	Job Title	Pay Grade	Job Code	Min***	Mid	Max	For Approval
	SharePoint Developer/Administrator Sr	N	397	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Social Worker	J	463	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Social Worker, Sr.	K	TBD	$70,000	$84,000	$98,000	New Position
*	Special Counsel	T	317	$182,000	$227,000	$272,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Sr Manager Financial Analysis	Q	660	$130,000	$157,000	$184,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Sr Manager Information Services	Q	650	$130,000	$157,000	$184,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Staff Attorney	P	195	$117,000	$141,000	$165,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Staff Attorney, Sr	R	TBD	$144,000	$174,000	$204,000	New Position
	Supervisor Accounting	M	434	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Supervisor Audit and Oversight	M	618	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Supervisor Behavioral Health	M	659	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Supervisor Budgeting	N	466	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Supervisor Case Management	M	86	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Supervisor Claims	I	219	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Supervisor Coding Initiatives	M	502	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Supervisor Credentialing	I	671	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Supervisor Customer Service	I	34	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Supervisor Data Entry	H	192	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Supervisor Day Center (PACE)	H	619	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Supervisor Dietary Services (PACE)	J	643	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Supervisor Encounters	I	253	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Supervisor Facilities	J	162	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Supervisor Finance	M	419	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Supervisor Grievance and Appeals	L	620	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Supervisor Information Services	N	457	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Supervisor Long Term Support Services	M	587	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
	Supervisor Member Outreach and Education	K	TBD	$70,000	$84,000	$98,000	New Position

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Job Title	Pay Grade	Job Code	Min***	Mid	Max	For Approval
Supervisor MSSP	M	348	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Supervisor Nursing Services (PACE)	M	662	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Supervisor OneCare Customer Service	I	408	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Supervisor Payroll	M	517	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Supervisor Pharmacist	Q	610	$130,000	$157,000	$184,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Supervisor Population Health Management	M	673	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Supervisor Provider Data Management Services	K	439	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Supervisor Provider Relations	L	652	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Supervisor Quality Analytics	M	609	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Supervisor Quality Improvement	M	600	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Supervisor Regulatory Affairs and Compliance	M	627	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Supervisor Social Work (PACE)	J	636	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Supervisor Therapy Services (PACE)	M	645	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Supervisor Utilization Management	M	637	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Systems Network Administrator Int	L	63	$77,000	$93,000	$109,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Systems Network Administrator Sr	M	89	$85,000	$103,000	$121,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Systems Operations Analyst	F	32	$51,000	$59,000	$67,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Systems Operations Analyst Int	G	45	$55,000	$63,000	$71,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Technical Analyst Int	I	64	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Technical Analyst Sr	K	75	$70,000	$84,000	$98,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Technical Writer	H	247	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Technical Writer Sr	J	470	$65,000	$78,000	$91,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Therapy Aide	E	521	$48,000	$55,000	$62,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Training Administrator	I	621	$61,000	$73,000	$85,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Training Program Coordinator	H	471	$59,000	$68,000	$77,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.

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Job Title	Pay Grade	Job Code	Min***	Mid	Max	For Approval
Translation Specialist	B	241	$38,000	$44,000	$50,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.
Web Architect	N	366	$95,000	$114,000	$133,000	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.

* These positions are identified for the purposes of CalOptima Policy GA. 8042: Supplemental Compensation as Director level and above positions for which eligible employees may qualify for Employer-Paid Member Contribution.

** These positions are identified for the purposes of CalOptima Policy GA. 8042: Supplemental Compensation as Director level and above positions for which eligible employees may qualify for Employer-Paid Member Contribution and are also Chief or Executive Director level positions.

*** A training rate of 10% below the minimum applies to all grades.

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Summary of Changes to Salary Schedule
GA.8058 Salary Schedule Attachment A

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Accountant	~~K~~	H	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$59,000	~~$61,360~~	$68,000	~~$75,504~~	$77,000	March 2020
Accountant Int	~~L~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$61,000	~~$70,512~~	$73,000	~~$86,736~~	$85,000	March 2020
Accountant Sr	~~M~~	K	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$70,000	~~$81,120~~	$84,000	~~$99,840~~	$98,000	March 2020
Accounting Clerk	~~I~~	D	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$37,128~~	$44,000	~~$46,384~~	$51,000	~~$55,640~~	$58,000	March 2020
Accounting Clerk, Sr (Proposed title)	N/A	E	Department requesting new title due to growth.		$48,000		$55,000		$62,000	March 2020
Activity Coordinator (PACE)	~~J~~	E	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$40,976~~	$48,000	~~$53,352~~	$55,000	~~$65,624~~	$62,000	March 2020

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Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Actuarial Analyst	~~L~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$61,000	~~$70,512~~	$73,000	~~$86,736~~	$85,000	March 2020
Actuarial Analyst Sr	~~M~~	L	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$77,000	~~$81,120~~	$93,000	~~$99,840~~	$109,000	March 2020
Actuary	O		Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$105,000	~~$107,328~~	$127,000	~~$131,976~~	$149,000	March 2020
Administrative Assistant	~~H~~	D	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$33,696~~	$44,000	~~$42,224~~	$51,000	~~$50,648~~	$58,000	March 2020
Analyst	~~K~~	H	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$59,000	~~$61,360~~	$68,000	~~$75,504~~	$77,000	March 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Analyst Int	~~L~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$61,000	~~$70,512~~	$73,000	~~$86,736~~	$85,000	March 2020
Analyst Sr	~~M~~	J	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$65,000	~~$81,120~~	$78,000	~~$99,840~~	$91,000	March 2020
Applications Analyst	~~K~~	H	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$59,000	~~$61,360~~	$68,000	~~$75,504~~	$77,000	March 2020
Applications Analyst Int	~~L~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$61,000	~~$70,512~~	$73,000	~~$86,736~~	$85,000	March 2020
Applications Analyst Sr	~~M~~	K	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$70,000	~~$81,120~~	$84,000	~~$99,840~~	$98,000	March 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Assistant Director (Proposed title)	N/A	P	Establishing title to assist departments organization wide with management leveling.		$117,000		$141,000		$165,000	March 2020
~~Associate Director Customer Service~~	~~O~~	N/A	Job title is not in use nor is it planned for use.							March 2020
Associate Director Information Services	~~Q~~	Q	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$114,400~~	$130,000	~~$154,440~~	$157,000	~~$194,480~~	$184,000	March 2020
~~Associate Director Provider Network~~	~~O~~	N/A	Job title is not in use nor is it planned for use.							March 2020
Auditor	~~K~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$61,000	~~$61,360~~	$73,000	~~$75,504~~	$85,000	March 2020
Auditor Sr	~~L~~	J	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$65,000	~~$70,512~~	$78,000	~~$86,736~~	$91,000	March 2020
Behavioral Health Manager	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	March 2020
Biostatistics Manager	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	March 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Board Services Specialist	~~J~~	E	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$40,976~~	$48,000	~~$53,352~~	$55,000	~~$65,624~~	$62,000	March 2020
Business Analyst	J		Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$40,976~~	$65,000	~~$53,352~~	$78,000	~~$65,624~~	$91,000	March 2020
Business Analyst Sr	~~M~~	L	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$77,000	~~$81,120~~	$93,000	~~$99,840~~	$109,000	March 2020
Business Systems Analyst Sr	~~M~~	K	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$70,000	~~$81,120~~	$84,000	~~$99,840~~	$98,000	March 2020
Buyer	~~J~~	G	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$40,976~~	$55,000	~~$53,352~~	$63,000	~~$65,624~~	$71,000	March 2020
Buyer Int	~~K~~	H	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$59,000	~~$61,360~~	$68,000	~~$75,504~~	$77,000	March 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Buyer Sr	~~L~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$61,000	~~$70,512~~	$73,000	~~$86,736~~	$85,000	March 2020
Care Manager	~~M~~	K	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$70,000	~~$81,120~~	$84,000	~~$99,840~~	$98,000	March 2020
Care Transition Intervention Coach (RN)	~~N~~	L	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$77,000	~~$93,184~~	$93,000	~~$114,712~~	$109,000	March 2020
Certified Coder	~~K~~	H	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$59,000	~~$61,360~~	$68,000	~~$75,504~~	$77,000	March 2020
Certified Coding Specialist	~~K~~	H	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$59,000	~~$61,360~~	$68,000	~~$75,504~~	$77,000	March 2020
Certified Coding Specialist Sr	~~L~~	J	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$65,000	~~$70,512~~	$78,000	~~$86,736~~	$91,000	March 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Change Control Administrator	~~L~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$61,000	~~$70,512~~	$73,000	~~$86,736~~	$85,000	March 2020
Change Control Administrator Int	~~M~~	J	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$65,000	~~$81,120~~	$78,000	~~$99,840~~	$91,000	March 2020
~~Change Management Analyst Sr~~	~~N~~	N/A	Job title is not in use nor is it planned for use.							March 2020
Chief Counsel	~~T~~	X	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$197,704~~	$347,000	~~$266,968~~	$434,000	~~$336,024~~	$521,000	March 2020
Chief Executive Officer	~~V~~	Z	Wage grade letter adjustment based on Grant Thornton revised salary structure, but no changes to pay range.							March 2020
Chief Financial Officer	~~U~~	X	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$237,224~~	$347,000	~~$320,216~~	$434,000	~~$403,312~~	$521,000	March 2020
Chief Information Officer	~~T~~	W	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$197,704~~	$295,000	~~$266,968~~	$369,000	~~$336,024~~	$443,000	March 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Chief Medical Officer	~~U~~	X	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$237,224~~	$347,000	~~$320,216~~	$434,000	~~$403,312~~	$521,000	March 2020
Chief Operating Officer	~~U~~	X	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$237,224~~	$347,000	~~$320,216~~	$434,000	~~$403,312~~	$521,000	March 2020
Claims - Lead	~~J~~	G	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$40,976~~	$55,000	~~$53,352~~	$63,000	~~$65,624~~	$71,000	March 2020
Claims Examiner	~~H~~	C	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$33,696~~	$41,000	~~$42,224~~	$47,000	~~$50,648~~	$53,000	March 2020
Claims Examiner - Lead	~~J~~	F	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$40,976~~	$51,000	~~$53,352~~	$59,000	~~$65,624~~	$67,000	March 2020
Claims Examiner Sr	~~I~~	E	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$37,128~~	$48,000	~~$46,384~~	$55,000	~~$55,640~~	$62,000	March 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Claims QA Analyst	~~I~~	E	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$37,128~~	$48,000	~~$46,384~~	$55,000	~~$55,640~~	$62,000	March 2020
Claims QA Analyst Sr.	~~J~~	F	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$40,976~~	$51,000	~~$53,352~~	$59,000	~~$65,624~~	$67,000	March 2020
Claims Recovery Specialist	~~I~~	F	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$37,128~~	$51,000	~~$46,384~~	$59,000	~~$55,640~~	$67,000	March 2020
Claims Resolution Specialist	~~I~~	F	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$37,128~~	$51,000	~~$46,384~~	$59,000	~~$55,640~~	$67,000	March 2020
Clerk of the Board	O		Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$105,000	~~$107,328~~	$127,000	~~$131,976~~	$149,000	March 2020
Clinical Auditor	~~M~~	L	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$77,000	~~$81,120~~	$93,000	~~$99,840~~	$109,000	March 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Clinical Auditor Sr	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	March 2020
Clinical Documentation Specialist (RN)	~~O~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$85,000	~~$107,328~~	$103,000	~~$131,976~~	$121,000	March 2020
Clinical Pharmacist	P		Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$95,264~~	$117,000	~~$128,752~~	$141,000	~~$162,032~~	$165,000	March 2020
Clinical Systems Administrator	~~M~~	K	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$70,000	~~$81,120~~	$84,000	~~$99,840~~	$98,000	March 2020
Clinician (Behavioral Health)	~~M~~	K	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$70,000	~~$81,120~~	$84,000	~~$99,840~~	$98,000	March 2020
Communications Specialist	~~J~~	G	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$40,976~~	$55,000	~~$53,352~~	$63,000	~~$65,624~~	$71,000	March 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Community Partner*	~~K~~	G	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$55,000	~~$61,360~~	$63,000	~~$75,504~~	$71,000	March 2020
Community Partner Sr	~~L~~	H	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$59,000	~~$70,512~~	$68,000	~~$86,736~~	$77,000	March 2020
Community Relations Specialist	~~J~~	G	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$40,976~~	$55,000	~~$53,352~~	$63,000	~~$65,624~~	$71,000	March 2020
Community Relations Specialist Sr	~~K~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$61,000	~~$61,360~~	$73,000	~~$75,504~~	$85,000	March 2020
Compliance Claims Auditor	~~K~~	G	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$55,000	~~$61,360~~	$63,000	~~$75,504~~	$71,000	March 2020
Compliance Claims Auditor Sr	~~L~~	H	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$59,000	~~$70,512~~	$68,000	~~$86,736~~	$77,000	March 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Contract Administrator	~~M~~	K	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$70,000	~~$81,120~~	$84,000	~~$99,840~~	$98,000	March 2020
Contracts Manager	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	March 2020
Contracts Manager, Sr (Proposed title)	N/A	N	Department requesting new title due to growth and to establish levels.		$95,000		$114,000		$133,000	March 2020
Contracts Specialist	~~K~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$61,000	~~$61,360~~	$73,000	~~$75,504~~	$85,000	March 2020
Contracts Specialist Int	~~L~~	J	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$65,000	~~$70,512~~	$78,000	~~$86,736~~	$91,000	March 2020
Contracts Specialist Sr	~~M~~	K	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$70,000	~~$81,120~~	$84,000	~~$99,840~~	$98,000	March 2020
Controller	~~Q~~	T	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$114,400~~	$182,000	~~$154,440~~	$227,000	~~$194,480~~	$272,000	March 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Credentialing Coordinator	~~J~~	E	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$40,976~~	$48,000	~~$53,352~~	$55,000	~~$65,624~~	$62,000	March 2020
Credentialing Coordinator - Lead	~~J~~	F	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$40,976~~	$51,000	~~$53,352~~	$59,000	~~$65,624~~	$67,000	March 2020
Customer Service Coordinator	~~J~~	E	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$40,976~~	$48,000	~~$53,352~~	$55,000	~~$65,624~~	$62,000	March 2020
Customer Service Rep	~~H~~	C	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$33,696~~	$41,000	~~$42,224~~	$47,000	~~$50,648~~	$53,000	March 2020
Customer Service Rep - Lead	~~J~~	E	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$40,976~~	$48,000	~~$53,352~~	$55,000	~~$65,624~~	$62,000	March 2020
Customer Service Rep Sr	~~I~~	D	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$37,128~~	$44,000	~~$46,384~~	$51,000	~~$55,640~~	$58,000	March 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Data Analyst*	K	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$61,000	~~$61,360~~	$73,000	~~$75,504~~	$85,000	March 2020
Data Analyst Int*	L	J	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$65,000	~~$70,512~~	$78,000	~~$86,736~~	$91,000	March 2020
Data Analyst Sr*	M	K	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$70,000	~~$81,120~~	$84,000	~~$99,840~~	$98,000	March 2020
Data and Reporting Analyst - Lead	~~O~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$85,000	~~$107,328~~	$103,000	~~$131,976~~	$121,000	March 2020
Data Entry Tech	~~F~~	A	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$27,872~~	$36,000	~~$34,840~~	$41,000	~~$41,808~~	$46,000	March 2020
Data Warehouse Architect	~~O~~	N	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$95,000	~~$107,328~~	$114,000	~~$131,976~~	$133,000	March 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Data Warehouse Programmer/Analyst	~~O~~	N	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$95,000	~~$107,328~~	$114,000	~~$131,976~~	$133,000	March 2020
~~Data Warehouse Project Manager~~	~~O~~	N/A	Job title is not in use nor is it planned for use.							March 2020
Data Warehouse Reporting Analyst	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	March 2020
Data Warehouse Reporting Analyst Sr	~~O~~	N	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$95,000	~~$107,328~~	$114,000	~~$131,976~~	$133,000	March 2020
Database Administrator	~~M~~	L	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$77,000	~~$81,120~~	$93,000	~~$99,840~~	$109,000	March 2020
Database Administrator Sr	~~O~~	N	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$95,000	~~$107,328~~	$114,000	~~$131,976~~	$133,000	March 2020
Deputy Chief Counsel	~~S~~	W	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$164,736~~	$295,000	~~$222,352~~	$369,000	~~$280,072~~	$443,000	March 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Deputy Chief Medical Officer	~~T~~	W	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$197,704~~	$295,000	~~$266,968~~	$369,000	~~$336,024~~	$443,000	March 2020
Deputy Clerk of the Board* (Proposed title)	N/A	J	Department requested new title to support Clerk duties and responsibilities.		$65,000		$78,000		$91,000	March 2020
~~Director Accounting~~	~~P~~	N/A	Job title is not in use nor is it planned for use.							March 2020
~~Director Applications Management~~	~~R~~	N/A	Job title is not in use nor is it planned for use.							March 2020
Director Audit & Oversight	~~Q~~	R	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$114,400~~	$144,000	~~$154,440~~	$174,000	~~$194,480~~	$204,000	March 2020
Director Behavioral Health Services	~~P~~	Q	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$95,264~~	$130,000	~~$128,752~~	$157,000	~~$162,032~~	$184,000	March 2020
Director Budget and Procurement	~~Q~~	S	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$114,400~~	$154,000	~~$154,440~~	$193,000	~~$194,480~~	$232,000	March 2020
~~Director Business Development~~	~~P~~	N/A	Job title is not in use nor is it planned for use.							March 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
~~Director Business Integration~~	~~Q~~	N/A	Job title is not in use nor is it planned for use.							March 2020
Director Case Management	Q	S	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$114,400~~	$154,000	~~$154,440~~	$193,000	~~$194,480~~	$232,000	March 2020
Director Claims Administration	~~P~~	R	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$95,264~~	$144,000	~~$128,752~~	$174,000	~~$162,032~~	$204,000	March 2020
~~Director Clinical Outcomes~~	~~Q~~	N/A	Job title is not in use nor is it planned for use.							March 2020
Director Clinical Pharmacy	~~R~~	T	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$137,280~~	$182,000	~~$185,328~~	$227,000	~~$233,376~~	$272,000	March 2020
Director Coding Initiatives	~~P~~	S	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$95,264~~	$154,000	~~$128,752~~	$193,000	~~$162,032~~	$232,000	March 2020
Director Communications	~~P~~	R	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$95,264~~	$144,000	~~$128,752~~	$174,000	~~$162,032~~	$204,000	March 2020
~~Director Community Relations~~	~~P~~	N/A	Job title is not in use nor is it planned for use.							March 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
~~Director Configuration & Coding~~	~~Q~~	N/A	Job title is not in use nor is it planned for use.							March 2020
Director Contracting	~~P~~	R	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$95,264~~	$144.000	~~$128,752~~	$174.000	~~$162,032~~	$204,000	March 2020
~~Director COREC~~	~~Q~~	N/A	Job title is not in use nor is it planned for use.							March 2020
Director Customer Service	~~P~~	R	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$95,264~~	$144,000	~~$128,752~~	$174,000	~~$162,032~~	$204,000	March 2020
~~Director Electronic Business~~	~~P~~	N/A	Job title is not in use nor is it planned for use.							March 2020
Director Enterprise Analytics	~~Q~~	R	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$114,400~~	$144,000	~~$154,440~~	$174,000	~~$194,480~~	$204,000	March 2020
Director Facilities	~~P~~	Q	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$95,264~~	$130,000	~~$128,752~~	$157,000	~~$162,032~~	$184,000	March 2020
~~Director Finance & Procurement~~	~~P~~	N/A	Job title is not in use nor is it planned for use.							March 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Director Financial Analysis	~~R~~	T	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$137,280~~	$182,000	~~$185,328~~	$227,000	~~$233,376~~	$272,000	March 2020
Director Financial Compliance	~~P~~	R	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$95,264~~	$144,000	~~$128,752~~	$174,000	~~$162,032~~	$204,000	March 2020
Director Fraud Waste & Abuse and Privacy	~~Q~~	R	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$114,400~~	$144,000	~~$154,440~~	$174,000	~~$194,480~~	$204,000	March 2020
~~Director Government Affairs~~	~~P~~	N/A	Job title is not in use nor is it planned for use.							March 2020
Director Grievance & Appeals	~~P~~	R	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$95,264~~	$144,000	~~$128,752~~	$174,000	~~$162,032~~	$204,000	March 2020
~~Director Health Services~~	~~Q~~	N/A	Job title is not in use nor is it planned for use.							March 2020
Director Human Resources	~~Q~~	R	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$114,400~~	$144,000	~~$154,440~~	$174,000	~~$194,480~~	$204,000	March 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Director Information Services	~~R~~	T	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$137,280~~	$182,000	~~$185,328~~	$227,000	~~$233,376~~	$272,000	March 2020
Director Long Term Support Services	~~Q~~	S	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$114,400~~	$154,000	~~$154,440~~	$193,000	~~$194,480~~	$232,000	March 2020
~~Director Medi-Cal Plan Operations~~	~~P~~	N/A	Job title is not in use nor is it planned for use.							March 2020
Director Network Management	~~P~~	R	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$95,264~~	$144,000	~~$128,752~~	$174,000	~~$162,032~~	$204,000	March 2020
~~Director OneCare Operations~~	~~P~~	N/A	Job title is not in use nor is it planned for use.							March 2020
~~Director Organizational Training & Education~~	~~P~~	N/A	Job title is not in use nor is it planned for use.							March 2020
Director PACE Program	~~Q~~	S	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$114,400~~	$154,000	~~$154,440~~	$193,000	~~$194,480~~	$232,000	March 2020
Director Population Health Management	Q		Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$114,400~~	$130,000	~~$154,440~~	$157,000	~~$194,480~~	$184,000	March 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Director ~~Process Excellence~~ Program & Process Management (Revised)	~~Q~~	R	Title changed due to department name change Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$114,400~~	$144,000	~~$154,440~~	$174,000	~~$194,480~~	$204,000	March 2020
Director Program Implementation	~~Q~~	R	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$114,400~~	$144,000	~~$154,440~~	$174,000	~~$194,480~~	$204,000	March 2020
~~Director Project Management~~	~~Q~~	N/A	Job title is not in use nor is it planned for use.							March 2020
Director Provider Data ~~Quality~~ Management Services (Revised)	Q		Title changed due to department name change Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$114,400~~	$130,000	~~$154,440~~		~~$194,480~~		March 2020
~~Director Provider Services~~	~~P~~	N/A	Job title is not in use nor is it planned for use.							March 2020
~~Director Public Policy~~	~~P~~	N/A	Job title is not in use nor is it planned for use.							March 2020
Director Purchasing*	N/A	Q	Department requested new title to provide support and oversight of this function.		$130,000		$157,000		$184,000	March 2020
~~Director Quality (LTSS)~~	~~Q~~	N/A	Job title is not in use nor is it planned for use.							March 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Director Quality Analytics	~~Q~~	R	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$114,400~~	$144,000	~~$154,440~~	$174,000	~~$194,480~~	$204,000	March 2020
Director Quality Improvement	~~Q~~	R	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$114,400~~	$144,000	~~$154,440~~	$174,000	~~$194,480~~	$204,000	March 2020
Director Regulatory Affairs and Compliance	~~Q~~	R	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$114,400~~	$144,000	~~$154,440~~	$174,000	~~$194,480~~	$204,000	March 2020
Director Strategic Development	~~P~~	R	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$95,264~~	$144,000	~~$128,752~~	$174,000	~~$162,032~~	$204,000	March 2020
~~Director Systems Development~~	~~R~~	N/A	Job title is not in use nor is it planned for use.							March 2020
Director Utilization Management	Q	S	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$114,400~~	$154,000	~~$154,440~~	$193,000	~~$194,480~~	$232,000	March 2020
~~Disease Management Coordinator~~	~~M~~	N/A	Job title is not in use nor is it planned for use.							March 2020
~~Disease Management Coordinator - Lead~~	~~M~~	N/A	Job title is not in use nor is it planned for use.							March 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
~~EDI Project Manager~~	~~O~~	N/A	Job title is not in use nor is it planned for use.							March 2020
Enrollment Coordinator (PACE)	~~K~~	F	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$51,000	~~$61,360~~	$59,000	~~$75,504~~	$67,000	March 2020
Enterprise Analytics Manager	~~P~~	O	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$95,264~~	$105,000	~~$128,752~~	$127,000	~~$162,032~~	$149,000	March 2020
Executive Administrative Services Manager	~~M~~	J	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$65,000	~~$81,120~~	$78,000	~~$99,840~~	$91,000	March 2020
Executive Assistant	~~K~~	G	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$55,000	~~$61,360~~	$63,000	~~$75,504~~	$71,000	March 2020
Executive Assistant to CEO	~~L~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.		$61,000	~~$70,512~~	$73,000		$85,000	March 2020
Executive Director Clinical Operations	~~S~~	V	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$164,736~~	$251,000	~~$222,352~~	$314,000	~~$280,072~~	$377,000	March 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Executive Director Compliance	~~S~~	V	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$164,736~~	$251,000	~~$222,352~~	$314,000	~~$280,072~~	$377,000	March 2020
Executive Director Human Resources	~~S~~	V	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$164,736~~	$251,000	~~$222,352~~	$314,000	~~$280,072~~	$377,000	March 2020
Executive Director Network Operations	~~S~~	V	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$164,736~~	$251,000	~~$222,352~~	$314,000	~~$280,072~~	$377,000	March 2020
Executive Director Operations	~~S~~	V	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$164,736~~	$251,000	~~$222,352~~	$314,000	~~$280,072~~	$377,000	March 2020
Executive Director Program Implementation	~~S~~	V	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$164,736~~	$251,000	~~$222,352~~	$314,000	~~$280,072~~	$377,000	March 2020
Executive Director Public Affairs	~~S~~	V	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$164,736~~	$251,000	~~$222,352~~	$314,000	~~$280,072~~	$377,000	March 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Executive Director Quality & Population Health Management	~~S~~	V	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$164,736~~	$251,000	~~$222,352~~	$314,000	~~$280,072~~	$377,000	March 2020
Executive Director, Behavioral Health Integration	~~S~~	V	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$164,736~~	$251,000	~~$222,352~~	$314,000	~~$280,072~~	$377,000	March 2020
Facilities & Support Services Coord - Lead	~~J~~	G	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$40,976~~	$55,000	~~$53,352~~	$63,000	~~$65,624~~	$71,000	March 2020
Facilities & Support Services Coordinator	~~J~~	E	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$40,976~~	$48,000	~~$53,352~~	$55,000	~~$65,624~~	$62,000	March 2020
Facilities & Support Services Coordinator, Sr (Proposed title)	N/A	F	Department requesting new title due to growth and to establish levels.		$51,000		$59,000		$67,000	March 2020
Facilities Coordinator	~~J~~	E	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$40,976~~	$48,000	~~$53,352~~	$55,000	~~$65,624~~	$62,000	March 2020
Financial Analyst	~~L~~	J	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$65,000	~~$70,512~~	$78,000	~~$86,736~~	$91,000	March 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Financial Analyst Sr	~~M~~	L	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$77,000	~~$81,120~~	$93,000	~~$99,840~~	$109,000	March 2020
Financial Reporting Analyst	~~L~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$61,000	~~$70,512~~	$73,000	~~$86,736~~	$85,000	March 2020
~~Gerontology Resource Coordinator~~	~~M~~	N/A	Job title is not in use nor is it planned for use.							March 2020
Graphic Designer	~~M~~	K	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$70,000	~~$81,120~~	$84,000	~~$99,840~~	$98,000	March 2020
Grievance & Appeals Nurse Specialist	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	March 2020
Grievance Resolution Specialist	~~J~~	F	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$40,976~~	$51,000	~~$53,352~~	$59,000	~~$65,624~~	$67,000	March 2020
Grievance Resolution Specialist - Lead	~~L~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$61,000	~~$70,512~~	$73,000	~~$86,736~~	$85,000	March 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Grievance Resolution Specialist Sr	~~K~~	H	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$59,000	~~$61,360~~	$68,000	~~$75,504~~	$77,000	March 2020
Health Coach	~~M~~	K	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$70,000	~~$81,120~~	$84,000	~~$99,840~~	$98,000	March 2020
Health Educator	~~K~~	H	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$59,000	~~$61,360~~	$68,000	~~$75,504~~	$77,000	March 2020
Health Educator Sr	~~L~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$61,000	~~$70,512~~	$73,000	~~$86,736~~	$85,000	March 2020
Health Network Liaison Specialist (RN)	~~N~~	L	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$77,000	~~$93,184~~	$93,000	~~$114,712~~	$109,000	March 2020
Health Network Oversight Specialist	~~M~~	K	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$70,000	~~$81,120~~	$84,000	~~$99,840~~	$98,000	March 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
HEDIS Case Manager	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	March 2020
~~HEDIS Case Manager (LVN)~~	~~M~~	N/A	Job title is not in use nor is it planned for use.							March 2020
Help Desk Technician	~~J~~	E	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$40,976~~	$48,000	~~$53,352~~	$55,000	~~$65,624~~	$62,000	March 2020
Help Desk Technician Sr	~~K~~	F	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$51,000	~~$61,360~~	$59,000	~~$75,504~~	$67,000	March 2020
HR Assistant	~~I~~	D	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$37,128~~	$44,000	~~$46,384~~	$51,000	~~$55,640~~	$58,000	March 2020
HR Business Partner	M		Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$85,000	~~$81,120~~	$103,000	~~$99,840~~	$121,000	March 2020
~~HR Compensation Specialist Sr~~	~~N~~	N/A	Job title is not in use nor is it planned for use.							March 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
HR Coordinator	~~J~~	F	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$40,976~~	$51,000	~~$53,352~~	$59,000	~~$65,624~~	$67,000	March 2020
HR Representative	~~L~~	J	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$65,000	~~$70,512~~	$78,000	~~$86,736~~	$91,000	March 2020
HR Representative Sr	~~M~~	L	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$77,000	~~$81,120~~	$93,000	~~$99,840~~	$109,000	March 2020
HR Specialist	~~K~~	G	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$55,000	~~$61,360~~	$63,000	~~$75,504~~	$71,000	March 2020
HR Specialist Sr	~~L~~	H	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$59,000	~~$70,512~~	$68,000	~~$86,736~~	$77,000	March 2020
~~HRIS Analyst Sr~~	~~M~~	N/A	Job title is not in use nor is it planned for use.							March 2020
~~ICD-10 Project Manager~~	~~O~~	N/A	Job title is not in use nor is it planned for use.							March 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Infrastructure Systems Administrator	~~J~~	F	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$40,976~~	$51,000	~~$53,352~~	$59,000	~~$65,624~~	$67,000	March 2020
Infrastructure Systems Administrator Int	~~K~~	G	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$55,000	~~$61,360~~	$63,000	~~$75,504~~	$71,000	March 2020
Inpatient Quality Coding Auditor	~~L~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$61,000	~~$70,512~~	$73,000	~~$86,736~~	$85,000	March 2020
Intern	~~E~~	A	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$25,272~~	$36,000	~~$31,720~~	$41,000	~~$37,960~~	$46,000	March 2020
Investigator Sr	~~L~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$61,000	~~$70,512~~	$73,000	~~$86,736~~	$85,000	March 2020
IS Coordinator	~~J~~	E	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$40,976~~	$48,000	~~$53,352~~	$55,000	~~$65,624~~	$62,000	March 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
IS Project Manager	~~O~~	N	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$95,000	~~$107,328~~	$114,000	~~$131,976~~	$133,000	March 2020
IS Project Manager Sr	~~P~~	O	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$95,264~~	$105,000	~~$128,752~~	$127,000	~~$162,032~~	$149,000	March 2020
IS Project Specialist	~~M~~	K	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$70,000	~~$81,120~~	$84,000	~~$99,840~~	$98,000	March 2020
IS Project Specialist Sr	~~N~~	L	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$77,000	~~$93,184~~	$93,000	~~$114,712~~	$109,000	March 2020
Kitchen Assistant	~~E~~	A	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$25,272~~	$36,000	~~$31,720~~	$41,000	~~$37,960~~	$46,000	March 2020
~~Legislative Program Manager~~	~~N~~	N/A	Job title is not in use nor is it planned for use.							March 2020
Licensed Clinical Social Worker	~~L~~	J	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$65,000	~~$70,512~~	$78,000	~~$86,736~~	$91,000	March 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Litigation Support Specialist	~~M~~	K	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$70,000	~~$81,120~~	$84,000	~~$99,840~~	$98,000	March 2020
LVN PACE	~~M~~	K	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$70,000	~~$81,120~~	$84,000	~~$99,840~~	$98,000	March 2020
LVN Specialist (Proposed title, to be adjusted)	N/A	K	Department requesting new title to clearly identify roles.		$70,000		$84,000		$98,000	March 2020
Mailroom Clerk	~~E~~	A	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$25,272~~	$36,000	~~$31,720~~	$41,000	~~$37,960~~	$46,000	March 2020
Manager Accounting	~~N~~	O	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$105,000	~~$93,184~~	$127,000	~~$114,712~~	$149,000	March 2020
Manager Actuary	~~P~~	Q	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$95,264~~	$130,000	~~$128,752~~	$157,000	~~$162,032~~	$184,000	March 2020
~~Manager Applications Management~~	~~P~~	N/A	Job title is not in use nor is it planned for use.							March 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Manager Audit & Oversight	O		Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$105,000	~~$107,328~~	$127,000	~~$131,976~~	$149,000	March 2020
Manager Behavioral Health	O		Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$105,000	~~$107,328~~	$127,000	~~$131,976~~	$149,000	March 2020
Manager Business Integration	O		Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$105,000	~~$107,328~~	$127,000	~~$131,976~~	$149,000	March 2020
Manager Case Management	~~O~~	P	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$117,000	~~$107,328~~	$141,000	~~$131,976~~	$165,000	March 2020
Manager Claims	~~N~~	O	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$105,000	~~$93,184~~	$127,000	~~$114,712~~	$149,000	March 2020
Manager Clinic Operations	~~O~~	N	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$95,000	~~$107,328~~	$114,000	~~$131,976~~	$133,000	March 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Manager Clinical Pharmacist	~~Q~~	R	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$114,400~~	$144,000	~~$154,440~~	$174,000	~~$194,480~~	$204,000	March 2020
Manager Coding Quality	N		Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$95,000	~~$93,184~~	$114,000	~~$114,712~~	$133,000	March 2020
Manager Communications	N		Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$95,000	~~$93,184~~	$114,000	~~$114,712~~	$133,000	March 2020
Manager Community Relations	~~M~~	N	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$95,000	~~$81,120~~	$114,000	~~$99,840~~	$133,000	March 2020
Manager Contracting	O		Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$105,000	~~$107,328~~	$127,000	~~$131,976~~	$149,000	March 2020
Manager Creative Branding	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	March 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Manager Cultural & Linguistic	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	March 2020
Manager Customer Service	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	March 2020
~~Manager Decision Support~~	~~O~~	N/A	Job title is not in use nor is it planned for use.							March 2020
Manager Electronic Business	~~O~~	N	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$95,000	~~$107,328~~	$114,000	~~$131,976~~	$133,000	March 2020
~~Manager Employment Services~~	~~N~~	N/A	Job title is not in use nor is it planned for use.	~~$71,760~~		~~$93,184~~		~~$114,712~~		March 2020
Manager Encounters	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	March 2020
Manager Environmental Health & Safety	N		Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$95,000	~~$93,184~~	$114,000	~~$114,712~~	$133,000	March 2020
~~Manager Facilities~~	~~N~~	N/A	Job title is not in use nor is it planned for use.							March 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Manager Finance	~~N~~	O	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$105,000	~~$93,184~~	$127,000	~~$114,712~~	$149,000	March 2020
Manager Financial Analysis	~~O~~	P	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$117,000	~~$107,328~~	$141,000	~~$131,976~~	$165,000	March 2020
~~Manager Government Affairs~~	~~N~~	N/A	Job title is not in use nor is it planned for use.							March 2020
Manager Grievance & Appeals	~~N~~	O	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$105,000	~~$93,184~~	$127,000	~~$114,712~~	$149,000	March 2020
~~Manager Health Education~~	~~N~~	N/A	Job title is not in use nor is it planned for use.							March 2020
~~Manager HEDIS~~	~~O~~	N/A	Job title is not in use nor is it planned for use.							March 2020
Manager Human Resources	O		Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$105,000	~~$107,328~~	$127,000	~~$131,976~~	$149,000	March 2020
Manager Information Services	P		Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$95,264~~	$117,000	~~$128,752~~	$141,000	~~$162,032~~	$165,000	March 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
~~Manager Information Technology~~	~~P~~	N/A	Job title is not in use nor is it planned for use.							March 2020
~~Manager Integration Government Liaison~~	~~N~~	N/A	Job title is not in use nor is it planned for use.							March 2020
Manager Long Term Support Services	~~O~~	O	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$105,000	~~$107,328~~	$127,000	~~$131,976~~	$149,000	March 2020
Manager Marketing & Enrollment (PACE)	~~O~~	N	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$95,000	~~$107,328~~	$114,000	~~$131,976~~	$133,000	March 2020
~~Manager Medical Data Management~~	~~O~~	N/A	Job title is not in use nor is it planned for use.							March 2020
~~Manager Medi-Cal Program Operations~~	~~N~~	N/A	Job title is not in use nor is it planned for use.							March 2020
Manager Member Liaison Program	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	March 2020
Manager Member Outreach & Education	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	March 2020
~~Manager Member Outreach Education & Provider Relations~~	~~O~~	N/A	Job title is not in use nor is it planned for use.							March 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Manager MSSP	~~O~~	O	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$105,000	~~$107,328~~	$127,000	~~$131,976~~	$149,000	March 2020
Manager OneCare Clinical	~~O~~	P	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$117,000	~~$107,328~~	$141,000	~~$131,976~~	$165,000	March 2020
Manager OneCare Customer Service	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	March 2020
~~Manager OneCare Regulatory~~	~~N~~	N/A	Job title is not in use nor is it planned for use.							March 2020
~~Manager OneCare Sales~~	~~O~~	N/A	Job title is not in use nor is it planned for use.							March 2020
Manager Marketing & Outreach* (Proposed title)	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities. New title requested by department to better reflect position duties.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	March 2020
Manager PACE Center	~~O~~	N	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$95,000	~~$107,328~~	$114,000	~~$131,976~~	$133,000	March 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Manager Population Health Management	~~O~~	N	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$95,000	~~$107,328~~	$114,000	~~$131,976~~	$133,000	March 2020
Manager Process Excellence	~~O~~	O	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$105,000	~~$107,328~~	$127,000	~~$131,976~~	$149,000	March 2020
Manager Program Implementation	~~O~~	N	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$95,000	~~$107,328~~	$114,000	~~$131,976~~	$133,000	March 2020
~~Manager Project Management~~	~~O~~	N/A	Job title is not in use nor is it planned for use.							March 2020
Manager Provider Data Management Services	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	March 2020
Manager Provider Network	O		Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$105,000	~~$107,328~~	$127,000	~~$131,976~~	$149,000	March 2020
Manager Provider Relations	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	March 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
~~Manager Provider Services~~	~~O~~	N/A	Job title is not in use nor is it planned for use.							March 2020
Manager Purchasing	~~N~~	O	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$105,000	~~$93,184~~	$127,000	~~$114,712~~	$149,000	March 2020
Manager QI Initiatives	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	March 2020
Manager Quality Analytics	~~O~~	N	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$95,000	~~$107,328~~	$114,000	~~$131,976~~	$133,000	March 2020
Manager Quality Improvement	~~O~~	N	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$95,000	~~$107,328~~	$114,000	~~$131,976~~	$133,000	March 2020
Manager Regulatory Affairs and Compliance	O		Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$105,000	~~$107,328~~	$127,000	~~$131,976~~	$149,000	March 2020
Manager Reporting & Financial Compliance	O		Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$105,000	~~$107,328~~	$127,000	~~$131,976~~	$149,000	March 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Manager Strategic Development	~~O~~	O	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$105,000	~~$107,328~~	$127,000	~~$131,976~~	$149,000	March 2020
~~Manager Strategic Operations~~	~~N~~	N/A	Job title is not in use nor is it planned for use.							March 2020
~~Manager Systems Development~~	~~P~~	N/A	Job title is not in use nor is it planned for use.							March 2020
Manager Utilization Management	~~O~~	P	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$117,000	~~$107,328~~	$141,000	~~$131,976~~	$165,000	March 2020
Marketing and Outreach Specialist	~~J~~	F	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$40,976~~	$51,000	~~$53,352~~	$59,000	~~$65,624~~	$67,000	March 2020
Medical Assistant	~~H~~	C	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$33,696~~	$41,000	~~$42,224~~	$47,000	~~$50,648~~	$53,000	March 2020
Medical Authorization Asst	~~H~~	C	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$33,696~~	$41,000	~~$42,224~~	$47,000	~~$50,648~~	$53,000	March 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Medical Case Manager	~~N~~	L	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$77,000	~~$93,184~~	$93,000	~~$114,712~~	$109,000	March 2020
Medical Case Manager (LVN)	~~L~~	K	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$70,000	~~$70,512~~	$84,000	~~$86,736~~	$98,000	March 2020
Medical Director	~~S~~	V	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$164,736~~	$251,000	~~$222,352~~	$314,000	~~$280,072~~	$377,000	March 2020
Medical Records & Health Plan Assistant	~~G~~	B	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$30,576~~	$38,000	~~$38,272~~	$44,000	~~$45,968~~	$50,000	March 2020
Medical Records Clerk	~~E~~	B	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$25,272~~	$38,000	~~$31,720~~	$44,000	~~$37,960~~	$50,000	March 2020
Medical Services Case Manager	~~K~~	G	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$55,000	~~$61,360~~	$63,000	~~$75,504~~	$71,000	March 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Member Liaison Specialist	~~I~~	C	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$37,128~~	$41,000	~~$46,384~~	$47,000	~~$55,640~~	$53,000	March 2020
MMS Program Coordinator	~~K~~	G	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$55,000	~~$61,360~~	$63,000	~~$75,504~~	$71,000	March 2020
Nurse Practitioner (PACE)	~~P~~	O	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$95,264~~	$105,000	~~$128,752~~	$127,000	~~$162,032~~	$149,000	March 2020
Occupational Therapist	~~N~~	L	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$77,000	~~$93,184~~	$93,000	~~$114,712~~	$109,000	March 2020
Occupational Therapist Assistant	~~M~~	H	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$59,000	~~$81,120~~	$68,000	~~$99,840~~	$77,000	March 2020
Office Clerk	~~C~~	A	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$21,008~~	$36,000	~~$26,208~~	$41,000	~~$31,408~~	$46,000	March 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
OneCare Operations Manager	~~O~~	N	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$95,000	~~$107,328~~	$114,000	~~$131,976~~	$133,000	March 2020
OneCare Partner - Sales	~~K~~	F	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$51,000	~~$61,360~~	$59,000	~~$75,504~~	$67,000	March 2020
OneCare Partner - Sales (Lead)	~~K~~	G	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$55,000	~~$61,360~~	$63,000	~~$75,504~~	$71,000	March 2020
OneCare Partner - Service	~~I~~	C	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$37,128~~	$41,000	~~$46,384~~	$47,000	~~$55,640~~	$53,000	March 2020
OneCare Partner (Inside Sales)	~~J~~	E	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$40,976~~	$48,000	~~$53,352~~	$55,000	~~$65,624~~	$62,000	March 2020
Outreach Specialist	~~I~~	C	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$37,128~~	$41,000	~~$46,384~~	$47,000	~~$55,640~~	$53,000	March 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Paralegal/Legal Secretary	~~K~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$61,000	~~$61,360~~	$73,000	~~$75,504~~	$85,000	March 2020
Payroll Specialist	~~J~~	E	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$40,976~~	$48,000	~~$53,352~~	$55,000	~~$65,624~~	$62,000	March 2020
Payroll Specialist, Sr (Proposed title)	N/A	G	Department requesting new title due to growth and to establish levels.		$55,000		$63,000		$71,000	March 2020
Performance Analyst	~~L~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$61,000	~~$70,512~~	$73,000	~~$86,736~~	$85,000	March 2020
Personal Care Attendant	~~E~~	A	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$25,272~~	$36,000	~~$31,720~~	$41,000	~~$37,960~~	$46,000	March 2020
Personal Care Attendant - Lead	~~E~~	B	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$25,272~~	$38,000	~~$31,720~~	$44,000	~~$37,960~~	$50,000	March 2020
Personal Care Coordinator	~~I~~	C	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$37,128~~	$41,000	~~$46,384~~	$47,000	~~$55,640~~	$53,000	March 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Personal Care Coordinator, Sr (Proposed title)	N/A	D	Department requesting new title due to growth and to establish levels.		$44,000		$51,000		$58,000	March 2020
Pharmacy Resident	~~K~~	G	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$55,000	~~$61,360~~	$63,000	~~$75,504~~	$71,000	March 2020
Pharmacy Services Specialist	~~I~~	C	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$37,128~~	$41,000	~~$46,384~~	$47,000	~~$55,640~~	$53,000	March 2020
Pharmacy Services Specialist Int	~~J~~	D	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$40,976~~	$44,000	~~$53,352~~	$51,000	~~$65,624~~	$58,000	March 2020
Pharmacy Services Specialist Sr	~~K~~	E	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$48,000	~~$61,360~~	$55,000	~~$75,504~~	$62,000	March 2020
Physical Therapist	~~N~~	L	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$77,000	~~$93,184~~	$93,000	~~$114,712~~	$109,000	March 2020
Physical Therapist Assistant	~~M~~	H	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$59,000	~~$81,120~~	$68,000	~~$99,840~~	$77,000	March 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Policy Advisor Sr	~~O~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$85,000	~~$107,328~~	$103,000	~~$131,976~~	$121,000	March 2020
Privacy Manager	N		Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$95,000	~~$93,184~~	$114,000	~~$114,712~~	$133,000	March 2020
Privacy Officer	~~P~~	O	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$95,264~~	$105,000	~~$128,752~~	$127,000	~~$162,032~~	$149,000	March 2020
Process Excellence Manager	~~O~~	N	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$95,000	~~$107,328~~	$114,000	~~$131,976~~	$133,000	March 2020
Program Assistant	~~I~~	C	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$37,128~~	$41,000	~~$46,384~~	$47,000	~~$55,640~~	$53,000	March 2020
Program Coordinator	~~I~~	C	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$37,128~~	$41,000	~~$46,384~~	$47,000	~~$55,640~~	$53,000	March 2020
~~Program Development Analyst Sr~~	~~M~~	N/A	Job title is not in use nor is it planned for use.	~~$62,400~~		~~$81,120~~		~~$99,840~~		March 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Program Manager	~~M~~	L	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$77,000	~~$81,120~~	$93,000	~~$99,840~~	$109,000	March 2020
Program Manager Sr	~~O~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$85,000	~~$107,328~~	$103,000	~~$131,976~~	$121,000	March 2020
Program Specialist	~~J~~	E	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$40,976~~	$48,000	~~$53,352~~	$55,000	~~$65,624~~	$62,000	March 2020
Program Specialist Int	~~K~~	G	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$55,000	~~$61,360~~	$63,000	~~$75,504~~	$71,000	March 2020
Program Specialist Sr	~~L~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$61,000	~~$70,512~~	$73,000	~~$86,736~~	$85,000	March 2020
Program/Policy Analyst	~~K~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$61,000	~~$61,360~~	$73,000	~~$75,504~~	$85,000	March 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Program/Policy Analyst Sr	~~M~~	K	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$70,000	~~$81,120~~	$84,000	~~$99,840~~	$98,000	March 2020
Programmer	~~L~~	K	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$70,000	~~$70,512~~	$84,000	~~$86,736~~	$98,000	March 2020
Programmer Int	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	March 2020
Programmer Sr	~~O~~	N	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$95,000	~~$107,328~~	$114,000	~~$131,976~~	$133,000	March 2020
Project Manager	~~M~~	L	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$77,000	~~$81,120~~	$93,000	~~$99,840~~	$109,000	March 2020
Project Manager - Lead	M		Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$85,000	~~$81,120~~	$103,000	~~$99,840~~	$121,000	March 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Project Manager Sr	~~O~~	N	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$95,000	~~$107,328~~	$114,000	~~$131,976~~	$133,000	March 2020
Project Specialist	~~K~~	E	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$48,000	~~$61,360~~	$55,000	~~$75,504~~	$62,000	March 2020
Project Specialist Sr	~~L~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$61,000	~~$70,512~~	$73,000	~~$86,736~~	$85,000	March 2020
Projects Analyst	~~K~~	G	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$55,000	~~$61,360~~	$63,000	~~$75,504~~	$71,000	March 2020
Provider ~~(Enrollment)~~ Data Management Services Coordinator (Revised)	~~I~~	D	Title changed due to department name change Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$37,128~~	$44,000	~~$46,384~~	$51,000	~~$55,640~~	$58,000	March 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Provider ~~(Enrollment)~~ Data Management Services Coordinator Sr (Revised)	~~J~~	F	Title changed due to department name change. Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$40,976~~	$51,000	~~$53,352~~	$59,000	~~$65,624~~	$67,000	March 2020
Provider Enrollment Manager	~~K~~	G	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$55,000	~~$61,360~~	$63,000	~~$75,504~~	$71,000	March 2020
Provider Network Rep Sr	~~L~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$61,000	~~$70,512~~	$73,000	~~$86,736~~	$85,000	March 2020
Provider Network Specialist	~~K~~	H	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$59,000	~~$61,360~~	$68,000	~~$75,504~~	$77,000	March 2020
Provider Network Specialist Sr	~~L~~	J	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$65,000	~~$70,512~~	$78,000	~~$86,736~~	$91,000	March 2020
Provider Office Education Manager	~~L~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$61,000	~~$70,512~~	$73,000	~~$86,736~~	$85,000	March 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Provider Relations Rep	~~K~~	G	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$55,000	~~$61,360~~	$63,000	~~$75,504~~	$71,000	March 2020
Provider Relations Rep Sr	~~L~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$61,000	~~$70,512~~	$73,000	~~$86,736~~	$85,000	March 2020
Publications Coordinator	~~J~~	G	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$40,976~~	$55,000	~~$53,352~~	$63,000	~~$65,624~~	$71,000	March 2020
QA Analyst	~~L~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$61,000	~~$70,512~~	$73,000	~~$86,736~~	$85,000	March 2020
QA Analyst Sr	~~N~~	L	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$77,000	~~$93,184~~	$93,000	~~$114,712~~	$109,000	March 2020
QI Nurse Specialist	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	March 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
QI Nurse Specialist (LVN)	~~M~~	L	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$77,000	~~$81,120~~	$93,000	~~$99,840~~	$109,000	March 2020
Receptionist	~~F~~	B	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$27,872~~	$38,000	~~$34,840~~	$44,000	~~$41,808~~	$50,000	March 2020
Records Manager* (Proposed title)	N/A	P	Department requested new title due to growth of duties.		$117,000		$141,000		$165,000	March 2020
Recreational Therapist	~~L~~	H	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$59,000	~~$70,512~~	$68,000	~~$86,736~~	$77,000	March 2020
~~Recruiter~~	~~L~~	N/A	Job title is not in use nor is it planned for use.							March 2020
~~Recruiter Sr~~	~~M~~	N/A	Job title is not in use nor is it planned for use.							March 2020
Registered Dietitian	~~L~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$61,000	~~$70,512~~	$73,000	~~$86,736~~	$85,000	March 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Regulatory Affairs and Compliance Analyst	~~K~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$61,000	~~$61,360~~	$73,000	~~$75,504~~	$85,000	March 2020
Regulatory Affairs and Compliance Analyst Sr	~~L~~	K	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$70,000	~~$70,512~~	$84,000	~~$86,736~~	$98,000	March 2020
Regulatory Affairs and Compliance Lead	~~M~~	L	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$77,000	~~$81,120~~	$93,000	~~$99,840~~	$109,000	March 2020
RN (PACE)	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	March 2020
Security Analyst Int	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	March 2020
Security Analyst Sr	~~O~~	N	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$95,000	~~$107,328~~	$114,000	~~$131,976~~	$133,000	March 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Security Officer	~~F~~	B	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$27,872~~	$38,000	~~$34,840~~	$44,000	~~$41,808~~	$50,000	March 2020
SharePoint Developer/Administrator Sr	~~O~~	N	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$95,000	~~$107,328~~	$114,000	~~$131,976~~	$133,000	March 2020
Social Worker	~~K~~	J	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$65,000	~~$61,360~~	$78,000	~~$75,504~~	$91,000	March 2020
Social Worker, Sr (Proposed title)	N/A	K	Department requesting new title due to growth and to establish levels.		$70,000		$84,000		$98,000	March 2020
Special Counsel	~~R~~	T	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$137,280~~	$182,000	~~$185,328~~	$227,000	~~$233,376~~	$272,000	March 2020
~~Sr Director Regulatory Affairs and Compliance~~	~~R~~	N/A	Job title is not in use nor is it planned for use.							March 2020
Sr Manager Financial Analysis	~~P~~	Q	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$95,264~~	$130,000	~~$128,752~~	$157,000	~~$162,032~~	$184,000	March 2020
~~Sr Manager Government Affairs~~	~~O~~	N/A	Job title is not in use nor is it planned for use.							March 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
~~Sr Manager Human Resources~~	~~P~~	N/A	Job title is not in use nor is it planned for use.							March 2020
Sr Manager Information Services	Q		Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.							March 2020
~~Sr Manager Provider Network~~	~~O~~	N/A	Job title is not in use nor is it planned for use.							March 2020
Staff Attorney	P		Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$95,264~~	$117,000	~~$128,752~~	$141,000	~~$162,032~~	$165,000	March 2020
Staff Attorney, Sr. (Proposed title)	N/A	R	Department requesting new title to establish levels.		$144,000		$174,000		$204,000	March 2020
Supervisor Accounting	M		Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$85,000	~~$81,120~~	$103,000	~~$99,840~~	$121,000	March 2020
Supervisor Audit and Oversight	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	March 2020
Supervisor Behavioral Health	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	March 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Supervisor Budgeting	~~M~~	N	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$95,000	~~$81,120~~	$114,000	~~$99,840~~	$133,000	March 2020
Supervisor Case Management	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	March 2020
Supervisor Claims	~~K~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$61,000	~~$61,360~~	$73,000	~~$75,504~~	$85,000	March 2020
Supervisor Coding Initiatives	M		Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$85,000	~~$81,120~~	$103,000	~~$99,840~~	$121,000	March 2020
Supervisor Credentialing	~~L~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$61,000	~~$70,512~~	$73,000	~~$86,736~~	$85,000	March 2020
Supervisor Customer Service	~~K~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$61,000	~~$61,360~~	$73,000	~~$75,504~~	$85,000	March 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Supervisor Data Entry	~~K~~	H	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$59,000	~~$61,360~~	$68,000	~~$75,504~~	$77,000	March 2020
Supervisor Day Center (PACE)	~~K~~	H	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$59,000	~~$61,360~~	$68,000	~~$75,504~~	$77,000	March 2020
Supervisor Dietary Services (PACE)	~~M~~	J	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$65,000	~~$81,120~~	$78,000	~~$99,840~~	$91,000	March 2020
~~Supervisor Disease Management~~	~~N~~	N/A	Job title is not in use nor is it planned for use.							March 2020
Supervisor Encounters	~~L~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$61,000	~~$70,512~~	$73,000	~~$86,736~~	$85,000	March 2020
Supervisor Facilities	~~L~~	J	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$65,000	~~$70,512~~	$78,000	~~$86,736~~	$91,000	March 2020
Supervisor Finance	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	March 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Supervisor Grievance and Appeals	~~M~~	L	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$77,000	~~$81,120~~	$93,000	~~$99,840~~	$109,000	March 2020
~~Supervisor Health Education~~	~~M~~	N/A	Job title is not in use nor is it planned for use.							March 2020
Supervisor Information Services	N		Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$95,000	~~$93,184~~	$114,000	~~$114,712~~	$133,000	March 2020
Supervisor Long Term Support Services	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	March 2020
Supervisor Member Outreach and Education (Proposed title)	N/A	K	Department requesting new title to assist with supervision of staff.		$70,000		$84,000		$98,000	March 2020
Supervisor MSSP	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	March 2020
Supervisor Nursing Services (PACE)	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	March 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Supervisor OneCare Customer Service	~~K~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$61,000	~~$61,360~~	$73,000	~~$75,504~~	$85,000	March 2020
Supervisor Payroll	M		Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$85,000	~~$81,120~~	$103,000	~~$99,840~~	$121,000	March 2020
Supervisor Pharmacist	~~P~~	Q	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$95,264~~	$130,000	~~$128,752~~	$157,000	~~$162,032~~	$184,000	March 2020
Supervisor Population Health Management	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	March 2020
Supervisor ~~(Provider Enrollment)~~ Provider Data Management Services (Revised)	K		Title changed due to department name change. Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$70,000	~~$61,360~~	$84,000	~~$75,504~~	$98,000	March 2020
Supervisor Provider Relations	~~M~~	L	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$77,000	~~$81,120~~	$93,000	~~$99,840~~	$109,000	March 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Supervisor Quality Analytics	~~M~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$85,000	~~$81,120~~	$103,000	~~$99,840~~	$121,000	March 2020
Supervisor Quality Improvement	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	March 2020
Supervisor Regulatory Affairs and Compliance	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	March 2020
Supervisor Social Work (PACE)	~~L~~	J	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$65,000	~~$70,512~~	$78,000	~~$86,736~~	$91,000	March 2020
~~Supervisor Systems Development~~	~~O~~	N/A	Job title is not in use nor is it planned for use.							March 2020
Supervisor Therapy Services (PACE)	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	March 2020
Supervisor Utilization Management	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	March 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
~~Systems Manager~~	~~N~~	N/A	Job title is not in use nor is it planned for use.							March 2020
Systems Network Administrator Int	~~M~~	L	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$77,000	~~$81,120~~	$93,000	~~$99,840~~	$109,000	March 2020
Systems Network Administrator Sr	~~N~~	M	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$71,760~~	$85,000	~~$93,184~~	$103,000	~~$114,712~~	$121,000	March 2020
Systems Operations Analyst	~~J~~	F	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$40,976~~	$51,000	~~$53,352~~	$59,000	~~$65,624~~	$67,000	March 2020
Systems Operations Analyst Int	~~K~~	G	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$55,000	~~$61,360~~	$63,000	~~$75,504~~	$71,000	March 2020
Technical Analyst Int	~~L~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$61,000	~~$70,512~~	$73,000	~~$86,736~~	$85,000	March 2020
Technical Analyst Sr	~~M~~	K	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$70,000	~~$81,120~~	$84,000	~~$99,840~~	$98,000	March 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Technical Writer	~~L~~	H	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$59,000	~~$70,512~~	$68,000	~~$86,736~~	$77,000	March 2020
Technical Writer Sr	~~M~~	J	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$62,400~~	$65,000	~~$81,120~~	$78,000	~~$99,840~~	$91,000	March 2020
Therapy Aide	~~J~~	E	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$40,976~~	$48,000	~~$53,352~~	$55,000	~~$65,624~~	$62,000	March 2020
Training Administrator	~~L~~	I	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$54,288~~	$61,000	~~$70,512~~	$73,000	~~$86,736~~	$85,000	March 2020
Training Program Coordinator	~~K~~	H	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$47,112~~	$59,000	~~$61,360~~	$68,000	~~$75,504~~	$77,000	March 2020
Translation Specialist	~~G~~	B	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$30,576~~	$38,000	~~$38,272~~	$44,000	~~$45,968~~	$50,000	March 2020

Job Title	Old Pay Grade	New Pay Grade	Notes / Reason	Min		Mid		Max		Month Added/ Changed
Web Architect	~~O~~	N	Pay range adjustment based on Grant Thornton and internal evaluation of job responsibilities.	~~$82,576~~	$95,000	~~$107,328~~	$114,000	~~$131,976~~	$133,000	March 2020

- *Reflects adjustments made to the salary schedule after February 6, 2020

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 5, 2020
Regular Meeting of the CalOptima Board of Directors

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

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

Recommended Action
The Provider Advisory Committee (PAC) recommends:
1. Appointment of the following agency-selected voting liaison representative to the Provider Advisory Committee effective upon Board Approval:
    a. Andrew E. Inglis, M.D., Medical Director, Orange County Health Care Agency Representative.

Background
Since CalOptima's inception, the CalOptima Board of Directors has benefited from stakeholder involvement in the form of advisory committees. The CalOptima Board of Directors established the Provider Advisory Committee by resolution on February 14, 1995 to provide input to the Board. The PAC is comprised of fifteen voting members. Pursuant to Resolution No. 15-0806-03, PAC members serve three-year terms with the exception of the one standing seat, which is represented by the Orange County Health Care Agency. The CalOptima Board of Directors is responsible for the appointment of all PAC members.

Discussion
Pursuant to Resolution No. 15-0806-03, upon notice of the retirement of PAC Member Mary R. Hale, Orange County Health Care Agency representative, CalOptima staff contacted the Orange County Health Care Agency (OCHCA) and requested they appoint a representative to serve as a voting member on the PAC. Upon consideration of the candidate at the February 13, 2020 PAC meeting, the PAC is unanimously recommending this appointment and is forwarding the following candidate to the Board of Directors for consideration.

The recommended voting candidate is:

Orange County Health Care Agency
Andrew E. Inglis, M.D.*

Andrew E. Inglis, M.D. is a Medical Director for the Orange County Healthcare Agency in the Behavior Health Services Department. Dr. Inglis has been with the OCHCA since 2003 and has oversight of the adults/older adult services, children/youth services, substance abuse services and quality improvement services. Dr. Inglis also provides clinical care in the Collaborative Court programs and with the Inpatient Services Department. Dr. Inglis is Board Certified in Psychiatry by the American Board of Psychiatry and Neurology.

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Fiscal Impact
There is no fiscal impact.

Rationale for Recommendation
The Health Care Agency representative on the PAC is a standing seat and not subject to the recommended three-year term. The nominee has been recommended for appointment to the PAC seat by the Orange County Health Care Agency as per policy and recommended by the PAC at its February 13, 2020 meeting.

Concurrence
Provider Advisory Committee
Gary Crockett, Chief Counsel

Attachment
1. Contracted Entity Covered by this Recommended Board Action

/s/ Michael Schrader — *02/26/2020*
Authorized Signature — **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip code
Andrew E. Inglis, M.D.	1434 Sea Ridge Drive	Newport Beach	CA	92660

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 5, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

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

Contact

Ladan Khamseh, Chief Operating Officer, (714) 246-8400
Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400

Recommended Actions

1) Adopt Resolution No. 20-0305-02, reclassifying a Long-Term Services and Supports seat as an Allied Health Services seat and renaming the Traditional/Safety Net seat to Safety Net Representative on the Board of Director' Provider Advisory Committee (PAC), effective upon Board approval.
2) Authorize updates to CalOptima Policy AA.1219b: Provider Advisory Committee to reflect the recommended changes

Background

Since CalOptima's inception, the CalOptima Board of Directors has benefited from member and provider involvement in the form of advisory committees. These committees, the Member Advisory Committee (MAC) and Provider Advisory Committee (PAC), function solely in an advisory capacity providing input and recommendations concerning the CalOptima program. The Board established the MAC and the PAC by resolution on February 14, 1995.

Discussion

Consistent with the policy of CalOptima's Board of Directors to encourage maximum member and provider involvement in the CalOptima program, CalOptima's PAC would benefit from taking one of its Long Term Services and Supports (LTSS) seats and creating an additional Allied Health Services seat. The PAC would also like to rename the Traditional/Safety Net seat to Safety Net Representative. These changes do not affect the number of seats on PAC.

Fiscal Impact

There is no fiscal impact.

Rationale for Recommendation

PAC is recommending the reclassification of a LTSS seat and re-naming it an additional Allied Health Services seat. This would allow for enhanced representation of providers that fall under the many allied health categories. Currently there is a need for an additional representative to represent independent, non-hospital, not-network allied health providers. Completing this reclassification to Create an additional allied health seat will allow a broader coverage of these services that are heavily utilized by CalOptima members. Also recommended is the renaming of the Traditional/Safety Net seat to Safety Net Representative to better reflect the role of the seat in the community and on the PAC.

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Concurrence

Provider Advisory Committee Recruitment Ad Hoc
Provider Advisory Committee
Gary Crockett, Chief Counsel

Attachments

1. Resolution Number 20-0305-02
2. AA.1219b Provider Advisory Committee Policy

/s/ Michael Schrader *02/26/2020*
Authorized Signature **Date**

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RESOLUTION NO. 20-0305-02

RESOLUTION OF THE BOARD OF DIRECTORS
ORANGE COUNTY HEALTH AUTHORITY
d.b.a. CalOptima

APPROVE RECLASSIFICATION OF LONG-TERM SERVICES AND SUPPORT SEAT AND CHANGE NAME OF TRADITIONAL/SAFETY NET REPRESENTATIVES

WHEREAS, the CalOptima Board of Directors established the Provider Advisory Committee (PAC) pursuant to Resolution No. 2-14-95 to represent the constituencies served by CalOptima and to advise the Board of Directors and later amended to add a Vice Chair position pursuant to Resolution No. 16-0804-01; and

WHEREAS, the members of the PAC recommend the reclassifying of two seats on PAC to better reflect the constituencies they represent, including the changing of one of the two Long-Term Services and Supports Representatives seats to an additional Allied Health Services Representative seat to better reflect the constituencies they represent, including changing the Traditional/Safety Net seat to Safety Net Representative.

NOW, THEREFORE, BE IT RESOLVED:

That the Board of Directors hereby approves the changes in seat classifications for one of the Long-Term Services and Supports Representative seats to become an Allied Health Services Representative and the Traditional/Safety Net Representative to become Safety Net Representative effective March 5, 2020. The PAC would therefore be representing:

a. Allied Health Services (two seats)
b. Behavioral/Mental Health
c. Community Health Centers
d. Health Care Agency Representative (Standing Seat)
e. Health Networks
f. Hospitals
g. Long Term Services and Supports
h. Non-Physician Medical Practitioner
i. Nurse
j. Pharmacy
k. Physician (three seats)
l. Safety Net

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a. CalOptima, this 5th day of March 2020.

AYES:
NOES:
ABSENT:
ABSTAIN:

/s/_____
Title: Chair, Board of Directors
Printed Name and Title: Paul Yost, M.D., Chair, Board of Directors

Attest:
/s/_____
Sharon Dwiers, Clerk of the Board

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Policy ~~#~~:	AA.1219b
Title:	**Provider Advisory Committee**
Department:	~~General Administration~~Network Operations
Section:	~~Not Applicable~~Provider Relations
CEO Approval:	Michael Schrader _____
Effective Date:	07/01/2015
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

I. PURPOSE

This policy describes the composition and role of CalOptima's ~~Provider Advisory Committee~~**Provider Advisory Committee** (~~PAC~~**PAC**) and establishes a process for recruiting, evaluating, and selecting prospective candidates to CalOptima's ~~PAC~~**PAC**.

II. POLICY

A. As directed by CalOptima's Board of Directors (CalOptima Board), ~~PAC~~**PAC** shall report to the CalOptima Board and shall provide advice and recommendations to the CalOptima Board relative to CalOptima's programs.

B. CalOptima's Board encourages ~~Provider~~**Provider** involvement in the CalOptima program.

C. ~~PAC~~**PAC** ~~members~~**Members** shall recuse themselves from voting or from decisions where a conflict of interest may ~~exist, and~~exist and shall abide by CalOptima's conflict of interest code and, in accordance with CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments.

D. The composition of ~~PAC~~**PAC** shall reflect the diversity of the healthcare ~~provider~~**Provider** community. All ~~PAC~~**PAC** ~~members~~**Members** shall have direct or indirect contact with CalOptima ~~Members~~**Members**.

E. In accordance with CalOptima Board Resolution Numbers 2-14-95 (effective in February 14, 1995), 06-0707 (effective in July 7, 2006), and 15-08-06-02 (effective July 1, 2015), ~~PAC~~**PAC** shall be comprised of fifteen (15) voting ~~members~~**Members**, each seat representing a constituency that works with CalOptima and its ~~Members~~**Members**.

1. One (1) of the fifteen (15) positions is a standing seat represented by the Orange County Health Care Agency (HCA).

2. The remaining fourteen (14) ~~members~~**Members** shall serve staggered terms of three (3) years.

   a. The three (3) year term shall coincide with CalOptima's fiscal year (i.e., July 1st through June 30th).

Terms in **bold** are included in the Glossary.
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b. Effective July 1, 2015, staggered nominations shall occur at a rate of approximately one-third (1/3) of the membership each year.

i. In order to achieve the staggered rate of one-third (1/3) each year, effective upon the completion date of the current term for the remaining eleven (11) ~~PAC~~**PAC** seats. The length of a term for the Allied Health Services seat, Health Network seat and Nurse seat will extend from a two (2)-year term to a three (3)-year term.

c. ~~PAC~~**PAC** ~~members~~**Members** may serve no more than two (2) consecutive terms or the equivalent of six (6) consecutive years in the category of membership they hold.

d. ~~PAC~~**PAC** ~~members~~**Members** shall be allowed to reapply after a hiatus of one (1) year.

i. ~~PAC~~**PAC** ~~members~~**Members** may submit an application for a different category of membership without a hiatus, if they qualify for the new category for which they are applying.

ii. In the event that a vacancy occurs, in which there are no qualified applicants, ~~PAC~~**PAC** shall approach the current incumbent to serve one (1) additional term.

iii. If the incumbent chooses not to serve, a special election shall be conducted, in accordance with this policy.

3. ~~PAC~~**PAC** may include, but is not limited to, individuals representing, or that represent the interest of:

a. Allied Health Services ~~providers~~**Providers (two (2) seats)**;

b. Behavioral/Mental health ~~providers~~**Providers**;

c. Community Health Centers;

d. Health Networks;

e. Hospitals;

f. Long Term Services and Supports ~~(two (2) seats)~~;

g. Nurses;

h. Non-Physician Medical Practitioners;

i. Orange County HCA;

j. Physicians (three seats);

k. Pharmacists; or

l. ~~Traditional S~~safety N~~n~~et ~~providers~~**Providers**.

F. ~~PAC~~**PAC** shall conduct a nomination process to recruit potential candidates for the impending vacant seats, in accordance with this policy.

1. ~~PAC~~**PAC** shall conduct an annual recruitment and nomination process.

a. At the end of each fiscal year, approximately one-third (1/3) of the seat~~s'~~ terms expire on ~~PAC~~**PAC**, alternating between six (6) vacancies one (1) year ~~(1)~~ and four (4) vacancies each of the following two (2) years. Standing seat in ~~PAC~~**PAC** is not ~~impacted~~impacted by term expiration.

2. ~~PAC~~**PAC** shall conduct a recruitment and nomination process if a seat is vacated mid-term.

a. Candidates that fill a vacated set mid-term shall complete the term for that specific seat, which will be less than a full three (3) year term for ~~PAC~~**PAC**.

G. Special Elections for ~~PAC~~**PAC**

1. Special elections for ~~PAC~~**PAC** shall occur under the following circumstances:

a. When a ~~PAC~~**PAC** seat is vacant due to the resignation of a sitting ~~PAC~~**PAC** ~~member~~**Member**; or

b. The current ~~PAC~~**PAC** ~~member~~**Member** is deemed unqualified to serve in his or her current ~~ca~~**pac**~~ity~~capacity as a ~~PAC~~**PAC** ~~member~~**Member**;

2. Any new ~~member~~**Member** appointed to fill an open seat created mid-term shall serve the remainder of the resigning ~~member~~**Member's** term.

H. ~~PAC~~**PAC** Vacancies

1. If the vacancy occurs prior to the start of the nomination process, there shall be no need for a special election, and the vacant seat shall be filled during that nomination process.

2. If the vacancy occurs after the annual nomination process is complete then a special election may be conducted to fill the open seat, subject to approval by the ~~PAC~~**PAC**.

I. On an annual basis, ~~PAC~~**PAC** shall select a chair and vice-chair from its membership to coincide with the annual recruitment and nomination process. Recruitment and selection shall be conducted in accordance with Section III.C-G of this policy.

1. The ~~PAC~~**PAC** chair and vice-chair may serve one (1) two (2) year term ~~two (2) consecutive one (1) year terms~~.

2. The ~~PAC~~**PAC** chair and vice-chair may be removed by a majority vote from CalOptima's Board.

J. To establish a nomination ad hoc subcommittee, ~~PAC~~**PAC** chair shall ask for three (3) to four (4) ~~members~~**Members** to serve the ad hoc subcommittee. ~~PAC~~**PAC** ~~members~~**Members**, who are being considered for reappointment, cannot participate in their respective nomination ad hoc subcommittee.

1. Each ~~PAC~~**PAC** nomination ad hoc subcommittee shall:

    a. Review, evaluate, and select a prospective chair and vice-chair as well as a candidate for each of the open seats, in accordance with Section III. C-G of this policy; and

    b. Forward the prospective chair's and vice-chair's name and slate of candidate(s) to the full advisory committee for review and approval.

2. Following approval from the full ~~PAC~~**PAC**, the recommended chair and vice chair as well as the slate of candidate(s) shall be forwarded to CalOptima's Board for review and approval.

K. CalOptima's Board shall review and have final approval for all appointments, reappointments, and chair appointments to ~~PAC~~**PAC**.

L. ~~PAC~~**PAC** ~~members~~**Members** shall attend all regularly scheduled meetings, unless they have an excused absence. An absence shall be considered excused if a ~~PAC~~**PAC** ~~member~~**Member** provides notification of an absence to CalOptima staff prior to the ~~PAC~~**PAC** meeting. CalOptima staff shall maintain an attendance log of the ~~PAC~~**PAC** ~~members~~**Members'** attendance at ~~PAC~~**PAC** meetings. Upon request from the ~~PAC~~**PAC** chair, the Chief Executive Officer, or the CalOptima Board, CalOptima staff shall provide a copy of the attendance log to the requester. In addition, the chair of the ~~PAC~~**PAC** shall contact any committee ~~member~~**Member** who has three consecutive unexcused absences.

1. ~~PAC~~**PAC** ~~members~~**Members'** attendance shall be considered as a criterion upon reappointment.

III. PROCEDURE

A. ~~PAC~~**PAC** composition

1. The composition of ~~PAC~~**PAC** shall reflect the cultural diversity and special needs of the CalOptima population.

2. Specific agency representatives shall serve on the advisory committee as standing ~~members~~**Members**.

    a. The ~~PAC~~**PAC** shall include the Director (or his or her designee) of the HCA.

    b. HCA representative shall serve as a standing ~~member~~**Member** and shall not be subject to reapplying.

B. ~~PAC~~**PAC** meeting frequency

1. ~~PAC~~**PAC** shall meet at least quarterly.

2. ~~PAC~~**PAC** shall adopt a yearly meeting schedule at the first regularly scheduled meeting in or after January of each year.

3. Attendance by a simple majority of appointed ~~members~~**Members** shall constitute a quorum.

a. A quorum must be present for any votes to be valid and a quorum consists of half (1/2) total ~~members~~membership~~hip~~ plus one.

C. ~~PAC~~**PAC** recruitment process

1. CalOptima shall begin recruitment of potential candidates in March of each year. In the recruitment of potential candidates, the ethnic and cultural diversity and special needs of the CalOptima population shall be considered. Nominations and input from interest groups and agencies shall be given due consideration.

2. CalOptima shall recruit for potential candidates utilizing a variety of notification methods, which may include, but are not limited to, the following:

a. Outreach to the respective ~~provider~~**Provider** community;

b. Placement of vacancy notices on the CalOptima website; and

c. Advertisement of vacancies in local newspapers in ~~Threshold Language~~**Threshold Language**s.

3. Prospective candidates shall be notified at the time of recruitment regarding the deadline to submit their application to CalOptima.

4. During the ~~PAC~~**PAC** meeting held in March, the chair or vice-chair shall inquire of its membership whether there are interested candidates who wish to be considered as a chair or vice-chair for the upcoming fiscal year. An application is not required for the chair or vice-chair nomination.

D. ~~PAC~~**PAC** nomination process

1. The ~~PAC~~**PAC** chair or vice-chair shall request three (3) to four (4) ~~members~~**Members**, who are not being considered for reappointment, to serve on the nominations ad hoc subcommittee.

a. At the discretion of the ~~PAC~~**PAC** nomination ad hoc subcommittee, a subject matter expert (SME) may be included on the subcommittee to provide consultation and advisement.

2. Prior to the ~~PAC~~**PAC** nomination ad hoc subcommittee meeting:

a. Ad hoc subcommittee ~~members~~**Members** shall individually evaluate and score the application for each of the prospective candidates using the Application Evaluation Tool.

b. The ad hoc subcommittee ~~members~~**Members** shall individually evaluate and select a chair.

3. The ad hoc subcommittee shall convene to discuss and select a candidate for each of the expiring seats by using the findings from the Application Evaluation Tool, the attendance record if relevant, and the prospective candidate's letters of support.

a. At the discretion of the ad hoc subcommittee, subcommittee ~~members~~**Members** may contact a prospective candidate's references for additional information and background validation.

E. Term limits and length of term for ~~PAC~~**PAC** ~~members~~**Members**

1. Pursuant to the Board approved Resolution 15-08-06-02, effective July 1, 2015 ~~PAC~~**PAC** ~~members~~**Members** are appointed for three-year terms by the CalOptima Board of Directors with two consecutive term limits.

F. CalOptima shall conduct a special election with a truncated recruitment and nomination process to fill a ~~PAC~~**PAC** seat that has been vacated mid-term.

G. ~~PAC~~**PAC** selection and approval process for prospective chairs and candidates

1. Upon selection of a recommendation for a chair and vice-chair, as well as the slate of candidates, the ad hoc subcommittee shall forward its recommendation to the ~~PAC~~**PAC** for consideration.

2. Following consideration, the ~~PAC~~**PAC's** recommendation for a chair and slate of candidates shall be submitted to CalOptima's Board for review and final approval.

3. Following CalOptima's Board approval of ~~PAC~~**PAC's** recommendations, the new ~~PAC~~**PAC** ~~members~~**Members'** terms shall be effective July 1.

4. In the case of a selected candidate filling a seat that was vacated mid-term, the new candidate shall attend the immediately following ~~PAC~~**PAC** meeting.

5. CalOptima shall provide new ~~PAC~~**PAC** ~~members~~**Members** with a new ~~member~~**Member** orientation.

IV. ATTACHMENT(S)

A. PAC Nomination Position Descriptions
B. PAC Application Evaluation Tool (AET)
C. PAC Application

V. REFERENCE(S)

A. CalOptima Board Resolution 2-14-95
B. CalOptima Board Resolution 06-0707
C. CalOptima Board Resolution 15-08-06-02
D. CalOptima Board Resolution 16-08-04-02
~~D.~~E. CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments

VI. REGULATORY AGENCY APPROVAL(S)

Not Applicable

VII. BOARD ACTION(S)

~~08/04/16: Regular Meeting of the CalOptima Board of Directors~~
~~08/06/15: Regular Meeting of the CalOptima Board of Directors~~

~~07/07/06: Regular Meeting of the CalOptima Board of Directors~~

~~02/14/95: Regular Meeting of the CalOptima Board of Directors~~

Date	Meeting
08/04/16	Regular Meeting of the CalOptima Board of Directors
08/06/15	Regular Meeting of the CalOptima Board of Directors
07/07/06	Regular Meeting of the CalOptima Board of Directors
02/14/95	Regular Meeting of the CalOptima Board of Directors

VIII. ~~REVIEW/~~REVISION HISTORY

~~Version~~ Action	Date	~~Policy Number~~Policy	Policy Title	~~Line(s) of Business~~Program(s)
Effective	02/14/1995	AA.1219	MAC and PAC	Medi-Cal
Revised	07/07/2006	AA.1219	MAC and PAC	Medi-Cal
Revised	12/01/2011	AA.1219	MAC and PAC	Medi-Cal
Revised	12/01/2013	AA.1219	MAC and PAC	Medi-Cal
Revised	07/01/2015	AA.1219b	Provider Advisory Committee	Medi-Cal OneCare OneCare Connect PACE
Revised	08/04/2016	AA.1219b	Provider Advisory Committee	Medi-Cal OneCare OneCare Connect PACE
Revised	08/01/2017	AA.1219b	Provider Advisory Committee	Medi-Cal OneCare OneCare Connect PACE
Revised	TBD	AA.1219b	Provider Advisory Committee	Medi-Cal OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Member	An enrollee-beneficiary of a CalOptima program.
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, health maintenance organization, or other person or institution that furnishes Covered Services.
Provider Advisory Committee (PAC)	A committee comprised of Providers, representing a cross-section of the broad Provider community that serves Members, established by CalOptima to advise its Board of Directors on issues impacting the CalOptima Provider community.
Threshold Language	Those languages identified based upon State requirements and/or findings of the ~~Group~~ Population Needs Assessment (~~GNA~~PNA).

Policy:	AA.1219b
Title:	**Provider Advisory Committee**
Department:	Network Operations
Section:	Provider Relations
CEO Approval:	Michael Schrader _____
Effective Date:	07/01/2015
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE

I. PURPOSE

This policy describes the composition and role of CalOptima's **Provider Advisory Committee (PAC)** and establishes a process for recruiting, evaluating, and selecting prospective candidates to CalOptima's **PAC**.

II. POLICY

A. As directed by CalOptima's Board of Directors (CalOptima Board), **PAC** shall report to the CalOptima Board and shall provide advice and recommendations to the CalOptima Board relative to CalOptima's programs.

B. CalOptima's Board encourages **Provider** involvement in the CalOptima program.

C. **PAC Members** shall recuse themselves from voting or from decisions where a conflict of interest may exist and shall abide by CalOptima's conflict of interest code and, in accordance with CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments.

D. The composition of **PAC** shall reflect the diversity of the healthcare **Provider** community. All **PAC Members** shall have direct or indirect contact with CalOptima **Members**.

E. In accordance with CalOptima Board Resolution Numbers 2-14-95 (effective in February 14, 1995), 06-0707 (effective in July 7, 2006), and 15-0806-02 (effective July 1, 2015), **PAC** shall be comprised of fifteen (15) voting **Members**, each seat representing a constituency that works with CalOptima and its **Members**.

1. One (1) of the fifteen (15) positions is a standing seat represented by the Orange County Health Care Agency (HCA).

2. The remaining fourteen (14) **Members** shall serve staggered terms of three (3) years.

   a. The three (3) year term shall coincide with CalOptima's fiscal year (i.e., July 1st through June 30th).

   b. Effective July 1, 2015, staggered nominations shall occur at a rate of approximately one-third (1/3) of the membership each year.

Terms in **bold** are included in the Glossary.

i. In order to achieve the staggered rate of one-third (1/3) each year, effective upon the completion date of the current term for the remaining eleven (11) **PAC** seats. The length of a term for the Allied Health Services seat, Health Network seat and Nurse seat will extend from a two (2)-year term to a three (3)-year term.

c. **PAC Members** may serve no more than two (2) consecutive terms or the equivalent of six (6) consecutive years in the category of membership they hold.

d. **PAC Members** shall be allowed to reapply after a hiatus of one (1) year.

i. **PAC Members** may submit an application for a different category of membership without a hiatus, if they qualify for the new category for which they are applying.

ii. In the event that a vacancy occurs, in which there are no qualified applicants, **PAC** shall approach the current incumbent to serve one (1) additional term.

iii. If the incumbent chooses not to serve, a special election shall be conducted, in accordance with this policy.

3. **PAC** may include, but is not limited to, individuals representing, or that represent the interest of:

a. Allied Health Services **Providers (two (2) seats)**;

b. Behavioral/Mental health **Providers**;

c. Community Health Centers;

d. Health Networks;

e. Hospitals;

f. Long Term Services and Supports;

g. Nurses;

h. Non-Physician Medical Practitioners;

i. Orange County HCA;

j. Physicians (three seats);

k. Pharmacists; or

l. Safety Net **Providers**.

F. **PAC** shall conduct a nomination process to recruit potential candidates for the impending vacant seats, in accordance with this policy.

1. **PAC** shall conduct an annual recruitment and nomination process.

a. At the end of each fiscal year, approximately one-third (1/3) of the seat terms expire on **PAC**, alternating between six (6) vacancies one (1) year and four (4) vacancies each of the following two (2) years. Standing seat in **PAC** is not impacted by term expiration.

2. **PAC** shall conduct a recruitment and nomination process if a seat is vacated mid-term.

a. Candidates that fill a vacated set mid-term shall complete the term for that specific seat, which will be less than a full three (3) year term for **PAC**.

G. Special Elections for **PAC**

1. Special elections for **PAC** shall occur under the following circumstances:

a. When a **PAC** seat is vacant due to the resignation of a sitting **PAC Member**; or

b. The current **PAC Member** is deemed unqualified to serve in his or her current capacity as a **PAC Member**;

2. Any new **Member** appointed to fill an open seat created mid-term shall serve the remainder of the resigning **Member's** term.

H. **PAC** Vacancies

1. If the vacancy occurs prior to the start of the nomination process, there shall be no need for a special election, and the vacant seat shall be filled during that nomination process.

2. If the vacancy occurs after the annual nomination process is complete then a special election may be conducted to fill the open seat, subject to approval by the **PAC**.

I. On an annual basis, **PAC** shall select a chair and vice-chair from its membership to coincide with the annual recruitment and nomination process. Recruitment and selection shall be conducted in accordance with Section III.C-G of this policy.

1. The **PAC** chair and vice-chair may serve one (1) two (2) year term.

2. The **PAC** chair and vice-chair may be removed by a majority vote from CalOptima's Board.

J. To establish a nomination ad hoc subcommittee, **PAC** chair shall ask for three (3) to four (4) **Members** to serve the ad hoc subcommittee. **PAC Members**, who are being considered for reappointment, cannot participate in their respective nomination ad hoc subcommittee.

1. Each **PAC** nomination ad hoc subcommittee shall:

a. Review, evaluate, and select a prospective chair and vice-chair as well as a candidate for each of the open seats, in accordance with Section III. C-G of this policy; and

b. Forward the prospective chair's and vice-chair's name and slate of candidate(s) to the full advisory committee for review and approval.

2. Following approval from the full **PAC**, the recommended chair and vice chair as well as the slate of candidate(s) shall be forwarded to CalOptima's Board for review and approval.

K. CalOptima's Board shall review and have final approval for all appointments, reappointments, and chair appointments to **PAC**.

L. **PAC Members** shall attend all regularly scheduled meetings, unless they have an excused absence. An absence shall be considered excused if a **PAC Member** provides notification of an absence to CalOptima staff prior to the **PAC** meeting. CalOptima staff shall maintain an attendance log of the **PAC Members'** attendance at **PAC** meetings. Upon request from the **PAC** chair, the Chief Executive Officer, or the CalOptima Board, CalOptima staff shall provide a copy of the attendance log to the requester. In addition, the chair of the **PAC** shall contact any committee **Member** who has three consecutive unexcused absences.

1. **PAC Members'** attendance shall be considered as a criterion upon reappointment.

III. PROCEDURE

A. **PAC** composition

1. The composition of **PAC** shall reflect the cultural diversity and special needs of the CalOptima population.

2. Specific agency representatives shall serve on the advisory committee as standing **Members**.

a. The **PAC** shall include the Director (or his or her designee) of the HCA.

b. HCA representative shall serve as a standing **Member** and shall not be subject to reapplying.

B. **PAC** meeting frequency

1. **PAC** shall meet at least quarterly.

2. **PAC** shall adopt a yearly meeting schedule at the first regularly scheduled meeting in or after January of each year.

3. Attendance by a simple majority of appointed **Members** shall constitute a quorum.

a. A quorum must be present for any votes to be valid and a quorum consists of half (1/2) total membership plus one.

C. **PAC** recruitment process

1. CalOptima shall begin recruitment of potential candidates in March of each year. In the recruitment of potential candidates, the ethnic and cultural diversity and special needs of the CalOptima population shall be considered. Nominations and input from interest groups and agencies shall be given due consideration.

2. CalOptima shall recruit for potential candidates utilizing a variety of notification methods, which may include, but are not limited to, the following:

a. Outreach to the respective **Provider** community;

b. Placement of vacancy notices on the CalOptima website; and

c. Advertisement of vacancies in local newspapers in **Threshold Languages**.

3. Prospective candidates shall be notified at the time of recruitment regarding the deadline to submit their application to CalOptima.

4. During the **PAC** meeting held in March, the chair or vice-chair shall inquire of its membership whether there are interested candidates who wish to be considered as a chair or vice-chair for the upcoming fiscal year. An application is not required for the chair or vice-chair nomination.

D. **PAC** nomination process

1. The **PAC** chair or vice-chair shall request three (3) to four (4) **Members**, who are not being considered for reappointment, to serve on the nominations ad hoc subcommittee.

a. At the discretion of the **PAC** nomination ad hoc subcommittee, a subject matter expert (SME) may be included on the subcommittee to provide consultation and advisement.

2. Prior to the **PAC** nomination ad hoc subcommittee meeting:

a. Ad hoc subcommittee **Members** shall individually evaluate and score the application for each of the prospective candidates using the Application Evaluation Tool.

b. The ad hoc subcommittee **Members** shall individually evaluate and select a chair.

3. The ad hoc subcommittee shall convene to discuss and select a candidate for each of the expiring seats by using the findings from the Application Evaluation Tool, the attendance record if relevant, and the prospective candidate's letters of support.

a. At the discretion of the ad hoc subcommittee, subcommittee **Members** may contact a prospective candidate's references for additional information and background validation.

E. Term limits and length of term for **PAC Members**

1. Pursuant to the Board approved Resolution 15-08-06-02, effective July 1, 2015 **PAC Members** are appointed for three-year terms by the CalOptima Board of Directors with two consecutive term limits.

F. CalOptima shall conduct a special election with a truncated recruitment and nomination process to fill a **PAC** seat that has been vacated mid-term.

G. **PAC** selection and approval process for prospective chairs and candidates

1. Upon selection of a recommendation for a chair and vice-chair, as well as the slate of candidates, the ad hoc subcommittee shall forward its recommendation to the **PAC** for consideration.

2. Following consideration, the **PAC's** recommendation for a chair and slate of candidates shall be submitted to CalOptima's Board for review and final approval.

3. Following CalOptima's Board approval of **PAC's** recommendations, the new **PAC Members'** terms shall be effective July 1.

4. In the case of a selected candidate filling a seat that was vacated mid-term, the new candidate shall attend the immediately following **PAC** meeting.

5. CalOptima shall provide new **PAC Members** with a new **Member** orientation.

IV. ATTACHMENT(S)

A. PAC Nomination Position Descriptions
B. PAC Application Evaluation Tool (AET)
C. PAC Application

V. REFERENCE(S)

A. CalOptima Board Resolution 2-14-95
B. CalOptima Board Resolution 06-0707
C. CalOptima Board Resolution 15-0806-02
D. CalOptima Board Resolution 16-0804-02
E. CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments

VI. REGULATORY AGENCY APPROVAL(S)

Not Applicable

VII. BOARD ACTION(S)

Date	Meeting
08/04/16	Regular Meeting of the CalOptima Board of Directors
08/06/15	Regular Meeting of the CalOptima Board of Directors
07/07/06	Regular Meeting of the CalOptima Board of Directors
02/14/95	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	02/14/1995	AA.1219	MAC and PAC	Medi-Cal
Revised	07/07/2006	AA.1219	MAC and PAC	Medi-Cal
Revised	12/01/2011	AA.1219	MAC and PAC	Medi-Cal
Revised	12/01/2013	AA.1219	MAC and PAC	Medi-Cal
Revised	07/01/2015	AA.1219b	Provider Advisory Committee	Medi-Cal OneCare OneCare Connect PACE
Revised	08/04/2016	AA.1219b	Provider Advisory Committee	Medi-Cal OneCare OneCare Connect PACE

Action	Date	Policy	Policy Title	Program(s)
Revised	08/01/2017	AA.1219b	Provider Advisory Committee	Medi-Cal OneCare OneCare Connect PACE
Revised	TBD	AA.1219b	Provider Advisory Committee	Medi-Cal OneCare OneCare Connect PACE

1

IX. GLOSSARY

Term	Definition
Member	An enrollee-beneficiary of a CalOptima program.
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, health maintenance organization, or other person or institution that furnishes Covered Services.
Provider Advisory Committee (PAC)	A committee comprised of Providers, representing a cross-section of the broad Provider community that serves Members, established by CalOptima to advise its Board of Directors on issues impacting the CalOptima Provider community.
Threshold Language	Those languages identified based upon State requirements and/or findings of the Population Needs Assessment (PNA).

2020 PAC Position Description

Allied Health Services (two seats)

Position Description

- Current experience collaborating with, and ability to reach out, seek input and represent; independent, non-hospital, non-network allied providers, such as:
  - Ambulatory surgery centers
  - Audiology
  - Certified Acupuncturist
  - Chronic Dialysis Center
  - Dialysis providers
  - Dispensing Opticians
  - DME providers
  - Emergency Transportation
  - Exempt from Licensure Clinics
  - Family planning centers
  - Hearing Aid Dispensers
  - Home health providers
  - Home infusion providers
  - Hospice
  - Laboratory
  - Non-emergency transportation (NEMT) providers
  - Occupational therapists
  - Physical therapists
  - Podiatrists
  - Portable X-ray Lab
  - Prosthetics
  - Psychologists
  - Radiation therapy centers
  - Radiology
  - Rehabilitation Clinics
  - Respiratory Care Practice
  - Speech Therapist
  - Surgery Clinics
- When license or credential is required, applicant must have active CA license/credential as appropriate
- Preferred for applicant to belong to appropriate professional/trade association(s)
- Knowledge of managed care systems and CalOptima programs

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- Minimum three years of experience as a provider for CalOptima or representing CalOptima providers directly
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc PAC meetings
- All appointments to the committee will be appointed by the CalOptima Board and are subject to OIG/GSA verification and possible background checks

Behavioral/Mental Health Provider

Position Description

- Current experience collaborating with, and ability to reach out, seek input and represent providers such as:
  - Licensed Clinical Social Worker (LCSW)
  - Marriage and Family Therapist (MFT)
  - Mental Health Facility
  - Psychologists
  - Psychiatrist
  - Registered Psychiatric Nurse (Psych RN)
  - Multi-Specialty Clinics/Group Practice
  - Community Mental Health Center
  - Board Certified Behavior Analyst-D (BCBA-D)
- When license or credential is required, applicant must have active CA license/credential as appropriate
- Preferred for applicant to belong to appropriate professional/trade association(s)
- Knowledge of managed care systems and CalOptima programs
- Minimum three years of experience as a provider for CalOptima or representing CalOptima providers directly
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc PAC meetings
- All appointments to the committee will be appointed by the CalOptima Board and are subject to OIG/GSA verification and possible background checks

Community Health Centers

Position Description

- Current experience collaborating with, and ability to reach out, seek input and represent Orange County Community Health Centers:
  - Representing a licensed community clinic

- When license or credential is required, applicant must have active CA license/credential as appropriate
- Preferred for applicant to belong to appropriate professional/trade association(s)
- Knowledge of managed care systems and CalOptima programs
- Minimum three years of experience as a provider for CalOptima or representing CalOptima providers directly
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc PAC meetings
- All appointments to the committee will be appointed by the CalOptima Board and are subject to OIG/GSA verification and possible background checks

Health Network

Position Description

- Current experience collaborating with, and ability to reach out, seek input and represent CalOptima contracted Health Networks.
- When license or credential is required, applicant must have active CA license/credential as appropriate
- Preferred for applicant to belong to appropriate professional/trade association(s)
- Knowledge of managed care systems and~~/or~~ CalOptima programs
- Minimum three years of experience working directly for a health network
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc PAC meetings
- All appointments to the committee will be appointed by the CalOptima Board and are subject to OIG/GSA verification and possible background checks

Hospital

Position Description

- Current experience collaborating with, and ability to reach out, seek input and represent Orange County CalOptima contracted Hospitals.
- When license or credential is required, applicant must have active CA license/credential as appropriate
- Preferred for applicant to belong to appropriate professional/trade association(s)
- Knowledge of managed care systems and CalOptima programs
- Minimum three years of experience as a hospital provider for CalOptima or representing CalOptima hospital providers directly

- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc PAC meetings
- All appointments to the committee will be appointed by the CalOptima Board and are subject to OIG/GSA verification and possible background checks

Long Term Services and Supports

Position Description

- Current experience collaborating with, and ability to reach out, seek input and represent providers, such as:
  - Intermediate Care Facility – Developmentally Disabled
  - Intermediate Care Facility – Developmentally Disabled – Nursing
  - Intermediate Care Facility -Developmentally Disabled – Habilitative
  - Level B Adult Subacute
  - Level B Pediatric Subacute
  - Level B Skilled Nursing Facility
  - Nursing Facilities – Intermediate Care Facility Level A
  - Skilled Nursing Facilities
  - Skilled Nursing Facilities/Subacute Level B
  - Adult Day Health Care
- When license or credential is required, applicant must have active CA license/credential as appropriate
- Preferred for applicant to belong to appropriate professional/trade association(s)
- Knowledge of managed care systems and CalOptima programs
- Minimum three years of experience as a provider for CalOptima or representing CalOptima providers directly
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc PAC meetings
- All appointments to the committee will be appointed by the CalOptima Board and are subject to OIG/GSA verification and possible background checks

Non-Physician Medical Practitioner Representative

Position Description

- Current experience collaborating with, and ability to reach out, seek input and represent such as: nurse practitioners, nurse midwife, physician assistants, registered psychiatric nurse (Psych RN), chiropractors, dentists, optometrists, and others as appropriate
- When license or credential is required, applicant must have active CA license/credential as appropriate
- Professional Degree (e.g. DC, DDS, DNP MMS, OD) required
- Preferred for applicant to belong to appropriate professional/trade association(s)
- Knowledge of managed care systems and CalOptima programs
- Minimum three years of experience as a provider for CalOptima or representing CalOptima providers directly
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc PAC meetings
- All appointments to the committee will be appointed by the CalOptima Board and are subject to OIG/GSA verification and possible background checks

Nurse Representative

Position Description

- Current experience collaborating with, and ability to reach out, seek input and represent such as; nurses, nurse Practitioner, nurse midwife, registered nurses, registered psychiatric nurse (Psych RN), nurse anesthetist, advanced practice nurse
- When license or credential is required, applicant must have active CA license/credential as appropriate
- Preferred for applicant to belong to appropriate professional/trade association(s) and local chapters.
- Knowledge of managed care systems and CalOptima programs
- Minimum three years of experience as a provider for CalOptima or representing CalOptima providers directly
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc PAC meetings
- All appointments to the committee will be appointed by the CalOptima Board and are subject to OIG/GSA verification and possible background checks

Pharmacy Representative

Position Description

- Current experience collaborating with, and ability to reach out, seek input and represent pharmacies and pharmacy associations
- When license or credential is required, applicant must have active CA license/credential as appropriate
- Preferred for applicant to belong to appropriate professional/trade association(s)
- Knowledge of managed care systems and CalOptima programs
- Minimum three years of experience as a provider for CalOptima or representing CalOptima providers directly
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc PAC meetings
- All appointments to the committee will be appointed by the CalOptima Board and are subject to OIG/GSA verification and possible background checks

Physician Representative (three positions)

Position Description

- Seats will individually be represented by:
  - Adult Primary Care Physician
  - Pediatric Physician
  - Specialist
- Current experience collaborating with, and ability to reach out, seek input, represent and secure input from their physician constituency as well as their community-based physician professional association. When license or credential is required, applicant must have active CA license/credential as appropriate
- Have an active, unrestricted California medical license and board certification as appropriate
- Membership in appropriate medical professional association(s)
- Knowledge of managed care systems and CalOptima programs
- Minimum three years of experience as a provider for CalOptima
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Familiarity with California and federal health care delivery regulatory requirements and mandates
- Familiarity with provider quality and service requirements and risk adjustment factors

- Availability and willingness to attend regular, special and ad hoc PAC meetings and actively contribute
- All appointments to the committee will be appointed by the CalOptima Board and are subject to OIG/GSA verification and possible background checks

Safety Net

Position Description

- Current experience collaborating with, and ability to reach out, seek input and represent safety net providers
    - **Safety-Net Provider** means a provider of comprehensive primary care and/or acute hospital inpatient services that provides these services to a significant total number of Medi-Cal and charity and/or medically indigent patients in relation to the total number of patients served by the provider. Examples of safety net providers include Federally Qualified Health Centers; governmentally operated health systems; community health centers; rural and Indian Health Service facilities; disproportionate share hospitals; and public, university, rural and children's hospitals.
- When license or credential is required, applicant must have active CA license/credential as appropriate
- Preferred for applicant to belong to appropriate professional/trade association(s)
- Knowledge of managed care systems and CalOptima programs
- Minimum three years of experience as a provider for CalOptima or representing CalOptima providers directly
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc PAC meetings
- All appointments to the committee will be appointed by the CalOptima Board and are subject to OIG/GSA verification and possible background checks

Health Care Agency Representative (Standing Seat)

Position Description

- Represent the Orange County Health Care Agency
- No term limits
- All appointments to the committee will be appointed by the CalOptima Board and are subject to OIG/GSA verification and possible background checks

PAC Chair

Position Description

- Availability and willingness to attend regular and special PAC meetings
- Facilitate all PAC meetings using standard meeting rules of order
- Demonstrate leadership and openness, enabling meeting attendees to achieve preset meeting goals
- Liaison between PAC, MAC and the Board of Directors
- Provide PAC Report to CalOptima Board of Directors' monthly meetings
- Two-year term
- All appointments to the committee will be appointed by the CalOptima Board and are subject to OIG/GSA verification and possible background checks

PAC Vice-Chair

Position Description

- Availability and willingness to attend regular and special PAC meetings
- Facilitate in absence of the PAC Chair all PAC meetings using standard meeting rules of order
- Demonstrate leadership and openness, enabling meeting attendees to achieve preset meeting goals
- Liaison in absence of the PAC Chair between PAC, MAC and the Board of Directors
- Provide PAC Report to CalOptima Board of Directors' monthly meetings when PAC Chair is unavailable
- Two-year term
- All appointments to the committee will be appointed by the CalOptima Board and are subject to OIG/GSA verification and possible background checks

CalOptima
A Public Agency
Better. Together.

Applicant Name:

Provider Advisory Committee

Position Applying for:

Applicant Evaluation Tool (use one per applicant)

Please rate questions 1 through 5 based on how well the applicant satisfies the following statements where:
5 is Excellent 4 is Very good 3 is Average 2 is Fair 1 is Poor

Criteria for Nomination Consideration and Point Scale	Possible Points	Awarded Points
1. Application is complete and meets minimum qualifications.	YES_____ NO_____	_____
2. Description/explanation of applicant's interest to serve on the PAC plus reasons applicant is qualified to represent constituents and uniquely contribute to the PAC.	1–5	_____
3. List of professional/trade associations related to specific constituency	1–5	_____
4. Ability and specific plan to reach out for input and communication to applicant's constituents including primary professional/trade association(s)	1–5	_____
5. Education and/or licenses	1–3	_____
6. Experience on similar committees or ability to collaborate in a multidisciplinary way	1–3	_____
7. Knowledge/familiarity with California and federal health regulations and requirements	1–5	_____
8. Availability and willingness to attend monthly meetings and serve on subcommittees	1–5	_____
9. Supportive letters of reference (minimum two).	1–2	_____
	Total Possible Points	33
	Total Points Awarded	_____

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PROVIDER ADVISORY COMMITTEE APPLICATION
2020

Instructions: Please answer all questions. You may write or type your answers. Please use a separate sheet if necessary. If you have any questions regarding the application, please call Cheryl Simmons at 714-347-5785.

Name: _____ Work Phone: _____

Address: _____ Cell Phone: _____

City, State, ZIP: _____ Fax: _____

Email: _____ Date: _____

Please submit my application for the following Provider Advisory Committee (PAC) seats:

☐ **Allied Health Services Representative (Fulfill remaining term through 2021)**
☐ **Community Health Centers Representative**
☐ **Hospital Representative**
☐ **Physician Representative**
☐ **Traditional/Safety Net Representative**

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1. Application is complete and meets minimum qualifications. ☐ Yes ☐ No

2. Please explain why you wish to serve on CalOptima's PAC, describe why you would be a qualified representative and how you might uniquely contribute to the PAC.

_____

_____

_____

_____

_____

_____

_____

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3. List any experience with professional/trade associations within the past five years, especially those related to the constituents that you would represent on the PAC:

   Organization: _____ Dates: _____

   Offices Held: _____

   Organization: _____ Dates: _____

   Offices Held: _____

   Organization: _____ Dates: _____

   Offices Held: _____

   Organization: _____ Dates: _____

   Offices Held: _____

4. Explain your ability and specific plan to reach out for input and communicate with the constituents you would represent on the PAC, including your primary professional/trade association(s).

   _____

   _____

   _____

   _____

5. Education and/or licenses:

   _____

   _____

   _____

6. List similar committees on which you have served or describe your ability to collaborate in a multidisciplinary way.

   _____

   _____

   _____

   _____

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7. Are you familiar with California and federal health regulations and requirements? Explain:

_____

_____

_____

8. If selected, are you able to commit to a monthly PAC meeting as well as serve on at least one subcommittee? ☐ Yes ☐ No

Please explain: _____

_____

_____

9. List and attach a minimum of two letters of reference (professional, community or personal):

Name: _____
Relationship: _____
Address: _____
City, State, ZIP: _____
Phone: _____
Email: _____

Name: _____
Relationship: _____
Address: _____
City, State, ZIP: _____
Phone: _____
Email: _____

Public Records Act Notice

Under California law, this form, the information it contains, and any further information submitted with it, such as biographical summaries and résumés, are public records, with the exception of your address, email address, and telephone numbers, and the same information of any references provided. These documents may be presented to the Board of Directors for their consideration at a public meeting, at which time they will be published, with the contact information removed, as part of the Board Materials that are available on CalOptima's website, and even if not presented to the Board, will be available on request to members of the public.

_____ _____

Signature **Date**

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Submit this form, along with a biography or résumé and at least two reference letters to:

CalOptima
505 City Parkway West
Orange, CA 92868
Attn: Cheryl Simmons

Phone: **714-347-5785** Fax: **714-571-2479** Email: csimmons@caloptima.org

Application must be received by March 31, 2020 for consideration.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 5, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

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

Contact

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

Recommended Actions

1. Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to amend CalOptima's contract with Pacific Health Consulting Group (PHCG) to include additional work related to the evaluation of the CalOptima provider network delivery system; and
2. Authorize additional expenditures on this engagement of unbudgeted funds in an amount not to exceed $72,000.00 from reserves to fund the additional work covered by the proposed contract amendment.

Background/Discussion

At the September 6, 2018, Board meeting, Management presented an Information Item on the CalOptima delivery system. As a follow up to that presentation, the Board directed Management to place an action item on the agenda for the October 2018 meeting to consider issuing a Request for Proposal (RFP) to conduct a market study to analyze CalOptima's provider network strategy, and to seek input from the Member Advisory Committee (MAC) and Provider Advisory Committee (PAC) regarding the provider network delivery system.

Pursuant to the Board's direction, Management made presentations on the CalOptima delivery system at the MAC and PAC meetings, held separately on September 13, 2018. To allow for more discussion and public comments, members of the MAC, OneCare Connect (OCC) MAC and PAC held a special joint meeting on October 11, 2018. The joint committee recommended that the Board not issue an RFP for consulting services to analyze the provider network strategy.

At the November 1, 2018, meeting, the Board received the recommendations from the joint MAC, OCC MAC and PAC. The Board authorized issuing an RFP for consulting services to assist in analyzing the CalOptima provider network strategy and approve the related scope of work.

At the February 7, 2019 meeting, the Board authorized the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to enter into an agreement with PHCG for consulting services to provide data analysis and to perform a market survey related to the CalOptima provider network delivery system. The Board authorized expenditure of unbudgeted funds in an amount not to exceed $300,000 from reserves to fund the agreement and directed staff to return to the Board if additional funding is recommended to complete the engagement.

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On May 7, 2019, Contract No. 19-10240 was executed between CalOptima and PHCG to complete the work in accordance with the approved scope of work, with the work performed by PHCG and Milliman, Inc.

Scheduled Stakeholder Meetings included in Scope of Work approved by the Board on November 1, 2018 and in the updated Scope of Work approved by the Board on November 7, 2019:

Kick Off Meeting with CalOptima Staff: June 7, 2019
Gather data, Research, Review and Analysis: May 2019 – October 2019
Present at Board Meeting (National models): August 1, 2019
Present at Board Meeting (Payments Models): September 5, 2019
PAC Meeting: September 12, 2019
Meetings with interested Health Networks and Hospitals: November 2019
Present at Board (draft findings): December 5, 2019
Present at PAC (draft findings): December 12, 2019
Present at Board (Final findings): February 2020
Final meeting discussion with CalOptima Staff

Following Pacific Consulting Group's and Milliman's presentation of their findings to the Board on February 6, 2020, the Chair appointed an ad hoc committee of the Board to continue to work with the consultants to review and consider the consultants' recommendations and to return to the full Board with further recommendations . As such, staff is requesting authorization to amend PHCG's contract along with additional funding to support ad hoc meetings with the consultants over a period of six (6) months.

Fiscal Impact
The estimated additional cost of the contract amendment with PHCG is $72,000.00 and is an unbudgeted item. Management requests authority to expend an amount not to exceed $72,000.00 from reserves to fund the recommended actions.

Rationale for Recommendation
Per Board's direction, Staff contracted with PHCG to conduct delivery system review consulting services pursuant to the approved Scope of Work. With the consultant's findings and recommendations presented to the Board in February, the recommendation is that a Board ad hoc will work with the consultant and return with recommendations. The recommended actions are to authorize a contract amendment and funding to allow for meetings with a Board ad hoc on updates to CalOptima's health care delivery system.

Concurrence
Gary Crockett, Chief Counsel

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Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. Board Action dated October 4, 2018, Consider Authorizing Issuance of a Request for Proposal for Consulting Services to Assist in Analyzing the CalOptima Provider Network Strategy, Approving Related Scope of Work, and Expansion of Existing Engagement with Milliman, Inc. for Actuarial Services
3. Board Action dated November 1, 2018, Consider Authorizing Issuance of a Request for Proposal for Consulting Services to Assist in Analyzing the CalOptima Provider Network Strategy and Approving Related Scope of Work
4. Board Action dated February 7, 2019, Consider Selecting Vendor and Authorizing Contract for Consulting Services Related to Evaluation of CalOptima's Provider Delivery System
5. Board Action dated November 7, 2019, Consider Authorizing Vendor Contract Amendment and Additional Funding for Consulting Services Related to Evaluation of CalOptima's Provider Delivery System

/s/ Michael Schrader — *02/26/2020*
Authorized Signature — **Date**

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Attachment to March 5, 2020 Board of Directors Meeting – Agenda Item 21

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Pacific Health Consulting Group	72 Oak Knoll Avenue	San Anselmo	CA	94960
Milliman	1301 Fifth Avenue, Suite 3800	Seattle	WA	98101-2646

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 4, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

9. Consider Authorizing Issuance of a Request for Proposal for Consulting Services to Assist in Analyzing the CalOptima Provider Network Strategy, Approving Related Scope of Work, and Expansion of Existing Engagement with Milliman, Inc. for Actuarial Services

Contact

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

Recommended Actions

~~1. Authorize the Chief Executive Officer (CEO) to issue a Request for Proposal (RFP) for consulting services to provide data analysis and to perform a market survey related to the CalOptima provider network delivery system;~~

~~2. Approve the related attached Scope of Work (SOW); and~~

Continued to 11/1/2018 meeting

3. Authorize the expansion of existing actuarial service engagement with Milliman, Inc. to include the exploration of risk adjustment methodologies that will allow for appropriate comparisons of financial and utilization metrics across different health network types and authorize expenditure of unbudgeted funds in an amount not to exceed $35,000 from reserves for this purpose.

Background

At the September 6, 2018 Board meeting, Management presented an Information Item on the CalOptima delivery system. As a follow up to that presentation, the Board directed Management to place an action item on the agenda for the October meeting to consider issuing an RFP to conduct a market study to analyze CalOptima's provider network strategy. Staff was also directed to seek input from the Member Advisory Committee (MAC) and Provider Advisory Committee (PAC) regarding the provider network delivery system.

Discussion

In response to the Board's directive, Staff considered the information that would be most helpful to the Board in evaluating the current delivery system and making recommendations on further refinements going forward. Staff has prepared the attached document delineating the proposed research information categories. The document also makes recommendations on whether information in each particular category would be gathered and presented by Staff, by expanding the scope of current consulting services being performed by Milliman, Inc., CalOptima's currently contracted actuarial consultants, or by engaging other outside consultant(s).

Milliman, Inc. currently provides CalOptima with actuarial services related to the Medicare bid development, capitation rebasing, and Chronic Illness and Disability Payment System (CDPS) risk scoring used to adjust health network capitation. These services are highly complex and require significant experience with CalOptima's data and business practices. Additional actuarial services as identified as the responsibilities of the "Existing Consultant" in the attachment are similar to services currently being performed and would be expedited by using Milliman, Inc.

Consistent with the Board's direction, Staff presented the same delivery system Information Items the Board received at its September 6th meeting to the MAC and PAC at their September 13, 2018,

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meetings. MAC and PAC members have scheduled a special joint meeting on October 11, 2018, for further discussion on these topics.

Pursuant to CalOptima Policy GA.5002: Purchasing, Staff plans to generate an RFP for consulting services to complete data analysis and perform a market survey. Upon completion of the contracted work, the findings will provide additional information to assist the Board in evaluating the current state of CalOptima's healthcare delivery system and setting future direction.

As proposed, an evaluation team consisting of CalOptima's Executive Director of Network Operations, CEO, Chief Operating Officer, Chief Financial Officer, and Procurement Manager, will evaluate each of the proposals received. Management anticipates returning to the Board to request authority to contract with the recommended consulting services vendor as soon as the Board's December 6, 2018, meeting. Assuming the Board is in agreement with the categories and breakdown of Staff/consultant responsibilities as summarized in Attachment 1, the SOW for the RFP for consulting services would be limited to those items designated as the responsibilities of the "New Consultant" in the attachment.

Fiscal Impact

In the event the Board adopts the recommended actions authorizing the CEO to issue an RFP for consulting services to provide data analysis and perform a market survey and to approve the related SOW, the fiscal impact is unknown at this time. Upon completion of the RFP, Staff will return to the Board to request appropriate funding for the cost of the consulting services.

Should the Board adopt the recommended action to expand CalOptima's existing actuarial service engagement with Milliman, Inc. to include additional risk adjustment activities, it is an unbudgeted item. Management requests an amount not to exceed $35,000 from reserves to fund the recommended action.

Rationale for Recommendation

In response to the Board directive, Staff recommends the proposed steps, including conducting an RFP for consulting services and expanding the scope of the existing contract with Milliman, Inc. to obtain information to assist the Board in evaluating the current delivery system and setting direction going forward. Following completion of the RFP process, Staff will return to the Board with further recommendations.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Proposed Research Information Categories and Breakdown of Staff and Consultant(s) Responsibilities
2. Contracted Entity Covered by this Recommended Board Action

/s/ Michael Schrader — *9/26/2018*

Authorized Signature — **Date**

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Attachment 1: Proposed Research Information Categories and Breakdown of Staff and Consultant(s) Responsibilities

Requirement	Responsible Party			Additional Information
	CalOptima	Existing Consultant	New Consultant	
1. Explore various actuarial methodologies to risk adjust revenues and medical expenses across health network types to account for differences in population acuity and expenses.		√		This will allow for a more complete comparison of various utilization metrics and Medical Loss Ratio (MLR) calculations for Medi-Cal; without risk adjusted revenues and expenses, various comparisons are not appropriate.
2. Perform network MLR comparative analysis	√			CalOptima has data providing expense side of the calculation; need Req. 1 to risk adjust the revenue. Without risk adjusted revenue, the comparison is not appropriate.
3. Establish pre-contracting criteria for additional new health networks			√	CalOptima has pre-contracting criteria in place (from last RFP). A Consultant can be engaged to develop and propose minimum requirements that must be met prior to actual contracting.
4. Develop rationale and support for minimum/maximum membership limitation			√	Related to Req. 3, a Consultant can be engaged to provide an independent analysis and supporting rationale for minimum/maximum membership requirements.
5. Review current auto assignment criteria and model, including survey of other Southern California health plans criteria/model			√	CalOptima has methodology in place. A Consultant would be engaged to survey other plans and provide independent support for an auto assignment model and process.
6. Survey and verify payment methodologies used by health networks			√	A Consultant would be engaged to survey payment methodologies used to pay downstream providers, including primary care providers, specialists and hospitals.
7. Develop network performance evaluation tool/report card			√	CalOptima has surveyed several other Southern California health plans, and has most all of the various benchmarks, scorecards and performance criteria that can be used to develop a network performance evaluation tool/report card
8. Perform survey of other Southern California health plans to include Delegated – Direct model mix, payment models (i.e., capitation, FFS,			√	CalOptima has informally surveyed several other Southern California health plans and has a good understanding of the various network models and different

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Attachment 1: Proposed Research Information Categories and Breakdown of Staff and Consultant(s) Responsibilities

Requirement	Responsible Party			Additional Information
	CalOptima	Existing Consultant	New Consultant	
other) and other obtainable comparative metrics				payment methodologies currently in place. Additional work can be performed to provide a more complete understanding.
9. Review Member Satisfaction Survey – Provide analysis and key recommended actions that may impact the network delivery system	√		√	CalOptima can provide the analysis and recommended actions.
10. Review Provider Satisfaction Survey – Provide analysis and key recommended actions that may impact the network delivery system	√		√	CalOptima can provide the analysis and recommended actions.
11. Develop an administrative cost allocation model to allocate costs to the networks that is based on appropriate methodologies	√		√	CalOptima has an administrative cost allocation methodology in place. It is in the process of being reviewed and modified.

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CONTRACTED ENTITY COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Milliman	1301 Fifth Avenue, Suite 3800	Seattle	WA	98101-2646

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

4. Consider Authorizing Issuance of a Request for Proposal for Consulting Services to Assist in Analyzing the CalOptima Provider Network Strategy and Approving Related Scope of Work

Contact

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

Recommended Actions

1. Authorize the Chief Executive Officer (CEO) to issue a Request for Proposal (RFP) for consulting services to provide data analysis and to perform a market survey related to the CalOptima provider network delivery system; and
2. Approve the related attached Scope of Work (SOW).

Background/Discussion

At the September 6, 2018 Board meeting, Management presented an Information Item on the CalOptima delivery system. As a follow up to that presentation, the Board directed Management to place an action item on the agenda for the October meeting to consider issuing an RFP to conduct a market study to analyze CalOptima's provider network strategy. Staff was also directed to seek input from the Member Advisory Committee (MAC) and Provider Advisory Committee (PAC) regarding the provider network delivery system.

Pursuant to the Board's direction, Management made presentations on the CalOptima delivery system at the MAC and PAC meetings, held separately on September 13, 2018. Both the MAC and PAC recommended holding a special joint meeting on October 11, 2018, with members of the MAC, OneCare Connect (OCC) MAC and PAC to allow for more discussion and public comments from providers and community stakeholders on this topic.

At the October 4, 2018 meeting, the Board authorized expansion of the existing actuarial service engagement with Milliman, Inc. to include additional actuarial work and the expenditure of unbudgeted funds in an amount not to exceed $35,000 from reserves. The additional actuarial activities are identified as the responsibilities of the "Existing Consultant" in Attachment 1.

On October 11, 2018, members of the MAC, OCC MAC and PAC held a special joint meeting. After further discussion and public comments from stakeholders, the committees did not support the issuance of an RFP for consulting services to analyze the provider network strategy. The main reasons given were:

- No major issues or concerns with the current delivery system – CalOptima and its existing delivery system was recently recognized as the top rated public Medi-Cal plan for the fifth consecutive year;
- Study lacks a clear purpose;
- May not be the best time to conduct a study; concerns about limited resources with new program implementation forthcoming; and

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- CalOptima already undergoes many audits and has quality matrices in place; no additional value to expending limited resources on retaining an outside consultant.

These concerns are addressed in greater detail in a separately agendized item under Advisory Committee Updates.

In response to the Board's prior directive, Staff considered the information that would be most helpful to the Board in evaluating the current delivery system and making recommendations on further refinements going forward. Staff prepared the attached document delineating the proposed research information categories. The document also makes recommendations on whether information in each particular category would be gathered and presented by Staff, by expanding the scope of current consulting services being performed by Milliman, Inc., CalOptima's currently contracted actuarial consultants, or by engaging other outside consultant(s). As indicated, the Board took action at its October 4, 2018 meeting to authorize expanding the scope of the existing Milliman contract.

Consistent with the Board's prior direction, Staff presented the same delivery system Information Items the Board received at its September 6th meeting to the MAC and PAC at their September 13, 2018 meetings. MAC and PAC members held a special joint meeting on October 11, 2018, for further discussion on these topics.

Should the Board elect to move forward with this initiative, pursuant to CalOptima Policy GA.5002: Purchasing, Staff would generate an RFP for consulting services to complete data analysis and perform a market survey. Upon completion of the contracted work, the findings would provide additional information to assist the Board in evaluating the current state of CalOptima's healthcare delivery system and setting future direction.

As proposed, an evaluation team consisting of CalOptima's Executive Director of Network Operations, CEO, Chief Operating Officer, Chief Financial Officer, and Procurement Manager, will evaluate each of the proposals received. Management would return to the Board to request authority to contract with the recommended consulting services vendor at a future Board meeting. Assuming the Board is in agreement with the categories and breakdown of Staff/consultant responsibilities as summarized in Attachment 1, the SOW for the RFP for consulting services would be limited to those items designated as the responsibilities of the "New Consultant" in the attachment.

Fiscal Impact

In the event the Board adopts the recommended actions authorizing the CEO to issue an RFP for consulting services to provide data analysis and perform a market survey and to approve the related SOW, the fiscal impact is unknown at this time. Upon completion of the RFP, Staff will return to the Board to request appropriate funding for the cost of the consulting services.

Rationale for Recommendation

In response to the Board directive, Staff has undertaken a vetting process on conducting an RFP for consulting services to obtain information to assist the Board in evaluating the current delivery system and setting direction going forward. Should the Board authorize moving forward with this initiative, following completion of an RFP process, Staff will return to the Board with further recommendations.

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Concurrence
Gary Crockett, Chief Counsel

Attachment
Attachment 1: Proposed Research Information Categories and Breakdown of Staff and Consultant(s) Responsibilities

/s/ Michael Schrader *10/24/2018*
Authorized Signature **Date**

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Attachment 1: Proposed Research Information Categories and Breakdown of Staff and Consultant(s) Responsibilities

Requirement	Responsible Party			Additional Information
	CalOptima	Existing Consultant	New Consultant	
1. Explore various actuarial methodologies to risk adjust revenues and medical expenses across health network types to account for differences in population acuity and expenses.		√		This will allow for a more complete comparison of various utilization metrics and Medical Loss Ratio (MLR) calculations for Medi-Cal; without risk adjusted revenues and expenses, various comparisons are not appropriate.
2. Perform network MLR comparative analysis	√			CalOptima has data providing expense side of the calculation; need Req. 1 to risk adjust the revenue. Without risk adjusted revenue, the comparison is not appropriate.
3. Establish pre-contracting criteria for additional new health networks			√	CalOptima has pre-contracting criteria in place (from last RFP). A Consultant can be engaged to develop and propose minimum requirements that must be met prior to actual contracting.
4. Develop rationale and support for minimum/maximum membership limitation			√	Related to Req. 3, a Consultant can be engaged to provide an independent analysis and supporting rationale for minimum/maximum membership requirements.
5. Review current auto assignment criteria and model, including survey of other Southern California health plans criteria/model			√	CalOptima has methodology in place. A Consultant would be engaged to survey other plans and provide independent support for an auto assignment model and process.
6. Survey and verify payment methodologies used by health networks			√	A Consultant would be engaged to survey payment methodologies used to pay downstream providers, including primary care providers, specialists and hospitals.
7. Develop network performance evaluation tool/report card			√	CalOptima has surveyed several other Southern California health plans, and has most all of the various benchmarks, scorecards and performance criteria that can be used to develop a network performance evaluation tool/report card
8. Perform survey of other Southern California health plans (particularly COHS and Local Initiative plans) to include Delegated – Direct			√	CalOptima has informally surveyed several other Southern California health plans and has a good understanding of the various network models and different

Attachment 1: Proposed Research Information Categories and Breakdown of Staff and Consultant(s) Responsibilities

Requirement	Responsible Party			Additional Information
	CalOptima	Existing Consultant	New Consultant	
model mix, payment models (i.e., capitation, FFS, other) and other obtainable comparative metrics. Include a clear statement and analysis of recommended future directions, given the progression of ideas, pilots, and other successful models of integrated, managed care delivery systems throughout the country.				payment methodologies currently in place. Additional work can be performed to provide a more complete understanding, including examples of progressive network models and/or payments systems employed in the country that CalOptima may want to consider in the design of its network delivery system.
9. Review Member Satisfaction Survey – Provide analysis and key recommended actions that may impact the network delivery system	√		√	CalOptima can provide the analysis and recommended actions.
10. Review Provider Satisfaction Survey – Provide analysis and key recommended actions that may impact the network delivery system	√		√	CalOptima can provide the analysis and recommended actions.
11. Develop an administrative cost allocation model to allocate costs to the networks that is based on appropriate methodologies	√		√	CalOptima has an administrative cost allocation methodology in place. It is in the process of being reviewed and modified.
12. Consider information from the CalOptima Member Health Needs Assessment that may impact the network delivery system	√		√	Consider information included in the CalOptima Member Health Needs Assessment as it may impact the network delivery system.

Attachment to the March 5, 2020 Board of Directors Meeting -- Agenda Item 21

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

6. Consider Selecting Vendor and Authorizing Contract for Consulting Services Related to Evaluation of CalOptima's Provider Delivery System

Contact

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

Recommended Actions

1. Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to enter into an agreement with ~~Health Management Associates (HMA)~~ Pacific Health Consulting Group for consulting services to provide data analysis and to perform a market survey related to the CalOptima provider network delivery system pursuant to the attached Scope of Work (SOW); and
2. Authorize expenditure of unbudgeted funds in an amount not to exceed ~~$250,000~~ $300,000 from reserves to fund the agreement. Staff will return to the Board if additional funding is recommended to complete the engagement.

Rev. 2/7/2019

Background

At the September 6, 2018, Board meeting, Management presented an Information Item on the CalOptima delivery system. As a follow up to that presentation, the Board directed Management to place an action item on the agenda for the October meeting to consider issuing a Request for Proposal (RFP) to conduct a market study to analyze CalOptima's provider network strategy, and to seek input from the Member Advisory Committee (MAC) and Provider Advisory Committee (PAC) regarding the provider network delivery system.

Pursuant to the Board's direction, Management made presentations on the CalOptima delivery system at the MAC and PAC meetings, held separately on September 13, 2018. To allow for more discussion and public comments, members of the MAC, OneCare Connect (OCC) MAC and PAC held a special joint meeting on October 11, 2018. The joint committee recommended that the Board not issue an RFP for consulting services to analyze the provider network strategy.

At the November 1, 2018, meeting, the Board received the recommendations from the joint MAC, OCC MAC and PAC. The Board authorized issuing an RFP for consulting services to assist in analyzing the CalOptima provider network strategy and approve the related scope of work.

Discussion

Following CalOptima's standard RFP process in accordance with CalOptima Policy GA.5002: Purchasing, Staff issued an RFP and received three (3) responses from:

- Health Management Associates (HMA);
- Pacific Health Consulting Group; and
- Mazars USA LLP.

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Staff held interviews between January 16, 2019, and January 24, 2019. The responses were reviewed by an evaluation team consisting of CalOptima's Executive Director of Network Operations, CEO, Chief Operating Officer, Chief Financial Officer (CFO), and Procurement Manager.

Vendor	Final Weighted Score
HMA	23.85
Pacific Health Consulting Group	22.96
Mazars USA LLP	16.67

Based on the final weighted scores, Management recommends contracting with HMA for consulting services to complete items designated as the responsibilities of the "New Consultant" in Attachment 1.

Founded in 1985, HMA is a consulting firm with significant and relevant expertise across all domains of publicly funded health care, including delivery system restructuring and procurement, strategic planning, behavioral health, long-term services and support, and managed care policy and operations. They are widely regarded as a leader in providing strategic, technical, analytical and implementation services with a special concentration on those who address the needs of the medically indigent and underserved.

In the event CalOptima cannot reach agreeable contract terms with HMA within thirty (30) days of CalOptima providing a response to any proposed contract changes, staff recommends the Board authorize a similar process with Pacific Health Consulting Group and attempt to reach agreement on contract terms within a thirty (30) day period. If neither of these contracting efforts are successful within the respective thirty (30) day periods, staff will return to the Board with further updates and recommendations.

Upon completion of the contracted work, the findings will inform the Board on the current state of CalOptima's healthcare delivery system and provide recommendation on setting a future direction.

Fiscal Impact

The estimated cost of the contract with HMA is $250,000 and is an unbudgeted item. Management requests an amount not to exceed $250,000 from reserves to fund the recommended action.

Rationale for Recommendation

In response to the Board directive, Staff conducted an RFP for consulting services and has returned to the Board with their recommendation to contract with HMA to obtain information to assist the Board in evaluating the current delivery system and setting direction going forward.

Concurrence

Gary Crockett, Chief Counsel

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Attachments

1. Research Information Categories and Breakdown of Staff and Consultant(s) Responsibilities
2. Contracted Entities Covered by this Recommended Board Action

/s/ Michael Schrader — *1/30/2019*

Authorized Signature — **Date**

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Attachment 1: Research Information Categories and Breakdown of Staff and Consultant(s) Responsibilities

Requirement	Responsible Party			Additional Information
	CalOptima	Existing Consultant	New Consultant	
1. Explore various actuarial methodologies to risk adjust revenues and medical expenses across health network types to account for differences in population acuity and expenses.		√		This will allow for a more complete comparison of various utilization metrics and Medical Loss Ratio (MLR) calculations for Medi-Cal; without risk adjusted revenues and expenses, various comparisons are not appropriate.
2. Perform network MLR comparative analysis	√			CalOptima has data providing expense side of the calculation; need Req. 1 to risk adjust the revenue. Without risk adjusted revenue, the comparison is not appropriate.
3. Establish pre-contracting criteria for additional new health networks			√	CalOptima has pre-contracting criteria in place (from last RFP). A Consultant can be engaged to develop and propose minimum requirements that must be met prior to actual contracting.
4. Develop rationale and support for minimum/maximum membership limitation			√	Related to Req. 3, a Consultant can be engaged to provide an independent analysis and supporting rationale for minimum/maximum membership requirements.
5. Review current auto assignment criteria and model, including survey of other Southern California health plans criteria/model			√	CalOptima has methodology in place. A Consultant would be engaged to survey other plans and provide independent support for an auto assignment model and process.
6. Survey and verify payment methodologies used by health networks			√	A Consultant would be engaged to survey payment methodologies used to pay downstream providers, including primary care providers, specialists and hospitals.
7. Develop network performance evaluation tool/report card			√	CalOptima has surveyed several other Southern California health plans, and has most all of the various benchmarks, scorecards and performance criteria that can be used to develop a network performance evaluation tool/report card
8. Perform survey of other Southern California health plans (particularly COHS and Local Initiative plans) to include Delegated – Direct			√	CalOptima has informally surveyed several other Southern California health plans and has a good understanding of the various network models and different

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Attachment 1: Research Information Categories and Breakdown of Staff and Consultant(s) Responsibilities

Requirement	Responsible Party			Additional Information
	CalOptima	Existing Consultant	New Consultant	
model mix, payment models (i.e., capitation, FFS, other) and other obtainable comparative metrics. Include a clear statement and analysis of recommended future directions, given the progression of ideas, pilots, and other successful models of integrated, managed care delivery systems throughout the country.				payment methodologies currently in place. Additional work can be performed to provide a more complete understanding, including examples of progressive network models and/or payments systems employed in the country that CalOptima may want to consider in the design of its network delivery system.
9. Review Member Satisfaction Survey – Provide analysis and key recommended actions that may impact the network delivery system	√		√	CalOptima can provide the analysis and recommended actions.
10. Review Provider Satisfaction Survey – Provide analysis and key recommended actions that may impact the network delivery system	√		√	CalOptima can provide the analysis and recommended actions.
11. Develop an administrative cost allocation model to allocate costs to the networks that is based on appropriate methodologies	√		√	CalOptima has an administrative cost allocation methodology in place. It is in the process of being reviewed and modified.
12. Consider information from the CalOptima Member Health Needs Assessment that may impact the network delivery system	√		√	Consider information included in the CalOptima Member Health Needs Assessment as it may impact the network delivery system.

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Health Management Associates	950 South Coast Drive Suite 280	Costa Mesa	CA	92626
Pacific Health Consulting Group	72 Oak Knoll Avenue	San Anselmo	CA	94960
Mazars USA LLP	1875 Century Park E. Suite 1130	Los Angeles	CA	90067

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 7, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

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

Contact

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

Recommended Actions

1. Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to amend CalOptima's contract with Pacific Health Consulting Group (PHCG) to include additional work related to the evaluation of the CalOptima provider network delivery system; and
2. Authorize additional expenditures on this engagement of unbudgeted funds in an amount not to exceed $35,000 from reserves to fund the additional work covered by the proposed contract amendment.

Background/Discussion

At the September 6, 2018, Board meeting, Management presented an Information Item on the CalOptima delivery system. As a follow up to that presentation, the Board directed Management to place an action item on the agenda for the October 2018 meeting to consider issuing a Request for Proposal (RFP) to conduct a market study to analyze CalOptima's provider network strategy, and to seek input from the Member Advisory Committee (MAC) and Provider Advisory Committee (PAC) regarding the provider network delivery system.

Pursuant to the Board's direction, Management made presentations on the CalOptima delivery system at the MAC and PAC meetings, held separately on September 13, 2018. To allow for more discussion and public comments, members of the MAC, OneCare Connect (OCC) MAC and PAC held a special joint meeting on October 11, 2018. The joint committee recommended that the Board not issue an RFP for consulting services to analyze the provider network strategy.

At the November 1, 2018, meeting, the Board received the recommendations from the joint MAC, OCC MAC and PAC. The Board authorized issuing an RFP for consulting services to assist in analyzing the CalOptima provider network strategy and approve the related scope of work.

At the February 7, 2019 meeting, the Board authorized the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to enter into an agreement with PHCG for consulting services to provide data analysis and to perform a market survey related to the CalOptima provider network delivery system. The Board authorized expenditure of unbudgeted funds in an amount not to exceed $300,000 from reserves to fund the agreement and directed staff to return to the Board if additional funding is recommended to complete the engagement.

On May 7, 2019, Contract No. 19-10240 was executed between CalOptima and PHCG to complete the work in accordance with the approved scope of work.

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Scheduled Stakeholder Meetings included in Scope of Work approved by Board (November 1, 2018):

Kick Off Meeting with CalOptima Staff: June 7, 2019
Gather data, Research, Review and Analysis: May 2019 – October 2019
Present at Board Meeting (National models): August 1, 2019
Present at Board Meeting (Payments Models): September 5, 2019
PAC Meeting: September 12, 2019
Present Final findings to the Board (originally scheduled for November 2019): February 2020
Final meeting discussion with CalOptima Staff

While completing the course of the contracted work, it was identified that the analysis should include more input from health networks, hospitals, providers, and advisory committees to gain a more thorough understanding of CalOptima's network delivery system. As such staff is requesting approval of additional funding to allow for additional meetings with providers and presentations at CalOptima Board and advisory committee meetings.

Proposed Additional Meetings:
Meetings with interested Health Networks and Hospitals: November 2019
Present draft findings to the Board: December 5, 2019
Present draft findings to PAC: December 12, 2019

Fiscal Impact
The estimated additional cost of the contract amendment with PHCG is $35,000 and is an unbudgeted item. Management requests an amount not to exceed $35,000 from reserves to fund the recommended action.

Rationale for Recommendation
In response to the Board approval, Staff contracted with PHCG to conduct services pursuant to the approved Scope of Work and has returned to the Board with their recommendation to authorize additional funding to complete the engagement.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Board Action dated October 4, 2018, Consider Authorizing Issuance of a Request for Proposal for Consulting Services to Assist in Analyzing the CalOptima Provider Network Strategy, Approving Related Scope of Work, and Expansion of Existing Engagement with Milliman, Inc. for Actuarial Services
2. Board Action dated November 1, 2018, Consider Authorizing Issuance of a Request for Proposal for Consulting Services to Assist in Analyzing the CalOptima Provider Network Strategy and Approving Related Scope of Work
3. Board Action dated February 7, 2019, Consider Selecting Vendor and Authorizing Contract for Consulting Services Related to Evaluation of CalOptima's Provider Delivery System

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4. Contracted Entities Covered by this Recommended Board Action

/s/ Michael Schrader *10/30/2019*
Authorized Signature **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 5, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

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

Contact

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

Recommended Actions

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

Background

CalOptima has a long history of participating in community events, health and resource fairs, town halls, workshops, and other public activities in furtherance of the organization's statutory purpose. Consistent with these activities, CalOptima has offered financial participation in public activities from time to time when such participation is in the public good, in furtherance of CalOptima's mission and statutory purpose, and encourages broader participation in CalOptima's programs and services, or promotes health and wellness among the populations CalOptima serves. As a result, CalOptima has developed and cultivated a strong reputation in Orange County with community partners, providers and key stakeholders.

Requests for participation are considered based on several factors, including: the number of people the activity/event will reach; the marketing benefits accrued to CalOptima; the strength of the partnership or level of involvement with the requesting entity; past participation; staff availability; and available budget.

Discussion

The recommended events will provide CalOptima with opportunities to conduct outreach and education to current and potential members, increase access to health care services, meet the needs of our community, and develop and strengthen partnerships.

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a. **Access California Services' 3rd Annual Peace of Mind: A Family and Wellness Event.** Staff recommends the authorization of expenditures for participation in Access California Services' Family Wellness Event. This is an educational event with a focus on mental health to address behavioral health challenges, stigma, cultural barriers, acculturation, and access to health/mental health services. CalOptima will have an opportunity to highlight behavioral health services available to our members. This event also provides an opportunity for CalOptima to interact with our members who speak the threshold languages of Arabic and Farsi and other attendees about our behavioral health services. A $2,000 financial commitment for Access California Services' 3rd Annual Peace of Mind Family Wellness Event includes: Opportunity for CalOptima leadership to share information about CalOptima's behavioral health services, CalOptima's name and logo on all marketing materials, one (1) resource booth and verbal recognition on the day of the event. Employee time will be used to participate in this event. Employees will have an opportunity to interact with current and potential members who speak Arabic and Farsi and share information about CalOptima's programs and services.

b. **Arts Orange County's 8th Annual Dia del Nino Festival.** Staff recommends the authorization of expenditures for participation in the Arts Orange County's Annual Dia del Nino Festival. This is an educational event and resource fair with 30 interactive arts workshops and performances by professional guest artists and community artists to celebrate the richness and cultural heritage of Orange County's Latino community. This event attracts over 10,000 attendees and provides CalOptima an opportunity to share information about our programs and services with our Latino membership, which comprises approximately 45% of our total membership. Employee time will be used to participate in this event. A $2,000 financial commitment for the Arts Orange County's 8th Annual Dia del Nino Festival includes: One (1) resource booth, CalOptima's name and logo on event promotional materials and social media and invitation for CalOptima leadership to be recognized at the event.

c. **Kid Healthy's 9th Annual Cooking Up Change Greater Orange County Event.** Staff recommends the authorization of expenditures for participation in Kid Healthy's Cooking Up Change Greater Orange County Event. This event is a collaboration with school districts throughout Orange County to empower students to create and advocate for healthy school meals. Students from low-income schools are provided a platform to transform the school lunch menu using cost guidelines and high nutrition standards and to develop their leadership skills. Twelve high school teams from the cities of Anaheim, Santa Ana, Fullerton, Buena Park, Garden Grove, La Habra and Whittier compete in this event. This event provides CalOptima an opportunity to share information about our programs and services with our members. A $2,500 financial commitment for Kid Healthy's 9th Annual Cooking Up Change Greater Orange County Event includes: One (1) resource booth, CalOptima's name and logo on event signage, social media and video, complimentary event tickets for six, and invitation for VIP reception for two. Employee time will be used to participate in this event. Employees will have an opportunity to interact with current and potential members to share information about CalOptima's programs and services. This event also provides CalOptima an opportunity to strengthen our relationship with the school districts serving our members.

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CalOptima staff has reviewed the request and it meets the requirements for participation as established in CalOptima Policy AA. 1223: Participation in Community Events Involving External Entities, including the following:

1. The number of people the activity/event will reach;
2. The marketing benefits accrued to CalOptima;
3. The strength of the partnership or level of involvement with the requesting entity;
4. Past participation;
5. Staff availability; and
6. Available budget.

CalOptima's involvement in community events is coordinated by the Community Relations Department. The Community Relations Department will take the lead to coordinate staff schedules, resources, and appropriate materials for the event.

As part of its consideration of the recommended actions, approval of this item would be based on the Board making a finding that the proposed activities and expenditures are in the public interest and in furtherance of CalOptima's statutory purpose.

Fiscal Impact
Funding for the recommended action of up to $6,500 is included as part of the Community Events budget under the CalOptima Fiscal Year 2019-20 Operating Budget approved by the CalOptima Board of Directors on June 6, 2019.

Rationale for Recommendation
Staff recommends approval of the recommended actions in order to support community activities that offer opportunities that are in alignment with CalOptima's mission, encourages broader participation in CalOptima's programs and services, promotes health and wellness, and/or develops and strengthens partnerships in support of CalOptima's programs and services.

Concurrence
Gary Crockett, Chief Counsel

Attachment
1. Entities Covered by this Recommended Board Action
2. Access California Peace of Mind Sponsorship Package
3. Arts Orange County Dia del Nino Festival Sponsorship Package
4. Kid Healthy Cooking Up Change Sponsorship Package

/s/ Michael Schrader *02/26/2020*
Authorized Signature **ate**

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Attachment 1 to the March 5, 2020 Board of Directors Meeting – Agenda Item 22

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip code
Access California Services	631 S. Brookhurst St., Suite 107	Anaheim	CA	92804
Arts Orange County	17620 Fitch Ave., Suite 255	Irvine	CA	92614
Kid Healthy	1725 S. Douglass Rd.	Anaheim	CA	92806

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ACCESS CALIFORNIA SERVICES

Serving all underserved communities since 1998

3RD ANNUAL PEACE OF MIND

Family Wellness Event

SAVE THE DATE
SUNDAY, APRIL 5, 2020

Topics will address the needs of Youth, Children & Families

SPONSORS

OC health CARE AGENCY

EachMind MATTERS
California's Mental Health Movement

SISTERS OF ST. JOSEPH HEALTHCARE FOUNDATION

COMMUNITY BENEFIT hoag MEMORIAL HOSPITAL PRESBYTERIAN

How to prevent practicing unhealthy behaviors when facing life challenges? **Youth**

Have you witnessed or gone through a traumatic event that's preventing you from living a happy life? **Family**

How can you positively prepare children with special needs and their families for success? **Children**

CHAIR MARWA AZAB, PH.D.

Register Today At No Cost!

RSVP to:
sara@accesscal.org

Location:
Delhi Center
505 E. Central Ave.
Santa Ana, CA 92707

ENDORSEMENTS

Islamic Shura Council OF SOUTHERN CALIFORNIA · MPAC · MEC · Back to Agenda · Multicultural Media for Development · Islamic Center Of Irvine · IIOC Islamic Institute of Orange County · OCIE · SOC · CAIR CALIFORNIA Council on American-Islamic Relations · SHAR MEDICAL CENTER

Funded by: OC Health Care Agency (OCHCA), Behavioral Health Services, Prevention & Intervention, Mental Health Services Act/Prop. 63

Arts Orange County's Día del Niño 2020

BRIEF DESCRIPTION OF PROJECT:

"Día del Niño," a free admission two-day festival, April 18-19, 2020, features daily 30 interactive arts workshops and performances by professional guest artists and community artists. It celebrates the artistic richness and cultural heritage of Orange County's multi-faceted Latino community through engaging arts experiences, connects residents to local arts organizations, provides them with access to new artistic disciplines, and fosters creativity and exploration among children and families of all backgrounds and heritages. Expected attendance: 10,000.

REQUEST AMOUNT: $10,000

TOTAL PROJECT BUDGET: $95,000

PRIMARY POPULATION: FAMILIES

NUMBER OF PEOPLE SERVED: 10,000

ORGANIZATION'S MISSION & VISION:

Arts Orange County's mission is to be the leader in building appreciation of, participation in, and support for the arts and arts education in Orange County, California. It aspires to play a key role in advancing the success of Orange County's creative community through excellence in its programs and services, advocacy

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Fern Street Circus at the 2018 and 2019 Dia del Ninos will again conduct workshops at the 2020 event.

efforts that result in increased private and public investment in arts and culture, community cultural planning, the expansion of art in public places, the full restoration of standards -based arts instruction in the public schools, equitable access to arts experiences countywide, and a thriving business community that embraces creativity and innovation. Governed by a diverse Board of Directors comprised of artists, leaders of arts organizations, the County Superintendent of Schools, leaders in higher education and business, and arts patrons, ArtsOC serves over 600 arts & culture organizations countywide. ArtsOC offers high quality core programs and services typical of local arts agencies that are supplemented with consulting services that are quite unusual for an organization of its type and serve an important local need.

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This painting workshop was popular at the 2018 and 2019 Dia del Ninos and is being offered again at this year's event.

WHAT RESULTS/IMPACT HAS YOUR ORGANIZATION ACHIEVED IN THE PAST THREE YEARS TOWARD MISSION?

ArtsOC has played a leading role in advocacy efforts at the local, state, and national level that have resulted in significant gains in the restoration of public funding for arts & culture that was decimated during the recession. This has brought tens of thousands of dollars in new and increased funding for arts organizations and for public schools in Orange County. With greater focus upon creative placemaking as a tool to help invigorate city life, ArtsOC has played a leading role in the installation of art in public places in Santa Ana, Costa Mesa, and Newport Beach as consultants and managers on contract with local government and nonprofit organizations. Additionally, ArtsOC has been at the forefront of programmatic innovation through being selected for pilot programs utilizing the arts for therapeutic purposes (our VOICES: Veterans Storytelling

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Crowds of all ages loved the performances by Relampago del Cielo at the 2018 and 2019 Dia del Nino.

Project), re-entry for offenders (Arts in OC Jail Project), and providing entry-level arts experiences for the underserved, as evidenced in the "Dia del Nino" Festival for which we are seeking Pacific Life Foundation support.

WHAT CHALLENGES HAS YOUR ORG FACED OVER PAST 3 YEARS AND HOW HAVE YOU MET THEM?

Nonprofit local arts agencies, like Arts Orange County, are at a competitive disadvantage in attracting support within the philanthropic marketplace--largely because the work they do is behind the scenes and in support of other arts organizations that have the natural attraction of constituencies through producing and presenting work. Additionally, a countywide organization like ours attempting to serve 34 cities, with their own identities and indigenous arts communities, has its work cut out for it to be effective. Probably the most effective tool in addressing these particular challenges has been ArtsOC's growing role as a cultural planner on contract with local municipalities. The planning process has created a by-product of building image and awareness of ArtsOC's mission and brand. Cultural planning work for Irvine, Mission Viejo, Newport

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Dance of the Jaguar performing at the 2019 Dia del Nino will return for 2020.

Beach and Costa Mesa has raised ArtsOC's profile considerably and connected it to new sources of support. Additional cities learn of ArtsOC's planning services directly or through their colleagues, and the demand shows signs of continuing to grow.

WHAT IS THE CHALLENGE OR OPPORTUNITY THIS PROJECT ADDRESSES?

The Latino community constitutes more than one-third of Orange County's overall population, there is limited representation of Latino arts and culture in the offerings of established organizations countywide, and a community "Dia del Nino" festival offered by another community arts organization was discontinued after a one-time presentation.

These led ArtsOC in 2012 to initiate its "Dia del Nino" festival, which will enter its ninth year in 2020. It was important to us from the beginning that the festival be authentic, be curated and presented in partnership with a local Latino community arts organization, that the event would go well beyond offering simply a passive

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Emily, a well-known Tejano singer will bring her sensational voice and smile to the 2020 Dia del Nino.

experience to attendees, and that each person who attends is directly engaged to participate and explore their own creativity in a variety of ways.

ANTICIPATED IMPACT OF PROJECT

"Dia del Nino" is designed to inspire lifelong learning and participation in the arts among 10,000 children and adults, to broaden the community's understanding of Latin-American arts & culture, to showcase talented student and amateur artists, to provide employment to outstanding professional teaching artists and world-class performing artists, and to introduce families to important local arts organizations, classes and agencies available throughout the county to continue their cultural exploration, enjoyment and artistic development.

KEY ELEMENTS OF THE PROJECT

To achieve the stated results, we will collaborate with a respected Latino community arts organization (Media Arts Santa Ana) together with which we will employ a curatorial approach that embraces presenting major national and regional Latin-American performers, including Grammy Award-winning recording

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Claudia de la Cruz is a nationally-known flamenco artist who will perform and teach at the festival.

artists, and the best local community artists and student talent from schools throughout Orange County.

All festival communications will be bilingual (English and Spanish) and the festival location will be fully accessible to those with disabilities. We will promote the event widely through the OC Department of Education, OC Public Libraries, shops and restaurants in Latino neighborhoods, a schedule of PSAs on KOCE-TV, the Los Angeles/Orange County flagship PBS station, and our media partner La Ranchera 96.7 FM, a popular Spanish-language Southern California radio station that reaches 420,000 listeners.

Throughout the days of the festival, there will be continuous performances on stage by such performing artists as the Latin Grammy Award-winning “kindie” band Lucky Diaz and the Family Jam Band (Día del Niño 2018), Grammy Award-nominated all-string Latin-American ensemble Trio Ellas (Día del Niño 2016-19), Latin Grammy nominee Ciro Hurtado, original and traditional Andean guitar music (Día del Niño 2014), Mariachi Divas, multiple Grammy Award-winning all-female mariachi band (Día del Niño 2016), Relámpago del Cielo Grupo Folklorico, a 40

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Student performers are part of the offerings at Dia del Nino.

year old professional traditional Mexican performing arts organization (Día del Niño 2012, 2018, 2019), Pacific Symphony String Quartet from Orange County's major orchestra (Día del Niño 2017), Moona Luna (Día del Niño 2018), Tejano singer Emily (Día del Niño 2018-19), Claudia de la Cruz Flamenco Dancers (Día del Niño 2018-19), and Fern Street Circus (Día del Niño 2018-19), among others.

Between performances, bi-lingual (English and Spanish) emcees will offer standup comedy, recite poetry, promote participating organizations and recognize the sponsors of the event—in 2018, Dyana Ortelli, the voice of Tia Victoria in the Academy Award winning Disney/Pixar film "Coco," emceed.

Ongoing workshops will offer instruction in a wide range of arts and crafts, including include flamenco, modern and hip-hop dance, clay flute making, papier-maché, drumming, beading, sketchbook making, poetry, video, theatre, painting, mosaics, puppetry, drum making, and circle painting.

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Workshops are offered in a wide variety of crafts: clay, fiber, and book-making are popular.

SUSTAINABILITY OF PROJECT

ArtsOC measures the event's success through the use of a face-to-face exit survey conducted in English and Spanish in order to determine if the festival experience would prompt attendees to pursue additional hands-on arts engagement throughout the year. ArtsOC will encourage featured local "Dia del Nino" festival workshop artists and performing artists to utilize their appearance in the festival as an opportunity to showcase their work to attendees as a means of encouraging continued participation--whether through ongoing classes they offer in the community or through private instruction. Exhibiting organizations at the festival also provide information about instructional programs they offer as well as opportunities for practitioners to hone their skills. Social media is used to continue the engagement and conversation with participants, leading up to the announcement of the following year's festival.

With respect to sustainable funding for "Dia del Nino," the festival has received seven consecutive years of funding from the National Endowment for the Arts

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Dia del Nino is a participatory experience for ALL ages!

and five consecutive years of funding from the Wells Fargo Foundation to support this program. While those are not guaranteed multi-year grants, our track record of success with those sources makes future grants more likely. Those grants are not alone sufficient to cover all of the costs, so additional funding from other sources is necessary and varies from year to year. But ArtsOC has thus far been successful in securing sufficient funds each year to sustain what has come to be regarded widely in the community as a worthwhile annual program.

CURRENT FUNDING FOR THE PROJECT:

National Endowment for the Arts - $25,000
California Arts Council - $15,000
The Crean Foundation - $15,000
The Lyons Share Foundation - $10,000
Pacific Life Foundation - $10,000
Wells Fargo Foundation - $5,000
OC Fair & Event Center - $5,000

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Cooking *up* Change®

NATIONAL

Join the Movement: Students Transforming the Future of School Food
Be a Lunch Hero: sponsor Cooking up Change® 2020 at the level indicated below (check one)

☐ **Super Hero: $20,000 or above:**

- Company Logo on ALL event print materials
- Recognition in social media campaign weekly
- Complimentary event tickets for 20
- Invitation for 10 to VIP Reception
- Company logo and hot link on event website
- Company representative to welcome attendees
- Company representative to present student awards
- Company representative interviewed in event video
- Company logo on chef jackets
- Company logo on photo booth backdrop
- Company logo in Cooking up Change® Cookbook
- Company representative on Judging panel

☐ **Power Partner: $15,000 or above:**

- Company logo on event print materials
- Company logo on event signage & video
- Recognition in social media campaign
- Complimentary event tickets for 15
- Invitation to VIP Reception for 8
- Company logo and hot link on event website
- Company representative to assist with awards presentation
- Company logo on photo booth backdrop
- Company logo in Cooking up Change® Cookbook
- Company representative on Judging panel

☐ **Awesome Ally: $10,000 or above**

- Company logo on event print materials
- Company logo on signage, social media campaign & video
- Complimentary event tickets for 10
- Invitation to VIP Reception for 6
- Company logo on website, photo booth props
- Company logo in Cooking up Change® Cookbook
- Company representative on Judging panel

☐ **Super Side-Kick: $5,000 or above:**

- Company Logo on event print materials
- Recognition on event signage
- Recognition in social media & video
- Complimentary event tickets for 8
- Invitation to VIP Reception for 4

☐ **Marvelous Mate: $2,500 or above:**

- Complimentary event tickets for 6
- Invitation to VIP Reception for 2
- Recognition in social media & video
- Recognition in event signage

☐ **Amazing Associate: $1,000 or above:**

- Recognition in event signage
- Complimentary event tickets for 4
- Recognition in social media & video

☐ **Sensational Supporter: $300 or above:**
(non- profits & individuals only)

- Complimentary event tickets for 2
- Recognition in event signage

☐ **Friendly Force:**
Please accept my donation of $_____

Thank you for your support of Kid Healthy, please return this form:

Mail to:
Kid Healthy c/o OneOC
1901 E. Fourth Street, Suite 100 Santa Ana, CA 92705
linda@mykidhealthy.org

For Further information Contact:
Linda Luna-Franks, Exec. Dir.
949.874.7701
linda@mykidhealthy.org

kid HEALTHY

Charge my (circle one): Visa MasterCard American Express Check (Enclosed)

Amount $_____(Please make checks payable to Kid Healthy)

Name on Card:_____CardNo._____

Signature:_____Expiration Date:_____SecurityCode:_____

Company/Name:_____

Address:_____

Contact:_____Phone: _____Email:_____

Kid Healthy is a fiscally sponsored project of OneOC, a 501C3 not for profit Organization. All gifts are tax deductible as allowed by law.

Tax ID# 95-2021700

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Board of Directors Meeting
March 5, 2020

Provider Advisory Committee (PAC) Update

February 13, 2020 PAC Meeting

At the February 13, 2020 meeting, the PAC members approved the recommendation to forward to the Board, Andrew Inglis, M.D., Medical Director, Behavioral Health Services at the Orange County Health Care Agency (OCHCA) for appointment as the OCHCA Representative on PAC.

Michael Schrader, Chief Executive Officer, provided update on how CalOptima's Program of All-Inclusive Care to the Elderly (PACE) has been recognized for successfully increasing access to services by the National PACE Association. CalOptima's PACE also achieved a "Supernova" distinction and a "Shooting Stars" distinction for growing more that 90% in the fourth quarter of 2019.

Ladan Khamseh, Chief Operating Officer, updated the members on the Qualified Medicare Beneficiary (QMB) Program outreach to members.

Emily Fonda, M.D., Deputy Chief Medical Officer, updated PAC members on the current Coronavirus outbreak and how the risk to the public in the Orange County area was considered low even though there was one confirmed case in the county. Dr. Fonda also updated PAC members on childhood lead levels and the appropriate testing for children. She noted that 10,000 children were diagnosed with elevated lead levels in 2019 which was higher than previous years. She also discussed the proposed pharmacy carve out and the CalAIM name change.

Betsy Ha, Executive Director, Quality and Population Health Management provided an in-depth and relevant presentation on Trauma-Informed Care and Adverse Childhood Screening (ACE) that elicited much conversation among the PAC members. PAC asked that Ms. Ha keep them informed of any changes to this program.

PAC also received a Health Homes Program update, Behavioral Health Update, Intergovernmental Transfer (IGT) 9 update and a Medi-Cal Healthier California for All update.

PAC members received information on the upcoming PAC recruitment which runs from March 1 – March 31, 2020.

Once again, the PAC appreciates and thanks the CalOptima Board for the opportunity to present input and updates on the PAC's current activities.

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A Public Agency

CalOptima

Better. Together.

Financial Summary

January 2020

Board of Directors Meeting
March 5, 2020

Nancy Huang
Chief Financial Officer

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FY 2019-20: Consolidated Enrollment

January 2020 MTD

Overall enrollment was 705,556 members

- Actual lower than budget 37,033 or 5.0%
  - Medi-Cal unfavorable to budget 37,079 or 5.1% due to member eligibility logic update for prior periods and annual Medi-Cal status redetermination
    - Medi-Cal Expansion (MCE) unfavorable variance of 31,714
    - Whole Child Model (WCM) unfavorable variance of 2,559
    - Seniors and Persons with Disabilities (SPD) unfavorable variance of 1,666
    - Temporary Assistance for Needy Families (TANF) unfavorable variance of 1,485
    - Long-Term Care (LTC) favorable variance of 345
  - OneCare Connect favorable to budget 129 or 0.9%
  - OneCare unfavorable to budget 91 or 6.0%
  - PACE favorable to budget 8 or 2.1%
- 32,978 decrease or 4.5% from December
    - Medi-Cal decrease of 32,771
    - OneCare Connect decrease of 160
    - OneCare decrease of 48
    - PACE increase of 1

FY 2019-20: Consolidated Enrollment (cont.)

January 2020 YTD

Overall enrollment was 5,189,094 member months

- Actual lower than budget 44,677 or 0.9%
  - Medi-Cal unfavorable to budget 45,175 or 0.9%
    - MCE unfavorable variance of 43,349
    - WCM unfavorable variance of 9,463
    - SPD favorable variance of 7,271
    - TANF unfavorable variance 121
    - LTC favorable variance of 486
  - OneCare Connect favorable to budget 392 or 0.4%
  - OneCare favorable to budget 80 or 0.8%
  - PACE favorable to budget 26 or 1.0%

FY 2019-20: Consolidated Revenues

January 2020 MTD

- Actual higher than budget $6.8 million or 2.3%
  - ➢ Medi-Cal favorable to budget $5.8 million or 2.2%
    - Unfavorable volume variance of $13.7 million
    - Favorable price variance of $19.5 million
      - $34.0 million of Coordinated Care Initiative (CCI) revenue, including $7.4 million from prior year due to updated rate and member mix
      - $3.0 million of fiscal year (FY) 2020 Department of Health Care Services (DHCS) acuity rate adjustment
      - Offset by $14.2 million of FY 2020 revenue due to retroactive enrollment adjustments
      - $3.3 million from WCM revenue
  - ➢ OneCare Connect favorable to budget $0.5 million or 2.1%
    - Favorable volume variance of $0.2 million
    - Favorable price variance of $0.3 million

FY 2019-20: Consolidated Revenues (cont.)

January 2020 MTD (cont.)

- OneCare favorable to budget $62.3 thousand or 3.7%
  - Unfavorable volume variance of $101.5 thousand
  - Favorable price variance of $163.8 thousand
- PACE favorable to budget $385.7 thousand or 12.9%
  - Favorable volume variance of $62.1 thousand
  - Favorable price variance of $323.6 thousand

FY 2019-20: Consolidated Revenues (cont.)

January 2020 YTD

- Actual higher than budget $143.6 million or 6.9%
  - ➢ Medi-Cal favorable to budget $136.3 million or 7.2%
    - Unfavorable volume variance of $16.6 million
    - Favorable price variance of $152.9 million
      - $104.3 million of directed payment (DP) revenue
      - $48.6 million of CCI revenue due to updated rate and member mix
      - $21.0 million due to DHCS acuity rate adjustment
      - $8.6 million of Behavioral Health Treatment (BHT) revenue
      - Offset by $22.8 million of WCM revenue
  - ➢ OneCare Connect favorable to budget $5.6 million or 3.3%
    - Favorable volume variance of $0.7 million
    - Favorable price variance of $4.9 million

FY 2019-20: Consolidated Revenues (cont.)

January 2020 YTD (cont.)

- OneCare favorable to budget $1.0 million or 8.9%
  - Favorable volume variance of $87.0 thousand
  - Favorable price variance of $925.3 thousand
- PACE favorable to budget $760.4 thousand or 3.9%
  - Favorable volume variance of $202.0 thousand
  - Favorable price variance of $558.4 thousand

FY 2019-20: Consolidated Medical Expenses

January 2020 MTD

- Actual lower than budget $4.4 million or 1.5%
  - ➢ Medi-Cal favorable variance of $3.5 million or 1.4%
    - Favorable volume variance of $13.2 million
    - Unfavorable price variance of $9.7 million
      - Facilities Claims unfavorable variance of $5.5 million due to WCM
      - Professional Claims unfavorable variance of $4.2 million due to crossover claims
  - ➢ OneCare Connect favorable variance of $0.5 million or 2.2%
    - Unfavorable volume variance of $0.2 million
    - Favorable price variance of $0.8 million

FY 2019-20: Consolidated Medical Expenses (cont.)

January 2020 YTD

- Actual higher than budget $152.2 million or 7.7%
  - ➢ Medi-Cal unfavorable variance of $150.1 million or 8.4%
    - Favorable volume variance of $15.8 million
    - Unfavorable price variance of $165.9 million
      - Reinsurance and Other Expense category unfavorable variance of $94.5 million due to $104.0 million of DP, offset by favorable variance in homeless health initiative
      - Facilities Claims unfavorable variance of $34.6 million
      - Professional Claims unfavorable variance of $23.5 million
      - MLTSS unfavorable variance of $16.5 million
  - ➢ OneCare Connect unfavorable variance of $3.3 million or 2.0%
    - Unfavorable volume variance of $0.7 million
    - Unfavorable price variance of $2.7 million

Medical Loss Ratio (MLR)

- January 2020 MTD: Actual: 92.6% Budget: 96.1%
- January 2020 YTD: Actual: 96.0% Budget: 95.3%

FY 2019-20: Consolidated Administrative Expenses

January 2020 MTD

- Actual lower than budget $1.2 million or 9.5%
  - Salaries, wages and benefits: favorable variance of $0.4 million
  - Other categories: favorable variance of $0.8 million

January 2020 YTD

- Actual lower than budget $12.2 million or 13.4%
  - Salaries, wages and benefits: favorable variance of $5.3 million
  - Other categories: favorable variance of $6.9 million

Administrative Loss Ratio (ALR)

- January 2020 MTD: Actual: 3.9% Budget: 4.4%
- January 2020 YTD: Actual: 3.5% Budget: 4.4%
  - Actual ALR (excluding DP revenue) is 3.7% YTD

FY 2019-20: Change in Net Assets

January 2020 MTD

- $13.8 million change in net assets
- $14.1 million favorable to budget
  - Higher than budgeted revenue of $6.8 million
  - Lower than budgeted medical expenses of $4.4 million
  - Lower than budgeted administrative expenses of $1.2 million
  - Higher than budgeted investment and other income of $1.7 million

January 2020 YTD

- $30.5 million change in net assets
- $15.3 million favorable to budget
  - Higher than budgeted revenue of $143.6 million
  - Higher than budgeted medical expenses of $152.2 million
  - Lower than budgeted administrative expenses of $12.2 million
  - Higher than budgeted investment and other income of $11.7 million

Enrollment Summary: January 2020

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	% Variance
68,160	65,978	2,182	3.3%	Aged	460,359	459,080	1,279	0.3%
519	615	(96)	(15.6%)	BCCTP	3,786	4,305	(519)	(12.1%)
39,905	43,657	(3,752)	(8.6%)	Disabled	312,840	306,329	6,511	2.1%
283,967	279,339	4,628	1.7%	TANF Child	1,982,930	1,984,198	(1,268)	(0.1%)
79,105	85,218	(6,113)	(7.2%)	TANF Adult	607,745	606,598	1,147	0.2%
3,749	3,404	345	10.1%	LTC	24,314	23,828	486	2.0%
203,855	235,569	(31,714)	(13.5%)	MCE	1,603,791	1,647,140	(43,349)	(2.6%)
10,381	12,940	(2,559)	(19.8%)	WCM	81,117	90,580	(9,463)	(10.4%)
689,641	**726,720**	**(37,079)**	**(5.1%)**	**Medi-Cal Total**	**5,076,883**	**5,122,058**	**(45,175)**	**(0.9%)**
14,104	**13,975**	**129**	**0.9%**	**OneCare Connect**	**99,059**	**98,667**	**392**	**0.4%**
1,417	**1,508**	**(91)**	**(6.0%)**	**OneCare**	**10,586**	**10,506**	**80**	**0.8%**
394	**386**	**8**	**2.1%**	**PACE**	**2,566**	**2,540**	**26**	**1.0%**
705,556	**742,589**	**(37,033)**	**(5.0%)**	**CalOptima Total**	**5,189,094**	**5,233,771**	**(44,677)**	**(0.9%)**

Financial Highlights: January 2020

Month-to-Date					Year-to-Date			
Actual	Budget	$ Budget	% Budget		Actual	Budget	$ Budget	% Budget
705,556	742,589	(37,033)	-5.0%	Member Months	5,189,094	5,233,771	(44,677)	-0.9%
304,391,865	297,586,136	6,805,729	2.3%	Revenues	2,224,316,657	2,080,692,509	143,624,149	6.9%
281,747,570	286,103,733	4,356,164	1.5%	Medical Expenses	2,135,672,806	1,983,467,625	(152,205,181)	-7.7%
11,767,943	13,005,601	1,237,658	9.5%	Administrative Expenses	78,554,221	90,754,048	12,199,827	13.4%
10,876,352	**(1,523,198)**	**12,399,550**	**814.0%**	**Operating Margin**	**10,089,630**	**6,470,835**	**3,618,794**	**55.9%**
2,913,553	1,250,000	1,663,553	133.1%	Non Operating Income (Loss)	20,453,665	8,750,000	11,703,665	133.8%
13,789,905	**(273,198)**	**14,063,104**	**5147.6%**	**Change in Net Assets**	**30,543,295**	**15,220,835**	**15,322,459**	**100.7%**
92.6%	96.1%	3.6%		Medical Loss Ratio	96.0%	95.3%	-0.7%	
3.9%	4.4%	0.5%		Administrative Loss Ratio	3.5%	4.4%	0.8%	
3.6%	-0.5%	4.1%		Operating Margin Ratio	0.5%	0.3%	0.1%	
100.0%	100.0%			Total Operating	100.0%	100.0%		
3.9%	4.4%	0.5%		Adminstrative Loss Ratio (excluding Directed Payments)*	3.7%	4.4%	0.7%	

*CalOptima updated the category of Directed Payments per Department of Healthcare Services instructions

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Consolidated Performance Actual vs. Budget: January 2020 (in millions)

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
9.9	(0.4)	10.3	Medi-Cal	12.5	16.0	(3.4)
0.1	(1.2)	1.3	OCC	(5.7)	(9.7)	4.0
0.1	(0.1)	0.2	OneCare	0.9	(0.9)	1.8
0.8	0.2	0.6	PACE	2.3	1.1	1.2
10.9	**(1.5)**	**12.4**	**Operating**	**10.1**	**6.5**	**3.6**
2.9	1.3	1.7	Inv./Rental Inc, MCO tax	20.5	8.8	11.7
2.9	**1.3**	**1.7**	**Non-Operating**	**20.5**	**8.8**	**11.7**
13.8	**(0.3)**	**14.1**	**TOTAL**	**30.5**	**15.2**	**15.3**

Consolidated Revenue & Expense: January 2020 MTD

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	475,405	203,855	10,381	689,641	14,104	1,417	394	705,556
REVENUES								
Capitation Revenue	158,941,224	$ 93,503,047	$ 21,955,116	$ 274,399,387	$ 24,868,299	$ 1,744,019	$ 3,380,159	$ 304,391,865
Other Income	-	-	-	-	-	-	-	-
Total Operating Revenue	158,941,224	93,503,047	21,955,116	274,399,387	24,868,299	1,744,019	3,380,159	304,391,865
MEDICAL EXPENSES								
Provider Capitation	38,007,462	41,391,788	9,616,861	89,016,111	10,895,496	507,987		100,419,595
Facilities	24,070,873	20,948,950	6,966,264	51,986,087	3,845,465	462,495	485,994	56,780,040
Professional Claims	17,995,909	6,791,196	1,787,600	26,574,705	939,199	41,642	522,645	28,078,192
Prescription Drugs	15,553,331	22,146,407	4,461,857	42,161,595	4,922,135	453,583	223,537	47,760,850
MLTSS	33,799,625	2,456,772	1,718,125	37,974,522	1,252,567	22,417	48,005	39,297,511
Medical Management	2,221,986	1,377,940	290,332	3,890,257	1,045,901	38,088	801,011	5,775,258
Quality Incentives	805,914	442,410	140,499	1,388,823	193,130		36,112	1,618,065
Reinsurance & Other	803,003	731,389	33,837	1,568,228	147,215		302,615	2,018,059
Total Medical Expenses	133,258,102	96,286,852	25,015,375	254,560,329	23,241,109	1,526,212	2,419,920	281,747,570
Medical Loss Ratio	83.8%	103.0%	113.9%	92.8%	93.5%	87.5%	71.6%	92.6%
GROSS MARGIN	**25,683,122**	**(2,783,805)**	**(3,060,259)**	**19,839,059**	**1,627,190**	**217,808**	**960,239**	**22,644,295**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				6,831,008	775,258	84,657	152,797	7,843,720
Professional fees				175,576	3,999	15,000	123	194,699
Purchased services				992,535	88,380	9,191	7,004	1,097,111
Printing & Postage				481,103	42,592	(33,127)	4	490,572
Depreciation & Amortization				292,394			2,057	294,451
Other expenses				1,439,499	56,916	547	5,263	1,502,225
Indirect cost allocation & Occupancy				(245,870)	548,726	38,274	4,036	345,165
Total Administrative Expenses				9,966,246	1,515,871	114,542	171,285	11,767,943
Admin Loss Ratio				3.6%	6.1%	6.6%	5.1%	3.9%
INCOME (LOSS) FROM OPERATIONS				9,872,813	111,319	103,266	788,955	10,876,352
INVESTMENT INCOME								5,324,825
TOTAL MCO TAX				(2,414,427)				(2,414,427)
TOTAL GRANT INCOME				3,036				3,036
OTHER INCOME				120				120
CHANGE IN NET ASSETS				**$ 7,461,541**	**$ 111,319**	**$ 103,266**	**$ 788,955**	**$ 13,789,905**
BUDGETED CHANGE IN NET ASSETS				(438,243)	(1,172,131)	(95,546)	182,722	(273,198)
VARIANCE TO BUDGET - FAV (UNFAV)				$ 7,899,785	$ 1,283,450	$ 198,812	$ 606,233	$ 14,063,104

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Consolidated Revenue & Expense: January 2020 YTD

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	3,391,974	1,603,791	81,117	5,076,882	99,059	10,586	2,566	5,189,093
REVENUES								
Capitation Revenue	1,085,954,507	$ 771,664,253	$ 161,356,933	$ 2,018,975,693	$ 172,403,309	$ 12,438,610	$ 20,499,046	$ 2,224,316,657
Other Income	-	-	-	-	-	-	-	-
Total Operating Revenue	1,085,954,507	771,664,253	161,356,933	2,018,975,693	172,403,309	12,438,610	20,499,046	2,224,316,657
MEDICAL EXPENSES								
Provider Capitation	272,493,099	311,703,880	69,678,291	653,875,270	77,371,385	3,354,544		734,601,198
Facilities	178,289,643	150,969,453	41,257,980	370,517,076	26,523,206	2,837,102	4,564,505	404,441,889
Professional Claims	125,721,130	49,116,100	9,459,613	184,296,842	5,053,001	310,407	3,820,650	193,480,900
Prescription Drugs	115,740,374	151,478,362	38,220,084	305,438,820	38,753,737	3,636,254	1,602,529	349,431,340
MLTSS	242,916,261	18,626,273	13,127,953	274,670,486	9,530,204	74,580	258,801	284,534,070
Medical Management	14,948,728	8,643,833	1,852,901	25,445,462	7,258,481	273,673	5,017,301	37,994,917
Quality Incentives	5,844,607	3,256,050	989,309	10,089,967	1,420,825		186,647	11,697,438
Reinsurance & Other	66,935,612	49,552,142	245,345	116,733,099	1,274,008		1,483,946	119,491,053
Total Medical Expenses	1,022,889,453	743,346,093	174,831,475	1,941,067,021	167,184,847	10,486,560	16,934,379	2,135,672,806
Medical Loss Ratio	94.2%	96.3%	108.4%	96.1%	97.0%	84.3%	82.6%	96.0%
GROSS MARGIN	**63,065,054**	**28,318,160**	**(13,474,542)**	**77,908,672**	**5,218,462**	**1,952,050**	**3,564,667**	**88,643,851**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				45,234,121	5,003,467	452,392	983,319	51,673,299
Professional fees				1,401,543	452,485	144,371	1,259	1,999,658
Purchased services				5,469,359	1,063,732	101,551	57,635	6,692,276
Printing & Postage				2,241,434	362,074	28,305	61,274	2,693,087
Depreciation & Amortization				2,450,272			14,599	2,464,871
Other expenses				10,265,983	163,903	1,974	28,103	10,459,964
Indirect cost allocation & Occupancy				(1,698,009)	3,899,834	281,191	88,050	2,571,066
Total Administrative Expenses				65,364,703	10,945,496	1,009,784	1,234,239	78,554,221
Admin Loss Ratio				3.2%	6.3%	8.1%	6.0%	3.5%
INCOME (LOSS) FROM OPERATIONS				12,543,969	(5,727,034)	942,266	2,330,428	10,089,630
INVESTMENT INCOME								22,867,659
TOTAL MCO TAX				(2,414,427)				(2,414,427)
TOTAL GRANT INCOME				(61)				(61)
OTHER INCOME				494				494
CHANGE IN NET ASSETS				**$ 10,129,976**	**$ (5,727,034)**	**$ 942,266**	**$ 2,330,428**	**$ 30,543,295**
BUDGETED CHANGE IN NET ASSETS				15,951,292	(9,723,876)	(854,800)	1,098,219	15,220,835
VARIANCE TO BUDGET - FAV (UNFAV)				$ (5,821,317)	$ 3,996,842	$ 1,797,066	$ 1,232,209	$ 15,322,459

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Balance Sheet:
As of January 2020

ASSETS		LIABILITIES & NET POSITION	
Current Assets		**Current Liabilities**	
Operating Cash	$520,760,769	Accounts Payable	$104,149,243
Investments	419,874,256	Medical Claims liability	748,671,289
Capitation receivable	407,851,922	Accrued Payroll Liabilities	12,364,162
Receivables - Other	33,438,568	Deferred Revenue	53,848,472
Prepaid expenses	8,401,246	Deferred Lease Obligations	-
		Capitation and Withholds	137,183,259
Total Current Assets	**1,390,326,761**	**Total Current Liabilities**	**1,056,216,426**
Capital Assets			
Furniture & Equipment	37,086,365		
Building/Leasehold Improvements	10,941,286		
505 City Parkway West	50,489,717		
	98,517,368		
Less: accumulated depreciation	(50,452,197)		
Capital assets, net	48,065,171	Other (than pensions) post employment benefits liability	25,577,893
Other Assets		Net Pension Liabilities	23,479,025
Restricted Deposit & Other	300,000	Bldg 505 Development Rights	-
Homeless Health Reserve	58,198,913		
Board-designated assets:		**TOTAL LIABILITIES**	**1,105,273,344**
Cash and Cash Equivalents	8,932,273		
Long-term Investments	561,852,777	**Deferred Inflows**	
Total Board-designated Assets	570,785,050	Excess Earnings	156,330
		Change in Assumptions	4,747,505
Total Other Assets	629,283,963	OPEB Changes in Assumptions	2,503,000
		Net Position	
TOTAL ASSETS	**2,067,675,894**	TNE	96,221,054
		Funds in Excess of TNE	869,865,110
Deferred Outflows		**TOTAL NET POSITION**	966,086,164
Contributions	686,962		
Difference in Experience	3,419,328		
Excess Earning	-		
Changes in Assumptions	6,428,159		
Pension Contributions	556,000		
TOTAL ASSETS & DEFERRED OUTFLOWS	**2,078,766,343**	**TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION**	**2,078,766,343**

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Board Designated Reserve and TNE Analysis
As of January 2020

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	156,396,836				
	Tier 1 - Logan Circle	155,186,728				
	Tier 1 - Wells Capital	155,655,503				
Board-designated Reserve		467,239,067	319,722,581	497,984,139	147,516,486	(30,745,072)
TNE Requirement	Tier 2 - Logan Circle	103,545,983	96,221,054	96,221,054	7,324,929	7,324,929
	Consolidated:	**570,785,050**	**415,943,635**	**594,205,193**	**154,841,415**	**(23,420,143)**
	Current reserve level	*1.92*	*1.40*	*2.00*		

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UNAUDITED FINANCIAL STATEMENTS

January 2020

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CalOptima - Consolidated
Financial Highlights
For the Seven Months Ended January 31, 2020

2,020 Month-to-Date Actual	Budget	$ Budget	% Budget		ACT 2,020 Year-to-Date Actual	Budget	$ Budget	% Budget
705,556	742,589	(37,033)	-5.0%	Member Months	5,189,094	5,233,771	(44,677)	-0.9%
304,391,865	297,586,136	6,805,729	2.3%	Revenues	2,224,316,657	2,080,692,509	143,624,149	6.9%
281,747,570	286,103,733	4,356,164	1.5%	Medical Expenses	2,135,672,806	1,983,467,625	(152,205,181)	-7.7%
11,767,943	13,005,601	1,237,658	9.5%	Administrative Expenses	78,554,221	90,754,048	12,199,827	13.4%
10,876,352	**(1,523,198)**	**12,399,550**	**814.0%**	**Operating Margin**	**10,089,630**	**6,470,835**	**3,618,794**	**55.9%**
2,913,553	1,250,000	1,663,553	133.1%	Non Operating Income (Loss)	20,453,665	8,750,000	11,703,665	133.8%
13,789,905	**(273,198)**	**14,063,104**	**5147.6%**	**Change in Net Assets**	**30,543,295**	**15,220,835**	**15,322,459**	**100.7%**
92.6%	96.1%	3.6%		Medical Loss Ratio	96.0%	95.3%	-0.7%	
3.9%	4.4%	0.5%		Administrative Loss Ratio	3.5%	4.4%	0.8%	
3.6%	-0.5%	4.1%		Operating Margin Ratio	0.5%	0.3%	0.1%	
100.0%	100.0%			Total Operating	100.0%	100.0%		
3.9%	4.4%	0.5%		Adminstrative Loss Ratio (excluding Directed Payments)*	3.7%	4.4%	0.7%	

*CalOptima updated the category of Directed Payments per Department of Healthcare Services instructions

CalOptima
Financial Dashboard
For the Seven Months Ended January 31, 2020

MONTH - TO - DATE

Enrollment

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	689,641	726,720	(37,079)	(5.1%)
OneCare Connect	14,104	13,975	129	0.9%
OneCare	1,417	1,508	(91)	(6.0%)
PACE	394	386	8	2.1%
Total	705,556	742,589	(37,033)	(5.0%)

Change in Net Assets (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 7,462	$ (438)	$ 7,900	1803.7%
OneCare Connect	111	(1,172)	1,283	109.5%
OneCare	103	(96)	199	207.3%
PACE	789	183	606	331.1%
505 Bldg.	-	-	-	0.0%
Investment Income & Other	5,325	1,250	4,075	326.0%
Total	$ 13,790	$ (273)	$ 14,063	5151.3%

MLR

	Actual	Budget	% Point Var
Medi-Cal	92.8%	96.1%	3.3
OneCare Connect	93.5%	97.6%	4.2
OneCare	87.5%	96.9%	9.4

Administrative Cost (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 9,966	$ 10,921	$ 954	8.7%
OneCare Connect	1,516	1,753	238	13.5%
OneCare	115	148	33	22.4%
PACE	171	184	13	6.9%
Total	$ 11,768	$ 13,006	$ 1,238	9.5%

Total FTE's Month

	Actual	Budget	Fav / (Unfav)
Medi-Cal	902	1,183	281
OneCare Connect	165	211	46
OneCare	10	9	(0)
PACE	67	93	25
Total	1,143	1,496	352

MM per FTE

	Actual	Budget	Fav / (Unfav)
Medi-Cal	765	614	150
OneCare Connect	86	66	19
OneCare	147	162	(15)
PACE	6	4	2
Total	1,003	847	156

YEAR - TO - DATE

Year To Date Enrollment

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	5,076,883	5,122,058	(45,175)	(0.9%)
OneCare Connect	99,059	98,667	392	0.4%
OneCare	10,586	10,506	80	0.8%
PACE	2,566	2,540	26	1.0%
Total	5,189,094	5,233,771	(44,677)	(0.9%)

Change in Net Assets (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 10,130	$ 15,951	$ (5,821)	(36.5%)
OneCare Connect	(5,727)	(9,724)	3,997	41.1%
OneCare	942	(855)	1,797	210.2%
PACE	2,330	1,098	1,232	112.2%
505 Bldg.	-	-	-	0.0%
Investment Income & Other	22,868	8,750	14,118	161.3%
Total	$ 30,543	$ 15,220	$ 15,323	100.7%

MLR

	Actual	Budget	% Point Var
Medi-Cal	96.1%	95.1%	(1.0)
OneCare Connect	97.0%	98.2%	1.2
OneCare	84.3%	98.5%	14.2

Administrative Cost (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 65,365	$ 75,734	$ 10,369	13.7%
OneCare Connect	10,945	12,711	1,766	13.9%
OneCare	1,010	1,030	20	2.0%
PACE	1,234	1,279	45	3.5%
Total	$ 78,554	$ 90,754	$ 12,200	13.4%

Total FTE's YTD

	Actual	Budget	Fav / (Unfav)
Medi-Cal	6,626	8,131	1,505
OneCare Connect	1,234	1,429	195
OneCare	59	65	6
PACE	494	644	149
Total	8,413	10,269	1,855

MM per FTE

	Actual	Budget	Fav / (Unfav)
Medi-Cal	766	630	136
OneCare Connect	80	69	11
OneCare	179	161	17
PACE	5	4	1
Total	1,030	864	166

CalOptima - Consolidated
Statement of Revenues and Expenses
For the One Month Ended January 31, 2020

	Actual		Budget		Variance	
	$	PMPM	$	PMPM	$	PMPM
MEMBER MONTHS	705,556		742,589		(37,033)	
REVENUE						
Medi-Cal	$ 274,399,387	$ 397.89	$ 268,552,864	$ 369.54	$ 5,846,523	$ 28.35
OneCare Connect	24,868,299	1,763.21	24,357,095	1,742.90	511,204	20.31
OneCare	1,744,019	1,230.78	1,681,686	1,115.18	62,333	115.60
PACE	3,380,159	8,579.08	2,994,491	7,757.75	385,668	821.33
Total Operating Revenue	304,391,865	431.42	297,586,136	400.74	6,805,729	30.68
MEDICAL EXPENSES						
Medi-Cal	254,560,329	369.12	258,070,538	355.12	3,510,210	(14.00)
OneCare Connect	23,241,109	1,647.84	23,775,850	1,701.31	534,741	53.47
OneCare	1,526,212	1,077.07	1,629,545	1,080.60	103,333	3.53
PACE	2,419,920	6,141.93	2,627,800	6,807.77	207,880	665.84
Total Medical Expenses	281,747,570	399.33	286,103,733	385.28	4,356,164	(14.05)
GROSS MARGIN	22,644,295	32.09	11,482,403	15.46	11,161,892	16.63
ADMINISTRATIVE EXPENSES						
Salaries and benefits	7,843,720	11.12	8,241,775	11.10	398,055	(0.02)
Professional fees	194,699	0.28	499,751	0.67	305,052	0.39
Purchased services	1,097,111	1.55	1,133,276	1.53	36,165	(0.02)
Printing & Postage	490,572	0.70	565,630	0.76	75,058	0.06
Depreciation & Amortization	294,451	0.42	457,866	0.62	163,415	0.20
Other expenses	1,502,225	2.13	1,726,937	2.33	224,712	0.20
Indirect cost allocation & Occupancy expense	345,165	0.49	380,366	0.51	35,201	0.02
Total Administrative Expenses	11,767,943	16.68	13,005,601	17.51	1,237,658	0.83
INCOME (LOSS) FROM OPERATIONS	10,876,352	15.42	(1,523,198)	(2.05)	12,399,550	17.47
INVESTMENT INCOME						
Interest income	2,607,882	3.70	1,250,000	1.68	1,357,882	2.02
Realized gain/(loss) on investments	266,596	0.38	-	-	266,596	0.38
Unrealized gain/(loss) on investments	2,450,347	3.47	-	-	2,450,347	3.47
Total Investment Income	5,324,825	7.55	1,250,000	1.68	4,074,825	5.87
TOTAL MCO TAX	(2,414,427)	(3.42)	-	-	(2,414,427)	(3.42)
TOTAL GRANT INCOME	3,036	-	-	-	3,036	-
OTHER INCOME	120	-	-	-	120	-
CHANGE IN NET ASSETS	**13,789,905**	**19.54**	**(273,198)**	**(0.37)**	**14,063,104**	**19.91**
MEDICAL LOSS RATIO	**92.6%**		**96.1%**		**3.6%**	
ADMINISTRATIVE LOSS RATIO	**3.9%**		**4.4%**		**0.5%**	

CalOptima - Consolidated
Statement of Revenues and Expenses
For the Seven Months Ended January 31, 2020

	Actual		Budget		Variance	
	$	PMPM	$	PMPM	$	PMPM
MEMBER MONTHS	5,189,094		5,233,771		(44,677)	
REVENUE						
Medi-Cal	$ 2,018,975,693	$ 397.68	$ 1,882,682,179	$ 367.56	$ 136,293,514	$ 30.12
OneCare Connect	172,403,309	1,740.41	166,845,377	1,690.99	5,557,932	49.42
OneCare	12,438,610	1,175.01	11,426,333	1,087.60	1,012,277	87.41
PACE	20,499,046	7,988.72	19,738,620	7,771.11	760,426	217.61
Total Operating Revenue	2,224,316,657	428.65	2,080,692,509	397.55	143,624,149	31.10
MEDICAL EXPENSES						
Medi-Cal	1,941,067,021	382.33	1,790,996,983	349.66	(150,070,037)	(32.67)
OneCare Connect	167,184,847	1,687.73	163,858,141	1,660.72	(3,326,706)	(27.01)
OneCare	10,486,560	990.61	11,251,138	1,070.92	764,578	80.31
PACE	16,934,379	6,599.52	17,361,363	6,835.18	426,984	235.66
Total Medical Expenses	2,135,672,806	411.57	1,983,467,625	378.97	(152,205,181)	(32.60)
GROSS MARGIN	88,643,851	17.08	97,224,883	18.58	(8,581,032)	(1.50)
ADMINISTRATIVE EXPENSES						
Salaries and benefits	51,673,299	9.96	56,937,138	10.88	5,263,839	0.92
Professional fees	1,999,658	0.39	3,319,976	0.63	1,320,318	0.24
Purchased services	6,692,276	1.29	8,532,932	1.63	1,840,656	0.34
Printing & Postage	2,693,087	0.52	3,968,096	0.76	1,275,009	0.24
Depreciation & Amortization	2,464,871	0.48	3,205,062	0.61	740,191	0.13
Other expenses	10,459,964	2.02	12,104,652	2.31	1,644,688	0.29
Indirect cost allocation & Occupancy expense	2,571,066	0.50	2,686,192	0.51	115,126	0.01
Total Administrative Expenses	78,554,221	15.14	90,754,048	17.34	12,199,827	2.20
INCOME (LOSS) FROM OPERATIONS	10,089,630	1.94	6,470,835	1.24	3,618,794	0.70
INVESTMENT INCOME						
Interest income	19,679,414	3.79	8,750,000	1.67	10,929,414	2.12
Realized gain/(loss) on investments	1,511,204	0.29	-	-	1,511,204	0.29
Unrealized gain/(loss) on investments	1,677,041	0.32	-	-	1,677,041	0.32
Total Investment Income	22,867,659	4.41	8,750,000	1.67	14,117,659	2.74
TOTAL MCO TAX	(2,414,427)	(0.47)	-	-	(2,414,427)	(0.47)
TOTAL GRANT INCOME	(61)	-	-	-	(61)	-
OTHER INCOME	494	-	-	-	494	-
CHANGE IN NET ASSETS	**30,543,295**	**5.89**	**15,220,835**	**2.91**	**15,322,459**	**2.98**
MEDICAL LOSS RATIO	**96.0%**		**95.3%**		**-0.7%**	
ADMINISTRATIVE LOSS RATIO	**3.5%**		**4.4%**		**0.8%**	

CalOptima - Consolidated - Month to Date
Statement of Revenues and Expenses by LOB
For the One Month Ended January 31, 2020

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	475,405	203,855	10,381	689,641	14,104	1,417	394	705,556
REVENUES								
Capitation Revenue	158,941,224	$ 93,503,047	$ 21,955,116	$ 274,399,387	$ 24,868,299	$ 1,744,019	$ 3,380,159	$ 304,391,865
Other Income	-	-	-	-	-	-	-	-
Total Operating Revenue	158,941,224	93,503,047	21,955,116	274,399,387	24,868,299	1,744,019	3,380,159	304,391,865
MEDICAL EXPENSES								
Provider Capitation	38,007,462	41,391,788	9,616,861	89,016,111	10,895,496	507,987		100,419,595
Facilities	24,070,873	20,948,950	6,966,264	51,986,087	3,845,465	462,495	485,994	56,780,040
Professional Claims	17,995,909	6,791,196	1,787,600	26,574,705	939,199	41,642	522,645	28,078,192
Prescription Drugs	15,553,331	22,146,407	4,461,857	42,161,595	4,922,135	453,583	223,537	47,760,850
MLTSS	33,799,625	2,456,772	1,718,125	37,974,522	1,252,567	22,417	48,005	39,297,511
Medical Management	2,221,986	1,377,940	290,332	3,890,257	1,045,901	38,088	801,011	5,775,258
Quality Incentives	805,914	442,410	140,499	1,388,823	193,130		36,112	1,618,065
Reinsurance & Other	803,003	731,389	33,837	1,568,228	147,215		302,615	2,018,059
Total Medical Expenses	133,258,102	96,286,852	25,015,375	254,560,329	23,241,109	1,526,212	2,419,920	281,747,570
Medical Loss Ratio	83.8%	103.0%	113.9%	92.8%	93.5%	87.5%	71.6%	92.6%
GROSS MARGIN	**25,683,122**	**(2,783,805)**	**(3,060,259)**	**19,839,059**	**1,627,190**	**217,808**	**960,239**	**22,644,295**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				6,831,008	775,258	84,657	152,797	7,843,720
Professional fees				175,576	3,999	15,000	123	194,699
Purchased services				992,535	88,380	9,191	7,004	1,097,111
Printing & Postage				481,103	42,592	(33,127)	4	490,572
Depreciation & Amortization				292,394			2,057	294,451
Other expenses				1,439,499	56,916	547	5,263	1,502,225
Indirect cost allocation & Occupancy				(245,870)	548,726	38,274	4,036	345,165
Total Administrative Expenses				9,966,246	1,515,871	114,542	171,285	11,767,943
Admin Loss Ratio				3.6%	6.1%	6.6%	5.1%	3.9%
INCOME (LOSS) FROM OPERATIONS				9,872,813	111,319	103,266	788,955	10,876,352
INVESTMENT INCOME								5,324,825
TOTAL MCO TAX				(2,414,427)				(2,414,427)
TOTAL GRANT INCOME				3,036				3,036
OTHER INCOME				120				120
CHANGE IN NET ASSETS				**$ 7,461,541**	**$ 111,319**	**$ 103,266**	**$ 788,955**	**$ 13,789,905**
BUDGETED CHANGE IN NET ASSETS				(438,243)	(1,172,131)	(95,546)	182,722	(273,198)
VARIANCE TO BUDGET - FAV (UNFAV)				$ 7,899,785	$ 1,283,450	$ 198,812	$ 606,233	$ 14,063,104

CalOptima - Consolidated - Year to Date
Statement of Revenues and Expenses by LOB
For the Seven Months Ended January 31, 2020

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	3,391,974	1,603,791	81,117	5,076,882	99,059	10,586	2,566	5,189,093
REVENUES								
Capitation Revenue	1,085,954,507	$ 771,664,253	$ 161,356,933	$ 2,018,975,693	$ 172,403,309	$ 12,438,610	$ 20,499,046	$ 2,224,316,657
Other Income	-	-	-	-	-	-	-	-
Total Operating Revenue	1,085,954,507	771,664,253	161,356,933	2,018,975,693	172,403,309	12,438,610	20,499,046	2,224,316,657
MEDICAL EXPENSES								
Provider Capitation	272,493,099	311,703,880	69,678,291	653,875,270	77,371,385	3,354,544		734,601,198
Facilities	178,289,643	150,969,453	41,257,980	370,517,076	26,523,206	2,837,102	4,564,505	404,441,889
Professional Claims	125,721,130	49,116,100	9,459,613	184,296,842	5,053,001	310,407	3,820,650	193,480,900
Prescription Drugs	115,740,374	151,478,362	38,220,084	305,438,820	38,753,737	3,636,254	1,602,529	349,431,340
MLTSS	242,916,261	18,626,273	13,127,953	274,670,486	9,530,204	74,580	258,801	284,534,070
Medical Management	14,948,728	8,643,833	1,852,901	25,445,462	7,258,481	273,673	5,017,301	37,994,917
Quality Incentives	5,844,607	3,256,050	989,309	10,089,967	1,420,825		186,647	11,697,438
Reinsurance & Other	66,935,612	49,552,142	245,345	116,733,099	1,274,008		1,483,946	119,491,053
Total Medical Expenses	1,022,889,453	743,346,093	174,831,475	1,941,067,021	167,184,847	10,486,560	16,934,379	2,135,672,806
Medical Loss Ratio	94.2%	96.3%	108.4%	96.1%	97.0%	84.3%	82.6%	96.0%
GROSS MARGIN	**63,065,054**	**28,318,160**	**(13,474,542)**	**77,908,672**	**5,218,462**	**1,952,050**	**3,564,667**	**88,643,851**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				45,234,121	5,003,467	452,392	983,319	51,673,299
Professional fees				1,401,543	452,485	144,371	1,259	1,999,658
Purchased services				5,469,359	1,063,732	101,551	57,635	6,692,276
Printing & Postage				2,241,434	362,074	28,305	61,274	2,693,087
Depreciation & Amortization				2,450,272			14,599	2,464,871
Other expenses				10,265,983	163,903	1,974	28,103	10,459,964
Indirect cost allocation & Occupancy				(1,698,009)	3,899,834	281,191	88,050	2,571,066
Total Administrative Expenses				65,364,703	10,945,496	1,009,784	1,234,239	78,554,221
Admin Loss Ratio				3.2%	6.3%	8.1%	6.0%	3.5%
INCOME (LOSS) FROM OPERATIONS				12,543,969	(5,727,034)	942,266	2,330,428	10,089,630
INVESTMENT INCOME								22,867,659
TOTAL MCO TAX				(2,414,427)				(2,414,427)
TOTAL GRANT INCOME				(61)				(61)
OTHER INCOME				494				494
CHANGE IN NET ASSETS				**$ 10,129,976**	**$ (5,727,034)**	**$ 942,266**	**$ 2,330,428**	**$ 30,543,295**
BUDGETED CHANGE IN NET ASSETS				15,951,292	(9,723,876)	(854,800)	1,098,219	15,220,835
VARIANCE TO BUDGET - FAV (UNFAV)				$ (5,821,317)	$ 3,996,842	$ 1,797,066	$ 1,232,209	$ 15,322,459

January 31, 2020 Unaudited Financial Statements

SUMMARY

MONTHLY RESULTS:

- Change in Net Assets is $13.8 million, $14.1 million favorable to budget
- Operating surplus is $10.9 million, with a surplus in non-operating income of $2.9 million

YEAR TO DATE RESULTS:

- Change in Net Assets is $30.5 million, $15.3 million favorable to budget
- Operating surplus is $10.1 million, with a surplus in non-operating income of $20.5 million

Change in Net Assets by Line of Business (LOB) ($ millions)

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
9.9	(0.4)	10.3	Medi-Cal	12.5	16.0	(3.4)
0.1	(1.2)	1.3	OCC	(5.7)	(9.7)	4.0
0.1	(0.1)	0.2	OneCare	0.9	(0.9)	1.8
0.8	0.2	0.6	PACE	2.3	1.1	1.2
10.9	**(1.5)**	**12.4**	**Operating**	**10.1**	**6.5**	**3.6**
2.9	1.3	1.7	Inv./Rental Inc, MCO tax	20.5	8.8	11.7
2.9	**1.3**	**1.7**	**Non-Operating**	**20.5**	**8.8**	**11.7**
13.8	**(0.3)**	**14.1**	**TOTAL**	**30.5**	**15.2**	**15.3**

CalOptima - Consolidated
Enrollment Summary
For the Seven Months Ended January 31, 2020

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	% Variance
68,160	65,978	2,182	3.3%	Aged	460,359	459,080	1,279	0.3%
519	615	(96)	(15.6%)	BCCTP	3,786	4,305	(519)	(12.1%)
39,905	43,657	(3,752)	(8.6%)	Disabled	312,840	306,329	6,511	2.1%
283,967	279,339	4,628	1.7%	TANF Child	1,982,930	1,984,198	(1,268)	(0.1%)
79,105	85,218	(6,113)	(7.2%)	TANF Adult	607,745	606,598	1,147	0.2%
3,749	3,404	345	10.1%	LTC	24,314	23,828	486	2.0%
203,855	235,569	(31,714)	(13.5%)	MCE	1,603,791	1,647,140	(43,349)	(2.6%)
10,381	12,940	(2,559)	(19.8%)	WCM	81,117	90,580	(9,463)	(10.4%)
689,641	**726,720**	**(37,079)**	**(5.1%)**	**Medi-Cal Total**	**5,076,883**	**5,122,058**	**(45,175)**	**(0.9%)**
14,104	**13,975**	**129**	**0.9%**	**OneCare Connect**	**99,059**	**98,667**	**392**	**0.4%**
1,417	**1,508**	**(91)**	**(6.0%)**	**OneCare**	**10,586**	**10,506**	**80**	**0.8%**
394	**386**	**8**	**2.1%**	**PACE**	**2,566**	**2,540**	**26**	**1.0%**
705,556	**742,589**	**(37,033)**	**(5.0%)**	**CalOptima Total**	**5,189,094**	**5,233,771**	**(44,677)**	**(0.9%)**
				Enrollment (by Network)				
150,328	161,288	(10,960)	(6.8%)	HMO	1,119,328	1,136,356	(17,028)	(1.5%)
200,479	207,258	(6,779)	(3.3%)	PHC	1,447,305	1,466,150	(18,845)	(1.3%)
162,009	186,071	(24,062)	(12.9%)	Shared Risk Group	1,252,871	1,312,395	(59,524)	(4.5%)
176,825	172,103	4,722	2.7%	Fee for Service	1,257,378	1,207,157	50,221	4.2%
689,641	**726,720**	**(37,079)**	**(5.1%)**	**Medi-Cal Total**	**5,076,883**	**5,122,058**	**(45,175)**	**(0.9%)**
14,104	**13,975**	**129**	**0.9%**	**OneCare Connect**	**99,059**	**98,667**	**392**	**0.4%**
1,417	**1,508**	**(91)**	**(6.0%)**	**OneCare**	**10,586**	**10,506**	**80**	**0.8%**
394	**386**	**8**	**2.1%**	**PACE**	**2,566**	**2,540**	**26**	**1.0%**
705,556	**742,589**	**(37,033)**	**(5.0%)**	**CalOptima Total**	**5,189,094**	**5,233,771**	**(44,677)**	**(0.9%)**

CalOptima
Enrollment Trend by Network
Fiscal Year 2020

	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	YTD Actual	YTD Budget	Variance
HMOs										
Aged	3,723	3,740	3,754	3,821	3,827	3,743	3,768	26,376	26,593	(217)
BCCTP	1	1	2	2	1	1	1	9	7	2
Disabled	6,539	6,547	6,572	6,613	6,633	6,546	6,468	45,918	46,264	(346)
TANF Child	54,046	53,703	52,620	53,069	52,791	51,642	50,877	368,748	370,405	(1,657)
TANF Adult	27,944	27,740	27,446	27,279	27,012	27,168	25,104	189,693	194,428	(4,735)
LTC	2	1	3	3	2	4		15	14	1
MCE	68,973	69,077	68,729	68,881	68,361	68,256	62,418	474,695	482,104	(7,409)
WCM	2,026	2,087	2,052	1,987	2,006	2,024	1,692	13,874	16,541	(2,667)
Total	**163,254**	**162,896**	**161,178**	**161,655**	**160,633**	**159,384**	**150,328**	**1,119,328**	**1,136,356**	**(17,028)**
PHCs										
Aged	1,548	1,540	1,524	1,542	1,577	1,579	1,516	10,826	10,693	133
BCCTP								-		0
Disabled	5,416	5,499	5,323	5,425	5,500	5,474	5,244	37,881	37,338	543
TANF Child	148,665	148,131	143,994	146,390	145,734	140,237	143,833	1,016,984	1,028,088	(11,104)
TANF Adult	11,149	11,322	10,925	10,865	10,743	11,285	9,797	76,086	72,441	3,645
LTC			1		1	1	2	5		5
MCE	37,510	37,479	37,084	37,037	36,728	36,708	33,716	256,262	263,802	(7,540)
WCM	7,209	7,276	7,190	7,151	7,070	6,994	6,371	49,261	53,788	(4,527)
Total	**211,497**	**211,247**	**206,041**	**208,410**	**207,353**	**202,278**	**200,479**	**1,447,305**	**1,466,150**	**(18,845)**
Shared Risk Groups										
Aged	3,569	3,523	3,470	3,501	3,527	3,364	3,301	24,255	25,377	(1,122)
BCCTP						1	(1)	-		0
Disabled	7,275	7,294	7,144	7,177	7,200	7,139	6,724	49,953	47,825	2,128
TANF Child	63,291	62,381	57,001	59,579	58,690	56,771	56,508	414,221	431,662	(17,441)
TANF Adult	28,681	28,390	27,842	27,428	26,946	27,269	24,473	191,029	199,938	(8,909)
LTC	1	3	3	2	1	1		11	7	4
MCE	84,595	83,922	82,492	81,749	80,096	79,714	69,637	562,205	593,817	(31,612)
WCM	1,732	1,706	1,620	1,598	1,581	1,593	1,367	11,197	13,769	(2,572)
Total	**189,144**	**187,219**	**179,572**	**181,034**	**178,041**	**175,852**	**162,009**	**1,252,871**	**1,312,395**	**(59,524)**
Fee for Service (Dual)										
Aged	51,730	52,454	52,097	52,050	52,649	51,770	54,711	367,461	364,892	2,569
BCCTP	15	18	17	18	19	20	13	120	126	(6)
Disabled	20,752	20,053	20,586	20,577	20,781	20,848	20,986	144,583	143,722	861
TANF Child		19	1	1	1	1	1	24		24
TANF Adult	964	1,923	949	941	963	938	1,528	8,206	6,247	1,959
LTC	3,044	3,097	3,061	3,161	3,204	2,971	3,389	21,927	21,343	584
MCE	2,116	2,171	1,935	1,717	1,737	2,255	876	12,807	14,455	(1,648)
WCM	15	15	15	16	15	16	15	107	112	(5)
Total	**78,636**	**79,750**	**78,661**	**78,481**	**79,369**	**78,819**	**81,519**	**555,235**	**550,897**	**4,338**
Fee for Service (Non-Dual - Total)										
Aged	4,682	4,211	4,370	4,583	4,890	3,841	4,864	31,441	31,525	(84)
BCCTP	550	542	484	532	525	518	506	3,657	4,172	(515)
Disabled	4,928	5,692	4,374	4,930	5,428	8,670	483	34,505	31,180	3,325
TANF Child	25,571	32,106	16,125	25,295	29,914	21,194	32,748	182,953	154,043	28,910
TANF Adult	19,658	19,951	19,512	19,854	23,011	22,542	18,203	142,731	133,544	9,187
LTC	328	326	331	347	364	302	358	2,356	2,464	(108)
MCE	40,680	41,152	40,342	41,308	48,994	48,138	37,208	297,822	292,962	4,860
WCM	843	960	978	1,008	1,079	874	936	6,678	6,370	308
Total	**97,240**	**104,940**	**86,516**	**97,857**	**114,205**	**106,079**	**95,306**	**702,143**	**656,260**	**45,883**
Grand Totals										
Aged	65,252	65,468	65,215	65,497	66,470	64,297	68,160	460,359	459,080	1,279
BCCTP	566	561	503	552	545	540	519	3,786	4,305	(519)
Disabled	44,910	45,085	43,999	44,722	45,542	48,677	39,905	312,840	306,329	6,511
TANF Child	291,573	296,340	269,741	284,334	287,130	269,845	283,967	1,982,930	1,984,198	(1,268)
TANF Adult	88,396	89,326	86,674	86,367	88,675	89,202	79,105	607,745	606,598	1,147
LTC	3,375	3,427	3,399	3,513	3,572	3,279	3,749	24,314	23,828	486
MCE	233,874	233,801	230,582	230,692	235,916	235,071	203,855	1,603,791	1,647,140	(43,349)
WCM	11,825	12,044	11,855	11,760	11,751	11,501	10,381	81,117	90,580	(9,463)
Total MediCal MM	**739,771**	**746,052**	**711,968**	**727,437**	**739,601**	**722,412**	**689,641**	**5,076,883**	**5,122,058**	**(45,176)**
OneCare Connect	**14,257**	**14,090**	**14,186**	**14,093**	**14,065**	**14,264**	**14,104**	**99,059**	**98,667**	**392**
OneCare	**1,530**	**1,545**	**1,564**	**1,567**	**1,498**	**1,465**	**1,417**	**10,586**	**10,506**	**80**
PACE	**335**	**345**	**356**	**368**	**375**	**393**	**394**	**2,566**	**2,540**	**26**
Grand Total	**755,893**	**762,032**	**728,074**	**743,465**	**755,539**	**738,534**	**705,556**	**5,189,094**	**5,233,771**	**(44,678)**

ENROLLMENT:

Overall January enrollment was 705,556

- Unfavorable to budget 37,033 or 5.0% due to member eligibility logic update for prior periods and annual Medi-Cal status redetermination
- Decreased 32,978 or 4.5% from prior month (PM) (December 2019)
- Decreased 58,350 or 7.6% from prior year (PY) (January 2019)

Medi-Cal enrollment was 689,641

- Unfavorable to budget 37,079 or 5.1%
  - Medi-Cal Expansion (MCE) unfavorable 31,714
  - Whole Child Model (WCM) unfavorable 2,559
  - Seniors and Persons with Disabilities (SPD) unfavorable 1,666
  - Temporary Assistance for Needy Families (TANF) unfavorable 1,485
  - Long-Term Care (LTC) favorable 345
- Decreased 32,771 from PM

OneCare Connect enrollment was 14,104

- Favorable to budget 129 or 0.9%
- Decreased 160 from PM

OneCare enrollment was 1,417

- Unfavorable to budget 91 or 6.0%
- Decreased 48 from PM

PACE enrollment was 394

- Favorable to budget 8 or 2.1%
- Increased 1 from PM

CalOptima
Medi-Cal Total
Statement of Revenues and Expenses
For the Seven Months Ending January 31, 2020

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
689,641	**726,720**	**(37,079)**	**(5.1%)**	**Member Months**	**5,076,883**	**5,122,058**	**(45,175)**	**(0.9%)**
				Revenues				
274,399,387	268,552,864	5,846,523	2.2%	Capitation Revenue	2,018,975,693	1,882,682,179	136,293,514	7.2%
-	-	-	0.0%	Other Income	-	-	-	0.0%
274,399,387	**268,552,864**	**5,846,523**	**2.2%**	**Total Operating Revenue**	**2,018,975,693**	**1,882,682,179**	**136,293,514**	**7.2%**
				Medical Expenses				
90,404,934	95,040,472	4,635,538	4.9%	Provider Capitation	663,965,236	665,914,218	1,948,982	0.3%
51,986,087	48,945,292	(3,040,795)	(6.2%)	Facilities Claims	370,517,076	338,924,148	(31,592,928)	(9.3%)
26,574,705	23,538,243	(3,036,462)	(12.9%)	Professional Claims	184,296,842	162,275,237	(22,021,605)	(13.6%)
42,161,595	44,523,139	2,361,545	5.3%	Prescription Drugs	305,438,820	308,801,853	3,363,033	1.1%
37,974,522	37,686,436	(288,086)	(0.8%)	MLTSS	274,670,486	260,500,694	(14,169,792)	(5.4%)
3,890,257	5,120,582	1,230,324	24.0%	Medical Management	25,445,462	32,181,252	6,735,790	20.9%
1,568,228	3,216,373	1,648,145	51.2%	Reinsurance & Other	116,733,099	22,399,582	(94,333,517)	(421.1%)
254,560,329	**258,070,538**	**3,510,210**	**1.4%**	**Total Medical Expenses**	**1,941,067,021**	**1,790,996,983**	**(150,070,037)**	**(8.4%)**
19,839,059	**10,482,326**	**9,356,733**	**89.3%**	**Gross Margin**	**77,908,672**	**91,685,195**	**(13,776,523)**	**(15.0%)**
				Administrative Expenses				
6,831,008	7,200,660	369,652	5.1%	Salaries, Wages & Employee Benefits	45,234,121	49,823,429	4,589,308	9.2%
175,576	400,322	224,746	56.1%	Professional Fees	1,401,543	2,623,974	1,222,431	46.6%
992,535	954,253	(38,282)	(4.0%)	Purchased Services	5,469,359	6,679,773	1,210,414	18.1%
481,103	442,570	(38,533)	(8.7%)	Printing and Postage	2,241,434	3,106,674	865,240	27.9%
292,394	455,750	163,356	35.8%	Depreciation & Amortization	2,450,272	3,190,250	739,978	23.2%
1,439,499	1,646,175	206,676	12.6%	Other Operating Expenses	10,265,983	11,539,317	1,273,334	11.0%
(245,870)	(179,161)	66,709	37.2%	Indirect Cost Allocation, Occupancy Expense	(1,698,009)	(1,229,514)	468,495	38.1%
9,966,246	**10,920,569**	**954,323**	**8.7%**	**Total Administrative Expenses**	**65,364,703**	**75,733,903**	**10,369,200**	**13.7%**
				Operating Tax				
12,773,391	11,205,849	1,567,542	14.0%	Tax Revenue	96,537,241	78,971,467	17,565,774	22.2%
15,187,818	11,205,849	(3,981,969)	(35.5%)	Premium Tax Expense	98,951,668	78,971,467	(19,980,201)	(25.3%)
-	-	-	0.0%	Sales Tax Expense	-	-	-	0.0%
(2,414,427)	-	2,414,427	**0.0%**	**Total Net Operating Tax**	(2,414,427)	-	2,414,427	**0.0%**
				Grant Income				
36,610	-	36,610	0.0%	Grant Revenue	83,261	-	83,261	0.0%
19,338	-	(19,338)	0.0%	Grant expense - Service Partner	10,625	-	(10,625)	0.0%
14,237	-	(14,237)	0.0%	Grant expense - Administrative	72,697	-	(72,697)	0.0%
3,036	-	3,036	**0.0%**	**Total Grant Income**	(61)	-	(61)	**0.0%**
120	**-**	**120**	**0.0%**	**Other income**	**494**	**-**	**494**	**0.0%**
7,461,541	**(438,243)**	**7,899,785**	**1802.6%**	**Change in Net Assets**	**10,129,976**	**15,951,292**	**(5,821,317)**	**(36.5%)**
92.8%	***96.1%***	***3.3%***	***3.5%***	***Medical Loss Ratio***	***96.1%***	***95.1%***	***(1.0%)***	***(1.1%)***
3.6%	***4.1%***	***0.4%***	***10.7%***	***Admin Loss Ratio***	***3.2%***	***4.0%***	***0.8%***	***19.5%***

MEDI-CAL INCOME STATEMENT - JANUARY MONTH:

REVENUES of $274.4 million are favorable to budget $5.8 million driven by:

- Unfavorable volume related variance of $13.7 million due to
- Favorable price related variance of $19.5 million due to:
  - $34.0 million of Coordinated Care Initiative (CCI) revenue, including $7.4 million from prior year due to updated rate and member mix
  - $3.0 million of fiscal year (FY) 2020 revenue due to Department of Health Care Services (DHCS) acuity rate adjustment
  - Offset by $14.2 million FY 2020 revenue due to retroactive enrollment adjustments
  - $3.3 million of WCM revenue

MEDICAL EXPENSES of $254.6 million are favorable to budget $3.5 million driven by:

- Favorable volume related variance of $13.2 million
- Unfavorable price variance of $9.7 million due to:
  - Facilities Claims unfavorable variance of $5.5 million due to WCM
  - Professional Claims unfavorable variance of $4.2 million due to crossover claims

ADMINISTRATIVE EXPENSES of $10.0 million are favorable to budget $1.0 million driven by:

- Salaries & Benefit expenses are favorable to budget $0.4 million
- Other Non-Salary expenses are favorable to budget $0.6 million

CHANGE IN NET ASSETS is $7.5 million for the month, favorable to budget $7.9 million

CalOptima
OneCare Connect Total
Statement of Revenue and Expenses
For the Seven Months Ending January 31, 2020

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
14,104	**13,975**	**129**	**0.9%**	**Member Months**	**99,059**	**98,667**	**392**	**0.4%**
				Revenues				
2,315,011	2,746,682	(431,671)	(15.7%)	Medi-Cal Capitation Revenue	16,897,108	19,466,996	(2,569,888)	(13.2%)
16,958,507	16,772,952	185,555	1.1%	Medicare Capitation Revenue Part C	117,874,838	113,847,113	4,027,725	3.5%
5,594,780	4,837,461	757,319	15.7%	Medicare Capitation Revenue Part D	37,631,363	33,531,268	4,100,095	12.2%
-	-	-	0.0%	Other Income	-	-	-	0.0%
24,868,299	**24,357,095**	**511,204**	**2.1%**	**Total Operating Revenue**	**172,403,309**	**166,845,377**	**5,557,932**	**3.3%**
				Medical Expenses				
11,088,626	11,091,136	2,510	0.0%	Provider Capitation	78,792,210	76,412,185	(2,380,025)	(3.1%)
3,845,465	3,589,514	(255,951)	(7.1%)	Facilities Claims	26,523,206	24,531,840	(1,991,366)	(8.1%)
939,199	706,497	(232,702)	(32.9%)	Ancillary	5,053,001	4,796,686	(256,315)	(5.3%)
1,252,567	1,551,065	298,498	19.2%	MLTSS	9,530,204	10,884,975	1,354,771	12.4%
4,922,135	5,465,302	543,167	9.9%	Prescription Drugs	38,753,737	37,920,959	(832,778)	(2.2%)
1,045,901	1,152,118	106,217	9.2%	Medical Management	7,258,481	7,786,604	528,123	6.8%
147,215	220,218	73,003	33.2%	Other Medical Expenses	1,274,008	1,524,892	250,884	16.5%
23,241,109	**23,775,850**	**534,741**	**2.2%**	**Total Medical Expenses**	**167,184,847**	**163,858,141**	**(3,326,706)**	**(2.0%)**
1,627,190	**581,245**	**1,045,945**	**179.9%**	**Gross Margin**	**5,218,462**	**2,987,236**	**2,231,226**	**74.7%**
				Administrative Expenses				
775,258	845,051	69,793	8.3%	Salaries, Wages & Employee Benefits	5,003,467	5,752,836	749,369	13.0%
3,999	77,796	73,797	94.9%	Professional Fees	452,485	544,571	92,086	16.9%
88,380	142,989	54,609	38.2%	Purchased Services	1,063,732	1,600,921	537,189	33.6%
42,592	95,860	53,268	55.6%	Printing and Postage	362,074	671,022	308,948	46.0%
-	-	-	0.0%	Depreciation & Amortization	-	-	-	0.0%
56,916	71,888	14,972	20.8%	Other Operating Expenses	163,903	503,218	339,315	67.4%
548,726	519,792	(28,934)	(5.6%)	Indirect Cost Allocation	3,899,834	3,638,544	(261,290)	(7.2%)
1,515,871	**1,753,376**	**237,505**	**13.5%**	**Total Administrative Expenses**	**10,945,496**	**12,711,112**	**1,765,616**	**13.9%**
111,319	**(1,172,131)**	**1,283,450**	**109.5%**	**Change in Net Assets**	**(5,727,034)**	**(9,723,876)**	**3,996,842**	**41.1%**
93.5%	***97.6%***	***4.2%***	***4.3%***	***Medical Loss Ratio***	***97.0%***	***98.2%***	***1.2%***	***1.3%***
6.1%	***7.2%***	***1.1%***	***15.3%***	***Admin Loss Ratio***	***6.3%***	***7.6%***	***1.3%***	***16.7%***

ONECARE CONNECT INCOME STATEMENT - JANUARY MONTH:

REVENUES of $24.9 million are favorable to budget $0.5 million driven by:

- Favorable volume related variance of $0.2 million
- Favorable price related variance of $0.3 million

MEDICAL EXPENSES of $23.2 million are favorable to budget $0.5 million

- Unfavorable volume related variance of $0.2 million
- Favorable price related variance of $0.8 million

ADMINISTRATIVE EXPENSES of $1.5 million are favorable to budget $0.2 million

CHANGE IN NET ASSETS is $0.1 million, favorable to budget $1.3 million

CalOptima
OneCare
Statement of Revenues and Expenses
For the Seven Months Ending January 31, 2020

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
1,417	**1,508**	**(91)**	**(6.0%)**	**Member Months**	**10,586**	**10,506**	**80**	**0.8%**
				Revenues				
1,173,921	1,156,931	16,990	1.5%	Medicare Part C revenue	8,507,909	7,794,140	713,769	9.2%
570,098	524,755	45,343	8.6%	Medicare Part D revenue	3,930,701	3,632,193	298,508	8.2%
1,744,019	**1,681,686**	**62,333**	**3.7%**	**Total Operating Revenue**	**12,438,610**	**11,426,333**	**1,012,277**	**8.9%**
				Medical Expenses				
507,987	448,054	(59,933)	(13.4%)	Provider capitation	3,354,544	3,078,531	(276,013)	(9.0%)
462,495	513,881	51,386	10.0%	Inpatient	2,837,102	3,546,658	709,556	20.0%
41,642	56,107	14,465	25.8%	Ancillary	310,407	387,350	76,943	19.9%
22,417	46,101	23,684	51.4%	Skilled nursing facilities	74,580	318,219	243,639	76.6%
453,583	506,339	52,756	10.4%	Prescription drugs	3,636,254	3,508,878	(127,376)	(3.6%)
38,088	48,179	10,091	20.9%	Medical Management	273,673	335,675	62,002	18.5%
-	10,884	10,884	100.0%	Other medical expenses	-	75,827	75,827	100.0%
1,526,212	**1,629,545**	**103,333**	**6.3%**	**Total Medical Expenses**	**10,486,560**	**11,251,138**	**764,578**	**6.8%**
217,808	**52,141**	**165,667**	**317.7%**	**Gross Margin**	**1,952,050**	**175,195**	**1,776,855**	**1014.2%**
				Administrative Expenses				
84,657	52,150	(32,507)	(62.3%)	Salaries, wages & employee benefits	452,392	361,236	(91,156)	(25.2%)
15,000	21,480	6,480	30.2%	Professional fees	144,371	150,360	5,989	4.0%
9,191	17,063	7,872	46.1%	Purchased services	101,551	119,441	17,890	15.0%
(33,127)	16,667	49,794	298.8%	Printing and postage	28,305	116,669	88,364	75.7%
547	4,738	4,191	88.5%	Other operating expenses	1,974	33,166	31,192	94.0%
38,274	35,589	(2,685)	(7.5%)	Indirect cost allocation, occupancy expense	281,191	249,123	(32,068)	(12.9%)
114,542	**147,687**	**33,145**	**22.4%**	**Total Administrative Expenses**	**1,009,784**	**1,029,995**	**20,211**	**2.0%**
103,266	**(95,546)**	**198,812**	**208.1%**	**Change in Net Assets**	**942,266**	**(854,800)**	**1,797,066**	**210.2%**
87.5%	***96.9%***	***9.4%***	***9.7%***	***Medical Loss Ratio***	***84.3%***	***98.5%***	***14.2%***	***14.4%***
6.6%	***8.8%***	***2.2%***	***25.2%***	***Admin Loss Ratio***	***8.1%***	***9.0%***	***0.9%***	***9.9%***

CalOptima
PACE
Statement of Revenues and Expenses
For the Seven Months Ending January 31, 2020

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
394	**386**	**8**	**2.1%**	**Member Months**	**2,566**	**2,540**	**26**	**1.0%**
				Revenues				
2,506,090	2,322,308	183,782	7.9%	Medi-Cal Capitation Revenue	15,971,065	15,272,480	698,585	4.6%
691,675	530,115	161,560	30.5%	Medicare Part C Revenue	3,526,001	3,529,427	(3,426)	(0.1%)
182,394	142,068	40,326	28.4%	Medicare Part D Revenue	1,001,979	936,713	65,266	7.0%
3,380,159	**2,994,491**	**385,668**	**12.9%**	**Total Operating Revenue**	**20,499,046**	**19,738,620**	**760,426**	**3.9%**
				Medical Expenses				
801,011	887,696	86,685	9.8%	Medical Management	5,017,301	6,124,837	1,107,536	18.1%
485,994	575,567	89,573	15.6%	Claims payments to hospitals	4,564,505	3,732,922	(831,583)	(22.3%)
522,645	629,781	107,136	17.0%	Professional claims	3,820,650	4,092,975	272,325	6.7%
302,615	256,608	(46,007)	(17.9%)	Patient transportation	1,483,946	1,633,936	149,990	9.2%
223,537	239,992	16,455	6.9%	Prescription drugs	1,602,529	1,556,668	(45,861)	(2.9%)
48,005	31,489	(16,516)	(52.5%)	MLTSS	258,801	173,358	(85,443)	(49.3%)
36,112	6,667	(29,445)	(441.7%)	Other Expenses	186,647	46,667	(139,980)	(300.0%)
2,419,920	**2,627,800**	**207,880**	**7.9%**	**Total Medical Expenses**	**16,934,379**	**17,361,363**	**426,984**	**2.5%**
960,239	**366,691**	**593,548**	**161.9%**	**Gross Margin**	**3,564,667**	**2,377,257**	**1,187,410**	**49.9%**
				Administrative Expenses				
152,797	143,914	(8,883)	(6.2%)	Salaries, wages & employee benefits	983,319	999,637	16,318	1.6%
123	153	30	19.4%	Professional fees	1,259	1,071	(188)	(17.6%)
7,004	18,971	11,967	63.1%	Purchased services	57,635	132,797	75,162	56.6%
4	10,533	10,529	100.0%	Printing and postage	61,274	73,731	12,458	16.9%
2,057	2,116	59	2.8%	Depreciation & amortization	14,599	14,812	213	1.4%
5,263	4,136	(1,127)	(27.2%)	Other operating expenses	28,103	28,951	848	2.9%
4,036	4,146	110	2.7%	Indirect Cost Allocation, Occupancy Expense	88,050	28,039	(60,011)	(214.0%)
171,285	**183,969**	**12,684**	**6.9%**	**Total Administrative Expenses**	**1,234,239**	**1,279,038**	**44,799**	**3.5%**
				Operating Tax				
5,847	-	5,847	0.0%	Tax Revenue	38,079	-	38,079	0.0%
5,847	-	(5,847)	0.0%	Premium Tax Expense	38,079	-	(38,079)	0.0%
-	-	-	**0.0%**	**Total Net Operating Tax**	-	-	-	**0.0%**
788,955	**182,722**	**606,233**	**331.8%**	**Change in Net Assets**	**2,330,428**	**1,098,219**	**1,232,209**	**112.2%**
71.6%	***87.8%***	***16.2%***	***18.4%***	***Medical Loss Ratio***	***82.6%***	***88.0%***	***5.3%***	***6.1%***
5.1%	***6.1%***	***1.1%***	***17.5%***	***Admin Loss Ratio***	***6.0%***	***6.5%***	***0.5%***	***7.1%***

CalOptima
Building - 505 City Parkway
Statement of Revenues and Expenses
For the Seven Months Ending January 31, 2020

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
-	-	-	0.0%	Rental Income	-	-	-	0.0%
-	**-**	**-**	**0.0%**	**Total Operating Revenue**	**-**	**-**	**-**	**0.0%**
				Administrative Expenses				
52,342	23,101	(29,241)	(126.6%)	Purchase services	340,009	161,708	(178,301)	(110.3%)
164,494	174,725	10,231	5.9%	Depreciation & amortization	1,151,457	1,223,075	71,618	5.9%
17,476	15,866	(1,610)	(10.2%)	Insurance expense	122,335	111,062	(11,273)	(10.2%)
99,133	140,162	41,029	29.3%	Repair and maintenance	734,781	981,134	246,353	25.1%
31,585	46,432	14,847	32.0%	Other Operating Expense	319,676	325,024	5,348	1.6%
(365,031)	(400,286)	(35,255)	(8.8%)	Indirect allocation, Occupancy	(2,668,257)	(2,802,003)	(133,746)	(4.8%)
0	**-**	**(0)**	**0.0%**	**Total Administrative Expenses**	**0**	**-**	**(0)**	**0.0%**
(0)	**-**	**(0)**	**0.0%**	**Change in Net Assets**	**(0)**	**-**	**(0)**	**0.0%**

OTHER INCOME STATEMENTS – JANUARY MONTH:

ONECARE INCOME STATEMENT

CHANGE IN NET ASSETS is $103.3 thousand, favorable to budget $198.8 thousand

PACE INCOME STATEMENT

CHANGE IN NET ASSETS is $789.0 thousand, favorable to budget $606.2 thousand

CalOptima
Balance Sheet
January 31, 2020

ASSETS		LIABILITIES & NET POSITION	
Current Assets		Current Liabilities	
Operating Cash	$520,760,769	Accounts Payable	$104,149,243
Investments	419,874,256	Medical Claims liability	748,671,289
Capitation receivable	407,851,922	Accrued Payroll Liabilities	12,364,162
Receivables - Other	33,438,568	Deferred Revenue	53,848,472
Prepaid expenses	8,401,246	Deferred Lease Obligations	-
		Capitation and Withholds	137,183,259
Total Current Assets	**1,390,326,761**	**Total Current Liabilities**	**1,056,216,426**
Capital Assets			
Furniture & Equipment	37,086,365		
Building/Leasehold Improvements	10,941,286		
505 City Parkway West	50,489,717		
	98,517,368		
Less: accumulated depreciation	(50,452,197)		
Capital assets, net	48,065,171	Other (than pensions) post	
		employment benefits liability	25,577,893
Other Assets		Net Pension Liabilities	23,479,025
Restricted Deposit & Other	300,000	Bldg 505 Development Rights	-
Homeless Health Reserve	58,198,913		
Board-designated assets:		**TOTAL LIABILITIES**	**1,105,273,344**
Cash and Cash Equivalents	8,932,273		
Long-term Investments	561,852,777	Deferred Inflows	
Total Board-designated Assets	570,785,050	Excess Earnings	156,330
		Change in Assumptions	4,747,505
Total Other Assets	629,283,963	OPEB Changes in Assumptions	2,503,000
		Net Position	
TOTAL ASSETS	**2,067,675,894**	TNE	96,221,054
		Funds in Excess of TNE	869,865,110
Deferred Outflows		**TOTAL NET POSITION**	966,086,164
Contributions	686,962		
Difference in Experience	3,419,328		
Excess Earning	-		
Changes in Assumptions	6,428,159		
Pension Contributions	556,000		
TOTAL ASSETS & DEFERRED OUTFLOWS	**2,078,766,343**	**TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION**	**2,078,766,343**

CalOptima
Board Designated Reserve and TNE Analysis
as of January 31, 2020

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	156,396,836				
	Tier 1 - Logan Circle	155,186,728				
	Tier 1 - Wells Capital	155,655,503				
Board-designated Reserve		467,239,067	319,722,581	497,984,139	147,516,486	(30,745,072)
TNE Requirement	Tier 2 - Logan Circle	103,545,983	96,221,054	96,221,054	7,324,929	7,324,929
	Consolidated:	**570,785,050**	**415,943,635**	**594,205,193**	**154,841,415**	**(23,420,143)**
	Current reserve level	*1.92*	*1.40*	*2.00*		

CalOptima
Statement of Cash Flows
January 31, 2020

	Month Ended	Year-To-Date
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets	13,789,905	30,543,295
Adjustments to reconcile change in net assets		
to net cash provided by operating activities		
Depreciation and amortization	458,945	3,616,327
Changes in assets and liabilities:		
Prepaid expenses and other	(1,336,117)	(2,613,505)
Catastrophic reserves		
Capitation receivable	(27,390,617)	(89,348,723)
Medical claims liability	(4,639,144)	(3,639,662)
Deferred revenue	20,962,634	2,813,709
Payable to health networks	5,290,584	28,280,119
Accounts payable	15,050,727	61,482,517
Accrued payroll	887,055	2,106,544
Other accrued liabilities	(6,359)	(44,512)
Net cash provided by/(used in) operating activities	23,067,614	33,196,108
GASB 68 CalPERS Adjustments	-	-
CASH FLOWS FROM CAPITAL AND RELATED FINANCING ACTIVITIES:		
Net Asset transfer from Foundation	-	-
Net cash provided by (used in) in capital and related financing activities	-	-
CASH FLOWS FROM INVESTING ACTIVITIES		
Change in Investments	36,248,742	153,832,041
Change in Property and Equipment	(317,125)	(5,056,609)
Change in Board designated reserves	(3,704,218)	(10,639,643)
Change in Homeless Health Reserve	-	1,801,087
Net cash provided by/(used in) investing activities	32,227,399	139,936,877
NET INCREASE/(DECREASE) IN CASH & CASH EQUIVALENTS	55,295,013	173,132,985
CASH AND CASH EQUIVALENTS, beginning of period	465,465,756	347,627,784
CASH AND CASH EQUIVALENTS, end of period	**520,760,769**	**520,760,769**

BALANCE SHEET - JANUARY MONTH:

ASSETS of $2.1 billion increased $51.3 million from December or 2.5%

- Operating Cash increased $55.3 million due to timing of capitation received
- Investments decreased $36.2 million due timing of capitation received
- Capitation Receivables increased $24.8 million due to timing of capitation received

LIABILITIES of $1.1 billion increased $37.5 million from December or 3.5%

- Deferred Revenue increased $21.0 million due to prepayment from the Centers for Medicare & Medicaid Services (CMS)
- Accounts Payable increased $15.1 million

NET ASSETS total $966.1 million

Homeless Health Initiative and Allocated Funds as of January 31, 2020

		Amount
Program Commitment		**$ 100,000,000**
Funds Allocation, approved initiatives:		
Be Well OC	$	11,400,000
Recuperative Care		8,500,000
Housing Supportive Services		2,500,000
Clinical Field Team Start-Up & Federally Qualified Health Center (FQHC)		1,600,000
Homeless Response Team (CalOptima)		6,000,000
Homeless Coordination at Hospitals		10,000,000
CalOptima Day & QI Program		1,231,087
FQHC – Expansion		570,000
Funds Allocation Total		**41,801,087**
Program Commitment Balance, available for new initiatives		**$ 58,198,913**

On June 27, 2019 at a Special Board meeting, the Board approved four funding categories. This report only lists Board approved projects.

Budget Allocation Changes
Reporting Changes for January 2020

Transfer Month	Line of Business	From	To	Amount	Expense Description
July	Medi-Cal	IS Application Development - Maintenance HW/SW (CalOptima Link Software)	IS Application Development - Maintenance HW/SW (Human Resources Corporate Application)	$32,700	Repurpose $32,700 from Maintenance HW/SW (CalOptima Link Software) to Maintenance HW/SW (Human Resources Corporate Application)
July	Medi-Cal	IS Infrastructure - Capital Project (Server 2016 Upgrade)	IS Infrastructure - Capital Projects (505 IDF Upgrade and MDF Switch Upgrade)	$38,300	Reallocate $38,300 from Capital Project (Server 2016 Upgrade) to Capital Projects (505 IDF Upgrade and MDF Switch Upgrade)
July	Medi-Cal	IS Infrastructure - Capital Project (LAN Switch Upgrade)	IS Infrastructure - Capital Projects (505 IDF Upgrade and MDF Switch Upgrade)	$25,700	Reallocate $25,700 from Capital Project (LAN Switch Upgrades) to Capital Projects (505 IDF Upgrade and MDF Switch Upgrade)
December	Medi-Cal	IS Infrastructure - Maintenance HW/SW - Microsoft True-Up	IS Infrastructure - Maintenance HW/SW - Network Connectivity - Extreme Networks	$53,000	Repurpose $53,000 from Microsoft True-Up to Network Connectivity - Extreme Networks.
December	Medi-Cal	Facilities - 6th Floor Lunchroom Remodel	Facilities - Replace Conference Room AV Equipment	$13,000	To reallocate $13,000 from Capital Projects 6th Floor Lunchroom Remodel and Conference Room 910 Upgrades to Capital Project Replace Conference Room AV Equipment.
December	Medi-Cal	Facilities - Conference Room 910 Upgrades	Facilities - Replace Conference Room AV Equipment	$17,000	To reallocate $17,000 from Capital Projects 6th Floor Lunchroom Remodel and Conference Room 910 Upgrades to Capital Project Replace Conference Room AV Equipment.
January	Medi-Cal	Member Survey - CG CAHPS	Inovalon Contract for HEDIS Software Training and Support hours	$40,000	To reallocate funds from Member Survey - CG CAHPS to Inovalon Contract for HEDIS Software Training and Support hours.

This report summarizes budget transfers between general ledger classes that are greater than $10,000 and less than $100,000.
This is the result of Board Resolution No. 12-0301-01 which permits the CEO to make budget allocation changes within certain parameters.

Board of Directors' Meeting
March 5, 2020

Monthly Compliance Report

The purpose of this report is to provide compliance updates to CalOptima's Board of Directors, including but may not be limited to, updates on internal and health network audits conducted by CalOptima's Audit & Oversight department, regulatory audits, privacy updates, fraud, waste, and abuse (FWA) updates, and any notices of non-compliance or enforcement action issued by regulators.

A. Updates on Regulatory Audits

1. OneCare

- Anticipated 2020 CMS Program Audit Readiness (OneCare and OneCare Connect):

  CalOptima anticipates that the Centers for Medicare & Medicaid Services (CMS) will issue an engagement notice for a program audit of its OneCare and OneCare Connect programs between March through July 2020. CMS will be performing a full-scale program audit using the Medicare Parts C and D Audit Protocols and the Program Audit Protocols for Medicare-Medicaid Plans (MMPs). In preparation, CalOptima's Office of Compliance has created a workplan outlining audit activities, deliverables and responsible parties. The Office of Compliance met with impacted departments and health networks in February 2020 to review the workplan and discuss audit readiness activities in anticipation of this audit engagement.

- CY2018 Medicare Part D Prescription Drug Event Validation (OneCare and OneCare Connect):

  On January 10, 2020, CMS informed CalOptima that its OneCare and OneCare Connect programs have been selected to participate in the Calendar Year (CY) 2018 Medicare Part D Prescription Drug Event Validation (PEPV) audit.

  CMS conducts the audit to validate the accuracy of prescription drug event (PDE) data submitted by Medicare Part D sponsors for CY 2018 payments. CMS released the contract-specific documentation for both programs on January 24, 2020. The audit submission window is now open, and all required documentation must be submitted by April 17, 2020.

- Timeliness Monitoring Project:

  On October 8, 2019, CMS announced that it will conduct an industry-wide monitoring project in 2020, to evaluate the timeliness of processing Medicare Advantage (Part C) organization determinations and reconsiderations and Medicare Prescription Drug (Part D)

coverage determinations and redeterminations. The requested review period for this monitoring effort is February 1, 2019 – April 30, 2019. Findings from this monitoring effort may result in compliance actions, if necessary, and may have implications for the Star Ratings data integrity reviews for the four (4) appeals measures. On January 6, 2020, CalOptima was formally notified of its selection for this monitoring effort. The CMS validation webinars were held on February 7, 2020. Audit results are pending.

- Calendar Year (CY) 2015 Medicare Part C National Risk Adjustment Data Validation (RADV) Audit:

  On November 21, 2019, CMS notified CalOptima that its OneCare program was selected to participate in the CY 2015 RADV audit. On January 10, 2020, CMS released the enrollee list and opened the submission window. CMS selected a total of thirty-three (33) members for this audit. CalOptima is working to provide the requested medical record documentation to CMS by the regulatory deadline of July 10, 2020.

- Medicare Data Validation Audit (applicable to OneCare and OneCare Connect):

  On an annual basis, CMS requires all plan sponsors to engage an independent consultant to conduct a validation audit of all Medicare Parts C and D data reported for the prior calendar year. A kick-off call with CalOptima's independent contractor, Advent, was held on January 6, 2020. The validation audit is expected to take place from March through June 2020. The audit includes a webinar validation and source documentation review for the following Medicare Parts C and D measures:

  - Parts C and D Grievances
  - Organization Determinations and Reconsiderations
  - Coverage Determinations and Redeterminations
  - Medicare Therapy Management (MTM) Program
  - Special Needs Plan (SNP) Care Management
  - Improving Drug Utilization Review (IDUR) Controls

2. OneCare Connect

- National 2018 Risk Adjustment Data Validation (NAT18 RADV) Audit:

  On January 13, 2020, CMS informed CalOptima that its OneCare Connect program has been selected to participate in the CY 2018 Medicare Part C Improper Payment Measurement, known as the National Risk Adjustment Data Validation (RADV) audit. CMS will be conducting medical record reviews to validate the accuracy of the CY 2018 Medicare Part C risk adjustment data. The results of this review will be used to calculate a program-wide improper payment rate for Medicare Part C.

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3. Medi-Cal

- 2020 DHCS Medical Audit (Medi-Cal and OneCare Connect):

  On November 7, 2019, DHCS sent CalOptima an engagement notice for a medical audit of CalOptima's Medi-Cal and OneCare Connect programs. The audit covered the review period of February 1, 2019 to January 31, 2020. The onsite audit took place from January 27, 2019 to February 7, 2019, and covered CalOptima's provision of Medi-Cal services to its non-Seniors and Persons with Disabilities (non-SPD) members, Medi-Cal services for SPDs, as well as Medicaid-based services in OneCare Connect.

  The DHCS evaluated CalOptima's compliance with its contract and regulations in the areas of utilization management, case management and coordination of care, member rights, quality management, and administrative and organizational capacity.

- Rate Development Template (RDT) Audit:

  On May 30, 2019, Mercer and the DHCS engaged CalOptima for the RDT audit, which focuses on the accuracy and completeness of CY 2017 Medi-Cal RDT encounter and financial data submitted to the DHCS as part of the rate development process for 2019-2020.

  On August 7, 2019, Mercer auditors came onsite to review CalOptima's claims systems as well as conduct staff interviews. CalOptima anticipates a final draft report from Mercer in the near future. CalOptima will have one (1) week to provide any feedback before Mercer communicates the report to the DHCS for final review and approval.

- Department of Managed Health Care (DMHC) Routine Examination:

  On August 8, 2019, the DMHC engaged CalOptima for the tri-annual Routine Examination. This examination reviewed CalOptima's fiscal and administrative affairs and included an examination of CalOptima's financial reports.

  On January 9, 2020, the DMHC provided CalOptima with a draft audit report. The DMHC report noted CalOptima was in compliance in all areas, and no deficiencies were identified. CalOptima completed its review of the draft final report within the required ten (10) calendar days. At this time, no further action is required from CalOptima. DMHC will publish the final report on its website.

- CMS Medicaid Expansion Medical Loss Ratio (MLR) Examination:

  On April 1, 2019, CMS informed CalOptima that it will perform a comprehensive examination and validation of California Medicaid managed care plans' MLR reporting for the reporting periods January 1, 2014 to June 30, 2015 and July 1, 2015 to June 30, 2016. The overall purpose of the examination is to ensure that the financial information submitted by the Medicaid managed care plans and used by the DHCS to perform the MLR calculations is consistent with contractual obligations and matches each Medicaid managed

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care plan's internal data and accounting systems. CMS expects that the review will be completed within six (6) months after all the data have been received by the reviewing contractor.

B. Regulatory Notices of Non-Compliance

On December 20, 2019, CalOptima received a Notice of Deficiency from the DHCS. In the notice, the DHCS identified two (2) instances in October 2019 where CalOptima failed to timely notify the DHCS of changes in the availability or location of covered services, including termination of network providers and subcontractors. CalOptima submitted a timely response to the DHCS on January 19, 2020.

On January 31, 2020, DHCS confirmed the acceptance and closure of CalOptima's plan for remediation. Regulatory Affairs & Compliance will continue to track this issue and may issue internal requests for corrective action, if necessary.

C. Updates on Internal and Health Network Monitoring and Audits

1. Internal Monitoring: Medi-Cal [a\]

- Medi-Cal: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
September 2019	100%	100%	100%	97%
October 2019	100%	100%	100%	100%
November 2019	100%	100%	100%	100%

➢ For the November 2019 file review of Medi-Cal claims, CalOptima's Claims department received a compliance score of 100% based on a focused review of sixty (60) claims.

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- Medi-Cal Claims: Provider Dispute Resolutions (PDRs)

Month	Paper PDRs Acknowledged within ≤ 15 Business Days	PDRs Resolved within ≤ 45 Business Days	Accurate PDR Determinations	Clear and Specific PDR Resolution Language	Interest Accuracy and Timeliness within ≤ 5 Business Days
September 2019	100%	100%	90%	100%	100%
October 2019	100%	100%	93%	100%	50%
November 2019	98%	100%	93%	100%	98%

- For the November 2019 file review of Medi-Cal PDRs, CalOptima's Claims department received a compliance score of 98% based on a focused review of forty (40) PDRs.
- The lower compliance score of 93% for accurate PDR determinations for November 2019 was due to inaccurate PDR determinations.
- CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the focused review of PDRs. The A&O department continues to work with the Claims department to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions --- to ensure accurate and timely processing of PDRs within regulatory requirements.

2. Internal Monitoring: OneCare [a\]

- OneCare Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
September 2019	100%	100%	100%	100%
October 2019	100%	100%	100%	100%
November 2019	100%	100%	100%	60%

- For the November 2019 file review of PACE claims, CalOptima's Claims department received a compliance score of 90% based on a focused review of thirty (30) paid and denied claims selected for review.
- The lower compliance score of 60% for denied claims accuracy for November 2019 was due to four (4) inaccurate claims.

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- CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the review of paid and denied claims. The A&O department continues to work with the Claims department to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions --- to ensure timely and accurate processing of claims within regulatory requirements.

- OneCare Claims: Provider Dispute Resolutions (PDRs)

Month	Determination Accuracy	Resolution Timeliness	Letter Accuracy
September 2019	100%	100%	N/A
October 2019	100%	100%	100%
November 2019	100%	100%	100%

- For the November 2019 file review of OneCare PDRs, CalOptima's Claims department received a compliance score of 100% based on a focused review of nine (9) PDRs selected for review.

3. Internal Monitoring: OneCare Connect [a\]

- OneCare Connect Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
August 2019	100%	90%	100%	100%
September 2019	90%	100%	100%	100%
November 2019	100%	100%	100%	100%

- For the November 2019 file review of OneCare Connect claims, CalOptima's Claims department received a compliance score of 100% based on a focused review of thirty (30) paid and denied claims selected for review.

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- OneCare Connect Claims: Provider Dispute Resolutions (PDRs)

Month	Determination Accuracy	Resolution Timeliness	Letter Accuracy
September 2019	100%	100%	N/A
October 2019	100%	100%	100%
November 2019	95%	100%	100%

  - For the November 2019 file review of OneCare Connect PDRs, CalOptima's Claims department received a compliance score of 98% based on a focused review of twenty (20) PDRs selected for review.

4. Internal Monitoring: PACE [a\]

- PACE Claims: Professional Claims

Month	Paid Claims Accuracy	Paid Claims Timeliness	Denied Claims Accuracy	Denied Claims Timeliness
September 2019	100%	100%	90%	100%
October 2019	100%	100%	100%	100%
November 2019	100%	100%	100%	100%

  - For the November 2019 file review of PACE claims, CalOptima's Claims department received a compliance score of 100% based on a focused review of thirty (30) paid and denied claims selected for review.

- PACE Claims: Provider Dispute Resolutions (PDRs)

Month	Determination Accuracy	Letter Accuracy	Resolution Timeliness	Check Lag
September 2019	100%	100%	100%	100%

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October 2019	100%	100%	100%	N/A
November 2019	100%	100%	100%	N/A

- For the November 2019 file review of PACE PDRs, CalOptima's Claims department received a score of 100% based on a focused review of twenty (20) PDRs selected for review.

- PACE: Service Delivery Requests (SDRs)

Month	SDR Denials	SDR Approvals
September 2019	100%	100%
October 2019	100%	100%
November 2019	0%	100%

- For the November 2019 file review of PACE SDRs, CalOptima's PACE department received a score of 50% based on a focused review of six (6) SDRs selected for review.
- The lower compliance score of 0% for SDR denials for November 2019 was due to missing documentation based on a review of three (3) SDRs.
- CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the focused review of SDRs. The A&O department continues to work with the PACE department to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions --- to ensure accurate processing of SDRs within regulatory requirements.

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5. Health Network Monitoring: Medi-Cal [a\]

- Medi-Cal Utilization Management (UM): Prior Authorization (PA) Requests

Month	Timeliness for Urgent	Clinical Decision Making (CDM) for Urgent	Letter Score for Urgent	Timeliness for Routine	Timeliness for Denials	CDM for Denials	Letter Score for Denials	Timeliness for Modified	CDM for Modified	Letter Score for Modified	Timeliness for Deferrals	CDM for Deferrals	Letter Score for Deferrals
September 2019	45%	89%	96%	68%	77%	77%	93%	86%	77%	94%	75%	67%	88%
October 2019	69%	80%	90%	67%	72%	83%	97%	71%	83%	92%	100%	84%	96%
November 2019	83%	80%	94%	89%	91%	72%	93%	84%	77%	93%	100%	61%	87%

- Based on a focused review of select files, six (6) health network drove the lower compliance score for clinical decision making (CDM). Seventy-two (72) of the eighty-nine (89) files received from the six (6) health networks were deficient. Deficiencies for the lower scores for CDM include the following:
  - Failure to obtain adequate clinical information
  - Failure to cite criteria for decision

- Based on a focused review of select files, six (6) health networks drove the lower compliance letter score. Twenty-eight (28) of the thirty-two (32) files received from the six (6) health networks were deficient. Deficiencies for the lower letter scores include the following:
  - Failure to provide letter with description of services in lay language
  - Failure to describe why the request did not meet criteria in lay language
  - Failure to include name and contact information for health care professional responsible for the decision to deny or modify
  - Failure to provide peer-to-peer discussion of the decision with medical reviewer

- Based on the overall universe of Medi-Cal authorizations for October 2019, CalOptima's health networks received an aggregate compliance score of 99.7% for timely processing of routine authorization requests and a compliance score of 96.9% for timely processing of expedited authorization requests.

- CalOptima's Audit & Oversight (A&O) department issued requests for corrective action plans (CAPs) to all health networks with deficiencies identified during the focused review of prior authorization requests. The A&O department continues to work with each health network to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as, but may not be limited to training, process development, system enhancements, ongoing inline monitoring, and policy revisions to

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ensure timeliness and accuracy of processing of authorizations within regulatory requirements.

- Medi-Cal Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
September 2019	95%	95%	88%	79%
October 2019	89%	93%	94%	92%
November 2019	98%	95%	99%	92%

  - Based on the overall universe of Medi-Cal claims for October 2019, CalOptima's health networks received an overall compliance score of 98% for timely processing of claims.

  - CalOptima's Audit & Oversight (A&O) department issued requests for corrective action plans (CAPs) to all health networks with deficiencies identified during the focused review of claims processing for timeliness and accuracy. The A&O department continues to work with each health network to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as, but may not be limited to training, process development, system enhancements, ongoing inline monitoring, and policy revisions to ensure timeliness and accuracy of claims processing within regulatory requirements.

6. Health Network Monitoring: OneCare [a\]

- OneCare Utilization Management: Prior Authorization Requests

Month	Timeliness for Expedited Initial Organization Determinations (EIOD)	Clinical Decision Making for EIOD	Letter Score for EIOD	Timeliness for Standard Organization Determinations (SOD)	Letter Score for SOD	Timeliness for Denials	Clinical Decision Making for Denials	Letter Score for Denials
September 2019	70%	100%	100%	94%	94%	100%	84%	96%
October 2019	100%	100%	100%	93%	97%	100%	84%	96%
November 2019	100%	NTR	100%	100%	91%	100%	75%	95%

  - Based on a focused review of select files, three (3) health networks drove the lower compliance score for clinical decision making (CDM). All four (4) of the files received from the three (3) health networks were deficient. Deficiencies for the lower scores for CDM include the following:

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  - Failure to cite criteria for decision

- Based on a focused review of select files, two (2) health networks drove the lower compliance letter score. Seven (7) files of the twelve (12) files received from the two (2) health networks were deficient. Deficiencies for the lower letter scores include the following:
  - Failure to provide letter with description of services in lay language
  - Failure to describe why the request did not meet criteria in lay language

- Based on the overall universe of OneCare authorization requests for CalOptima's health networks for October 2019, CalOptima's health networks received an overall compliance score of 98% for timely processing of standard Part C authorization requests and 88% for timely processing of expedited Part C authorization requests.

- CalOptima's Audit & Oversight (A&O) department issued requests for corrective action plans (CAPs) to all health networks with deficiencies identified during the review of prior authorization requests. The A&O department continues to work with each health network to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as, but may not be limited to training, process development, system enhancements, ongoing inline monitoring, and policy revisions to ensure timeliness and accuracy of processing of authorizations within regulatory requirements.

- OneCare Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
September 2019	100%	100%	94%	88%
October 2019	100%	100%	96%	82%
November 2019	100%	100%	89%	100%

- Based on a focused review of select files, the compliance score for denied claims timeliness decreased from 96% in October 2019 to 89% in November 2019 due to untimely processing of multiple claims. The lower score was driven by one (1) health network with seven (7) of the eleven (11) files received marked as deficient for denied claims timeliness for November 2019.

- Based on the overall universe of OneCare claims for CalOptima's health networks for October 2019, CalOptima's health networks received the following overall compliance scores for timely processing of claims:
  - 88% for non-contracted clean claims paid or denied within thirty (30) calendar days of receipt

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- 99.8% for contracted clean and unclean and non-contracted unclean claims paid or denied within sixty (60) calendar days of receipt

➢ CalOptima's Audit & Oversight (A&O) department issued requests for corrective action plans (CAPs) to all health networks with deficiencies identified during the focused review of claims processing for timeliness and accuracy. The A&O department continues to work with each health network to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as, but may not be limited to training, process development, system enhancements, ongoing inline monitoring, and policy revisions to ensure timeliness and accuracy of claims processing within regulatory requirements.

7. Health Network Monitoring: OneCare Connect [a\]

- OneCare Connect Utilization Management: Prior Authorization Requests

Month	Timeliness for Urgents	Clinical Decision Making (CDM) for Urgents	Letter Score for Urgents	Timeliness For Routine	Letter Score for Routine	Timeliness for Denials	CDM for Denials	Letter Score for Denials	Timeliness for Modifieds	CDM for Modifieds	Letter Score for Modifieds
September 2019	72%	100%	98%	86%	86%	93%	74%	92%	100%	83%	96%
October 2019	88%	100%	99%	90%	92%	70%	60%	73%	100%	89%	95%
November 2019	91%	100%	93%	81%	82%	96%	73%	96%	57%	84%	95%

➢ Based on a focused review of select files, five (5) health networks drove the lower compliance score for timeliness. Ten (10) files of the thirty-four (34) files received from the five (5) health networks were deficient. Deficiencies for the lower scores for timeliness include the following:
- Failure to meet timeframe for decision (Routine – 5 Business Days)
- Failure to meet timeframe for provider initial notification (All-24 hours)
- Failure to meet timeframe for provider written notification (2 Business Days)

➢ Based on a focused review of select files, one (1) health network drove the lower compliance score for clinical decision making (CDM). All three (3) of the files received from the health network were deficient. Deficiencies for the lower scores for CDM include the following:
- Failure to cite criteria for decision

➢ Based on a focused review of select files, five (5) health networks drove the lower compliance letter score. Nineteen (19) files of the fifty-five (55) files received from the five (5) health networks were deficient. Deficiencies for the lower letter scores include the following:
- Failure to provide letter with description of services in lay language

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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- Based on the overall universe of OneCare Connect authorization requests for CalOptima's health networks for October 2019, CalOptima's health networks received an overall compliance score of 98% for timely processing of routine authorization requests and 99% for timely processing of expedited authorization requests.

- CalOptima's Audit & Oversight (A&O) department issued requests for corrective action plans (CAPs) to all health networks with deficiencies identified during the review of prior authorization requests. The A&O department continues to work with each health network to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as, but may not be limited to training, process development, system enhancements, ongoing inline monitoring, and policy revisions to ensure timeliness and accuracy of processing of authorizations within regulatory requirements.

- OneCare Connect Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
September 2019	83%	92%	98%	93%
October 2019	88%	88%	94%	85%
November 2019	97%	98%	98%	97%

- Based on the overall universe of OneCare Connect claims for CalOptima's health networks for October 2019, CalOptima's health networks received the following overall compliance scores:
  - 96% for non-contracted and contracted clean claims paid or denied within 30 calendar days of receipt
  - 98% for non-contracted and contracted unclean claims paid or denied within 45 calendar days of receipt
  - 99% for non-contracted and contracted clean claims paid or denied within 90 calendar days of receipt

- CalOptima's Audit & Oversight (A&O) department issued requests for corrective action plans (CAPs) to all health networks with deficiencies identified during the review of claims processing for timeliness and accuracy. The A&O department continues to work with each health network to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as, but may not be limited to training, process development, system enhancements, ongoing inline monitoring, and policy revisions to ensure timeliness and accuracy of claims processing within regulatory requirements.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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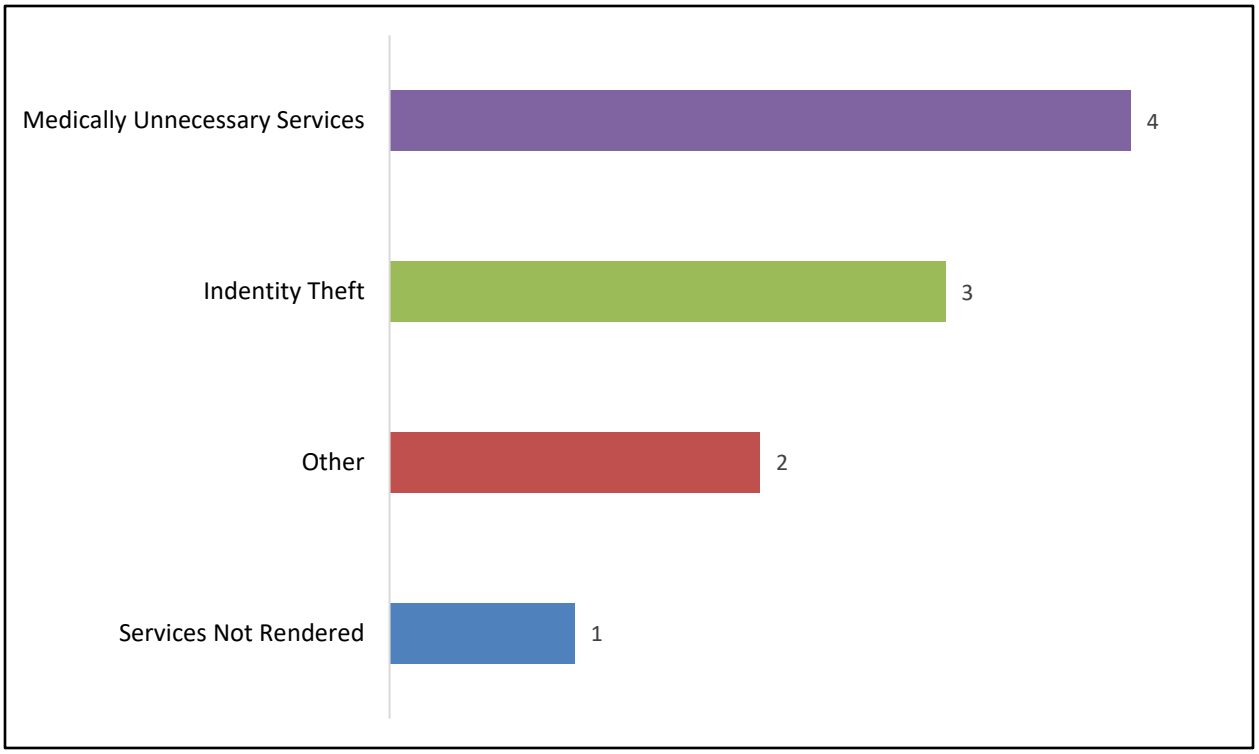
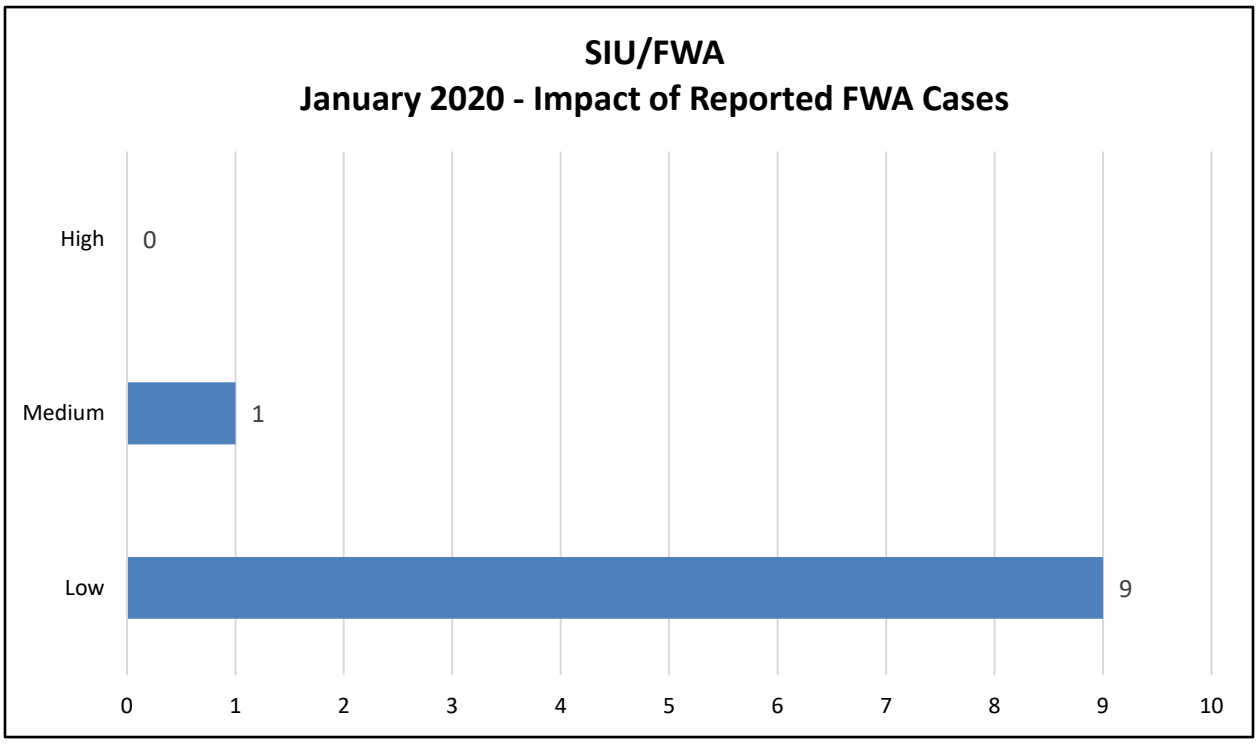
D. Special Investigations Unit (SIU) / Fraud, Waste & Abuse (FWA) Investigations

Types of FWA Cases: (Received in January 2020)





a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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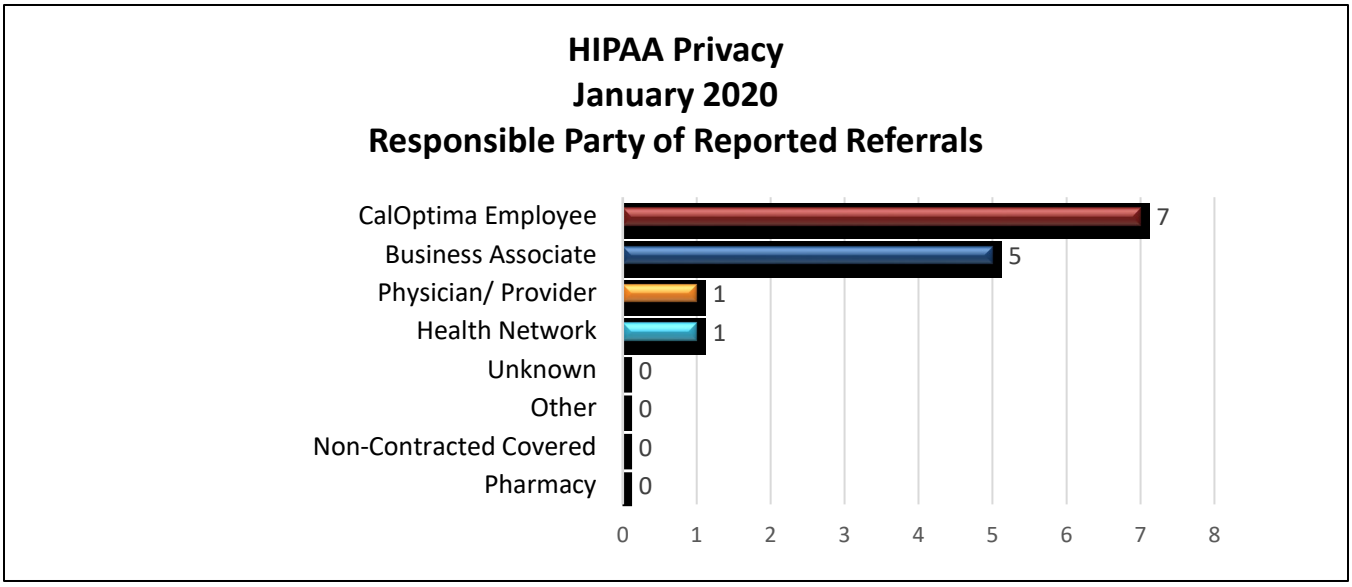
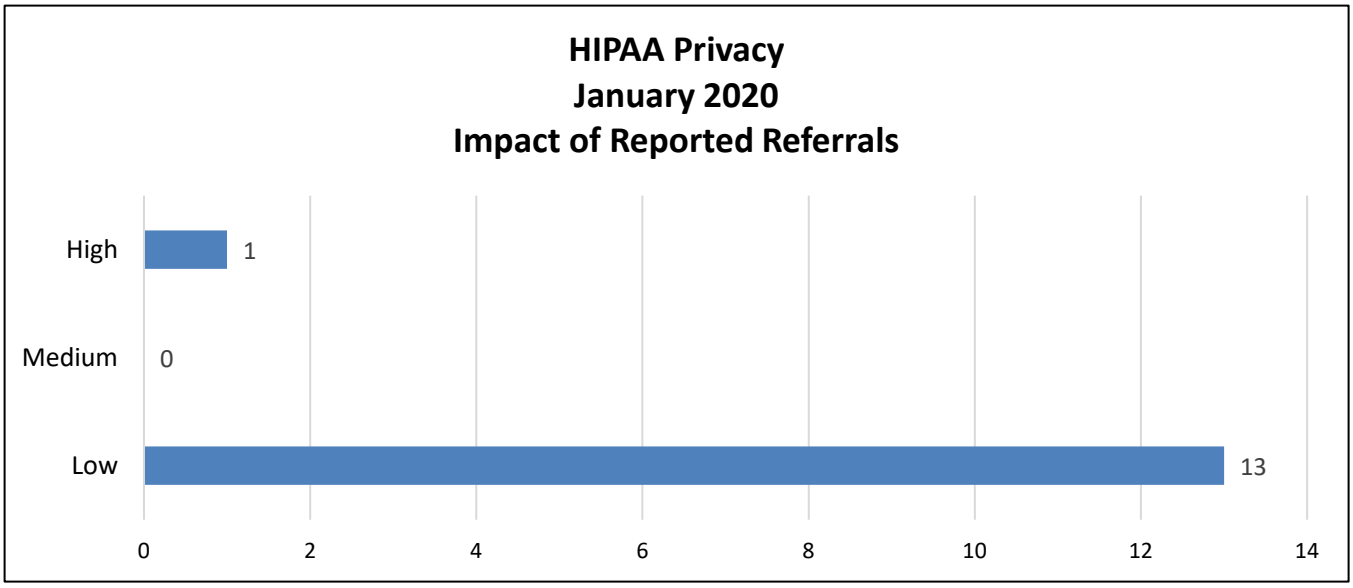
E. Privacy Update (January 2020)





Total Number of Referrals Reported to DHCS (State)	13
Total Number of Referrals / Breaches Reported to DHCS and Office for Civil Rights (OCR)	1
Total Number of Referrals Reported	**14**

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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Akin Gump
STRAUSS HAUER & FELD LLP

M E M O R A N D U M

February 11, 2020

To: CalOptima

From: Akin Gump Strauss Hauer & Feld, LLP

Re: February Board of Directors Report

The release of the President's Budget Request kicked off the appropriations process on February 10; though a final spending deal is unlikely to be inked before the election, the next few months will see a flurry of hearings and markups on fiscal 2021 funding. In other news, several House committees are moving forward with differing versions of surprise medical billing legislation, hoping to reach agreement before the May 22 deadline for the next extension of expiring health care programs. This report covers legislative activity through February 11, 2020, and previews upcoming activity.

President's Budget

The White House released President Trump's $4.8 trillion Fiscal Year (FY) 2021 Budget Request on February 10, proposing steep cuts to health care and safety net programs while boosting spending for the military and border security. The Budget requests $94.5 billion in discretionary funding for the Department of Health and Human Services (HHS), a 10-percent decrease from the 2020 enacted level. The Administration proposes to save roughly $465 billion over 10 years by eliminating "wasteful federal spending" in Medicare and an additional $52 billion by eliminating "wasteful spending, fraud and abuse" in Medicaid.

The Budget contains a number of proposals related to the Medicaid program. Notably, the document calls for finalization of the Medicaid Fiscal Accountability Rule, stating that the regulation would "improve the transparency and oversight of Medicaid supplemental payments" and prevent "gaming" by government entities and private providers. In addition, the Budget proposes to limit Medicaid reimbursement for health care providers operated by a governmental entity to an amount not exceeding the actual cost of providing those services. According to the summary document, this change will prevent states from using supplemental payments to public providers to circumvent Medicaid matching requirements.

The President's Budget also proposes several changes to Medicaid waiver policies. Touting recent changes, the Budget states that the Centers for Medicare and Medicaid Services (CMS) has adopted new strategies for more efficient approvals of Section 1115 and 1915 waivers and is offering states "unprecedented flexibility" in designing new programs. The Budget proposes to eliminate the current five-year time limit for Section 1915(b) waivers and would give the HHS

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Secretary flexibility to determine the approval timeframe for Medicaid managed care enrolled populations. Additionally, the Budget includes a proposal that would allow states to grandfather managed care authorities in waivers and demonstrations under their state plans if there are no substantive changes and the state has renewed the waiver at least once before.

A number of Medicaid provisions in the President's Budget achieve savings by tightening or restricting eligibility for the program. Most notably, the Administration proposes to save $152 billion over 10 years by implementing "community engagement requirements" that would require "able-bodied, working-age individuals" Medicaid enrollees to find employment, train for work, or perform community service in order to receive benefits. Another proposal would require individuals to provide documentation of citizenship or eligible immigration status before receiving Medicaid benefits. Under current law, states must enroll individuals who claim they have such documentation. After a certain period, individuals must submit this documentation in order to maintain enrollment. By prohibiting federal payments for Medicaid benefits during this period, the Budget proposes to save $2.2 billion over 10 years. The Budget proposes to allow states the option to apply asset tests to populations determined financially eligible by the Modified Adjusted Gross Income (MAGI) standard, including individuals eligible through the MAGI standard who are receiving long-term care.

The President's Budget also contains proposals on current Medicaid policies related to the Institutions for Mental Diseases (IMD) payment exclusion, non-emergency medical transportation, and disproportionate share hospital (DSH) allotments.

Democrats have criticized the President's Budget, with House Speaker Nancy Pelosi (D-CA) decrying the "savage" cuts to Medicare and Medicaid proposed by the White House. While many of the proposals contained in the President's Budget are unlikely to be taken up by Congress, the document does provide insight into the Administration's policy goals and potential regulatory actions.

Surprise Medical Billing

House Ways and Means Committee Chairman Richie Neal (D-MA) and Ranking Member Kevin Brady (R-TX) on February 7 released their surprise billing legislation, the Consumer Protection Against Surprise Medical Bills Act. Unlike the bill negotiated by House Energy and Commerce Committee leaders and Senate Health, Education, Labor and Pensions (HELP) Committee Chairman Lamar Alexander (R-TN), the Ways and Means legislation does not rely on a benchmark payment approach to determine reimbursement in out-of-network billing situations. Rather, the bill would allow either party to initiate an open negotiation process. If no agreement on payment is reached after 30 days, an independent third party would mediate a dispute

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resolution process using "baseball-style" arbitration. The Committee plans to mark up the legislation on February 12.

House Education and Labor Committee Chairman Bobby Scott (D-VA) is also proceeding to mark up surprise billing legislation on February 11. The Ban Surprise Billing Act includes two mechanisms to resolve payment disputes: for amounts less than or equal to $750 (or $25,000 for air ambulance services), the bill relies on the median in-network payment rate; for amounts above $750 (or $25,000 for air ambulance), the parties may elect to use an independent dispute resolution process. Some Members on the Committee, including Reps. Phil Roe (R-TN) and Donna Shalala (D-FL), have complained that the bill favors insurers and said they would oppose the legislation as currently written.

Meanwhile, leaders of the House Energy and Commerce Committee and the Senate HELP Committee stated that they look forward to working together with the Ways and Means and Education and Labor Committees on a bipartisan, bicameral solution. House Speaker Nancy Pelosi (D-CA) had asked Members to work quickly to ready surprise billing legislation for the May 22 health package that is expected to extend a number of expiring health care provisions, including several Medicaid programs.

Drug Pricing

Drug pricing proposals also have been targeted for potential inclusion in the May "extenders" legislative package. House Democrats voted in December to approve the Elijah E. Cummings Lower Drug Costs Now Act (H.R. 3), but Senate Majority Leader Mitch McConnell (R-KY) continues to refuse to take up the bill, which relies on government price negotiation and international reference pricing. Nor has Leader McConnell committed to bringing the Senate Finance Committee-passed Prescription Drug Pricing Reduction Act (S. 2543) to the floor, despite the President voicing support for the measure. Many Republican Senators are opposed to the bill's penalties for drug price increases that outpace inflation. A group of six Republican Senate Finance Committee Members have also introduced an alternative drug pricing bill, S. 3129, which further complicates Finance Chairman Chuck Grassley's (R-IA) efforts to pass S. 2543.

The Trump Administration still has yet to release its International Pricing Index (IPI) Model proposed rule, which would tie the price of certain Medicare Part B drugs to reference prices in other countries. The unpopularity of the IPI Model proposal is seen as a potential catalyst for Senate action on drug pricing.

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Affordable Care Act Litigation

The Supreme Court will use its private conference on February 21 to consider whether to hear *Texas v. United States* during the current term. The lawsuit was brought by Republican state attorneys general who argue that the Affordable Care Act (ACA) is no longer constitutional after the so-called individual mandate penalty was zeroed out in 2017. In December, the Court of Appeals for the Fifth Circuit remanded the case back to the Texas district court to reconsider the scope of the severability of the individual mandate from other provisions of the 2010 law. If four justices vote to review the case during the current term, a final decision could be handed down this year. Meanwhile, GOP-led states and the Department of Justice are urging the Supreme Court to wait for in the district court to reconsider the severability arguments on remand before taking up the case.

Irrespective of what happens in the legal proceedings, Congressional Democrats are seeking to include ACA "fix" bills as part of the upcoming health extenders package. Legislation to align ACA enrollment with tax filing, amend health savings account rules, enhance provider directories, extend the enhanced federal matching rates for Medicaid expansion, and grant states flexibility to pursue universal coverage has recently gained the support of moderate Democrats. These bills, along with legislation to fix glitches in the ACA, make subsidies more generous, and reverse the Administration's actions to promote short-term plans, may be taken up by the House on or around the law's ten-year anniversary in March.

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CALOPTIMA
LEGISLATIVE REPORT
By Don Gilbert and Trent Smith
February 24, 2020

The deadline to introduce new bills was February 21. Close to 1500 bills were introduced in the week before the deadline. A total of over 4800 bills were introduced in the two-year session spanning 2019 and 2020, which is reported to be a new record for the most bills introduced in a single legislative session. Many of the newly introduced bills are "spot bills" that propose only minor or technical changes in law. Spot bills are usually introduced to provide the author with a bill that can be amended with more substantial language at a later date. By legislative rule, bills cannot be amended for 30 days after they are introduced. This means that in late March hundreds of bills will be amended with new legislative proposals, thereby creating what is essentially a second bill introduction deadline.

Last month, the Chairman of the Assembly Health Committee, Assemblyman Jim Wood, sent a letter to all Legislators warning them to be judicious in introducing bills that mandate new health care services. He warned that a fiscal analysis on new mandates must be provided and that he wants to balance the need and desire to provide new services with the growing cost of providing health care and health insurance.

While we are still reviewing many of the bills introduced in the last few days, below are some bills of interest that we have already identified.

AB 2239 Health care: physician loan repayment
Would require $2,000,000 to be annually transferred from the Managed Care Administrative Fines and Penalties Fund to the Medically Underserved Account for Physicians.

AB 2258 Doula care: Medi-Cal pilot program
Would require the State Department of Health Care Services (DHCS) to establish, commencing July 1, 2021, a full-spectrum doula care pilot program to operate for three years for pregnant and postpartum Medi-Cal beneficiaries residing in 14 counties, including Orange County that experience the highest burden of birth disparities in the state.

AB 2276 Medi-Cal: Blood lead screening tests
Would require the State Department of Health Care Services to ensure that a Medi-Cal beneficiary who is a child receives blood lead screening tests at 12 and 24 months of

age, and that a child two to six years of age, inclusive, receives a blood lead screening test if there is no record of a previous test for that child.

AB 2277 Medi-Cal: blood lead screening tests
Would require any Medi-Cal managed care health plan contract to impose requirements on the contractor on blood lead screening tests for children, including identifying every enrollee who does not have a record of completing those tests and reminding the responsible health care provider of the need to perform those tests.

AB 2278 Childhood lead poisoning prevention
This bill would require the laboratory to report the name of the health plan paying for the test to DHCS for each analysis on every person tested.

AB 2288 Schedule II controlled substances: partial fill
The Pharmacy Law specifies the functions pharmacists are authorized to perform, including to administer, orally or topically, drugs and biologicals pursuant to a prescriber's order, and to administer immunizations pursuant to a protocol with a prescriber. Current law authorizes a pharmacist to dispense a Schedule II controlled substance as a partial fill if requested by the patient or prescriber. This bill would require a pharmacist to offer to a patient to dispense a Schedule II controlled substance containing an opioid as a partial fill if the prescription is for greater than seven days.

AB 2295 State real property: Fairview Developmental Center
Would declare the intent of the Legislature to enact legislation relating to the development of the state real property known as the Fairview Developmental Center in the City of Costa Mesa, County of Orange.

AB 2144 Health care coverage: step therapy
Would clarify that a health care service plan may require step therapy if there is more than one drug that is appropriate for the treatment of a medical condition. The bill would require a health care service plan or health insurer to expeditiously grant a step therapy exception if specified criteria are met. The bill would authorize an enrollee or insured or their designee, guardian, primary care physician, or health care provider to file an appeal of a prior authorization or the denial of a step therapy exception request, and would require a health care service plan or health insurer to designate a clinical peer to review those appeals. The bill would require a health care service plan, health insurer, or utilization review organization to annually report specified information about their step therapy exception requests and prior authorization requests to DHCS of Managed Health Care or DHCS of Insurance, as appropriate.

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AB 2170 Eligibility: redetermination
Would require a county welfare department to conduct a redetermination of eligibility for the Medi-Cal program for any juvenile who is either detained at a juvenile detention enter or an inmate of a public institution and would provide that Medi-Cal eligibility be restored upon their release from that facility if they meet eligibility requirements.

AB 2100 Medi-Cal: pharmacy benefits
By executive order, the Governor directed the State Department of Health Care Services Department to transition pharmacy services for Medi-Cal managed care to a fee-for-service benefit by January 1, 2021. This bill would require DHCS to establish the Independent Medical Review System (system) for the outpatient pharmacy benefit, and to develop a framework for the system that models the Knox-Keene Health Care Service Plan Act.

AB 2001 Alzheimer's Disease and Dementia Caregiver pilot program
Would require the California Department of Aging, upon appropriation by the Legislature, to establish and administer the Alzheimer's Disease and Dementia Caregiver Pilot Program, a three-year pilot program, to support expanded access to evidence-based or evidence-derived dementia caregiver education programs, and to perform specified duties, including prioritizing innovative proposals seeking to reach specified communities, and awarding grants.

AB 2007 Medi-Cal: federally qualified health center: rural health clinic: telehealth
Current law prohibits a requirement of in-person contact between a health care provider and a Medi-Cal patient when the service may be provided by telehealth, and for purposes of telehealth, prohibits DHCS from limiting the type of setting where Medi-Cal services are provided. Current law authorizes, to the extent that federal financial participation is available, the use of health care services by store and forward under the Medi-Cal program, subject to billing and reimbursement policies developed by DHCS, and prohibits a requirement of in-person contact between a health care provider and a Medi-Cal patient when these services are provided by store and forward. This bill would provide that an FQHC or RHC "visit" includes an encounter between an FQHC or RHC patient and a health care provider using telehealth by synchronous real time or asynchronous store and forward.

AB 1986 Health care coverage: colorectal cancer: screening and testing
Would require a health care service plan contract or a health insurance policy, except as specified, that is issued, amended, or renewed on or after January 1, 2021, to provide coverage for colorectal cancer screening examinations and laboratory tests, as specified.

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SB 885 Sexually transmitted diseases
Would specify that family planning services for which a Medi-Cal managed care plan may not restrict a beneficiary's choice of a qualified provider include sexually transmitted disease (STD) testing and treatment.

AB 1943 Insulin affordability
Would state the intent of the Legislature to enact legislation that would help ensure that insulin is available and affordable to all Californians.

AB 1965 Family Planning, Access, Care, and Treatment (Family PACT) Program
Would expand comprehensive clinical family planning services under the Family Planning, Access, Care, and Treatment (Family PACT) Program to include the human papillomavirus (HPV) vaccine for persons of reproductive age.

SB 854 Health care coverage: substance use disorders
Would require health care service plans and health insurers that provide prescription drug benefits for the treatment of substance use disorders to place prescription medications approved by the United States Food and Drug Administration (FDA) on the lowest cost-sharing tier of the plan or insurer's prescription drug formulary.

AB 910 Medi-Cal: dispute resolution
Would require a county mental health plan and Medi-Cal managed care plan that are unable to resolve a dispute to submit a request for resolution to the State Department of Health Care Services. The bill would require DHCS to issue a written decision to the plans within 30 calendar days from receipt of the request by either the county mental health plan or the Medi-Cal plan. The bill would also prohibit the dispute from delaying the provision of medically necessary services, as specified.

SB 852 Health care: prescription drugs
Would state the intent of the Legislature to introduce legislation to require the State of California to manufacture generic prescription drugs for the purposes of controlling prescription drug costs. The bill would also make related findings and declarations.

AB 2266 Mental Health Services Act: use of funds for substance use disorder treatment
This bill would require DHCS to establish a pilot program in up to 10 counties and would authorize funding from the MHSA, commencing January 1, 2022, and continuing until January 1, 2027, to be used by participating counties to treat a person with co-occurring mental health and substance use disorders when the person would be eligible for treatment of the mental health disorder pursuant to the MHSA.

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AB 2492 California Program of All-Inclusive Care for the Elderly (PACE program)
This bill would require DHCS, if DHCS approves a PACE center to provide PACE services, to authorize the PACE center to provide services for the maximum number of individuals for which the PACE center is eligible to provide. The bill would further require DHCS to give this authorization in writing and provide detailed reasons for the specific maximum number of individuals for which the PACE center is eligible to provide services.

AB 2739 Medi-Cal: monthly maintenance amount: personal and incidental needs
Existing law requires DHCS to establish income levels for maintenance needs at the lowest levels that reasonably permit a medically needy person to meet their basic needs for food, clothing, and shelter, and for which federal financial participation will still be provided under applicable federal law. In calculating the income of a medically needy person in a medical institution or nursing facility, or a person receiving institutional or non-institutional services from a Program of All-Inclusive Care for the Elderly organization, the required monthly maintenance amount includes an amount providing for personal and incidental needs in the amount of not less than $35 per month while a patient. Existing law authorizes DHCS to increase, by regulation, this amount as necessitated by increasing costs of personal and incidental needs.

This bill would increase the monthly maintenance amount for personal and incidental needs from $35 to $80 and would require DHCS to annually adjust that amount by the same percentage as the Consumer Price Index.

We will be adding more bills to the tracking list in the coming days and weeks once we can finish our review process and after bills are amended in 30 days. Committee hearings to debate these bills will begin in mid-March.

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2019–20 Legislative Tracking Matrix

BEHAVIORAL HEALTH

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 910 Wood	**Mental Health Services Dispute Resolution:** Would provide the Department of Health Care Services (DHCS) more authority to resolve coverage disputes between the specialty mental health plan (MHP) and the Medi-Cal managed care plan (MCP) if the MHP and the MCP are unable to do so within 15 days. Would require the MHP and the MCP to continue to provide mental health services during the DHCS review period. DHCS would have no more than 30 days to resolve the dispute to determine which agency is responsible for that Medi-Cal beneficiary.	**01/30/2020** Passed Assembly floor; Referred to Senate floor **02/20/2020** Introduced	CalOptima: Watch
AB 2265 Quirk-Silva	**Mental Health Services Act (MHSA) Funds for Cooccurring Conditions:** Similar to AB 2266, would authorize MHSA funds to provide care for an individual experiencing a behavioral health-related issue that cooccurs with a substance use disorder. The authorization would apply across the state.	**02/14/2020** Introduced	CalOptima: Watch
AB 2265 Quirk-Silva	**Mental Health Services Act (MHSA) Funds for Cooccurring Conditions:** Similar to AB 2265, would authorize MHSA funds to be used for a pilot program to provide care for an individual experiencing a behavioral health-related issue that cooccurs with a substance use disorder. The pilot program would take place in 10 counties, including the County of Orange, beginning January 1, 2022 and ending on December 31, 2026.	**02/14/2020** Introduced	CalOptima: Watch
SB 803 Beall	**Mental Health Services Act (MHSA) Funds for Cooccurring Conditions:** Would create the Certified Support Specialist (CSS) certificate program. Would allow parents, peers, and family, 18 years of age or older and who have experienced a mental illness and/or a substance use disorder, to become a CSS. A CSS would be able to provide non-medical mental health and substance abuse support services. Additionally, would require the Department of Health Care Services to include CSS as a provider type, covered by Medi-Cal, no sooner than July 1, 2021. If federally approved, the peer-support program would be funded through Medi-Cal reimbursement.	**01/08/2020** Introduced	CalOptima: Watch

BLOOD LEAD SCREENINGS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 2276 Reyes	**Blood Lead Screening Tests Age Guidelines:** Would require the Medi-Cal managed care plan (MCP) to conduct blood lead screening tests for a Medi-Cal beneficiary at 12 and 24 months of age. Additionally, if a child 2 to 6 years of age does not have medical records stating the completion of a blood lead screening test, the MCP would be required to provide that test. This bill would also require the Department of Health Care Services to notify the beneficiary's parent or guardian that the beneficiary is eligible for blood lead screening tests.	**02/14/2020** Introduced	CalOptima: Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 2277 Salas	**Mental Health Services Act (MHSA) Funds for Cooccurring Conditions:** Similar to AB 2266, would authorize MHSA funds to provide care for an individual experiencing a behavioral health-related issue that cooccurs with a substance use disorder. The authorization would apply across the state.	**02/14/2020** Introduced	CalOptima: Watch
AB 2265 Quirk-Silva	**Blood Lead Screening Tests Contracted Providers:** Would require the Medi-Cal managed care plan (MCP) to impose requirements of the contracted provider to conduct blood lead screenings tests and for the provider to identify patients eligible to receive such tests. Would require the MCP to remind the contracted provider to conduct blood lead screening tests and identify eligible beneficiaries on a monthly basis.	**02/14/2020** Introduced	CalOptima: Watch
AB 2278 Quirk	**Childhood Lead Poisoning Prevention Health Plan Identification:** Would require the name of the health plan financially liable for conducting blood lead screenings tests to be reported by the laboratory to the Department of Health Care Services once the screening test has been completed. The name of the health plan is to be reported for each Medi-Cal beneficiary who receives the blood lead screening tests.	**02/14/2020** Introduced	CalOptima: Watch
AB 2279 Garcia	**Childhood Lead Poisoning Prevention Risk Factors:** Would require the following risk factors be included in the standard risk factors guide, which are to be considered during each beneficiary's periodic health assessment: ■ A child's residency or visit to a foreign country ■ A child's residency in a high-risk ZIP Code ■ A child's relative who has been exposed to lead poisoning ■ The likelihood of a child placing nonfood items in the mouth ■ A child's proximity to current or former lead-producing facilities ■ The likelihood of a child using food, medicine, or dishes from other countries	**02/14/2020** Introduced	CalOptima: Watch
AB 2422 Grayson	**Blood Lead Screening Tests Medi-Cal Identification Number:** Would require the Medi-Cal identification number to be added to the list of patient identification information collected during each blood test. Would require the laboratory conducting the blood lead screening tests to report all patient identification information to the Department of Health Care Services.	**02/19/2020** Introduced	CalOptima: Watch
SB 1008 Leyva	**Childhood Lead Poisoning Prevention Act Online Registry:** Would require the Department of Public Health to design, implement, and maintain an online lead information registry available to the general public. Would require the information registry to include items such as the location and status of properties being inspected for lead contaminants.	**02/14/2020** Introduced	CalOptima: Watch

COVERED BENEFITS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
H.R. 4618 McBath	**Medicare Hearing Act of 2019:** Effective no sooner than January 1, 2022, would require Medicare Part B to cover the cost of hearing aids for Medicare beneficiaries. Hearing aids would be provided every five years and would require a prescription from a doctor or qualified audiologist.	**10/17/2019** Passed the Committee on Energy and Commerce **10/08/2019** Introduced	CalOptima: Watch
H.R. 4650 Kelly	**Medicare Dental Act of 2019:** Effective no sooner than January 1, 2022, would require Medicare Part B to cover the cost of dental health services for Medicare beneficiaries. Covered benefits would include preventive and screening services, basic and major treatments, and other care related to oral health.	**10/17/2019** Passed the Committee on Energy and Commerce **10/11/2019** Introduced	CalOptima: Watch
H.R. 4665 Schrier	**Medicare Vision Act of 2019:** No sooner than January 1, 2022, would require Medicare Part B to cover the cost of vision care for Medicare beneficiaries. Covered benefits would include routine eye exams and corrective lenses. Corrective lenses covered would be either one pair of conventional eyeglasses or contact lenses.	**10/17/2019** Passed the Committee on Energy and Commerce **10/11/2019** Introduced	CalOptima: Watch
AB 1904 Boerner Horvath	**Maternal Physical Therapy:** Would include pelvic floor physical therapy for women post-pregnancy as a Medi-Cal benefit.	**01/08/2020** Introduced	CalOptima: Watch
AB 1965 Aguiar-Curry	**Human Papillomavirus (HPV) Vaccine:** Would expand comprehensive clinical family planning services under the program to include the HPV vaccine for persons of reproductive age.	**01/21/2020** Introduced	CalOptima: Watch
AB 2258 Reyes	**Doula Care:** Would require full-spectrum doula care to be included as a covered benefit for pregnant and postpartum Medi-Cal beneficiaries. The program would be established as a 3-year pilot program in 14 counties, including the County of Orange, beginning July 1, 2021. Prior authorization or cost-sharing to receive doula care would not be required.	**02/13/2020** Introduced	CalOptima: Watch

EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT)

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 385 Calderon	**Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Performance Outcome System:** Would require the Department of Health Care Service to improve existing performance outcome systems measuring the outcomes of EPSDT services.	**01/31/2020** Died **05/16/2019** Committee on Appropriations; Held under submission **02/05/2019** Introduced	CalOptima: Watch

ELIGIBILITY

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 4 Arambula	**Medi-Cal Eligibility Expansion:** Would extend eligibility for full-scope Medi-Cal to eligible individuals of all ages regardless of their immigration status. The Legislative Analyst's Office projects this expansion would cost approximately $900 million General Fund (GF) in 2019-2020 and $3.2 billion GF each year thereafter, including the costs if In-Home Supportive Services.	**07/02/2019** Hearing canceled at the request of the author **06/06/2019** Referred to Senate Committee on Health **05/28/2019** Passed Assembly floor **12/03/2018** Introduced	CalOptima: Watch CAHP: Support LHPC: Support
AB 526 Petrie-Norris	**Women, Infants, and Children (WIC) to Medi-Cal Express Lane:** Would establish an "express lane" eligibility pathway for pregnant women and children from the California Special Supplemental Nutrition Program for WIC to Medi-Cal. WIC, within the Children's Health Insurance Program, is a federally funded program that provides supplemental food, health care referrals, and nutrition education for low-income pregnant, breastfeeding, and postpartum women, and infants and children up to age five. The bill intends to leverage the similarity between WIC and Medi-Cal eligibility rules, to ensure that uninsured children and pregnant women who are eligible for Medi-Cal are able to conveniently enroll in the program through the express lane. Of note, the express lane program was never implemented due to a lack of funding.	**08/30/2019** Senate Committee on Appropriations; Held under submission **06/27/2019** Passed Senate Committee on Health **05/23/2019** Passed Assembly floor **02/13/2019** Introduced	CalOptima: Watch
AB 683 Carrillo	**Adjusting the Assets Test for Medi-Cal Eligibility:** Would eliminate specific assets tests, such as life insurance policies, musical instruments, and living trusts, when determining eligibility for Medi-Cal enrollment.	**05/16/2019** Committee on Appropriations; Hearing postponed at the request of the Committee **04/02/2019** Passed Committee on Health **02/15/2019** Introduced	CalOptima: Watch
SB 29 Durazo	**Medi-Cal Eligibility Expansion:** Would extend eligibility for full-scope Medi-Cal to eligible individuals ages 65 years or older, regardless of their immigration status. The Assembly Appropriations Committee projects this expansion would cost approximately $134 million each year ($100 million General Fund, $21 federal funds) by expanding full-scope Medi-Cal to approximately 25,000 adults who are undocumented and 65 years of age and older. The financial costs for In-Home Supportive Services is estimated to cost $13 million General Fund.	**09/13/2019** Held in Assembly **05/29/2019** Passed Senate floor **12/03/2018** Introduced	CalOptima: Watch

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HOMELESSNESS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
H.R. 1978 Correa/Lieu	**Fighting Homelessness Through Services and Housing Act:** Similar to S. 923, would establish a federal grant program within the Health Resources and Services Administration to fund comprehensive homeless support services through the appropriation of $750 million each year for five years, beginning in FY 2020. Included would be a one-time grant of $100,000 to support program planning for existing programs serving those who are homeless or at risk of being homeless. Each eligible entity would be able to receive up to $25 million each year for up to five years. Government entities eligible to apply for grant funding would include counties, cities, regional or local agencies, Indian tribes or tribal organizations. Each agency would be able to enter partnerships to meet eligibility status. Additionally, comprehensive homeless support services, such as mental health services, supportive housing, transitional support, and case management must be provided by the agency to be considered to receive grant funding. Individuals eligible to receive comprehensive homeless support services through this program include persons who are homeless or are at risk of becoming homeless, including families, individuals, children and youths.	**03/28/2019** Introduced; Referred to the House Committee on Financial Services	CalOptima: Watch
S. 923 Feinstein	**Fighting Homelessness Through Services and Housing Act:** Similar to H.R. 1978, would establish a federal grant program within the Health Resources and Services Administration to fund comprehensive homeless support services through the appropriation of $750 million each year for five years, beginning in FY 2020. Included would be a one-time grant of $100,000 to support program planning for existing programs serving those who are homeless or at risk of being homeless. Each eligible entity would be able to receive up to $25 million each year for up to five years. Government entities eligible to apply for grant funding would include counties, cities, regional or local agencies, Indian tribes or tribal organizations. Each agency would be able to enter partnerships to meet eligibility status. Additionally, comprehensive homeless support services, such as mental health services, supportive housing, transitional support, and case management must be provided by the agency to be considered to receive grant funding. Individuals eligible to receive comprehensive homeless support services through this program include persons who are homeless or are at risk of becoming homeless, including families, individuals, children and youths.	**03/28/2019** Introduced; Referred to Committee on Health, Education, Labor, and Pensions	CalOptima: Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 563 Quirk-Silva	**Mental Health Funding for the North Orange County Public Safety Task Force:** Would establish a two-year pilot program in Orange County with the appropriation of $16 million from the General Fund to support those experiencing a mental health crisis. Funds to be allocated to the North Orange County Public Safety Task Force: $8 million by January 1, 2020 and $8 million by January 1, 2021. Funds would establish programs such as urgent and nonurgent telephone lines, case management, and a mobile response team.	**01/31/2020** Died **05/16/2019** Committee on Appropriations; Held under submission **02/13/2019** Introduced	CalOptima: Watch Orange County Board of Supervisors: Support
AB 2295 Quirk-Silva	Fairview Developmental Center: Would require the State Legislature to enact legislation relating to the development of the Fairview Developmental Center (Center) located in Costa Mesa, CA. Of note, the Governor's Fiscal Year 2019-2020 budget included funds to utilize the Center temporarily to provide housing and services for those experiencing a severe mental illness. Additionally, AB 1199, signed into law in 2019, allows a public hearing to determine the use of the Center. This bill is still early in the legislative process. The pending legislation to define use of the Center is unknown at this time.	**02/14/2020** Introduced	CalOptima: Watch

MEDI-CAL MANAGED CARE PLANS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
SB 936 Pan	**Medi-Cal Managed Care Plans Contract Procurement:** Would require the Department of Health Care Services Director to conduct a contract procurement at least once every five years with a contracted commercial Medi-Cal managed care plan providing care for Medi-Cal beneficiaries on a state-wide or limited geographic basis.	**02/06/2020** Introduced	CalOptima: Watch

PHARMACY

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 2100 Wood	**Pharmacy Carve-Out Benefit:** Would require the Department of Health Care Services to establish the Independent Medical Review System for the outpatient pharmacy benefit, and to develop a framework for the system that models the requirements of the Knox-Keene Health Care Service Plan Act. Additionally, would establish prior authorization requirements, such as a 24-hour response, a 72-hour supply during emergency situations, and a minimum 180 days for continuity of care for medications regardless if listed on the Medi-Cal contract drug list.	**02/05/2020** Introduced	CalOptima: Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
SB 852 Pan	**California Generic Prescription Drugs:** Would authorize the State of California to manufacture and manage their own generic prescription drugs.	**01/13/2020** Introduced	CalOptima: Watch

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 2492 Choi	**Program of All-Inclusive Care for the Elderly (PACE) Enrollment:** Would require the Department of Health Care Services to establish a maximum number of eligible participants each PACE center can enroll.	**02/19/2019** Introduced	CalOptima: Watch

PROVIDERS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 741 Kalra	**Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program Provider Training:** Would expand provider training, for those providing EPSDT services, to include universal trauma screenings. Training would include how to administer and use the new trauma screening tool, providing care, proper diagnosis and referrals for patients who have tested positive in trauma screenings, and connecting patients to proper resources and care.	**01/31/2020** Died **05/16/2019** Committee on Appropriations; Held Under Submission **02/19/2019** Introduced	CalOptima: Watch
AB 890 Wood	**Nurse Practitioners:** Would permit a nurse practitioner to practice without direct, ongoing supervision of a physician when practicing in an office managed by one or more physicians. Would create the Advanced Practice Registered Nursing Board within the Department of Consumer Affairs to certify nurse practitioners wanting to practice without direct, ongoing supervision of one or more physicians.	**01/27/2019** Passed Assembly floor **02/20/2019** Introduced	CalOptima: Watch LHPC: Support

REIMBURSEMENT RATES

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
SB 66 Atkins/ McGuire	**Federally Qualified Health Center (FQHC) Reimbursement**: Would allow an FQHC to be reimbursed by the state for a mental health or dental health visit that occurs on the same day as a medical face-to-face visit. Currently, California is one of the few states that do not allow an FQHC to be reimbursed for a mental or dental and physical health visits on the same day. A patient must seek mental health or dental treatment on a subsequent day for an FQHC to receive reimbursement for that service. This bill would distinguish a medical visit through the member's primary care provider and a mental health or dental visit as two separate visits, regardless if at the same location on the same day. As a result, the patient would no longer have to wait a 24-hour time period in order to receive medical and dental or mental health services, while ensuring that clinics are appropriately reimbursed for both services. Additionally, acupuncture services would be included as a covered benefit when provided at an FQHC.	**09/13/2019** Carry-over bill; Moved to inactive filed at the request of the author **08/30/2019** Passed Assembly Committee on Appropriations **05/23/2019** Passed Senate floor **01/08/2019** Introduced	CalOptima: Watch CAHP: Support LHPC: Co-Sponsor, Support
AB 316 Ramos/Rivas	**Medi-Cal Dental Services:** Would increase the fee-for-service reimbursement rate for Denti-Cal providers that provide services to individuals with special needs. Pending approval from the Centers for Medicare & Medicaid Services, the increase in reimbursement rates to Denti-Cal providers would allow the provider to be reimbursed for the additional time and resources required to treat a patient with special needs. Providers are currently not receiving additional funds if a patient with specials needs uses more time and resources than originally allocated. Would allow the member four dental visits within a twelve-month period. The reimbursement rate would increase from $100 per visit to $140 per visit with support from Proposition 56 dollars.	**01/31/2019** Died **05/17/2019** Committee on Appropriations; Held Under Submission **01/30/2019** Introduced	CalOptima: Watch

TELEHEALTH

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
H.R. 4932 Thompson	**Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act of 2019:** Similar to S. 2741, would expand telehealth services for those receiving Medicare benefits and remove restrictions in the Medicare program that prevent physicians from using telehealth technology. Would also: ■ Provide the Secretary of Health and Human Services with the authority to waive telehealth restrictions when necessary; ■ Remove geographic and originating site restrictions for services like mental health and emergency medical care; ■ Allow rural health clinics and other community-based health care centers to provide telehealth services; and ■ Require a study to explore more ways to expand telehealth services so that more people can access health care services in their own homes.	**10/30/2019** Introduced; Referred to the Committees on Energy and Commerce; Ways and Means	CalOptima: Watch AHIP: Support

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
S. 2741 Schatz	**Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act of 2019:** Similar to H.R. 4932, would expand telehealth services for those receiving Medicare benefits and remove restrictions in the Medicare program that prevent physicians from using telehealth technology. Would also: ■ Provide the Secretary of Health and Human Services with the authority to waive telehealth restrictions when necessary; ■ Remove geographic and originating site restrictions for services like mental health and emergency medical care; ■ Allow rural health clinics and other community-based health care centers to provide telehealth services; and ■ Require a study to explore more ways to expand telehealth services so that more people can access health care services in their own homes.	**10/30/2019** Introduced; Referred to the Senate Committee on Finance	CalOptima: Watch AHIP: Support
AB 1676 Maienschein	**Telehealth Mental Health Services for Children, Pregnant Women, and Postpartum Persons:** Would create a telehealth program used to conduct mental health consultations and treatments for children, pregnant women, and postpartum persons, effective no sooner than January 1, 2021. Consultation and treatment services, provided by a psychiatrist, would be accessible during standard business hours, with the option for evening and weekend hours. Would also require adequate staffing to ensure calls are answered within 60 seconds. Payment structure has yet to be defined.	**05/16/2019** Committee on Appropriations; Held under submission **04/24/2019** Passed Committee on Health **02/22/2019** Introduced	CalOptima: Watch CAHP: Oppose

TRAILER BILLS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
RN 2002918 Trailer Bill – Medi-Cal Expansion	**Medi-Cal Eligibility Expansion:** Would extend eligibility for full-scope Medi-Cal to eligible individuals 65 years of age or older regardless of their immigration status. The Governor's Fiscal Year 2020-2021 proposed budget anticipates the expansion of full-scope Medi-Cal will cost $80.5 million ($62.4 million General Fund) in 2021 and $350 million ($320 million General Fund) each year after, including the cost of In-Home Supportive Services.	**01/31/2020** Published on the Department of Finance website	CalOptima: Watch
RN 2003830 Trailer Bill: Drug Price Negotiations	**Med-Cal Drug Pricing Negotiations:** Would authorize the Department of Health Care Services negotiate "best prices" with drug manufacturers, both within and outside of the United States, and to establish and administer a drug rebate program in order to collect rebate payments from drug manufacturers for drugs furnished to California residents who are ineligible for full-scope Medi-Cal. Would authorize a Medi-Cal beneficiary to receive more than six medications without prior approvals. Additionally, this Trailer Bill would modify the current co-pay amount for a drug prescription refill.	**01/31/2020** Published on the Department of Finance website	CalOptima: Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
RN 2006526 Trailer Bill – Medication-Assisted Treatment	**Medication-Assisted Treatment (MAT):** Would expand narcotic treatment program services to include MAT under Drug Medi-Cal.	**01/31/2020** Published on the Department of Finance website	CalOptima: Watch

*Information in this document is subject to change as bills are still going through the early stages of the legislative process.

CAHP: California Association of Health Plans
CalPACE: California PACE Association
LHPC: Local Health Plans of California
NPA: National PACE Association

Last Updated: February 19, 2020

2020 Federal Legislative Dates

April 4–19	Spring recess
August 10–September 7	Summer recess
October 12–November 6	Fall recess

2020 State Legislative Dates

January 6	Legislature reconvenes
January 31	Last day for bills introduced in 2019 to pass their house of origin
February 21	Last day for legislation to be introduced
April 2–12	Spring recess
April 24	Last day for policy committees to hear and report bills to fiscal committees
May 1	Last day for policy committees to hear and report non-fiscal bills to the floor
May 15	Last day for fiscal committees to report fiscal bills to the floor
May 26–29	Floor session only
May 29	Last day to pass bills out of their house of origin
June 15	Budget bill must be passed by midnight
July 2–August 3	Summer recess
August 14	Last day for fiscal committees to report bills to the floor
August 17–31	Floor session only
August 31	Last day for bills to be passed. Final recess begins upon adjournment
September 30	Last day for Governor to sign or veto bills passed by the Legislature
November 3	General Election
December 7	Convening of the 2021–22 session

Sources: 2020 State Legislative Deadlines, California State Assembly: http://assembly.ca.gov/legislativedeadlines

About CalOptima

CalOptima is a county organized health system that administers health insurance programs for low-income children, adults, seniors and people with disabilities. As Orange County's community health plan, our mission is to provide members with access to quality health care services delivered in a cost-effective and compassionate manner. We provide coverage through four major programs: Medi-Cal, OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan), OneCare (Medicare Advantage Special Needs Plan), and the Program of All-Inclusive Care for the Elderly (PACE).

Board of Directors Meeting
March 5, 2020

CalOptima Community Outreach Summary — February 2020

Background
CalOptima is committed to serving our community by sharing information with current and potential members and strengthening relationships with our community partners. One of the ways CalOptima accomplishes this is through our participation in public events and public activities that meet at least one of the following criteria:

- Member interaction/enrollment: The event/activity attracts a significant number of CalOptima members and/or potential members who could enroll in a CalOptima program.
- Branding: The event/activity promotes awareness of CalOptima in the community.
- Partnerships: The event/activity has the potential to create positive visibility for CalOptima and create a long-term collaborative partnership between CalOptima and the requesting entity.

We consider requests for sponsorship based on several factors pursuant to Policy AA. 1223: Participation in Community Events Involving External Entities including, but not limited to: the number of people the activity/event will reach; the marketing benefits for CalOptima; the strength of the partnership or level of involvement with the requesting entity; past participation; staff availability; and budget availability.

In addition to participating in community events, CalOptima staff actively participates in several community meetings including coalitions/collaboratives, committees and advisory groups focused on community health issues related to improving access to health care, reducing health disparities, strengthening the safety net system and promoting a healthier Orange County.

CalOptima Community Events Update
On January 8, Community Relations kicked off the new year by hosting a Community Alliances Forum on "Leading with Gratitude" at the Delhi Center in Santa Ana. The event was held with the support of our Community Alliances Advisory Committee. Staci Ingram, Senior Vice President of Corporate Communications & Development with Roth Staffing, shared a message of gratitude with more than 120 community partners who were in attendance.

The event highlighted the science that reinforces gratitude and creates humility in the workplace, practical ways to create an action plan to implement the act of gratitude and how to lead by example. The forum included a networking activity where attendees shared messages of gratitude by decorating a "gratitude rock" and hand-written notes to their colleagues. Attendees took away various examples of gratitude to help create a more positive culture in the workplace.

For additional information or questions, please contact CalOptima Community Relations Manager Tiffany Kaaiakamanu at **657-235-6872** or tkaaiakamanu@caloptima.org.

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Summary of Public Activities

Please note the following CalOptima hosted event, as the OneCare Member Retention/Outreach Event was inadvertently excluded in the February 6, 2020 CalOptima Community Event Summary.

TARGET AUDIENCE: MEMBERS/POTENTIAL MEMBERS

Date	# Staff/ Volunteers to Attend	Events/Meetings
1/25//2020	16	• OneCare Connect Member Retention/Outreach Event

As of January 20, 2020, CalOptima expects to participate in 36 community events, coalitions and committee meetings:

TARGET AUDIENCE: HEALTH AND HUMAN SERVICES PROVIDERS

Date	Events/Meetings
2/03/2020	• Orange Cunty Health Care Agency Mental Health Services Act Steering Committee Meeting • Fullerton Collaborative Meeting
2/04/2020	• Collaborative to Assist Motel Families
2/05/2020	• Orange County Aging Services Collaborative General Meeting • Anaheim Human Services Network Meeting • Orange County Healthy Aging Initiative Meeting
2/06/2020	• Continuum of Care Homeless Provider Forum • Garden Grove Community Collaborative Advisory Meeting
2/07/2020	• Covered Orange County General Meeting • Help Me Grow Advisory Meeting
2/10/2020	• Orange County Veterans and Military Families Collaborative — Children and Family Workgroup Meeting
2/11/2020	• Orange County Strategic Plan for Aging — Social Engagement Committee Meeting • Orange County Cancer Coalition Meeting • San Clemente Youth Wellness and Prevention Coalition Meeting
2/12/2020	• Orange County Communications Workgroup Meeting • Anaheim Homeless Collaborative Meeting

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2/13/2020	• Buena Park Collaborative Meeting • Kid Healthy Community Advisory Committee Meeting
2/18/2020	• Placentia Community Collaborative Meeting
2/19/2020	• Orange County Promotoras Meeting • Covered Orange County Steering Committee Meeting • Minnie Street Family Resource Center Professional Roundtable
2/20/2020	• Surf City Senior Providers Network Meeting • Garden Grove Community Collaborative Meeting • Orange County Children's Partnership Meeting
2/24/2020	• Community Health Research and Exchange Meeting • Stanton Collaborative Meeting
2/25/2020	• Orange County Senior Roundtable • Orange County Women's Health Project Advisory Meeting
2/27/2020	• Orange County Care Coordination for Kids Meeting

TARGET AUDIENCE: MEMBERS/POTENTIAL MEMBERS

Date	# Staff/ Volunteers to Attend	Events/Meetings
2/01/2020	4	• Orange County Black History Parade and Cultural Faire hosted by Orange County Heritage Council (Registration Fee: $175 included one resource table at the event for outreach)
2/08/2020	1	• Family Health Expo at Higher Ground Youth and Family Services hosted by Clinic in the Park
2/20/2020	1 4	• Family Expo hosted by Centralia School District • Health Care Forecast Conference hosted by UCI Paul Merage School of Business (Sponsorship Fee: $1,000 included one admission to attend the conference)
2/28/2020	4	• OC Youth Service Providers Consortium hosted by Laura's House (Sponsorship Fee: $600 included agency logo prominently displayed on all event collateral, digital marketing and social media, a half page ad in event resource guide, inclusion of promotional item in swag bag, one resource table for outreach at event and 15 opportunity drawing tickets)

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2/29/2020	1	• Annual ActNOW Health Education Conference hosted by GREEN Foundation (Sponsorship Fee: $1,000 included one admission to attend the conference, half page ad in program booklet and one resource table for outreach at the conference)

As of January 20, 2020, CalOptima expected to organize or convene the following five community stakeholder events, meetings and presentations:

TARGET AUDIENCE: HEALTH AND HUMAN SERVICES PROVIDERS

Date	Events/Meetings/Presentations
2/20/2020	• CalOptima's Health Network Forum
2/26/2020	• Cafecito: Latino Community Collaborative Meeting

TARGET AUDIENCE: MEMBERS/POTENTIAL MEMBERS

Date	Events/Meetings/Presentations
2/04/2020	• Population Health Management Workshop — Topic: Shape Your Life: Healthy Weight, Healthy You
2/11/2020	• Population Health Management Workshop — Topic: Shape Your Life: Healthy Weight, Healthy You
2/18/2020	• Population Health Management Workshop — Topic: Shape Your Life: Healthy Weight, Healthy You

CalOptima did not provide any endorsements during this reporting period (e.g., letters of support, program/public activity events with support or use of name/logo).

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CalOptima Board of Directors
Community Activities

CalOptima is committed to serving our community by sharing information with current and potential members and strengthening relationships with our community partners. One of the ways CalOptima accomplishes this is through participation in public activities, which meet at least one of the following criteria:

- Member interaction/enrollment: The event/activity attracts a significant number of CalOptima members and/or potential members who could enroll in a CalOptima program.
- 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 partnership between CalOptima and the requesting entity.

We consider requests for sponsorship based on several factors pursuant to Policy AA. 1223: Participation in Community Events Involving External Entities, including but not limited to: the number of people the activity/event will reach; the marketing benefits for CalOptima; the strength of the partnership or level of involvement with the requesting entity; past participation; staff availability; and budget availability.

In addition to participating in community events, CalOptima staff actively participates in several community meetings, including coalitions, committees and advisory groups focused on community health issues related to improving access to health care, reducing health disparities, strengthening the safety net system and promoting a healthier Orange County.

For more information on the listed items, contact Tiffany Kaaiakamanu, Manager of Community Relations, at 657-235-6872 or by email at tkaaiakamanu@caloptima.org.

March

Date and Time	Event Title	Event Type/Audience	Staff/ Financial Participation	Location
Monday, 3/2 1–4 p.m.	++ OCHCA Mental Health Services Act Steering Committee	Steering Committee Meeting: Open to Collaborative Members	N/A	Delhi Center 505 E. Central Ave. Santa Ana

Monday, 3/2 2:30–3:30 p.m.	++ Fullerton Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Fullerton Library 353 W. Commonwealth Ave. Fullerton
Tuesday, 3/3 9:30–11 a.m.	++ Collaborative to Assist Motel Families	Steering Committee Meeting: Open to Collaborative Members	N/A	Anaheim Downtown Community Center 250 E. Center St. Anaheim
Tuesday, 3/3 6:30–8:30 p.m.	*CalOptima CME Workshop: Diabetes Mellitus: Progress and New Concepts	Workshop for Physicians and Licensed Health Care Professionals Registration required	N/A	Double Tree Hotel 100 The City Drive Orange
Thursday, 3/5 9–11 a.m.	++ Continuum of Care Homeless Provider Forum	Steering Committee Meeting: Open to Collaborative Members	N/A	Covenant Presbyterian Church 1855 Orange Olive Rd. Orange
Thursday, 3/5 9–10:30 a.m.	++ Refugee Forum of Orange County	Steering Committee Meeting: Open to Collaborative Members	N/A	Access California Services 631 S. Brookhurst St. Anaheim
Thursday, 3/5 11 a.m.–1 p.m.	++ Garden Grove Community Collaborative Advisory Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	The Courtyard Center 12732 Main St. Garden Grove
Friday, 3/6 9–10:30 a.m.	++ Covered Orange County General Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	The Village 1505 E. 17th St. Santa Ana
Saturday, 3/7 8 a.m.–1 p.m.	+ Fullerton School District Champion for Children	Health/Resource Fair Open to the Public	1 Staff	Ladera Vista Junior High School of the Arts 1700 E. Wilshire Ave. Fullerton
Monday, 3/9 1–2:30 p.m.	++ Orange County Veterans and Military Families Collaborative - Children and Family Working Group	Steering Committee Meeting: Open to Collaborative Members	N/A	Child Guidance Center 525 N. Cabrillo Park Dr. Santa Ana
Tuesday, 3/10 9–10:30 a.m.	++ Orange County Strategic Plan for Aging-Social Engagement Committee	Steering Committee Meeting: Open to Collaborative Members	N/A	Alzheimer's OC 2515 McCabe Way Irvine

Tuesday, 3/10 3:30–5:30 pm	++ San Clemente Youth Wellness and Prevention Coalition	Steering Committee Meeting: Open to Collaborative Members	N/A	189 Avenida La Cuesta San Clemente
Wednesday, 3/11 12–1:30 pm	++ Anaheim Homeless Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Anaheim Central Library 500 W. Broadway Anaheim
Wednesday, 3/11 3:30–4:30 pm	++ Orange County Communications Workgroup	Steering Committee Meeting: Open to Collaborative Members	N/A	Various locations
Thursday, 3/12 10–11:30 am	++ Buena Park Collaborative Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	Buena Park Community Center 6640 Beach Blvd. Buena Park
Thursday, 3/12 12:30–1:30 pm	++ Kid Healthy Community Advisory Committee Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	OneOC Building C 1901 E. Fourth St. Santa Ana
Thursday, 3/12 3:30–5:30 p.m.	++ State Council on Developmental Disabilities Regional Advisory Committee	Steering Committee Meeting: Open to Collaborative Members	N/A	2000 East Fourth St. Santa Ana
Friday, 3/13 9–10 a.m.	++ Orange County Diabetes Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Orange County Health Care Agency 1725 W. 17th St. Santa Ana
Friday, 3/13 9:30–11 a.m.	++ Senior Citizen Advisory Council Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	Location varies
Saturday, 3/14 9:30–11 a.m.	* OneCare Connect Member Retention Event	Community Presentation Open to the Public	2 Staff	Delhi Center 505 E. Central Ave. Santa Ana
Tuesday, 3/17 8:30–10 a.m.	++ North Orange County Senior Collaborative All Members Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	St. Jude Community Services 130 W. Bastanchury Rd. Fullerton
Tuesday, 3/17 11 a.m.–12 p.m.	++ Placentia Community Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Placentia Library Community Room 411 Chapman Ave. Placentia
Wednesday, 3/18 8:45–10:30 a.m.	++ La Habra Community Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	900 W. La Habra Blvd. La Habra

Wednesday, 3/18 9:15–11 a.m.	++ Covered Orange County Steering Committee	Steering Committee Meeting: Open to Collaborative Members	N/A	The Village 1505 E. 17th St. Santa Ana
Wednesday, 3/18 10 a.m.–1 p.m.	+ City of Costa Mesa Knowledge and Health Fair Expo	Health/Resource Fair Open to the Public	N/A	City of Costa Mesa Senior Center 695 West 19th St. Costa Mesa
Wednesday, 3/18 11 a.m.–1 p.m.	++ Minnie Street Family Resource Center Professional Roundtable	Steering Committee Meeting: Open to Collaborative Members	N/A	1300 McFadden Ave. Santa Ana
Wednesday, 3/18 1–4 pm	++ Orange County Promotoras	Steering Committee Meeting: Open to Collaborative Members	N/A	Location varies
Thursday, 3/19 8:30–10 am	++ Orange County Children's Partnership Committee (OCCP)	Steering Committee Meeting: Open to Collaborative Members	N/A	Orange County Hall of Administration 10 Civic Center Plaza Santa Ana
Thursday, 3/19 11:30–1 pm	++ Garden Grove Collaborative Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	Garden Grove Community Center 11300 Stanford Ave. Garden Grove
Thursday, 3/19 2:30 p.m.–4:30 p.m.	++ Orange County Women's Health Project Advisory Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	The Village 1505 E. 17th St. Santa Ana
Monday, 3/23 12:30–1:30 p.m.	++ Stanton Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Stanton Civic Center 7800 Katella Ave. Stanton
Tuesday, 3/24 7:30–9 am	++ OC Senior Roundtable	Steering Committee Meeting: Open to Collaborative Members	N/A	Orange Senior Center 170 S. Olive Orange
Thursday, 3/26 1:30–3:30 pm	++ Orange County Care Coordination for Kids	Steering Committee Meeting: Open to Collaborative Members	N/A	CHOC Centrum Building 1120 W. La Veta Orange

INFORMATION ITEM (SUPPLEMENTAL)

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

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MEMORANDUM

To: Michael Schrader, CalOptima CEO

From: Chairwoman Michelle Steel, Supervisor 2nd District
Vice Chairman Andrew Do, Supervisor 1st District

Date: February 28, 2020

Subject: Request to add Coronavirus (COVID-19) Update and Next Steps Item to the CalOptima Board of Directors Meeting on March 5, 2020

The Novel Coronavirus (COVID-19) has infected more than 83,000 individuals and killed more than 2,800 individuals in at least 49 countries worldwide. Among the 60 reported cases of the COVID-19 in the United States, 33, or more than half, are in California. On February 26th, the State of California reported the first known case in the United States of a patient who acquired the COVID-19 from an unknown origin who had no known exposure to the virus through travel or close contact with a known infected individual. To date, Orange County had one confirmed case in late January, a man in his 50s who has fully recovered.

On February 20th, the county learned that the state volunteered the Fairview Developmental Center, property that it owns, located in the city of Costa Mesa, to the federal government to temporarily house individuals from the Diamond Princess cruise ship who are California residents and tested positive for COVID-19; but are not showing symptoms. On February 26th, we filed an amicus brief in federal court to support the city of Costa Mesa's effort to temporarily block the planned move as it poses an imminent threat to public health, and on February 24th county health officer Dr. Nichole Quick declared a local health emergency for the county following the announcement from Dr. Nancy Messonnier from the Centers for Disease Control (CDC) to expect to see community spread in the United States.

As the county's public health plan, CalOptima plays a critical role in addressing this potential public health crisis, as such, we are requesting that CalOptima add an item to the March 5, 2020 Board of Directors (Board) Meeting to allow Dr. Quick to provide the Board with an update on COVID-19 and discuss the next steps CalOptima needs to take expeditiously including but not limited to the following:

- **Prevention: Steps CalOptima can take in partnership with the county to prevent an outbreak**
- **Response Plan: What will CalOptima do should an outbreak happen in Orange County?**

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- **Budget: (Authorizations & Approvals)**
- **Protecting frontline workers including Homeless Response Teams and PACE employees**
- **Public and Stakeholder Communication: Steps to inform and educate the public and healthcare partners**
- **Updating of necessary Policies and Procedures related to communicable diseases and pharmaceutical needs**

We appreciate your cooperation.

Respectfully submitted,

MICHELLE STEEL, CHAIRWOMAN
CALOPTIMA BOARD OF DIRECTORS

ANDREW DO, VICE CHAIRMAN
CALOPTIMA BOARD OF DIRECTORS

Cc: Members of the Board of Supervisors
CalOptima Board of Directors
CalOptima Clerk of the Board
Frank Kim, CEO
Richard Sanchez, Health Care Agency Director
Dr. Nichole Quick, County Health Officer

Attachments
- Declaration of local health emergency
- Amicus Brief filed by Chairwoman Steel and Vice Chair Do

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DECLARATION OF A LOCAL HEALTH EMERGENCY

WHEREAS, Health and Safety Code section 101080 authorizes a local health officer to declare a local health emergency in the health officer's jurisdiction, or any part thereof, whenever the health officer reasonably determines that there is an imminent and proximate threat of the introduction of any contagious, infectious, or communicable disease, chemical agent, non-communicable biologic agent, toxin, or radioactive agent;

WHEREAS, the Centers for Disease Control and Prevention announced on February 25, 2020 that community spread of COVID-19 is likely to occur in the United States;

WHEREAS, based on the Centers for Disease Control and Prevention statements, there is an ongoing risk and likelihood of COVID-19 positive patients being identified in Orange County;

WHEREAS, based on the foregoing, there is an imminent and proximate threat of the introduction of COVID-19 in the County of Orange and a threat to the public health of the County residents;

THEREFORE, the County Health Officer hereby declares a health emergency.

Nichole Quick, MD, MPH
Health Officer

2/26/2020
Date

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MICHELLE STEEL, CHAIRWOMAN
ANDREW DO, VICE CHAIR
333 West Santa Ana Boulevard
Santa Ana, California 92701
(714) 834-32200

UNITED STATES DISTRICT COURT

CENTRAL DISTRICT

CITY OF COSTA MESA AND KATRINA FOLEY,

Plaintiffs,

vs.

UNITED STATES OF AMERICA, et al..,

Defendants.

Case No. 8:20-cv-00368-JLS-JDE

AMICUS BRIEF OF CHAIRWOMAN MICHELLE STEEL AND VICE CHAIR ANDREW DO IN SUPPORT OF APPLICATION FOR TEMPORARY RESTRAINING ORDER

Hearing Date: February 20, 2020
Time: 2:00 p.m.

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I. IDENTITY AND INTEREST OF AMICI CURIAE

Amicus Curiae, Chairwoman Michelle Steel and Vice-Chair Andrew Do of the Orange County Board of Supervisors, are constitutionally elected officials for the County of Orange, sworn to enforce the Constitutions of Defendants UNITED STATES OF AMERICA and STATE OF CALIFORNIA. Chairwoman Steel represents District 2, which includes the City of Costa Mesa. Vice-Chair Andrew Do represents District 1, which includes the largest population of Americans of Asian descent who have substantial business and familial ties to China and throughout Asia. The Board of Supervisors is responsible for the public health of the County of Orange and oversees Orange County Health Care Agency. Both Amici Curiae hereby submit this brief in support of Plaintiffs' Application for Temporary Restraining Order and Order to Show Cause Re Issuance of Preliminary Injunction. The Undersigned have authored this brief in whole.

II. DISCUSSION

Plaintiffs' Application should be granted because Defendants failed to comply with statutory mandates to seek "input from and engagement with" local stakeholders. Dr. Mark Ghaly's Declaration in Support of State of California's Opposition, page 7, clearly acknowledged the existence of those mandates. In fact, Dr. Ghaly claim on page 6 of his Declaration that the State "engaged with local partners to discuss" the possibility of allowing patients who have tested positive for COVIC-19 to stay at Fairview. This was, categorically, not done.

Richard Sanchez, Director of Orange County Health Care Agency, stated in his attached Declaration the followings:

1. The relationship and communication between the California Department of Public Health and the Orange County Health Care Agency has not been timely and has been inadequate in providing information required to respond to COVID-19 in a consistent manner.

2. California Department of Public Health officials have been unresponsive to direct

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requests form the Orange County Heath Care Agency officials for timely COIVD-19 guidance including guidance for schools, colleges, and universities, and guidance for workplaces. Timely guidance was not provided leaving Orange County public health officials having to create guidance for schools, colleges and universities, and the workplace.

3. California Department of Public Health officials have been repeatedly unresponsive to requests from Orange County public health officials for detailed information on the proposed federal operation to house COVID-19 patients at Fairview Developmental Center.

4. Orange County Health Care Agency staff were requested by California Department of Public Health staff to assess infection control risk at Fairview Developmental Center? This raises questions as to the veracity of the state and federal assessment of the suitability of Fairview Developmental Center for housing COVID-19 positive patients.

5. There is currently Section 8 housing on the Fairview Developmental Center premises. What is the plan to minimize risk to residents of these housing units? Was HUD consulted on the plan to use Fairview Developmental Center to house COVID-19 patients in close proximity to Section 8 housing residents.

6. The Costa Mesa press conference on Saturday February 22, 2020 regarding the federal operation at Fairview Developmental Center to house COVID-19 patients included a large gathering of federal, state, and local elected officials all expressing concern and outrage at housing COVID-19 patients at Fairview Developmental Center. Only after this press conference did California Department of Public Health Director Dr. Sonia Angell reach out to Orange County public health officials offering

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to hastily arrange a conference call between local public health officials and state and federal officials to answer questions about the proposed federal operation at Fairview Developmental Center. Orange County public health officials repeatedly told Dr. Angell that the California Department of Public Health needed to include all relevant stakeholders in any discussion regarding the federal operation at Fairview Developmental Center. Despite this repeated suggestion, I am not aware that the California Department of Public Health reached out to other stakeholders to include in conference calls over the weekend.

7. Information flow from the California Department of Public Health to the Orange County Health Care Agency has been consistently poor to the point that relevant information regarding COVID-19 has been willfully withheld and only discovered through media stories or direct calls from members of the media.

It is important to note the State of California merely offered the Federal Government the use of Fairview Developmental Center, since there was no declaration of a heath emergency due to COVIC-19 by the State, and this offer was subject to certain conditions. These conditions clearly identified a cogent concern to protect public health and the risks to local residents. Yet, these conditions fell short of the protection required by mandates of local input and engagement. Dr. Nichole Quick's and Richard Sanchez's Declarations (see attached) highlight some of the questions that remain unanswered, among other, such as:

1. Impacts to the community affecting the health and safety of Orange County residents

2. Characteristics of COVID-19 positive individuals including health status, total number, timeline of prior tests, timing of transport, and method of transport to Fairview Developmental Center.

3. Is the transport of patients from Travis Airforce Base to Fairview Developmental Center consistent with Centers for Disease Control and Prevention guidance on

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transport of COVID-19 positive patients?

4. Will COVID-19 patients who become symptomatic be cared for at Fairview Developmental Center or transported to local hospitals?

5. In the event COVID-19 positive patients are transported to local hospitals, who will be monitoring exposed health care workers?

6. Who will pay for transport and medical care, and will the 911 system be used for transport?

7. How will individuals be cleared? Will it be two consecutive negative specimens separated by 24 hours, and which laboratory and which tests will be used?

8. How will specimens be processed and sent for testing?

9. Is there onsite capacity for blood draw, oropharyngeal and nasopharyngeal swabbing, and chest X-ray?

10. After clearing how will COVID-19 patients get to their county of residence.

11. What are the final cleaning and disinfection plans/protocols for Fairview Developmental Center to assure no further transmission?

12. What are the provisions for isolation of patients consistent with Centers for Disease;

13. Control and Prevention guidance such as use of individual living quarters?

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14. What are the local transportation and hospitalization plans for patients who become symptomatic and require hospitalization.

15. What is the need for and anticipated impact on the local EMS system.

III. CONCLUSION

In summary, the patients who tested positive for COVID-19 have been quarantined appropriately. A decision was made by the Federal Government to move these patients, despite CDC's mandate that Coronavirus patients should not be moved, and the State of California volunteered certain locations, Fairview Developmental Center being one, without abiding by the statutory mandates required under California law. There have been no efforts to engage local partners or obtain their inputs. There is no operational plan to provide for responses to contingencies once such a COVID-19 facility begins operation. Therefore, Amici Curiae respectfully request that this Court grant the Application for Temporary Restraining Order and Order to Show Cause Re Issuance of Preliminary Injunction.

DATED: February 24, 2020

Respectfully submitted,

MICHELLE STEEL, CHAIRWOMAN
ANDREW STEEL, VICE CHAIR

By: /s/
Michelle Steel, Chairwoman

By: /s/
Andrew Do, Vice Chair

Members of the Orange County Board of Supervisors

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CITY OF COSTA MESA and KATRINA FOLEY

UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA – SOUTHERN DIVISION

CITY OF COSTA MESA, and KATRINA FOLEY,

Plaintiff,

vs.

UNITED STATES OF AMERICA, THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, THE UNITED STATES DEPARTMENT OF DEFENSE, THE UNITED STATES AIR FORCE, THE CENTERS FOR DISEASE CONTROL AND PREVENTION, THE STATE OF CALIFORNIA, FAIRVIEW DEVELOPMENTAL CENTER (FAIRVIEW), THE CALIFORNIA GOVERNOR'S OFFICE OF EMERGENCY SERVICES, and THE CALIFORNIA DEPARTMENT OF GENERAL SERVICES,

Defendants.

Case No. 8:20-cv-00368-JLS-JDE

DECLARATION OF RICHARD SANCHEZ IN SUPPORT OF *EX PARTE* APPLICATION FOR TEMPORARY RESTRAINING ORDER AND ORDER TO SHOW CAUSE RE ISSUANCE OF PRELIMINARY INJUNCTION

DATE: FEBRUARY 24, 2020
TIME: 2:00 P.M.
COURTROOM: 10A

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DECLARATION OF RICHARD SANCHEZ

I, Richard Sanchez, declare:

1. I am employed by the County of Orange ("County") as the Director of OC Health Care Agency. I have personal knowledge of the following unless stated to be on information and belief, in which case I am informed and believe such facts to be true. If called as a witness, I could and would testify competently to the facts contained herein.

2. I have held the position of the Director of the OC Health Care Agency since 2017 and have worked for the OC Health Care Agency since 2005. A copy of my C.V. is attached hereto as Exhibit A, which accurately reflects my educational and employment background.

3. As Director of OC Health Care Agency, I lead a multi-faceted agency with approximately 2,700 full-time employees working in more than 100 separate locations. I am responsible for the overall direction and operation of five core service areas: Public Health Services, Behavioral Health Services, Correctional Health Services, Regulatory/Medical Health Services, and Administrative Services. Part of my duties as the Director of the OC Health Care Agency include, but are not limited to, the following: (a) implement goals and policies as set by the Orange County Board of Supervisors under the direction, and in collaboration with, the County Executive Officer; (b) establish guidance for programmatic modification in response to changes in policy, legislation and funding; and (c) develop policy recommendations or options for the County Executive Officer or Orange County Board of Supervisors in conjunction with elected and appointed officials, members of the community, civil and industry leaders as well as others.

4. The relationship and communication between the California Department of Public Health and the OC Health Care Agency has not been timely and has been inadequate in providing information required to respond to novel coronavirus ("COVID-19") in a consistent manner. California Department of

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Public Health officials have been unresponsive to direct requests from the OC Heath Care Agency officials for routine COVID-19 guidance including guidance for schools, colleges, and universities, and for workplaces. Timely guidance was not provided leaving Orange County public health officials having to create guidance for schools, colleges and universities, childcare settings, and the workplace.

5. Late in the afternoon Thursday, February 20, 2020, I received news for the first time of the State's intention to transport individuals who are currently under quarantine for the COVID-19 to the Fairview Developmental Center ("Fairview") in the City of Costa Mesa. However, California Department of Public Health officials have been repeatedly unresponsive to requests from OC Health Care Agency/County of Orange public health officials for detailed information on the proposed federal operation to place COVID-19 patients at Fairview Developmental Center.

6. OC Health Care Agency staff were requested to assess infection control risk at Fairview Developmental Center. This raises questions as to the veracity of whether an adequate state and federal assessment of the suitability of Fairview Developmental Center for placing COVID-19 positive patients took place.

7. There is currently housing on the Fairview Developmental Center premises. The OC Health Care Agency/County of Orange does not know of any plan to minimize risk to residents of these housing units or if the U.S. Department of Housing and Urban Development consulted on the plan to use Fairview Developmental Center for placement of COVID-19 patients in close proximity to housing residents.

8. The City of Costa Mesa's press conference on Saturday, February 22, 2020, included a large gathering of federal, state, and local elected officials all expressing concern and outrage regarding the potential placement of COVID-19

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patients at Fairview Developmental Center. Only after this press conference did California Department of Public Health Director Dr. Sonia Angell reach out to OC Health Care Agency/County of Orange public health officials offering to hastily arrange a conference call between local public health officials and state and federal officials to answer questions about the proposed federal operation at Fairview Developmental Center. OC Health Care Agency/County of Orange public health officials repeatedly told Dr. Angell that the California Department of Public Health needed to include all relevant stakeholders and impacted jurisdictions in any discussion regarding the federal operation at Fairview Developmental Center. Despite this repeated suggestion, I am not aware that the California Department of Public Health reached out to other relevant parties to include in conference calls over the weekend.

9. Information flow from the California Department of Public Health to the OC Health Care Agency has been consistently poor to the point that relevant information regarding COVID-19 has been, in my opinion, willfully withheld and only discovered through media coverage and/or direct calls from members of the media.

10. On Friday, February 21, 2020, state officials hosted an Orange County Representatives Call for elected officials to which OC Health Care Agency officials were invited to, including a pre-call meeting. During the pre-call meeting, an unknown official from the state who was dominating the conversation stated that Orange County "tends to spin" in reference to how to manage and message information.

11. In past public health situations, the California Department of Public Health has been much more communicative, collaborative, and timely in providing guidance and information to the OC Health Care Agency. Given my prior experience with the California Department of Public Health, I am surprised and

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disappointed in the California Department of Public Health's response to COVID-19.

I declare under penalty of perjury under the laws of the United States of America and the State of California that the foregoing is true and correct.

Executed this 24th day of February 2020, in Santa Ana, California

Richard Sanchez, Declarant

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EXHIBIT

A

EXHIBIT A

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RICHARD SANCHEZ

1954 n. Warbler Pl.
Orange, CA 92867
Phone: (714) 586-7728
Email: Richard.Sanchez@ochca.com

SUMMARY

Highly effective, results oriented executive with over 36 years of demonstrated success managing multifaceted health care programs, diverse teams and multi-million dollar budgets while adeptly navigating complex system of operations comprised of more than 160 funding sources as well as County, State, and Federal mandates. Strong communicator with expert ability to analyze complex situations and provide concise and pertinent written and verbal reports and recommendations in advance of and response to high-level issues and incidents. Outstanding relationships across broad spectrum of public and private sector agencies and organizations at all levels.

EXPERIENCE

2017 to Present

COUNTY OF ORANGE, HEALTH CARE AGENCY

Agency Director, Health Care Agency

Leads a multi-faceted agency with approximately 2,700 full-time employees working in more than 100 separate locations. Responsible for the overall direction and operation of five core service areas: Public Health Services, Behavioral Health Services, Correctional Health Services, Regulatory/Medical Health Services, and Administrative Services. The Agency has an operating budget of $650M with more than 120 separate funding sources in addition to a wide array of regulatory and direct service mandates.

Key Achievements

- Directed and completed the outreach efforts and relocation of nearly 700 homeless individuals from the Santa Ana Flood Control Channel in a one month period.
- Managed the interagency reorganization bringing homeless services to the Health Care Agency to streamline care coordination for those experiencing homelessness.
- Oversaw the development of the County's first payer agnostic behavioral health campus.
- Acted as the Interim Behavioral Health Director for nearly a year.

2013 to 2017

COUNTY OF ORANGE, HEALTH CARE AGENCY

Assistant Director, Health Care Agency

Responsible for strategic direction and daily operation of the Health Care Agency, which is comprised of 2,700 employees, an operating budget of $650 million, and organized into five core service areas: Public Health Services, Behavioral Health Services, Correctional Health Services, Regulatory/Medical Health Services and Administrative Services. Implement goals and policies as set by the Orange County Board of Supervisors under the direction, and in collaboration with, the County Executive Officer and Agency Director (while serving as Agency Director in his Absence). Establish guidance for programmatic modification in response to changes In policy, legislation and funding.

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EXPERIENCE *Continued*

Key Achievements

- Directed and completed contracting of ambulance services in major portions of the county.
- Conducted assessment of executive team in the Health Care Agency resulting in reorganization of services and staff leading to increased efficiencies and improved performance.
- Worked collaboratively with CalOptima to transfer 44,500 HCA/Medical Services for Indigents patients who became Medi-Cal eligible on January 1, 2014.
- Provided leadership and mentoring to executive team to be collaborative in program areas where possible, creating synergy and efficiencies in providing services under budget.
- Worked directly on recruitment of six new CalOptima Board members.
- Oversaw Health Care Agency's response to Board Directives regarding Orange County's homeless population, focusing on results oriented services through collaboration with other County agencies and private sector providers.
- Continuously focused on opportunities to meet Board direction while focusing on service oriented, cost effective methods. An example is the Whole Person Care project, which will target the impacts of homelessness while promoting mental and physical wellness.

2008 to 2013

COUNTY OF ORANGE, HEALTH CARE AGENCY
Director, Environmental Health – Public Health Services

Lead $22 million Environmental Health division of the Health Care Agency with staff of more than180 employees serving the entirety of Orange County residents and visitors. Directed both short and long-term development of high-profile food protection, hazardous materials, water quality, solid waste, medical waste, emergency response, San Onofre Nuclear Generator Station (SONGS) response and industrial clean-up programs. Provided operations and programmatic direction on environmental health standards for quality and policy issues, while providing related briefings to executives and elected as requested. Responded to media requests and served as liaison with federal, state and local officials. Coordinated development of budget and fees studies; evaluated legislative, procedural and staffing challenges and made thorough and thoughtful recommendations to Agency administration to increase efficiencies.

Key Achievements

- Two time recipient of Orange County Business Council's "Turning Red Tape into Red Carpet" award in recognition of the collaborative effort of regulators working with business to promote economic growth.
- Directed the development and implementation of a countywide public notification system for food inspection results. Provided inspection results at food establishments and via an interactive website through Orange County Board of Supervisors leadership and in collaboration with industry representatives.
- Worked with OC Public Works and City planners to ensure smooth implementation of new legislation impacting both food protection program and zoning regulations related to home businesses.
- Collaborated with private and public agencies to conduct a pilot study allowing for same- day notification of ocean water conditions to the public.

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EXPERIENCE

Continued

Key Achievements

- Member of Executive Team and Operations Team of Agency, providing guidance and input on policy and decision making affecting the entire Agency.
- Member of Balanced Scorecard committee of Agency (and assisted with OC Waste and Recycling's Balanced Scorecard process as a stakeholder) providing input and feedback on each of the measures.
- Author of Agenda Staff Reports (ASR) for Division and attend Board of Supervisor meetings to answer questions and respond to inquiries regarding ASRs.
- Served as staff at the County Emergency Operations Center during exercises and during events related to SONGS.
- Met with OC Sanitation District and OC Water District on regular basis regarding various issues of mutual interest such as waste outfall repair planning and Groundwater Replenishment System (GRWS) project.
- Served as Operations Chief at Health Emergency Operations Center during H1N1 event.
- Member of the Compliance Committee representing Public Health Services on Agency-wide compliance policy decisions and issues.

2005 to 2008

COUNTY OF ORANGE, HEALTH CARE AGENCY

Assistant Director, Environmental Health – Public Health Services

Responsible for providing daily operational oversight for all environmental health programs to ensure effective, high quality implementation. Ensured new laws, codes and regulations pertaining to environmental health were implemented in a consistent, efficient manner. Provided oversight to federal and state audits of programs and ensured regulatory mandates were met. Updated division policies as needed in response to legislative changes, federal/state guidance and efficiency processes developed in house.

Key Achievements

- Worked with stakeholder group of food industry representatives within Orange County impacted by fee adjustments to ensure ongoing necessary program revenue. Successfully presented fee package to Board of Supervisors with endorsement from stakeholders, which was approved.
- Executed audits of staff performance and monthly expenditure/revenue review resulting in improved program efficiencies in both program output and fiscal monitoring.
- Implemented Board approved policy to ensure rate payer revenue had a fee for service basis resulting in a reduction of money spent on collections in turn ensuring fee rates were appropriate.
- Collaborated with OC Watersheds to provide helpful educational information to business community regarding storm water/National Pollutant Discharge Elimination System.

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EXPERIENCE *Continued*

2001 to 2005

COUNTY OF SACRAMENTO, ENVIRONMENTAL MANAGEMENT DEPARTMENT
Environmental Health Chief/Director/Deputy Health Officer

Planned, directed and implemented goals, objectives and mandates of the Environmental Health division comprised of 72 staff with a $12 million operating Budget. Responsible for management, operations, finances, human resources and Information technology needs for environmental health programs. Working with PIO, responded to media requests and public requests for information. Managed contract negotiation, grant submittals and oversight audits for programs. Served as Deputy Health Officer to provide subject area expertise to County Health Officer on issues related to environmental health issues at federal/state and local meetings. Met with State legislators and provided testimony at committee hearing on legislative issues related to environmental health. Researched, prepared and presented agenda items at Board of Supervisor meetings. Had frequent direct interaction with executive management, elected officials, as well as federal/state and local agencies.

Key Achievements

- Collaborated with other County agencies to assist businesses in understanding environmental requirements when starting up a business to strengthen the Business Environmental Resource Center' established by the Department.
- Oversaw complete reorganization and program improvement of Food Protection Program as a result of media expose of previously existing deficiencies. At time of departure, program was recognized by Board of Supervisors and media as markedly improved.
- Recipient of National Association of Counties Achievement Award for Food Worker Education Program.
- As a result of issues related to a solid waste facility in the County, worked with state legislators and solid waste stakeholder business community in improving efficiencies of regulations regarding solid waste.
- Directed review of fiscal/revenue policies and procedures and successfully implemented changes to allow for multi-year fee studies, ability to carry over revenue and updated County code to allow for cost recovery from nonpaying rate payers.

1984-2001

COUNTY OF SAN BERNADINO, ENVIRONMENTAL MANAGEMENT DEPARTMENT
Environmental Health Specialist/Supervisor/Program Manager

Began career as field staff and promoted to Program Manager with oversight of Food Protection/Recreational Health, Solid Waste, Vector Control, and Land Use/ Water Protection programs. Managed budget of $7 million with 62 staff in five Offices located throughout the county. Programs varied in coverage area ranging from the entirety of the county to districts. Responsible for directing daily operation of varied regulatory environmental health programs ensuring quality, compliance and cost effective implementation. Serve as liaison to various service area clients including cities and special districts, managing communication of service levels and responding to concerns and inquiries.

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EXPERIENCE

Continued

Key Achievements

- While still staff level serves as principle author of award winning submission for nationally recognized Food Safety Award (Samuel J. Crumbine Award).
- Served as standing panel member for review of RFPs for other agencies within the county.
- Reviewed and recommended implemented reduction in number of satellite offices, resulting in cost savings and necessary increased oversight of field staff.
- Served on multiple statewide committees including but not limited to California Retail Food Safety Advisory Council, Local Solid Waste Enforcement Round table and Mosquito and Vector Control Association of California.

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EXPERIENCE

Continued

EDUCATION

1984	Master of Public Health, Loma Linda University
1981	Bachelor of Science, Biological Sciences, UC Irvine

TEACHING EXPERIENCE

2009 to 2011	Lecturer, Health & Human Services, Cal State Long Beach
1998 to 2001	Adjunct Faculty, Public Health, Loma Linda University Adjunct
1991 to 1997	Faculty, Business & Applied Tech, Chaffey College

PROFESSIONAL AFFILIATIONS

2017 to Present	Member, CalOptima Board of Directors
	Member, First 5 Orange County
2012 to 2013	President, California Conference of Directors of Environmental Health (CCDEH)
2011 to 2012	President Elect, CCDEH
1996 to 2000	Co-Chair Committee to Review California Retail Food Facilities Law

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Attorneys for Plaintiff,
CITY OF COSTA MESA and KATRINA FOLEY

UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA – SOUTHERN DIVISION

CITY OF COSTA MESA, and KATRINA FOLEY,

Plaintiff,

vs.

UNITED STATES OF AMERICA, THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, THE UNITED STATES DEPARTMENT OF DEFENSE, THE UNITED STATES AIR FORCE, THE CENTERS FOR DISEASE CONTROL AND PREVENTION, THE STATE OF CALIFORNIA, FAIRVIEW DEVELOPMENTAL CENTER (FAIRVIEW), THE CALIFORNIA GOVERNOR'S OFFICE OF EMERGENCY SERVICES, and THE CALIFORNIA DEPARTMENT OF GENERAL SERVICES,

Defendants.

Case No. 8:20-cv-00368-JLS-JDE

DECLARATION OF DR. NICHOLE QUICK IN SUPPORT OF *EX PARTE* APPLICATION FOR TEMPORARY RESTRAINING ORDER AND ORDER TO SHOW CAUSE RE ISSUANCE OF PRELIMINARY INJUNCTION

DATE: FEBRUARY 24, 2020
TIME: 2:00 P.M.
COURTROOM: 10A

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DECLARATION OF DR. NICHOLE QUICK

I, Dr. Nichole Quick, declare:

1. I am employed by the County of Orange ("County") as the County Health Officer. I have personal knowledge of the matters set forth below and if called upon to testify as to the accuracy of its contents, I could and would do so.

2. I received a M.D. degree from the University of Utah School of Medicine in 2008. I completed my residency in preventative medicine at University of California at San Diego in 2011. I received a Master of Public Health degree from San Diego State in 2011. I am Board Certified in Preventative Medicine and Public Health. Since that time, I have worked in various positions in the health care industry. I was appointed as the Interim County Health Officer in 2018, until my appointment as the County Health Officer in 2019. From 2015 through 2018, I served as the Health Officer of the County of Yuba, Health and Human Services Public Health Division. A copy of my C.V. is attached hereto as Exhibit A, which accurately reflects my educational and employment background.

3. As the County Health Officer, it is my duty to protect the health and safety of Orange County's residents to the best of my ability. Part of my duties include being involved in decisions with respect to the containment of infectious diseases that pose a serious health threat to the county's residents.

4. On Thursday, February 20, 2020, I received news of the State's intention to transport individuals who are currently under quarantine or isolation for the coronavirus ("COVID-19") to the Fairview Developmental Center "Fairview" in the City of Costa Mesa. This raises a number of questions and concerns which have yet to be addressed by the State. These questions concern the health and safety of Orange County residents, including but not limited to the following:

a. What are the details and characteristics of COVID-19 patients? We have no information regarding the health status, total number, timeline

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of prior tests, timing of transport, and method of transport to Fairview Developmental Center.

b. Is the transport of patients from Travis Airforce Base to Fairview Developmental Center consistent with Centers for Disease Control and Prevention guidance on transport of COVID-19 positive patients?

c. Will COVID-19 patients who become symptomatic be cared for at Fairview Developmental Center or transported to local hospitals?

d. In the event COVID-19 positive patients are transported to local hospitals, who will be monitoring exposed health care workers?

e. Who will pay for transport and medical care, and will the 911 system be used for transport?

f. How will individuals be cleared? Will it be two consecutive negative specimens separated by 24 hours, and which laboratory and which tests will be used?

g. How will specimens be processed and sent for testing?

h. Is there onsite capacity for blood draw, oropharyngeal and nasopharyngeal swabbing, and chest X-ray?

i. After clearing how will COVID-19 patients get to their county of residence?

j. What are the final cleaning and disinfection plans/protocols for Fairview Developmental Center to assure no further transmission?

k. Are the provisions for isolation of patients consistent with Centers for Disease Control and Prevention guidance, such as use of individual living quarters?

l. What are the local transportation and hospitalization plans for patients who become symptomatic and require hospitalization?

m. What is the need for and anticipated impact on the local EMS system?

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n. What are the plans for enforcing isolation orders to prevent possible community exposure of COVID-19?

o. Who is assessing infection control risk at Fairview Developmental Center?

p. What is the workforce infection control plan and living arrangements to prevent possible community exposures as well as who will provide active monitoring for the workforce?

q. What is the infection control training for workforce on the property including medical, custodial, food service, and maintenance staff, among others?

r. What are the infection control plans for other individuals residing or working at the Fairview Developmental Center?

s. What is the ongoing communications plan for all partners for the duration of the operation?

5. It is important to obtain answers to each of these questions prior to any decision being made as to whether the quarantined or isolated individuals should be transported to Fairview, as it is imperative that all necessary measures are taken to ensure the public safety of the county's residents.

I declare under penalty of perjury under the laws of the United States of America and the State of California that the foregoing is true and correct.

Executed this 24th day of February 2020 in Santa Ana, California.

Dr. Nichole Quick

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EXHIBIT

A

EXHIBIT A

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Nichole A. Quick, MD, MPH

nicholequickmd@gmail.com / (801) 885-4285

PROFESSIONAL EXPERIENCE

County of Orange Health Care Agency
County Health Officer – Santa Ana, California ▪ Current

County of Orange Health Care Agency
Interim Health Officer – Santa Ana, California ▪ 2019

County of Orange Health Care Agency
Deputy Health Officer – Santa Ana, California ▪ 2018- 2019

Health Equity Committee
Chair – Santa Ana, California ▪ 2018- Current

Clinical Quality Assurance Committee
Chair – Santa Ana, California ▪ 2018- Current

California Conference of Local Health Officers Environmental Health Committee
Co-Chair – Sacramento, California ▪ 2018- Current

County of Yuba Health & Human Services Public Health Division
Health Officer – Marysville, California ▪ 2015- 2018

Health Officers Association of California
Treasurer – Sacramento, California ▪ 2016- 2018

Yuba Sutter Colusa Medical Society
President Elect & CMA Delegate – Yuba County, California ▪ 2016- 2018

Peach Tree Health
Board of Directors & Quality Assurance Committee– Marysville, California ▪ 2015-2018

Riverwoods Neurological Center & Integrated Healing Arts
Primary care and addiction medicine practice
Director of Preventive Services – Provo, Utah ▪ 2012- 2015

Discovery House Opiate Treatment Program
Medical Director – Layton, Utah ▪ 2014- 2015

Thistle Creek Ranch
Dual diagnosis residential treatment center
Medical Director – Spanish Fork, Utah ▪ 2013- 2015

Utah Addiction Center
Dual diagnosis residential treatment center
Medical Director – Eagle Mountain, Utah ▪ 2012- 2015

San Diego Family Care
Medical Staff – San Diego, California ▪ 2011- 2012

EDUCATION

University of California, San Diego, San Diego, CA ▪ 2009–2011
Residency, Preventive Medicine

San Diego State University, San Diego, CA ▪ 2009–2011
Master of Public Health

University of California, Davis, Sacramento CA ▪ 2008–2009
Internship, Emergency Medicine

University of Utah School of Medicine, Salt Lake City, UT
MD, 2008

University of Utah, Salt Lake City, UT
BS Philosophy, May 2004

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BOARD CERTIFICATION

American Board of Preventive Medicine, Public Health & General Preventive Medicine

American Board of Preventive Medicine, Addiction Medicine

American Board of Addiction Medicine

LICENSURE

California State Medical License

Utah State Medical License

PUBLICATIONS & REFERENCE

Publication list and peer references available upon request

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