NOTICE OF A REGULAR MEETING OF THE CALOPTIMA BOARD OF DIRECTORS

THURSDAY, MARCH 2, 2017
2:00 P.M.

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

BOARD OF DIRECTORS

Mark Refowitz, Chair	Lee Penrose, Vice Chair
Supervisor Lisa Bartlett	Supervisor Andrew Do
Ria Berger	Ron DiLuigi
Dr. Nikan Khatibi	Alexander Nguyen, M.D.
J. Scott Schoeffel	Paul Yost, M.D.

Supervisor Michelle Steel, Alternate

CHIEF EXECUTIVE OFFICER	CHIEF COUNSEL	CLERK OF THE BOARD
Michael Schrader	Gary Crockett	Suzanne Turf

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

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

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

CALL TO ORDER
Pledge of Allegiance
Establish Quorum

PRESENTATIONS/INTRODUCTIONS

MANAGEMENT REPORTS

1. Chief Executive Officer Report
   a. Program of All-Inclusive Care for the Elderly (PACE)
   b. Regulatory Audit
   c. OneCare Connect
   d. Affordable Care Act (ACA)
   e. Informational Series on Opioid Epidemic

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 2, 2017 Regular Meeting of the CalOptima Board of Directors
   b. Receive and File Minutes of the November 17, 2016 Regular Meeting of the CalOptima Board of Directors' Finance and Audit Committee, and the November 16, 2016 Regular Meeting of the CalOptima Board of Directors' Quality Assurance Committee

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

4. Consider Approval of the 2017 CalOptima Program of All-Inclusive Care for the Elderly (PACE) Quality Assessment and Performance Improvement (QAPI) Plan

5. Consider Approval of the Fiscal Year (FY) 2018 (Measurement Year 2017) Pay for Value Programs for Medi-Cal and OneCare Connect

6. Consider Authorizing Staff to Develop and Implement Medi-Cal Quality Improvement and Accreditation Activities During CalOptima Fiscal Year (FY) 2016-17 for Member and Provider Incentives

7. Receive and File Compliance Strategies' 2016 Compliance Program Effectiveness (CPE) Audit Report

8. **Acting as the CalOptima Foundation:** Consider Reappointments to the CalOptima Foundation Audit Committee

REPORTS

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

10. Consider Authorizing Pursuit of Proposals with Qualifying Funding Partners to Secure Medi-Cal Funds Through the Voluntary Intergovernmental Transfer (IGT) Rate Range Program for Rate Years 2015-16 (IGT 6) and 2016-17 (IGT 7)

11. Consider Authorizing Contract with Vendor to Assist with the Member Health Needs Assessment Activities

12. Consider Adoption of Resolution Approving Updated Human Resources Policies

13. Consider Modifications to CalOptima Policy FF.2008 Health Insurance Premium Payment, and Wind Down and Termination of the Program

14. Consider Temporarily Waiving Enforcement of the Bed Day Utilization Requirement and Related Policy for Physician Hospital Consortia (PHC)

15. Consider Authorizing Issuance of Request for Proposal (RFP) for Medi-Cal Perinatal Support Services (PSS), Contracts with Qualifying RFP Responders, and Amendment of Contract with Current Vendor

16. Consider Options for Development Rights at 505 City Parkway West, Orange, California Site

17. Consider Ratification and Approval of Expenditures Related to Emergency Repairs for CalOptima Facilities

18. Consider Election of Board of Directors Chair Effective March 31, 2017 through June 30, 2017

ADVISORY COMMITTEE UPDATES

19. Provider Advisory Committee Update

20. OneCare Connect Cal MediConnect (Medicare-Medicaid Plan) Member Advisory Committee Update

21. Member Advisory Committee Update

INFORMATION ITEMS

22. PACE Operational Analysis and Business Plan Follow Up

23. CalOptima Opioid Reduction Program

24. January 2017 Financial Summary

25. Compliance Report

26. Federal and State Legislative Advocates Reports

27. CalOptima Community Outreach and Program Summary

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

ADJOURNMENT

NEXT REGULAR MEETING: Thursday, April 6, 2017 at 2:00 p.m.

MEMORANDUM

DATE:	March 2, 2017
TO:	CalOptima Board of Directors
FROM:	Michael Schrader, CEO
SUBJECT:	CEO Report
COPY:	Suzanne Turf, Clerk of the Board; Member Advisory Committee; Provider Advisory Committee; OneCare Connect Member Advisory Committee

Program of All-Inclusive Care for the Elderly (PACE)
In February 2016, CalOptima's Board outlined next steps for PACE expansion via the Alternative Care Setting (ACS) model once the Garden Grove center's financial performance and enrollment trends were positive. Before PACE expansion, the Board directed that the Finance and Audit Committee (FAC) first receive a thorough analysis of existing PACE operations and of the ACS model using Community-Based Adult Services (CBAS) centers as satellite locations. FAC has received two presentations sharing extensive data, most recently on February 16, 2017. Performance indicators show that CalOptima PACE is on solid financial and operational footing, with six months of breakeven or better financial results and enrollment growth bringing the census to 195 participants. As part of the expansion plan, the Board also approved the submission to regulators of a PACE Service Area Expansion application for south Orange County and the initiation of a Request for Proposal (RFP) process for PACE satellite locations, including CBAS centers. CalOptima is ready to begin these two steps as we strive to offer PACE's comprehensive, community-based care to a wider geographic population of frail seniors. In another step for the longer term, the Board directed that once the Garden Grove center reaches 80 percent capacity, staff should request that the Board consider authorizing additional centers. At this time, center capacity is approximately 600 participants, so the center is not yet near that benchmark. Given the community's interest in our PACE expansion plans, I am including an Information Item on your agenda this month and will provide periodic updates as the process moves forward.

Regulatory Audit
From February 6–17, approximately 20 Department of Health Care Services (DHCS) and Department of Managed Health Care (DMHC) auditors conducted a major yet routine regulatory review of CalOptima. DHCS evaluated Medi-Cal's compliance with our contract and regulations in the areas of utilization management, case management and care coordination, access and availability, member rights and responsibilities, quality improvement system, CalOptima organization and administration, facility site reviews, and medical records review. DMHC reviewed Medi-Cal's compliance with the Seniors and Persons with Disabilities 1115 Waiver and OneCare Connect's provision of Medicaid-based services, evaluating compliance in the areas of utilization management, continuity of care, availability and accessibility of services, member rights, and quality management. CalOptima expects that DHCS will distribute a draft

Back to Agenda

findings report sometime in April, followed by an exit conference. A final report is expected about four weeks after the exit conference.

OneCare Connect
Health plans participating in Cal MediConnect (CMC), including CalOptima, are pleased that Gov. Brown's proposed Fiscal Year 2017–18 state budget includes an extension of the program until December 31, 2019. Advocacy to ensure that the provision remains in the final budget is ongoing. Toward this end, Local Health Plans of California held a legislative briefing on February 14 in Sacramento. I gave a joint presentation with another health plan CEO focused on the positive impact CMC plans have had in reducing costs and increasing quality. About 25 key staff from regulatory agencies and legislative committees attended. Separately, I had the opportunity while in Washington, D.C., to provide an update about OneCare Connect for two Centers for Medicare & Medicaid Services (CMS) officials: Tim Engelhardt, Director, Federal Coordinated Health Care Office, and Cheri Rice, Acting Deputy Center Director for the Center for Medicare. In these meetings, I shared about the continuation of CMC in the proposed state budget and our recent program innovations, including a new initiative to improve the level of care for OneCare Connect members who reside in long-term care facilities. Both officials were pleased about our continued commitment to the dual-eligible population. Further, to highlight the value of OneCare Connect in our community, I contributed an opinion article to the Orange County Register about the benefits of coordinated care in improving care, lowering costs and enhancing the patient experience. The piece ran February 23 in the print edition and online here.

Affordable Care Act (ACA)
CalOptima continues to track potential changes to the ACA provisions involving Medicaid expansion and to advocate for the best possible outcome for Orange County. In February, I participated in Washington, D.C., fly-in sponsored by the Association for Community Affiliated Plans and in meetings organized by Local Health Plans of California (LHPC). LHPC's public managed care plans, including CalOptima, met with key staff from the four congressional committees working on ACA changes: Senate Finance; Senate Health, Education, Labor and Pensions; House Energy and Commerce; and House Ways and Means. Staff was interested in learning about how managed care plans in California are able to provide high-quality, cost-effective care. They asked that LHPC stay in contact to serve as an information resource as the process of changing ACA moves forward. While in Washington, I also met with Reps. Mimi Walters, Alan Lowenthal, Lou Correa and Dana Rohrabacher, and staff to Reps. Ed Royce and Darrell Issa, and Sens. Dianne Feinstein and Kamala Harris. My focus was sharing the economic impact of Medi-Cal growth in Orange County. As you know, Medi-Cal expansion has resulted in 234,000 new CalOptima members and $1.1 billion in revenue. These two facts were of significant interest to the delegation, especially given that CalOptima's public-private partnership has increased revenue to hospitals by $227 million and to health networks by $565 million. Members of Congress and their staff appreciated the information and requested that CalOptima continue to provide details about the local impact of any potential ACA changes.

Informational Series on Opioid Epidemic
At your November 2016 strategic planning session, your Board highlighted the growing epidemic of opioid abuse in Orange County and charged CalOptima with addressing the problem

Back to Agenda

in our member population. On March 3, a CalOptima Informational Series event will raise community awareness about the issue and share our efforts to prevent opioid abuse. Featured speakers will include Board Member Dr. Nikan Khatibi, a pain management specialist, as well as Richard Bock, M.D., CalOptima's Deputy Chief Medical Officer, Sandra Fair from Orange County Health Care Agency Behavioral Health Services, and Bharath Chakravarthy, M.D., of SafeRx OC. Approximately 150 attendees are expected, including providers, member advocates and community-based organizations.

Back to Agenda

MINUTES

REGULAR MEETING
OF THE
CALOPTIMA BOARD OF DIRECTORS

February 2, 2017

A Regular Meeting of the CalOptima Board of Directors was held on February 2, 2017, at CalOptima, 505 City Parkway West, Orange, California. Chair Mark Refowitz called the meeting to order at 2:03 p.m. Suzanne Turf, Clerk of the Board, led the Pledge of Allegiance.

ROLL CALL

Members Present: Mark Refowitz, Chair (non-voting); Lee Penrose, Vice Chair; Ria Berger, Ron DiLuigi, Supervisor Andrew Do, Dr. Nikan Khatibi, Alexander Nguyen, M.D., Scott Schoeffel, Paul Yost, M.D. (at 2:08 p.m.)

Members Absent: Supervisor Lisa Bartlett

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

PRESENTATIONS/INTRODUCTIONS

On behalf of the Board of Directors, Chair Refowitz presented recognition to former Board Director Peter Agarwal in honor of his service on the Board of Directors and his commitment to CalOptima and to Orange County's Medi-Cal beneficiaries. Supervisor Do presented a Certificate of Recognition on behalf of himself and Supervisor Bartlett in appreciation of Mr. Agarwal's service on the Board of Directors and to the health and well being of CalOptima's members.

MANAGEMENT REPORTS

1. Chief Executive Officer (CEO) Report

CEO Michael Schrader provided a brief report on the Governor's proposed FY 2017-18 State Budget, which extends the Cal MediConnect program, known as OneCare Connect in Orange County, until December 31, 2019, discontinues the broader Coordinated Care Initiative on January 1, 2018, returns responsibility for all functions of the In Home Supportive Services (IHSS) program to counties, and removes IHSS benefits from health plan capitation rates.

Mr. Schrader stated that CalOptima continues to track potential changes to the Affordable Care Act (ACA) that could impact the Medi-Cal program. Congress has started the reconciliation process by passing a budget blueprint that instructs four congressional committees to develop ACA repeal language for a reconciliation bill, which could reduce or eliminate funding for Medicaid expansion. It was noted that Medicaid expansion represents approximately 30% of CalOptima's membership, and annual revenue could be decreased by approximately $1 billion if these members were no longer covered by the Medi-Cal program. Staff will keep the Board informed of any significant developments.

Back to Agenda

PUBLIC COMMENTS
There were no requests for public comment.

CONSENT CALENDAR
Consent Calendar items 3 and 4 were pulled by staff for minor revisions.

2. Minutes
   a. Approve Minutes of the December 1, 2016 Regular Meeting of the CalOptima Board of Directors; and
   b. Receive and File Minutes of the November 10, 2016 Meeting of the CalOptima Board of Directors' Provider Advisory Committee, the November 10, 2016 Meeting of the CalOptima Board of Directors' Member Advisory Committee, and the November 17, 2016 Meeting of the CalOptima Board of Directors' OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) Member Advisory Committee

3. Consider Appointment of CalOptima Treasurer
The recommended action was revised to read "Appoint Nancy Huang, CalOptima Interim Chief Financial Officer, as Interim Treasurer."

Action: ***On motion of Supervisor Do, seconded and carried, the Board appointed Nancy Huang, Interim Chief Financial Officer, as Interim Treasurer. (Motion carried 8-0-0; Supervisor Bartlett absent)***

4. **Acting as the CalOptima Foundation:** Consider Appointment of CalOptima Foundation Chief Foundation Officer
The recommended action was revised to read "Appoint Nancy Huang, CalOptima Interim Chief Financial Officer (CFO), as the Interim CalOptima Foundation CFO."

Action: ***On motion of Vice Chair Penrose, seconded and carried, the Foundation Board of Directors appointed Nancy Huang, Interim Chief Financial Officer, as Interim CalOptima Foundation Chief Financial Officer. (Motion carried 8-0-0; Supervisor Bartlett absent)***

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

REPORTS

Chair Refowitz reordered the agenda to address Agenda Item 13, Consider Modifications to CalOptima Policy FF.2008, Health Insurance Premium Payment, and Wind Down and Termination of the Program.

13. Consider Modifications to CalOptima Policy FF.2008, Health Insurance Premium Payment, and Wind Down and Termination of the Program.
Chair Refowitz reported that at the request of a Board member, this item will be continued to the March 2, 2017 Board meeting to allow for additional analysis.

Back to Agenda

Action: ***On motion of Supervisor Do, seconded and carried, the Board of Directors continued Agenda Item 13, Consider Modifications to CalOptima Policy FF.2008, Health Insurance Premium Payment, and Wind Down and Termination of the Program, to the March 2, 2017 Board of Directors meeting. (Motion carried 8-0-0; Supervisor Bartlett absent)***

5. Consider Ratifying the Timeframe Extension for Qualifying New Network(s) to Complete Readiness Assessment Requirements

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

Action: ***On motion of Supervisor Do, seconded and carried, the Board of Directors ratified and extended the deadline to December 1, 2017, for St. Joseph Heritage Healthcare, selected through the Request for Proposal process for health networks, to meet all applicable readiness requirements. (Motion carried 5-0-0; Director Yost recused; Vice Chair Penrose, Supervisor Bartlett, and Director Schoeffel absent)***

6. Consider Appointment to the CalOptima Board of Directors' Member Advisory Committee

Action: ***On motion of Director DiLuigi, seconded and carried, the Board of Directors appointed Jaime Munoz to serve as the Foster Children Representative of the Member Advisory Committee for the remainder of the term ending June 30, 2018. (Motion carried 8-0-0; Supervisor Bartlett absent)***

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

Action: ***On motion of Vice Chair Penrose, seconded and carried, the Board authorized and directed the Chairman of the Board of Directors to execute Amendment(s) to the Primary Agreement between DHCS and CalOptima related to rate changes, incorporation of language to the Primary Agreement related to Managed Medi-Cal Long-Term Supports and Services, and addition of covered Aid Codes. (Motion carried 8-0-0; Supervisor Bartlett absent)***

8. Consider Approval of Proposed Revisions to CalOptima Security-Related Policies

Len Rosignoli, Chief Information Officer, presented the recommended action to authorize and approve updates to the following policies, subject to regulatory approval, as necessary: GA.5005a: Use of Technology Resources; IS.1102: Electronic Media, Electronic Storage Devices, and Hardware Controls; IS.1201: EPHI Technical Safeguards – Access Controls; IS.1202: EPHI Technical Safeguards – Data Controls; IS.1301: Security of Workforce Access to EPHI; and IS.1303: Audit, Review, Testing, and Change Management. Mr. Rosignoli reported that the proposed changes to these policies restrict the use of USB and other electronic storage devices, updates definitions, clarifies and expands language to more accurately reflect federal and state requirements and best practices.

Back to Agenda

Action: ***On motion of Supervisor Do, seconded and carried, the Board of Directors authorized and approved updates to the following security-related policies, subject to regulatory approval, as necessary: GA.5005a: Use of Technology Resources; IS.1102: Electronic Media, Electronic Storage Devices, and Hardware Controls; IS.1201: EPHI Technical Safeguards – Access Controls; IS.1202: EPHI Technical Safeguards – Data Controls; IS.1301: Security of Workforce Access to EPHI; and IS.1303: Audit, Review, Testing, and Change Management. (Motion carried 8-0-0; Supervisor Bartlett absent)***

9. Consider Authorization of Expenditures in Support of CalOptima's Participation in the 2017 ActNOW Conference and South Orange County Senior Day

Action: ***On motion of Supervisor Do, seconded and carried, the Board of Directors: 1) Authorized expenditures of up to $1,000 and staff participation at The G.R.E.E.N. Foundation's 2017 ActNOW Conference on February 25, 2017 at California State University, Fullerton, and up to $1,000 and staff participation at Senator Patricia C. Bates and Assemblyman William P. Brough's South Orange County Senior Day 2017 on Friday, March 10, 2017 in Mission Viejo; 2) Made a finding that such expenditures are for a public purpose and in furtherance of CalOptima's mission and statutory purpose; and 3) Authorized the Chief Executive Officer to execute agreements as necessary for the events and expenditures. (Motion carried 8-0-0; Supervisor Bartlett absent)***

10. Consider Selection and Contracting with Vendor for Federal Legislative Advocacy Services

Director DiLuigi reported on behalf of the Federal Legislative Advocacy Services Request for Proposal (RFP) Ad Hoc Committee. The ad hoc, composed of Supervisors Bartlett and Do, and Directors DiLuigi and Khatibi, met to interview the top four RFP finalists. After evaluation of the proposals and in-person interviews conducted by the ad hoc, two finalists were identified. Based on the review of the best and final offers submitted by the two finalists, the ad hoc recommended authorizing the Chief Executive Officer to enter into a three-year contract with Akin Gump Strauss Hauer & Feld LLP for federal regulatory and advocacy services, authorize expenditures of up to $32,000 from existing reserves for the additional costs in excess of the Board approved budget for federal legislative advocacy services for Fiscal Year 2016-17 to deliver all services detailed in the RFP Statement of Work, with total expenditures not to exceed $10,000 per month.

Action: ***On motion of Supervisor Do, seconded and carried, the Board of Directors approved federal advocacy firm Akin Gump Strauss Hauer & Feld LLP to represent CalOptima for federal regulatory and advocacy services, authorized the Chief Executive Officer to execute applicable contract, and authorized expenditures of up to $32,000 from existing reserves for the additional costs in excess of the Board approved budget for federal regulatory and advocacy services for Fiscal Year 2016-17 to deliver all services detailed in the RFP Statement of Work, with total expenditures not to exceed $10,000 per month. (Motion carried 8-0-0; Supervisor Bartlett absent)***

11. Consider Approval and Implementation of Revised CalOptima Endorsement Policy AA.1214 and Proposed New Policy Regarding Participation in Community Events

Vice Chair Penrose reported on behalf of the Endorsement/Community Events Policy Ad Hoc Committee. The ad hoc, composed of Supervisors Bartlett and Do, Vice Chair Penrose and Director

Nguyen, met to review CalOptima's Endorsement Policy, use of CalOptima's logo, and financial participation in community events. Based on the ad hoc's review, the recommended revisions to AA.1214, CalOptima Endorsement Policy, and new policy AA.1223, Participation in Community Events Involving External Entities, establish criteria and guide the decision making process related to the request for letters of support, use of CalOptima's name or logo, and staff and financial participation in external community oriented events. The criteria established in the policies are focused on participation in events that are consistent with CalOptima's mission and statutory purpose to assist our members in obtaining needed health care services and information. In addition, policy AA.1223 memorializes that requests for financial participation in amounts greater than $1,000 require Board of Directors approval. For financial participation in an amount up to and including $1,000, authority is delegated to the Chief Executive Officer based on the criteria set forth in these policies.

Action: ***On motion of Vice Chair Penrose, seconded and carried, the Board of Directors approved revised CalOptima Policy AA.1214: Guidelines for Endorsements by CalOptima, for Letters of Support, and Use of CalOptima's Name or Logo; approved CalOptima Policy AA.1223: Participation in Community Events Involving External Entities, and authorized the Chief Executive Officer to implement the policies. (Motion carried 8-0-0; Supervisor Bartlett absent)***

12. Consider Adoption of Resolution Approving Updated Human Resources Policies and Revised CalOptima Employee Handbook

Action: ***On motion of Director Nguyen, seconded and carried, the Board of Directors adopted Resolution No. 17-0202, Approving CalOptima's Updated Human Resources Policies and Revised Employee Handbook. (Motion carried 8-0-0; Supervisor Bartlett absent)***

ADVISORY COMMITTEE UPDATES

Member Advisory Committee (MAC) Update

Mallory Vega, MAC Chair, reported that recruitment efforts will begin for the following seats expiring on June 30, 2017: Adult Beneficiaries, Family Support, Medi-Cal Beneficiaries, Persons with Disabilities, Recipients of CalWORKs and Seniors. At the January 12, 2017 MAC meeting, the Committee received an overview of the pilot proposal for the Whole Person Care Program, member experience survey results for Medi-Cal and OneCare, and an update on the implementation of CalOptima's Managed Behavioral Health program.

Provider Advisory Committee (PAC) Update

Teri Miranti, PAC Chair, provided an update of the activities at the December 8, 2016 PAC meeting, including an update on the future of Medicaid expansion and the Cal MediConnect/OneCare Connect program. The PAC reiterated its commitment to assist in the decision-making process that will affect providers, and local trade organizations will support lobbying the appropriate government officials.

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

Gio Corzo, OCC MAC Vice Chair, reported that at their December 22, 2016 meeting, the Committee received an overview of the Multipurpose Senior Services Program and on Orange County Advance

Care Planning Partners, a program that provides advance care planning information on issues related to end of life care and planning.

INFORMATION ITEMS

The following Information Items were accepted as presented:

17. December 2016 and November 2016 Financial Summaries
18. Compliance Report
19. Federal and State Legislative Advocates Reports
20. CalOptima Community Outreach and Program Summary

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

Members of the Board commented on the potential changes in health care at the state and federal level in 2017, and the importance of actively working together with our provider and community partners to develop one clear, concise message concerning the impact of these changes, and to ensure the continuation of CalOptima's mission to provide high quality, cost effective health care for our members.

Director Berger requested that the Board consider directing staff to explore the possibility of carving in Denti-Cal as a CalOptima benefit.

Chair Refowitz announced his retirement as Director of the Orange County Health Care Agency, and the completion of his service on the CalOptima Board of Directors, effective March 31, 2017. Mr. Refowitz directed staff to place an item on the March 2, 2017 Board meeting agenda for the Board to elect a new Chair effective March 31, 2017 through June 30, 2017. To facilitate that process, Chair Refowitz announced that he would be forming a Nominations Ad Hoc Committee, composed of himself and at least one other member of the Board, to provide information on the duties, responsibilities and the number of extra hours the Chair position typically requires above and beyond serving as a member of the Board. Board members were asked to contact the ad hoc with interest in being considered or to nominate a fellow Board member for the Chair position. The Nominations Ad Hoc will present nominations, along with any from the floor, for consideration at the March 2, 2017 Board meeting.

Supervisor Do congratulated Chair Refowitz on his retirement, and commented that leadership, vision, a track record of success, and transparency are important factors to consider in the process of selecting the next Board Chair.

ADJOURNMENT

Hearing no further business, Chair Refowitz adjourned the meeting at 3:31 p.m.

/s/ Suzanne Turf
Suzanne Turf
Clerk of the Board

Approved: March 2, 2017

Back to Agenda

MINUTES

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

CALOPTIMA
505 CITY PARKWAY WEST
ORANGE, CALIFORNIA

NOVEMBER 17, 2016

CALL TO ORDER

Chair Lee Penrose called the meeting to order at 2:07 p.m. Director Schoeffel led the Pledge of Allegiance.

Members Present: Lee Penrose, Chair; Scott Schoeffel

Members Absent: Ron DiLuigi

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

Chair Penrose announced the following change to the agenda: Closed Session Item CS 1, Conference with Real Property Negotiators, pursuant to Government Code section 54956.8, was continued to a future meeting.

MANAGEMENT REPORTS

Chief Executive Officer (CEO) Report

CEO Michael Schrader reported on the uncertainty at the state level regarding the future of the Cal MediConnect program, OneCare Connect in Orange County. At the federal level, with the recent presidential election there is uncertainty regarding the Affordable Care Act, the future of Medi-Cal expansion, and potential changes to the structure of the federal Medicaid program. It is anticipated that there will be numerous discussions on these issues during 2017. CalOptima is working with our partners at the state and federal level, health plans, associations and stakeholders to advocate for the agency.

Chief Financial Officer (CFO) Report

CFO Chet Uma provided an update on the Medi-Cal Expansion Medical Loss Ratio (MLR) reconciliation to be conducted by the California Department of Health Care Services (DHCS); a date for this reconciliation has not yet been identified. It was noted that CalOptima's audit of health network self-reported MLR data will begin this month.

Back to Agenda

PUBLIC COMMENT

There were no requests for public comment.

INVESTMENT ADVISORY COMMITTEE UPDATE

1. Treasurer's Report

Mr. Uma presented an overview of the Treasurer's Report for the period July 1, 2016 through September 30, 2016. Based on a review by the Board of Directors' Investment Advisory Committee, all investments were compliant with Government Code section 53600 *et seq.*, and with CalOptima's Annual Investment Policy for Calendar Year 2016.

CONSENT CALENDAR

2. Approve the Minutes of the September 15, 2016 Regular Meeting of the CalOptima Board of Directors' Finance and Audit Committee; Receive and File Minutes of the July 25, 2016 Meeting of the CalOptima Board of Directors' Investment Advisory Committee

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

REPORTS

3. Consider Recommending Board of Directors' Approval of Medi-Cal Quality Improvement and Accreditation Activities During CalOptima Fiscal Year 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

Deputy Chief Medical Officer Richard Bock, M.D., presented the action to recommend Board of Directors' approval of Medi-Cal Quality Improvement and accreditation activities during Fiscal Year 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.

Dr. Bock reported that ongoing investment in innovative quality initiatives is required in order to maintain CalOptima's "commendable" accreditation status and rating by the National Committee for Quality Assurance (NCQA) as a top Medicaid plan in California. The following proposed expenditures were presented to the Committee for consideration: budget augmentation totaling $457,740 for current quality initiatives including surveys and NCQA fees, a NCQA consultant, quality initiatives in progress, and required staff training; and $605,839 in new requests for quality initiatives for member and provider programs, member experience initiatives, provider toolkits, and outreach projects. It was noted that 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 presented to the Board for approval prior to implementation, as well as regulatory approval, as applicable.

Back to Agenda

Chair Penrose commented on the importance of coordinating with the health networks and providers to encourage awareness and to avoid duplicative efforts.

Action: ***On motion of Director Schoeffel, seconded and carried, the Committee recommended that the Board of Directors: 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. (Motion carried 2-0-0; Director DiLuigi absent)***

4. Recommend Board of Directors' Approval of Annual Investment Policy for Calendar Year 2017

Action: ***On motion of Director Schoeffel, seconded and carried, the Committee recommended the Board of Directors' approve the extension of the current Annual Investment Policy for Calendar Year 2017. (Motion carried 2-0-0; Director DiLuigi absent)***

5. Consider Options Related to CalOptima's Development Rights at the 505 City Parkway Site; Authorize Vendor Contract(s) and/or Contract Amendment(s); Authorize Funding to Develop a Site Plan

Mr. Uma presented the action to consider options related to CalOptima's development rights at the 505 City Parkway site, authorize vendor contract(s) and/or contract amendment(s), and authorize funding to develop a site plan. On August 4, 2016, the Board of Directors authorized a contract with a real estate consultant to assist in evaluating options related to CalOptima's development rights, and approved a budget allocation of $22,602 from existing reserves to fund the contract through June 30, 2017. CalOptima contracted with real estate consultant Newport Real Estate Services to provide market research, evaluate development and financial feasibility, and recommend options based on CalOptima's development rights. An overview of the details of the Amended and Restated Development Agreement with the City of Orange was provided to the Committee.

Glen Allen of Newport Real Estate Services, Inc., provided a review of the following options: Option 1 – develop the site pursuant to the current development agreement; or Option 2 – Third Party or Disposition Alternatives that include directly selling the development rights and secure space for CalOptima's use, lease the property to a developer, assign the development rights to a developer who would provide space back to CalOptima in return, develop the property jointly with a developer, or exchange the development rights for a developed property. Mr. Allen also noted additional factors to consider when evaluating these options, including extending the lease at the current PACE Center or relocating the PACE center to the new site, and relocating the Board meeting room and external

meetings to the new site. If the Board and external meeting rooms are moved to the new site, the 505 Building could be a secured building occupied by CalOptima employees only.

After discussion of the matter, Director Schoeffel directed staff to work with the consultant and present three to five proposed projects comprised of a mix and match of the recommended alternatives, including financial modeling, for review and discussion by the Committee.

Action: ***On motion of Director Schoeffel, seconded and carried, the Committee recommended that the Board of Directors: 1) Authorize the Chief Executive Officer to further explore options related to CalOptima's development rights based on input from the Board of Directors' Finance and Audit Committee; 2) Authorize the amendment of CalOptima's contract with real estate consultant Newport Real Estate Services to include site plan development; and 3) Appropriate expenditures from existing reserves of up to $7,000 to provide funding for this contract amendment. (Motion carried 2-0-0; Director DiLuigi absent)***

6. Recommend Authorizing Proposed Budget Allocation Changes in the CalOptima Fiscal Year 2016-17 Operating Budget

Katia Taylor, Associate Director of Human Resources, presented the action to recommend that the Board of Directors: 1) Authorize reallocation of budgeted but unused funds of $500,000 from Salaries, Wages and Benefits to Purchased Services, to fund the use of executive search consultants and/or executive temporary staffing firm(s) to assist in filling hard to fill vacancies; and 2) Authorize the Chief Executive Officer, with the assistance of legal counsel, to contract with such firms consistent with CalOptima's Board-approved purchasing policy.

Chair Penrose inquired about reallocating budgeted items from one area to another versus approving an unbudgeted item. Mr. Schrader added that staff will present the current Board policy for further discussion at a future Committee meeting.

Action: ***On motion of Director Schoeffel, seconded and carried, the Committee recommended that the Board of Directors authorize reallocation of budgeted but unused funds of $500,000 from Salaries, Wages and Benefits to Purchased Services, to fund the use of executive search consultants and/or executive temporary staffing firm(s) to assist in filling hard to fill vacancies, and authorize the Chief Executive Officer, with the assistance of legal counsel, to contract with such firms consistent with CalOptima's Board-approved purchasing policy. (Motion carried 2-0-0; Director DiLuigi absent)***

INFORMATION ITEMS

The following Information Items were accepted as presented:

7. September 2016 Financial Summary
8. CalOptima Computer Systems Security Update
9. Cost Containment Improvements/Initiatives

Back to Agenda

10. Quarterly Reports to the Finance and Audit Committee
    a. Shared Risk Pool Performance
    b. Reinsurance Report
    c. Health Network Financial Report
    d. Purchasing Report

ADJOURNMENT

Hearing no further business, Chair Penrose adjourned the meeting at 3:28 p.m.

/s/ Suzanne Turf
Suzanne Turf
Clerk of the Board

Approved: February 16, 2017

Back to Agenda

MINUTES

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

CALOPTIMA
505 CITY PARKWAY WEST
ORANGE, CALIFORNIA

November 16, 2016

CALL TO ORDER

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

Members Present: Paul Yost, M.D., Chair; Ria Berger (at 3:08 p.m.); Dr. Nikan Khatibi; Alexander Nguyen M.D.

Members Absent: All members present

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

PUBLIC COMMENTS

There were no requests for public comment.

CONSENT CALENDAR

1. Approve the Minutes of the September 21, 2016 Regular Meeting of the CalOptima Board of Directors Quality Assurance Committee

Action: ***On motion of Director Khatibi, seconded and carried, the Committee approved the Minutes of the September 21, 2016 Regular Meeting of the CalOptima Board of Directors' Quality Assurance Committee as presented. (Motion carried 3-0-0; Director Berger absent)***

Back to Agenda

REPORTS

2. Consider Recommending Board of Directors' Authorization to Request a Waiver Allowing Nurse Practitioners to Provide Primary Care at the CalOptima Program of All-Inclusive Care for the Elderly (PACE) Center

Rena Smith, PACE Program Director, presented the action to recommend Board of Directors' authorization to request a waiver allowing Nurse Practitioners (NP) to provide primary care at the CalOptima PACE Center.

Ms. Smith provided an overview of Section 903of the Benefits Improvement and Protection Act (BIPA) of 2000, which allows for specific modifications or waivers of certain regulatory provisions to meet the needs of PACE organizations. It was noted that CalOptima PACE has experienced significant difficulty in recruiting and retaining primary care physicians to meet its growth needs. As proposed, a waiver of certain regulatory sections of Title 42: Public Health, Section 460 – PACE: Section 460.012 (c), Interdisciplinary Team, primary care physician, and Section 460.104 (a) and (c) regarding participant assessments, would be submitted to the Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS), to allow PACE NPs to conduct services that, as set forth in the PACE regulation, are currently assigned to the primary care physician, including assessments and reassessments, care plans, prescribing medications, and to serve on the interdisciplinary team as a primary care provider, in addition to, an in collaboration with, the PACE primary care physicians.

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

Action: ***On motion of Director Nguyen, seconded and carried, the Committee recommended that the Board of Directors authorize the Chief Executive Officer to file a waiver request for CalOptima's PACE for Section 903 of the Benefits Improvement and Protection Act of 2000, to the Department of Health Care Services and the Centers for Medicare & Medicaid Services in order to allow Nurse Practitioners (NPs) to provide primary care, in addition to and in collaboration with the PACE primary care physicians; and authorize contracts with NPs to provide such services, subject to the requested waiver first being granted. . (Motion carried 4-0-0)***

3. Consider Recommending Board of Directors' Approval of Medi-Cal Quality Improvement and Accreditation Activities During CalOptima Fiscal Year 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

Richard Bock, M.D., Deputy Chief Medical Officer, presented the action to consider recommending Board of Directors' approval of Medi-Cal Quality Improvement and Accreditation activities during CalOptima 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.

Dr. Bock reported that ongoing investment in innovative quality initiatives is required in order to maintain CalOptima's "commendable" accreditation status and rating by the National Committee for Quality Assurance (NCQA) as a top Medicaid plan in California. The following proposed expenditures were presented to the Committee for consideration: budget augmentation totaling $457,740 for current quality initiatives including surveys and NCQA fees, a NCQA consultant, quality initiatives in progress,

and required staff training; and $605,839 in new requests for quality initiatives for member and provider programs, member experience initiatives, provider toolkits, and outreach projects. It was noted that 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 presented to the Board for approval prior to implementation, as well as regulatory approval, as applicable.

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

Action: ***On motion of Director Nguyen, seconded and carried, the Committee recommended that the Board of Directors: 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. (Motion carried 4-0-0)***

4. Consider Recommending Board of Directors' Ratification of the 2016 CalOptima Utilization Management Work Plan

Dr. Bock presented the action to recommend Board of Directors' ratification of the 2016 CalOptima Utilization Management Work Plan. On March 23, 2016, revisions to the 2016 Utilization Management Program were presented to the CalOptima Board of Directors' Quality Assurance Committee for the Committee's recommendation to the CalOptima Board of Directors. On April 7, 2016, the proposed revisions to the 2016 Utilization Management Program were presented to, and approved by, the CalOptima Board of Directors. It was intended that the 2016 Utilization Management Work Plan would accompany the Utilization Management Program for approval, but the Work Plan was not included in the documents reviewed by the Quality Assurance Committee and approved by the Board of Directors. As proposed, approval of the 2016 Utilization Management Work Plan will ensure implementation of the approved 2016 Utilization Management Program.

Action: ***On motion of Director Berger, seconded and carried, the Committee recommended Board of Directors' ratification of the 2016 CalOptima Utilization Management Work Plan as presented. (Motion carried 3-0-0)***

INFORMATION ITEMS

5. Program of All-Inclusive Care for the Elderly (PACE) Member Advisory Committee Update

Mallory Vega, PACE Member Advisory Committee (PMAC) Community Representative, reported on activities at the November 16, 2016 PMAC meeting, including: the addition of five new transportation vans and the implementation of an efficient transportation route process beginning on October 12, 2016;

and staff training on the scheduling process, which will result in shorter wait times for specialist appointments. PMAC participant members discussed the upcoming participant satisfaction survey, and new participant orientation groups will begin at the end of the year. PMAC participant member's suggestions and comments included requests for a library with current reading materials, assistance with getting back into the workforce, and distributing a list of all PACE staff and their responsibilities for participants to use as a resource.

6. PACE Program Update

Ms. Smith presented an overview of CalOptima's PACE Program, including services provided and eligibility criteria. As of November 1, 2016, 183 participants are enrolled in the program. Future plans for PACE include the proposed expansion of the PACE service area to include south Orange County. The Board of Directors authorized the submittal of a PACE Service Area Expansion application in February 2016. A brief overview of the Alternative Care Setting (ACS) model was presented, which has been identified as the most advantageous approach to best address the needs of eligible PACE participants in Orange County.

7. Medical Affairs Updates

a. Long-Term Care Update

Tracy Hitzeman, Interim Executive Director of Clinical Operations, provided an update on CalOptima's Long-Term Care (LTC) program, which is designed to encourage more frequent LTC provider visits with the goal of improved coordination of care, increased member and family satisfaction, and enhanced communication with specialty care. CalOptima currently contracts with approximately 100 area LTC facilities in Orange County, and adjacent counties; approximately 4,300 CalOptima members are in LTC. The proposed LTC Provider Incentive Program will be presented to the Board of Directors for approval, subject to regulatory approval as applicable.

b. Update on Perinatal Support Services

Pshyra Jones, Health Education and Disease Management Director, provided an overview of the Perinatal Support Services Program, and the new approach for a comprehensive, coordinated program with more emphasis on member-initiated activity, outreach and program marketing strategy. CalOptima's Perinatal Services Program components include identification of pregnant members, assessment, health education, high-risk case management, improve prenatal and postpartum HEDIS rates, and monitor program effectiveness through evaluation of outcomes.

Director Berger requested a follow-up presentation to the Committee to include steps taken to improve outcomes.

8. Quarterly Reports to the Quality Assurance Committee

The following Quarterly Reports were accepted as presented:

a. Quality Improvement Report
b. Member Trend Report

Back to Agenda

COMMITTEE MEMBER COMMENTS
Committee members extended their wishes for a Happy Thanksgiving.

ADJOURNMENT
Hearing no further business, Chair Yost adjourned the meeting at 5:00 p.m.

/s/ Suzanne Turf
Suzanne Turf
Clerk of the Board

Approved: February 15, 2017

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Consent Calendar

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

Contact

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

Recommended Action

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

Background

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

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

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

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

Discussion

The 2017 Quality Improvement Program is based on the Board-approved 2016 Quality Improvement Program and describes: (i) the scope of services provided; (ii) the population served; (iii) key business processes; and (iv) important aspects of care and service for all programs to ensure they are consistent with regulatory requirements, NCQA standards, and CalOptima's own Success Factors.

Back to Agenda

The revisions are summarized as follows:

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

The recommended changes are designed to better review, analyze, implement and evaluate the components of the QI Program and Work Plan. In addition, the changes are necessary to meet the requirements specified by the Centers for Medicare and Medicaid Services, California Department of Health Care Services, and NCQA accreditation standards.

Fiscal Impact

There is no fiscal impact for the recommended action to approve the CalOptima QI Program and Work Plan.

Concurrence

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

Attachments

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

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

Back to Agenda

Quality Improvement (QI) Program 2017

Executive Summary of Revisions

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

Back to Agenda

2016~~6~~7

QUALITY IMPROVEMENT PROGRAM

~~REVISED 10/6/2016~~

Back to Agenda

2016~~6~~7 QUALITY IMPROVEMENT PROGRAM SIGNATURE PAGE

Quality Improvement Committee Chair:

_____ _____

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

Board of Directors' Quality Assurance Committee Chair:

_____ _____

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

Board of Directors Chair:

_____ _____

Mark Refowitz **Date**

Back to Agenda

TABLE OF CONTENTS

Back to Agenda

Back to Agenda

Back to Agenda

WE ARE CALOPTIMA

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

Our Mission

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

The mission of CalOptima is the foundation of everything we do. It permeates every level of the organization. Our mission is focused on our members, and our members are the sole reason why CalOptima exists.

Our Vision

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

Our Values — CalOptima CARES

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

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

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

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

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

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

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

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

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

Strategic Priorities:

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

Building Blocks:

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

WHAT IS CALOPTIMA?

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

As both, CalOptima must:

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

Back to Agenda

How We Became CalOptima

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

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

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

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

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

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

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

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

In July 2015, CalOptima launched OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan). ~~This~~ OneCare Connect (OCC) is a demonstration project in an effort by California and the Federal government to begin the process — through a single organized health care delivery system — of integrating medical, behavioral health, long-term care services and supports, and community-based services for dual eligible beneficiaries. One of t~~T~~he program's goal is to help members stay in their homes for as long as possible and shift services out of institutional settings and into the home and community. A key feature of CalOptima is identifying high-risk enrollees who need comprehensive care coordination, and assembling an appropriate care team to develop and track an individual care plan. Members eligible for OCC cannot enroll in OC.

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

WHAT ~~W~~WE OFFER:

Medi-Cal

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

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

Scope of Services~~:~~

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

These services include but are not limited to the following:

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

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

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

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

Members With Special Health Care Needs

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

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

Medi-Cal Managed Long-Term Services and Supports

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

LTSS includes four programs:

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

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

OneCare (HMO SNP)

OneCare (HMO SNP) means total care. Our members with Medicare and Medi-Cal benefits are covered in one single plan, making it easier for our members to get the health care they need. ~~For more than a decade~~Since 2005, CalOptima has been offering ~~OneCare~~OC to low-income seniors and people with disabilities who quality for both Medicare and Medi-Cal**.** ~~We have~~OC has extensive experience serving the complex needs of the frail, disabled, dual eligible members in Orange County.

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

Scope of Services~~:~~

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

These services include but are not limited to the following:

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

OneCare Connect

~~OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) is a new plan that launched in 2015 for people who qualify for both Medicare and Medi-Cal. OneCare Connect also integrates the Multipurpose Senior Services Program (MSSP), In-Home Supportive Services (IHSS) and Long-Term Care (LTC).~~

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

OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) launched in 2015 for people who qualify for both Medicare and Medi-Cal. OneCare Connect (OCC) is part of Cal MediConnect, a demonstration program operating in seven counties throughout California. The demonstration aims to transform the health care delivery system for people eligible for Medicare and Medi-Cal.

These members often have several chronic health conditions and multiple providers, yet their separate insurance plans often create confusion and fragmented care. By combining all benefits into one plan, OCC delivers coordinated care. Care coordination eliminates duplicated services and shifts services from more expensive institutions to home and community-based settings.

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

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

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

Scope of Services:

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

These services include but are not limited to the following:

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

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

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

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

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

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

Scope of Services

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

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

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

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

NEW PROGRAM INITIATIVES O~~O~~N O~~O~~UR H~~H~~ORIZON:

Palliative Care

CalOptima expects to implement palliative care standards for its Medi-Cal members no sooner than ~~April 1, 2017~~July 1, 201~~7~~8.

Whole-Person Care

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

Long-Term Connect

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

WHOM WWE WWORK WWITH:

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

CalOptima members can choose one of 14 health networks (HNs), representing more than 7,500 practitioners.

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

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

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

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

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

The following are CalOptima's contracted Health Networks:

Health Network/Delegate ~~No.~~	Medi-Cal	OneCare	OneCare Connect
AltaMed Health Services	SRG	PMG	SRG
AMVI Care Health Network	PHC	PMG	PHC
Arta Western Health Network	SRG	PMG	SRG
CHOC Health Alliance	PHC		
Family Choice Health Network	SRG	PMG	SRG
Heritage	HMO		HMO
Kaiser Permanente	HMO		
Monarch Family HealthCare	~~SRG~~HMO	PMG	~~SRG~~HMO
Noble Mid-Orange County	SRG	PMG	SRG
OC Advantage Medical Group	PHC		PHC
Prospect Medical Group	SRG		SRG
Talbert Medical Group	SRG	PMG	SRG
United Care Medical Group	SRG	PMG	SRG

Upon successful completion of readiness reviews and audits, the ~~health networks~~HNs may be delegated for clinical and administrative functions, which may include:

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

BEHAVIORAL HEALTH SERVICES

Medi-Cal Ambulatory Behavioral Health Services

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

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

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

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

OneCare and OneCare Connect Behavioral Health Services

CalOptima is also contracted with ~~has contracted with Windstone Behavioral Health~~Magellan Health, Inc. for the behavioral health services portion of ~~OneCare~~OC and ~~OneCare Connect~~OCC. ~~CalOptima~~ The ~~F~~delegated functions are identical to those listed above. ~~delegatesd to Magellan include utilization management (UM), credentialing and customer service. to Windstone. Evidence-based MCG guidelines are used in the UM decision-making process.~~

~~Our Lines Of Business:~~

~~Medi-Cal~~

~~Scope of Services~~

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

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

~~Adult preventive services~~	~~Hospital/inpatient care~~	~~Pediatric preventive services~~
~~Community-based adult services~~	~~Immunizations~~	~~Child health and disability prevention (CHDP)~~
~~Doctor visits~~	~~Laboratory services~~	~~Physical therapy~~
~~Durable medical equipment~~	~~Limited allied health services~~	~~Prenatal care~~
~~Emergency care~~	~~Medical supplies~~	~~Specialty care services~~
~~Emergency transportation~~	~~Medications~~	~~Speech therapy~~
~~Non-emergency medical~~	~~Newborn care~~	~~Substance use disorder~~

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

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

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

California Children's Services

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

Members With Special Health Care Needs

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

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

Medi-Cal Managed Long-Term Services and Supports

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

LTSS includes four programs:

- Community-Based Adult Services (CBAS)

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

OneCare (HMO SNP)

Scope of Services

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

These services include but are not limited to the following:

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

OneCare Connect

Scope of Services

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

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

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

These services include but are not limited to the following:

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

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY

~~Scope of Services~~

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

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

Membership Demographics

CalOptima
A Public Agency
Better. Together.

Fast Facts: February 2017

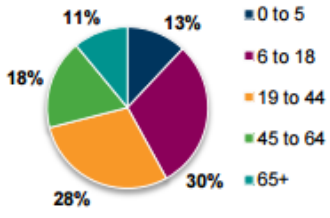
Mission: To provide members with access to quality health care services delivered in a cost-effective and compassionate manner

Membership Data as of December 31, 2016

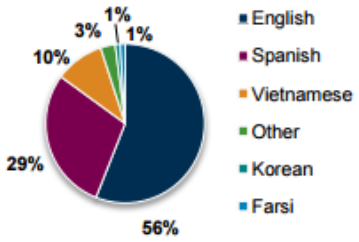
Total CalOptima Membership
800,001

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

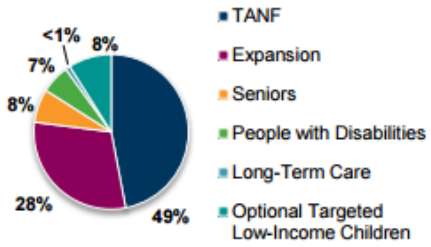
Member Age (All Programs)



Languages Spoken (All Programs)



Medi-Cal Aid Categories



Back to Agenda

CalOptima
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Fast Facts: February 2016

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

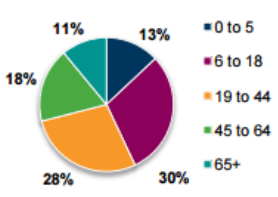
Membership Data as of December 31, 2015

Total CalOptima Membership
779,410

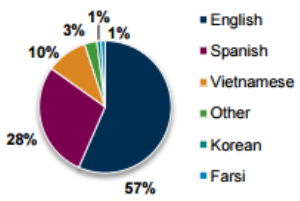
Program	Members
Medi-Cal	779,410
OneCare (HMO SNP)*	11,891
OneCare Connect*	4,437
Multipurpose Senior Services Program*	464
Program of All-Inclusive Care for the Elderly (PACE)*	129

*Membership already accounted for in total Medi-Cal membership

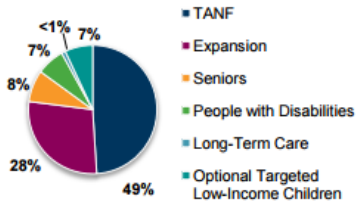
Member Age (All Programs)



Languages Spoken (All Programs)



Medi-Cal Aid Categories



Back to Agenda

QUALITY IMPROVEMENT PROGRAM

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

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

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

AUTHORITY, ~~A~~ACCOUNTABILITY AND RESPONSIBILITY

Board of Directors

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

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

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

Quality Improvement Program, Role of CalOptima Officers

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

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

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

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

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

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

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

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

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

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

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

QUALITY IMPROVEMENT PROGRAM PURPOSE

The purpose of the CalOptima QI Program is to establish objective methods for systematically evaluating and improving the quality of care provided to CalOptima members through CalOptima CCN and COD, as well as our contracted provider networks. Through the QI Program, and in collaboration with its providers, CalOptima strives to continuously improve the structure, processes and outcomes of its health care delivery system.

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

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

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

QUALITY IMPROVEMENT DEPARTMENT

The ~~Quality Improvement~~QI department is responsible for the execution and coordination of the quality assurance and improvement activities. ~~The QI Department~~It also supports the specific focus of monitoring quality of care issues and assuring the credentialing standards, policies and procedures are implemented to provide a qualified provider network for our members. The QI department fully aligns with the other areas of the QI team to support the organizational mission, strategic goals, and processes to monitor and drive improvements to the quality of care and services, and that care and services are rendered appropriately and safely to all CalOptima members.

~~Quality Improvement~~QI department activities include:

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

QUALITY ANALYTICS DEPARTMENT

The Quality Analytics (QA) department fully aligns with the QI team to support the organizational mission, strategic goals, required regulatory quality metrics ~~and~~, programs~~,~~ and ~~and~~ processes to monitor and drive improvements to the quality of care and services, and ensure that care and services are rendered appropriately and safely to all CalOptima members.

The ~~Quality Analytics~~QA department activities include design, implementation and evaluation of initiatives to:

- Report, m~~M~~onitor and trend outcomes
- Drive solutions and interventions to improve quality of care, access to preventive care, and management of chronic conditions to clinical guidelines
- Support efforts to improve internal and external customer satisfaction

- Improve organizational quality improvement functions and processes to both internal and external customers
- Collect clear, accurate and appropriate data used to analyze problems and measure improvement
- Coordinate and communicate organizational information, both division and department specific, and agencywide
- Participate in various reviews through the QI Program such as the All Cause Readmission monitoring, access to care, availability of practitioners and other reviews
- Facilitate satisfaction surveys for members and practitioners
- ~~Evaluate and monitor provider credentials~~
- Provide agencywide oversight of monitoring activities that are:

  Balanced: Measures clinical quality of care and customer service
  Comprehensive: Monitors all aspects of the delivery system
  Positive: Provides incentive to continuously improve

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

- Claims information/activity
- Encounter data
- Utilization data
- Case Management reports
- Pharmacy data
- CMS Stars Ratings (Stars) and Health Outcomes Survey (HOS) scores ~~STARS and HOCC~~ data
- Group Needs Assessments
- Results of Risk Stratification
- HEDIS Performance
- Member and Provider satisfaction surveys
- ~~Quality Improvement~~QI Projects (QIPs, PIPs and CCIPs)
- Health Risk Assessment (HRA) data

HEALTH EDUCATION & DISEASE MANAGEMENT DEPARTMENT

The Health Education & Disease Management (HE & DM) department is the third area in Quality that provides program development and implementation for ~~the~~ agencywide ~~chronic condition~~population health ~~improvement~~ programs. ~~Health Education & Disease Management (~~HE & DM~~)~~ Programs provide for the identification, assessment, stratification and implementation of appropriate interventions for members with certain conditions or chronic diseases. Programs and materials use educational strategies and methods appropriate for members and designed to achieve behavioral change for improved health and are reviewed on an annual basis.~~-~~ Program topics covered include Asthma, Congestive Heart Failure, Diabetes, Exercise, Nutrition, Hyperlipidemia, Hypertension, Perinatal Health, ~~Pediatric~~ Shape Your Life/Weight Management and Tobacco Cessation.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Director of Clinical Pharmacy Management leads the development and implementation of the Pharmacy Management (PM) ~~P~~program, develops and implements ~~Pharmacy Management~~PM ~~D~~department policies and procedures; ensures that a licensed pharmacist conducts reviews on cases that do not meet review criteria/guidelines for any potential adverse determinations, provides supervision of the coordination of Pharmacy related clinical affairs, and serves on the Pharmacy ~~and~~& Therapeutics Subcommittee and ~~Quality Improvement~~QI Committees. The ~~D~~director of ~~Pharmacy Management~~PM also guides the identification and interventions on key pharmacy quality and utilization measures.

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

Director of Long Term Services and Supports is responsible for LTSS programs which include ~~Community Based Adult Services (~~CBAS~~)~~, In-Home Supportive Services (IHSS), ~~Long Term Care Services (~~LTC~~)~~, and ~~Multipurpose Senior Services Program (~~MSSP~~)~~. The position supports "Member-Centric" approach and helps keep~~ing~~ members ~~at~~in the least restrictive living environment, collaborate with stakeholders including community partners, and ensure LTSS services are available to the appropriate population. The ~~D~~director also develops and implements policies, procedures, and processes related to the LTSS program operations and quality measures.

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

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

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

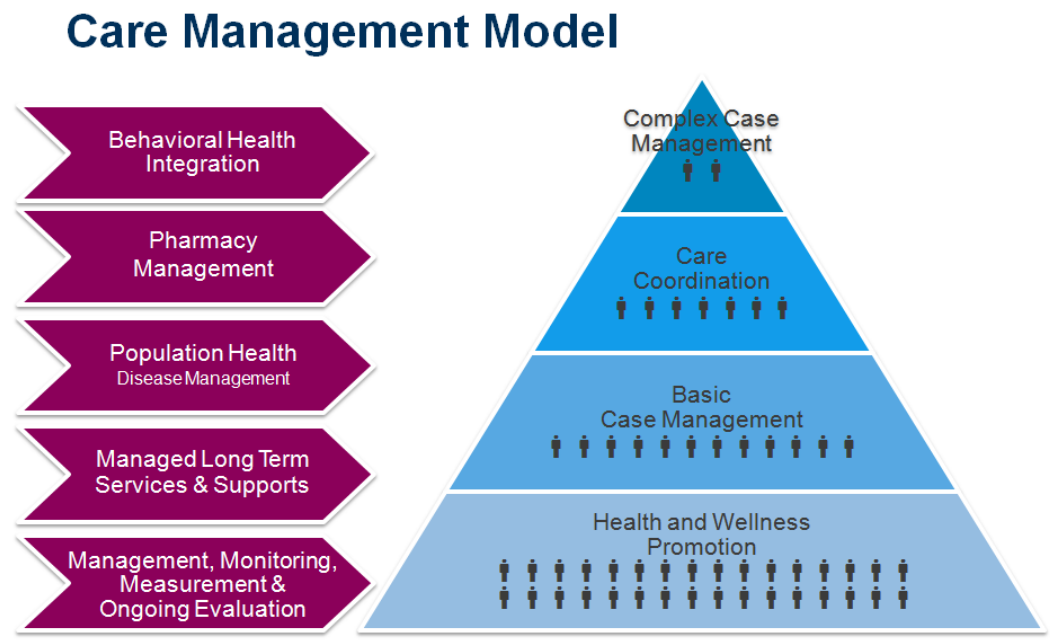
QUALITY IMPROVEMENT ~~(QI)~~ STRATEGIC GOALS

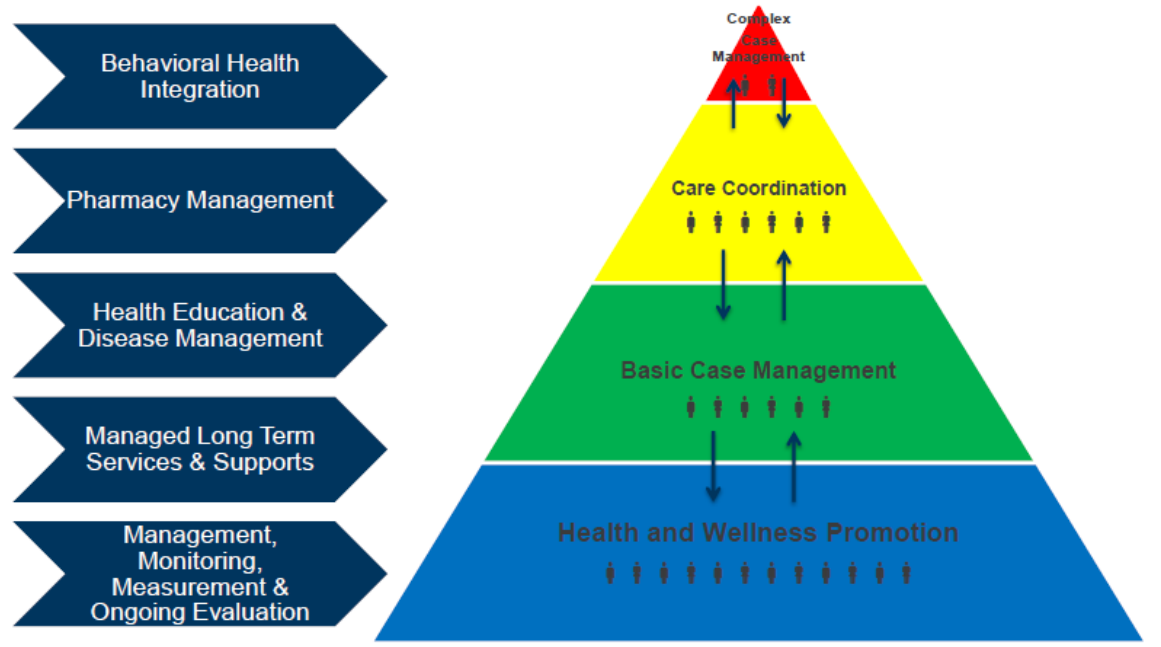
The purpose of the QI Program is to establish objective methods for systematically evaluating and improving the quality of care provided to CalOptima members. Through the QI Program, CalOptima strives to continuously improve the structure, processes and outcomes of its health care delivery system.

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

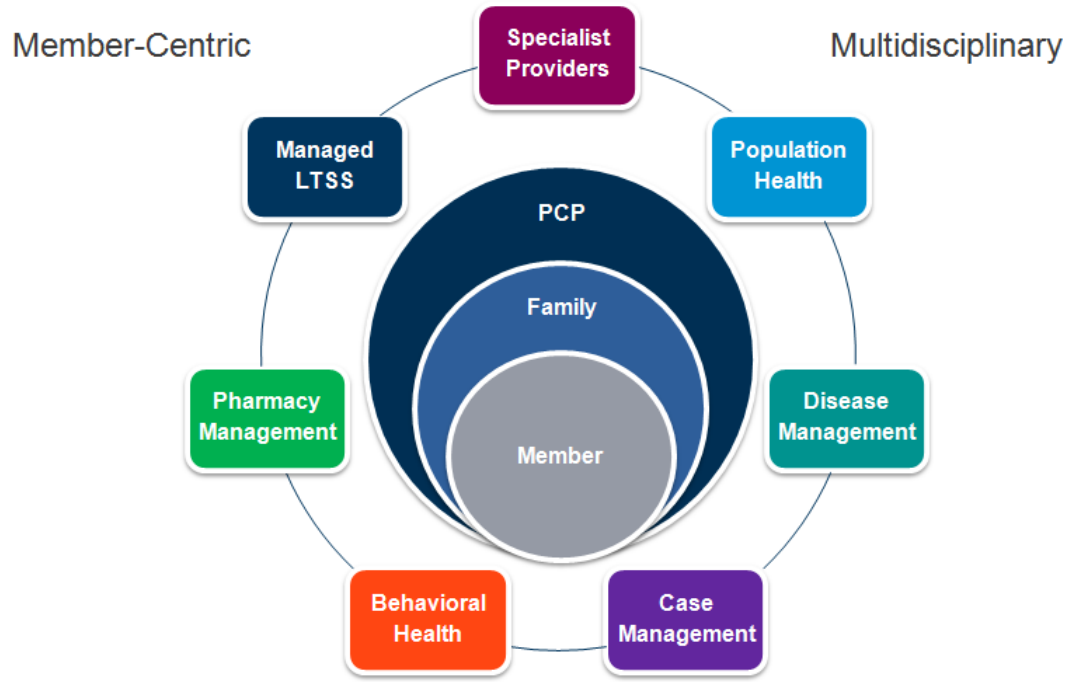
- It is organized to identify and analyze significant opportunities for improvement in care and service
- It fosters the development of quality improvement strategies, along with systematic tracking, to determine whether these strategies result in progress towards established benchmarks or goals
- It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

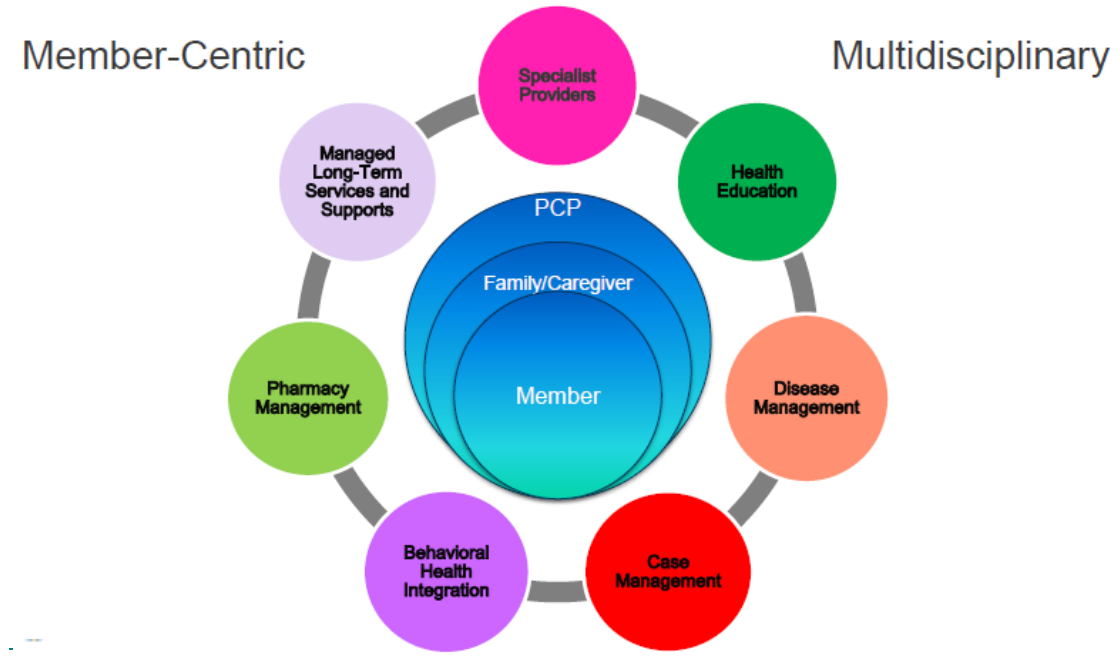
The QI Program supports a population health management approach, stratifying our population based on their health needs, conditions, and issues and aligning the appropriate resources to meet these needs. Our model follows an intervention hierarchy, as shown below:





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





QI Goals and Objectives

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

- The quality of clinical care and services provided by the health care delivery system in all settings, especially as it pertains to the unique needs of the population
- The important clinical and service issues facing the Medi-Cal, ~~OneCare~~OC ~~&~~and ~~OneCare Connect~~OCC populations relevant to its demographics, high-risks, disease profiles for both acute and chronic illnesses, and preventive care

- The continuity and coordination of care between specialists and primary care practitioners, and between medical and behavioral health practitioners by annually acting on at least three identified opportunities
- The accessibility and availability of appropriate clinical care and to a network of providers with experience in providing care to the population
- The qualifications and practice patterns of all individual providers in the network to deliver quality care and service
- Member and provider satisfaction, including the timely resolution of complaints and grievances
- Risk prevention and risk management processes
- Compliance with regulatory agencies and accreditation standards
- Annual review and acceptance of the UM Program Description and Work Plan
- The effectiveness and efficiency of internal operations
- The effectiveness and efficiency of operations associated with functions delegated to the contracted medical groups
- The effectiveness of aligning ongoing quality initiatives and performance measurements with CalOptima's strategic direction in support of its mission, vision and values
- Compliance with Clinical Practice Guidelines and evidence-based medicine
- Compliance with regulatory agencies and accreditation standards (NCQA)
- Support of the agency's strategic quality and business goals by utilizing resources appropriately, effectively and efficiently

- In addition, the QI Program:
  - Set expectations to develop plans to design, measure, assess, and improve the quality of the organization's governance, management and support processes
  - Support the provision of a consistent level of high quality of care and service for members throughout the contracted network, as well as monitor utilization practice patterns of practitioners, contracted hospitals, contracted services, ancillary services and specialty providers
  - Provide oversight of quality monitors from the contracted facilities to continuously assess that the care and service provided satisfactorily meet quality goals
  - Makes certain contracted facilities report outbreaks of conditions and/or diseases to the public health authority — Orange County Health Care Agency — which may include but are not limited to ~~M~~methicillin ~~R~~resistant ~~s~~*Staphylococcus aureus* (MRSA), ~~staphylococcus aureus infections,~~ scabies, ~~T~~tuberculosis, etc.~~,~~ as reported by the ~~health networks~~HNs.
  - Promote patient safety and minimize risk through the implementation of patient safety programs and early identification of issues that require intervention and/or education and work with appropriate committees, departments, staff, practitioners, provider medical groups, and other related health care delivery organizations (HDOs) to assure that steps are taken to resolve and prevent recurrences
    -

QI Measureable Goals from the Model of Care

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

The MOC goals are:

- Improving access to essential services
- Improving access to affordable care
- Improving coordination of care through an identified point of contact
- Improving seamless transitions of care across health care settings, providers and health services
- Improving access to preventive health services
- Assuring appropriate utilization of services
- Improving integration of medical and, behavioral health servicesand pharmacy services
- Improving beneficiary health outcomes

A formal annual performance evaluation is conducted and strategies for continuous improvement for the coming year are established. These are reported to the QI Committee. Please see the Model of Care Quality Matrix in the 2017 QI Work Plan.

QUALITY IMPROVEMENT WORK PLAN

(SEE ATTACHMENT A — 20162017 QI WORK PLAN)

The QI Work Plan outlines key activities for the upcoming year. It is reviewed and approved by the QIC and the CalOptima's Board of Directors' Quality Assurance Committee of the Board. The QI Work Plan indicates objectives, scope, timeline, planned monitoring and accountable persons for each activity. Progress against the QI Work Plan is monitored throughout the year. QI Work Plan addendums may be established to address the unique needs of members in special needs plans or other health plan products as needed to capture the specific scope of the plan.

The QI Work Plan is the operational and functional component of the QI Program and is based on the most recent and trended HEDIS, Consumer Assessment of Healthcare Providers & Systems (CAHPS), Stars and HOS scores, physician quality measures, and other measures identified for attention, including any specific requirements mandated by the State or accreditation standards where these apply. As such, measures targeted for improvement may be adjusted mid-year when new scores are received.

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

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

- Access and Availability to Care
- Member Experience and Service (CAHPS)
- Patient Safety and Pharmacy Initiatives
- HEDIS~~/~~, STARS and~~/ Health Outcomes Survey (~~HOS~~)~~)~~ Improvement
- Delegation Oversight
- Organizational Quality Projects
- QI Program scope
- Yearly objectives
- Yearly planned activities
- Time frame for each activity's completion
- Staff member responsible for each activity
- Monitoring of previously identified issues
- Annual evaluation of the QI Program
- Priorities for QI activities based on the specific needs of Cal-Optima's organizational needs and specific needs of Cal Optima's populations for key areas or issues identified as opportunities for improvement
- Priorities for QI activities based on the specific needs of Cal-Optima's populations, and on areas identified as key opportunities for improvement
- Ongoing review and evaluation of the quality of individual patient care to aid in the development of QI studies based on quality of care trends identified

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

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

UTILIZATION MANAGEMENT

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

Use of evidence-based, industry-recognized criteria promotes efforts to ensure that medical decisions are not influenced by fiscal and administrative management considerations. As described in the ~~2016~~2017 ~~Utilization Management (~~UM~~)~~ Program all review staff are trained and audited in these principles. Clinical staff makes all medical necessity decisions and any denial based on medical necessity is made only by a physician reviewer, including those decisions made by delegated ~~health networks~~HNs. Medical Directors actively engage subspecialty physicians as peer review consultants to assist in medical necessity determinations. Adherence to standards and evidence-based clinical criteria is obtained by cooperative educational efforts, personal contact with providers and monitoring through clinical studies.

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

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

BEHAVIORAL HEALTH

CalOptima focuses on the continuum of care for both medical and behavioral health services. Focusing on continuity and coordination of care, CalOptima monitors and works to improve the quality of behavioral health care and services provided to our members. The QI Program includes services for behavioral health and review of the quality and outcomes of those services delivered to the members within our network of practitioners and providers.

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

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

- Language assistance
- HEDIS and STAR measurements

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

CONFIDENTIALITY

CalOptima has policies and procedures to protect and promote proper handling of confidential and privileged medical record information. Upon employment, all CalOptima employees — including contracted professionals who have access to confidential or member information — sign a written statement delineating responsibility for maintaining confidentiality. In addition, all Committee members of each entity are required to sign a Confidentiality Agreement on an annual basis. Invited guests must sign a Confidentiality Agreement at the time of Committee attendance.

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

CONFLICT OF INTEREST

CalOptima maintains a Conflict of Interest policy that addresses the process to identify and evaluate potential social, economic and professional conflicts of interest and take appropriate actions so that they do not compromise or bias professional judgment and objectivity in quality, credentialing and peer review matters. ~~CalOptima maintains a Conflict of Interest policy to make certain potential conflicts area Conflict of Interest policy to make certain potential conflicts is avoided by staff and members of Committees.~~ This policy precludes using proprietary or confidential CalOptima information for personal gain or the gain of others, as well as direct or indirect financial interests in, or relationships with, current or potential providers, suppliers, or members, except when it is determined that the financial interest does not create a conflict. All employees ~~sign a Conflict of Interest statement~~ who make or participate in the making of decisions that may foreseeably have a material effect on economic interests, file a Statement of Economic Interests form on an annual basis.

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

STAFF ORIENTATION, TRAINING A~~A~~ND EDUCATION

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

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

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

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

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

SAFETY PROGRAM

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

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

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

- Identification and prioritization of patient safety-related risks for all CalOptima members, regardless of line of business and contracted health care delivery organizations
- Operational objectives, roles and responsibilities, and targets based on the risk assessment
- Plans to conduct appropriate patient safety training and education are available to members, families and health care personnel/physicians
- Patient safety program and its outcomes~~,~~ to be reviewed annually
- Health education and promotion
- Group Needs Assessment
- Over/Under ~~u~~Utilization monitoring
- Medication Management
- Case Management/Disease Management
- Operational Aspects of Care and Service

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

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

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

- ~~i~~Improving medical record documentation and legibility, establishing timely follow-up for lab results; addressing and distributing data on adverse outcomes or polypharmacy issues by the Pharmacy & Therapeutics (P&T) Committee, and maintaining continuous quality improvement with pharmaceutical management practices to require safeguards to enhance patient safety
- Alerting the pharmacy to potential drug interactions and/or duplicate therapies, and discussing these potential problems with the prescribing physician(s), allows the opportunity for the practitioner to correct the amount of the appropriate drug is being delivered
- Improving continuity and coordination between sites of care, such as hospitals and skilled nursing facilities, to assure timely and accurate communication
- Utilizing facility site review, Physical Accessibility Review Survey (PARS) and medical record review results from practitioner and health care delivery organization at the time of credentialing to improve safe practices, and incorporating ~~ADA (~~Americans with Disabilities Act (ADA) and ~~SPD (~~Seniors and Persons with Disabilities (SPD) site review audits into the general facility site review process

- Tracking and trending of adverse event reporting to identify system issues that contribute to poor safety

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

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

COMMITTEES AND KEY GROUP STRUCTURES

~~(SEE PAGE 52 — 2017 QUALITY IMPROVEMENT COMMITTEE ORGANIZATION STRUCTURE DIAGRAM)~~

Board of Directors' Quality Assurance Committee

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

Member Advisory Committee

The Member Advisory Committee (MAC) is ~~composed~~ comprised of 15 voting members, each seat represent~~satives of the population~~a constituency served by CalOptima ~~serves~~. The MAC ensures that CalOptima members' values and needs are integrated into the design, implementation, operation, and evaluation of the overall QI program. The MAC provides advice

and recommendations on community outreach, cultural and linguistic needs and needs assessment, member survey results, access to health care, preventative services and contracting. The MAC meets on a bi-monthly basis and reports directly to the CalOptima Board of Directors. MAC meetings are open to the public.

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

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

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

OneCare Connect Member Advisory Committee

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

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

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

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

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

Provider Advisory Committee

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

- ~~composed of representatives from the following constituencies:~~ ~~Health Networks~~
- HNs
- Hospitals
- Physicians
- Nurses
- Allied Health Services
- Community Clinics
- ~~The~~ Orange County Health Care Agency (HCA)
- ~~Long-Term Services and Supports~~LTSS including (LTC ~~F~~facilities and CBAS)
- Mid-~~L~~level ~~P~~practitioners
- Behavioral/mental health

Quality Improvement Committee (QIC)

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

The purpose of the QIC is to assure that all QI activities are performed, integrated, and communicated internally and to the contracted HMOs, PHCs, SRGs, MBHO, and PMGs to achieve the end result of improved care and services for members. The QIC oversees the performance of delegated functions by its HMOs, PHCs, SRGs, MBHO, and PMGs and contracted provider and practitioner partners. The composition of the QIC includes a participating Behavioral Health ~~P~~practitioner to specifically address integration of behavioral and physical health, appropriate utilization of recognized criteria, development of policies and procedures, and case review as needed, and identification of opportunities to improve care.

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

Responsibilities of the QI Committee include the following:

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

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

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

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

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

- **Plan** — ~~d~~Detailed description and goals
- **Do** — ~~I~~Implementation of the plan
- **Study** — D~~d~~ata and collection
- **Act** — A~~a~~nalyze data and develop conclusions

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

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

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

Voting Members~~:~~

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

The QIC is supported by:

Executive Director, Quality Improvement

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

Quorum
A quorum consists of a majority of the voting members (at least six) of which at least four are physicians or practitioners. ~~–~~Once a quorum is attained, the meeting may proceed and any vote will be considered official, even if the quorum is not maintained. Participation is defined as attendance in person or participation by phone.

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

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

Minutes of the Quality Improvement Committee (QIC)
Contemporaneous minutes reflect all Committee decisions and actions. These minutes are dated and signed by the Committee Chair to demonstrate that they are representative of the official findings of the committee.

Minutes of the QIC meeting include, but are not limited to:

- ~~g~~Goals and objectives outlined in the QI Charter ~~and which include but are not limited to:~~
- Active discussion and analysis of quality issues analysis
- Credentialing or re-credentialing issues, as appropriate
- Establishment or approval of clinical practice guidelines
- Reports from various committees and subcommittees
- Recommendations, actions and follow-up actions
- Plans to disseminate Quality Management/Improvement information to network providers and practitioners
- Tracking of work plan activities

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

~~THE FOLLOWING ARE~~ QUALITY IMPROVEMENT C~~C~~OMMITTEES A~~A~~ND S~~S~~UBCOMMITTEES ~~OF THE QIC:~~

Credentialing and Peer Review Committee (CPRC)

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

The goals of the CPRC include:

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

CPRC primary responsibilities include:

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

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

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

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

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

Grievance and Appeals Resolution Services Subcommittee (GARS)

The ~~Grievance and Appeals Resolution Services~~GARS subcommittee serves to protect the rights of our members, and to promote the provision of quality health care services and enforces that the policies of CalOptima are consistently applied to resolve member complaints in an equitable and compassionate manner through oversight and monitoring. The GARS subcommittee serves to provide a mechanism to resolve provider ~~and practitioner~~ complaints and appeals expeditiously for all CalOptima providers. It protects the rights of practitioners and providers by providing a multilevel process that is fair and progressive in nature, leading to the resolution of provider complaints. The GARS subcommittee meets at least quarterly and reports to the QIC.

Pharmacy & Therapeutics Subcommittee (P&T)

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

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

Utilization Management Subcommittee (UM)

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

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

The UM subcommittee includes a minimum of four ~~(4)~~ practicing physician representatives, reflecting CalOptima's HMO, PHC, SRG, MBHO, and PMG composition, and is appointed by the CMO. The composition includes a participating Behavioral Health practitioner* to specifically address integration of behavioral and physical health, appropriate utilization of recognized criteria, development of policies and procedures, and case review, as needed. Additionally, the UMC also includes and is supported by the following staff positions:

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

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

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

Benefit Management Subcommittee (BMSC)

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

Long-Term Services and Supports Subcommittee (LTSS)

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

~~**Benefit Management Subcommittee (BMSC)**~~

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

Behavioral Health Quality Improvement Committee (BHQIC)

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

The BHQIC responsibilities are to:

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

- Document and report all monitoring activities to appropriate committees

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

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

- Medical Director, Behavioral Health Integration (Chair)
- Chief Medical Officer/Deputy Chief Medical Officer
- Medical Director, Quality and Analytics
- Executive Director, Clinical Operations
- Executive Director, Quality Analytics
- Medical Director, Utilization Management
- Director, Behavioral Health Integration
- Clinical Pharmacist
- Medical Director, Orange County Health Care Agency
- Medical Director, ~~Medi-Cal~~ MBHO
- Chief Clinical Officer, ~~Medi-Medi~~ MBHO
- Medical Director, Health Network
- Medical Director, Regional Center of Orange County
- Contracting Behavioral Health Care Practitioners

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

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

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

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

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

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

Member Experience Subcommittee :(MES)

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

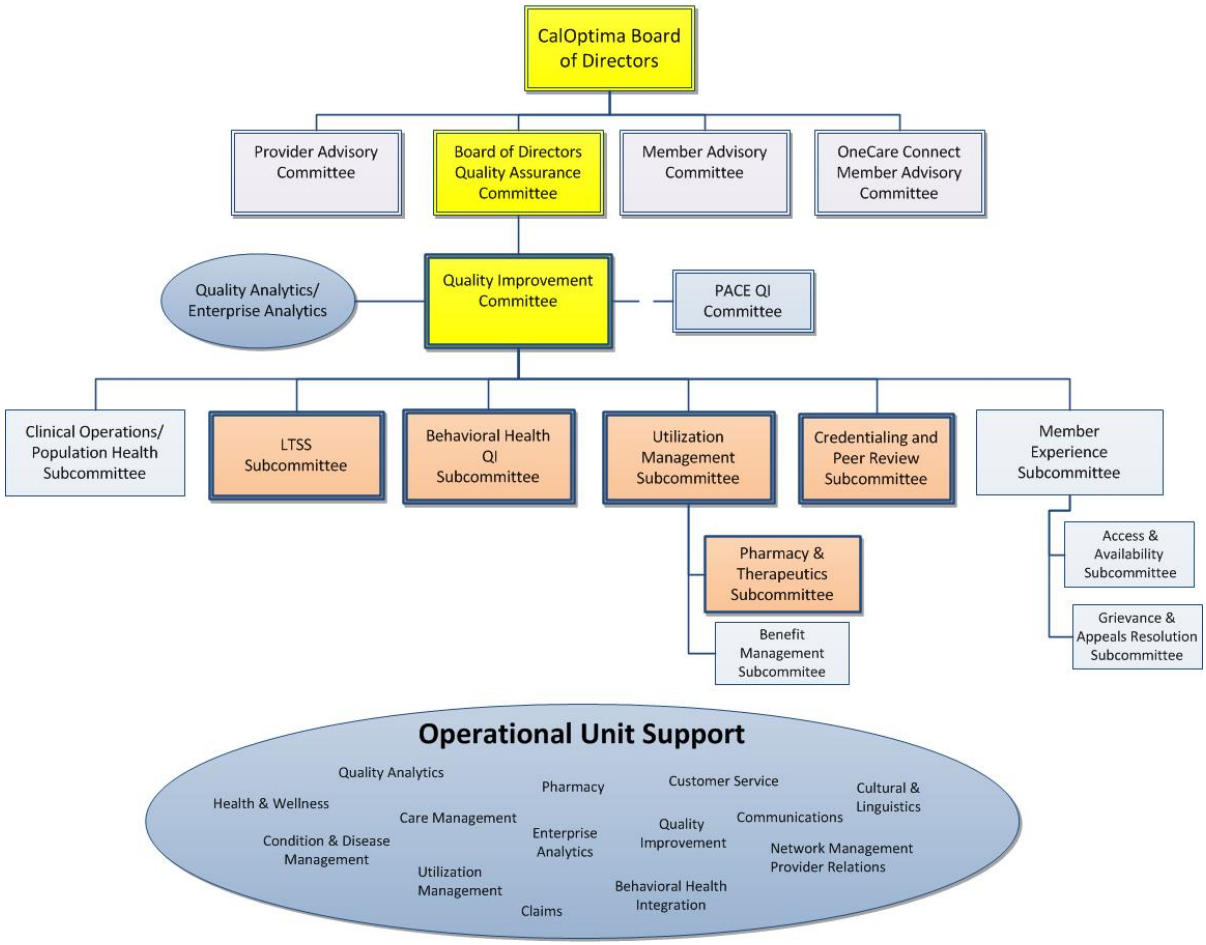
-This subcommittee meets at least bi-monthly and includes the following key individuals:

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

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

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

2017 Committee Organization Structure — Diagram



METHODOLOGY

QI Project Selections and Focus Areas

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

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

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

- Access to and availability of services, including appointment availability, as described in the ~~Utilization Management~~UM Program and in policy and procedure
- Coordination and continuity of care for ~~seniors and persons with disabilities~~SPD
- Provisions of chronic, complex care management and case management services

- Access to and provision of preventive services

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

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

QI Project Quality Indicators

Each QI Project will have at least one (and frequently more) quality indicator(s). While at least one quality indicator must be identified at the start of a project, more may be identified after analysis of baseline measurement or re-measurement. Quality indicators will measure changes in health status, functional status, member satisfaction, and provider/staff, HMO, PHC, SRG, MBHO, PMG, or system performance. Quality indicators will be clearly defined and objectively measurable. Standard indicators from HEDIS & STARS measures are acceptable.

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

QI Project Measurement Methodology

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

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

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

Plan 1) Identify opportunities for improvement
2) Define baseline
3) Describe root cause(s)
4) Develop an action plan

Do 5) Communicate change/plan
6) Implement change plan

Study 7) Review and evaluate result of change
8) Communicate progress

Act 9) Reflect and act on learning
10) Standardize process and celebrate success

CARE OF MEMBERS WITH COMPLEX NEEDS

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

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

- Monitoring, reassessing, and modifying the plan of care to drive appropriate quality, timeliness, and effectiveness of services
- Ongoing assessment of outcomes

CalOptima's case management program includes three care management levels that reflect the health risk status of members. ~~All~~ SPD, OCC and OC members are stratified using a plan-developed ~~stratification~~ tool that utilizes information from data sources such as acute hospital/emergency department utilization, severe and chronic conditions, and pharmacy. ~~The members are stratified into complex, care coordination and basic care management levels.~~ This s~~S~~tratification results in the ~~categories~~categorizing members as ~~of~~ "high" ~~and~~or "low" ~~risk, for those members who are stratified. The~~risk. The case management levels (CML) of complex, care coordination and basic are specific to SPD, OCC and OC members who have either completed a HRA or have been identified by or referred to case management.

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

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

The ~~members of the~~ ICT always includes the member (and caregivers or an authorized representative with member approval or appropriate authorization to act on behalf of a member) and PCP. For members with more needs, other disciplines are included, but not limited to a Medical Director, specialist(s), case management team, behavioral health specialist, pharmacist, social worker, dietician, and/or long-term care manager. The teams are designed to see that members' needs are identified and managed by an appropriately composed team.

The Interdisciplinary Care Teams process includes:

- Basic ICT for Low-Risk Members — ~~Basic Team~~occurs at the PCP level
  - Team Composition: member, caregiver or authorized representative, PCP, PCP support staff (nurse, etc.)
    - Roles and responsibilities of this team:
      - Basic case management, including advanced care planning
      - Medication reconciliation

        - Identification of member at risk of planned and unplanned transitions
        - Referral and coordination with specialists
        - Development and implementation of an ICP
        - Communication with members or their representatives, vendors, and medical group
        - Review and update the ICP at least annually, and when there is a change in the member's health status
        - Referral to the primary ICT, as needed

- Primary ICT for Moderate to High-Risk Members — ICT occurs at the Physician Medical Group (PMG) level or the Health Plan for Community Network
    - ICT Composition (appropriate to identified needs): member, caregiver, or authorized representative, ~~PMG~~ health network (HN) Medical Director, PCP and/or specialist, ambulatory case manager (CM), hospitalist, hospital CM and/or discharge planners, ~~PMG~~ HN ~~Utilization Management~~UM staff, behavioral health specialist and social worker
        - Roles and responsibilities of this team:
            - Identification and management of planned transitions
            - Case management of high risk members
            - Coordination of ICPs for high risk members
            - Facilitating member, PCP and specialists, and vendor communication
            - Meets as frequent as is necessary to coordinate and care and stabilize member's medical condition

- Complex ICT for High-Risk Members — ICT at the Physician Medical Group (PMG) level or Health Plan for Community Network
    - Team Composition (a~~A~~s appropriate for identified needs): member, caregiver, or authorized representative, ~~PMG~~ HN Medical Director, CalOptima clinical/~~PMG~~ HN case manager, PCP and/or specialist, social worker, and behavioral health specialist
        - Roles and responsibilities of this team:
            - Consultative for the PCP and ~~PMG~~ HN teams
            - Encourages member engagement and participation in the IC~~D~~T process
            - Coordinating the management of members with complex transition needs and development of ICP
            - Providing support for implementation of the ICP by the ~~PMG~~HN
            - Tracks and trends the activities of the ~~IDTs~~ICTs
            - Analyze data from different data sources in the plan to evaluate the management of transitions and the activities of the ~~IDTs~~ ICTs to identify areas for improvement
            - Oversight of the activities of all transition activities at all levels of the delivery system
            - Meets as often as needed until member's condition is stabilized

Dual Eligible Special Needs Plan (SNP)/~~OneCare~~ OC and ~~OneCare Connect~~OCC

The goal of D-SNPs is to provide health care and services to those who can benefit the most from the special expertise of CalOptima providers and focused care management. Care management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet the comprehensive medical, behavioral health, and psychosocial needs of an individual and the individual's family, while promoting quality and cost-effective outcomes.

The goal of care management is to help patients regain optimum health or improved functional capability, cost-effectively and in the right setting. It involves comprehensive assessment of the patient's condition, determining benefits and resources, and developing and implementing a care management plan that includes performance goals, monitoring and follow-up.

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

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

CalOptima's goals for ~~2016~~2017 are:

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

Please reference the ~~2016~~2017 Case Management Program Description for further details and program plans.

DISEASE MANAGEMENT PROGRAM

The Disease Management (DM) program is a comprehensive system of caring for members with chronic illnesses. A system-wide, multidisciplinary approach is utilized that entails the formation of a partnership between the patient, the health care practitioner and CalOptima. The DM program stratifies the population and identifies appropriate interventions based on member needs.

These interventions include coordinatinges care for members across time, localtes and providinges services, and resources, and support tos the members as they learn to care for themselves and their condition. The Disease Management (DM) Pprogram also is a targeted programidentifies those members in need of closer for the management, coordination, and intervention. for a highly vulnerable patient population. CalOptima assumes responsibility for the Disease ManagemenDMt program for all of its lines of business, therefore the management for Disease ManagementDM is non-not delegated to the PHCs, SRGs, HMOs and PMGs. -The contracted PHCs, SRGs, HMOs and PMGs must participate collaboratively with interventions necessary to produce compliant identified quality outcomes. The DM Program is evaluated on an annual basis.

~~The DM program is a comprehensive system of caring for members with chronic illnesses. A system-wide, multidisciplinary approach is utilized that entails the formation of a partnership between the patient, the healthcare practitioner and CalOptima. The DM program coordinates care for members across time, locates and provides services and resources, and supports the members as they learn to care for themselves.~~

Further details of the Disease ManagementDM Pprograms, activities and measurements can be found in the 2017 Disease ManagementDM Program Description.

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

CLINICAL DATA WAREHOUSEQUALITYQUALITY ANALYTICSNALYTICS

Core to the QI Program is the statistical analysis of various data sources to support continuous quality improvement of our programs, projects, activities, and initiatives. The CalOptima's Clinical Data Warehouse is a dynamic environment which aggregates data from CalOptima's various core business systems and processes, such as member eligibility, provider, encounters, claims, and pharmacy and care management systems to support the QI program. The clinical data warehouse allows staff to apply logic, population definitions and/or evidence-based clinical practice guidelinesbased guidelines to analyze data for quality purposes, such as disease management population identification, risk stratification, process measures and outcomes measures. CalOptima staff creates and maintains the data-base with quarterly data updates.

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

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

Identification/Stratification of Members

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

Identify Over/Under Utilization of Services

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

Identify Missing Preventive Care Services

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

Identify Members for Targeted Interventions

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

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

Medical Record Review

Wherever possible, administrative data is utilized to obtain measurement for some or all project quality indicators. Medical record review may be utilized as appropriate to augment administrative data findings. In cases where medical record abstraction is used, appropriately trained and qualified individuals are utilized. Training for each data element (quality indicator) is accompanied by clear guidelines for interpretation. Validation will be done through a minimum 10% sampling of abstracted data for rate to standard reliability, and will be conducted by the Director, Quality Analytics or designee. If validation is not achieved on all records samples, a

further 25% sample will be reviewed. If validation is not achieved, all records completed by the individual will be re-abstracted by another staff member.

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

Interventions

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

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

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

Improvement Standards

A. Demonstrated Improvement

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

B. Sustained Improvement

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

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

Documentation of QI Projects

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

- Project description, including relevance, literature review (as appropriate), source and overall project goal.
- Description of target population
- Description of data sources and evaluation of their accuracy and completeness
- Description of sampling methodology and methods for obtaining data

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

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

CalOptima provides comprehensive acute and preventive care services, which are based on the philosophy of a medical "home" for each member. The primary care practitioner is this medical "home" for members who previously found it difficult to access services within their community.

The Institute of Medicine describes the concepts of primary care and community oriented primary care, which apply to the CalOptima model:

- Primary Care, by definition, is accessible, comprehensive, coordinated, and continual care delivered by accountable providers of personal health services.

- Community Oriented Primary Care is the provision of primary care to a defined community, coupled with systematic efforts to identify and address the major health problems of that community.

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

Clinical Care and Service:

- Access and availability
- Continuity and coordination of care
- Preventive care, including:
  - Initial Health Assessment
  - Initial Health Education
  - Behavioral Assessment
- Patient diagnosis, care and treatment of acute and chronic conditions
- Complex Case Management: CalOptima coordinates services for members with multiple and/or complex conditions to obtain access to care and services via the Utilization and

Case Management departments, which details this process in its UM/CM Program and other related policies and procedures.

- Drug utilization
- Health education and promotion
- Over/under utilization
- Disease management

Administrative Oversight:

- Delegation oversight
- Member rights and responsibilities
- Organizational ethics
- Effective utilization of resources
- Management of information
- Financial management
- Management of human resources
- Regulatory and contract compliance
- Customer satisfaction
- Fraud and abuse* as it relates to quality of care

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

DELEGATED AND NON-DELEGATED ACTIVITIES

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

Delegation Oversight

Participating entities are required to meet CalOptima's QI standards and to participate in CalOptima's QI Program. CalOptima has a comprehensive interdisciplinary team that is assembled for evaluating any new potential delegate for ability to perform its contractual scope of responsibilities. Predelegation review is conducted through the Audit and Oversight department and overseen by the Delegation Oversight Committee reporting to the Compliance Committee. ~~(See Attachment B for the 20162017 Delegation Grid.)~~

Non-Delegated Activities

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

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

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

SEE APPENDIX BC — 2017 DELEGATION GRID

~~PEER REVIEW PROCESS~~

~~Peer Review is coordinated through the QI Ddepartment. Medical staff triage potential quality of care issues and conduct reviews of suspected physician and ancillary quality of care issues. All closed cases are presented to CPRC to assess if documentation is complete, and no further action is required. The QI department also tracks, monitors, and trends, service and access issues to determine if there is an opportunity to improve care and service. Results of Quality of Care reviews and tracking and trending of service and access issues are reported to the CPRC at time of re-credentialing. Quality of care case referral to the QI department are based on referrals to the QI department originated from multiple areas, which include, but are not limited to, the following: prior authorization, concurrent review, case management, legal, compliance, customer service, pharmacy, or grievances and appeals resolution.~~

CULTURAL & LINGUISTIC SERVICES

CalOptima serves a large and culturally diverse population. The five most common languages spoken for all CalOptima programs are: English at 57 percent, Spanish at 28 percent, Vietnamese at 10 percent, Farsi at one percent, Korean at one percent, Chinese at one percent, Arabic at one percent and all others at three percent, combined. CalOptima provides member materials in:

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

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

Objectives for serving a culturally and linguistically diverse membership include:

- Analyze significant health care disparities in clinical areas

- Use practitioner and provider medical record reviews to understand the differences in care provided and outcomes achieved
- Consider outcomes of member grievances and complaints
- Conduct patient-focused interventions with culturally competent outreach materials that focus on race/ethnicity/~~language~~ language or gender specific risks
- Identify and reduce a specific health care disparity affecting a ~~with~~particular cultur~~e~~al, race or~~,~~ gender group
- Provide information, training and tools to staff and practitioners to support culturally competent communication

PEER REVIEW PROCESS

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

COMPREHENSIVE CREDENTIALING PROGRAM STANDARDS

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

Practitioners are credentialed and re-credentialed according to regulatory and accreditation standards (DHCS, DMHC, CMS and NCQA). The scope of the credentialing program includes all licensed M.D.s, D.O.s, DPMs (doctor of podiatric medicine), DC (doctor of chiropractic medicine), DDS (doctor of dental surgery), allied health and midlevel practitioners, which include, but are not limited to: behavioral health practitioners, certified nurse midwives, certified nurse specialists, nurse practitioners, optometrist, physician assistants, optometrists, registered physician therapists, occupational therapists, speech therapists and audiologists, ~~etc.,~~ both in the delegated and CalOptima direct environments. Credentialing and recredentialing activities are delegated to the ~~Health Networks~~HNs and performed by CalOptima for CCN.

Health Care Delivery Organizations

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

Use of Quality Improvement Activities in the Re-credentialing Process
Findings from quality improvement activities are included in the re-credentialing process.

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

FACILITY SITE REVIEW, MEDICAL RECORD AND PHYSICAL ACCESSIBILITY REVIEW SURVEY

CalOptima does not delegate Primary Care Practitioner (PCP) site and medical records review to its contracted HMOs, PHCs, SRGs, MBHO, and PMGs. CalOptima does, however, delegate this function to designated health plans in accordance with standards set forth by MMCD -Policy Letter ~~02-02~~ 14-004. CalOptima assumes responsibility and conducts and coordinates Facility Site Review (FSR), Medical Record Review (~~/~~MRR) for the non-delegated SRGs and PMGs. CalOptima retains coordination, maintenance, and oversight of the FSR/MRR process. CalOptima collaborates with the SRGs and PMGs to coordinate the FSR/MRR process, minimize the duplication of site reviews, and support consistency in PCP site reviews for shared PCPs.

Site reviews are completed as part of the initial credentialing process, except in those cases where the requirement is waived because the provider received a passing score on another full scope site review performed by another health plan in the last three years, in accordance with MMCD Policy Letter ~~02-02~~14-004 and CalOptima policies. Medical records of new providers shall be reviewed within ninety calendar days of the date on which members are first assigned to the provider. An additional extension of ninety calendar days may be allowed only if the provider does not have sufficient assigned members to complete review of the required number of medical records.

Physical Accessibility Review Survey for Seniors and Persons with Disabilities (SPD)
CalOptima conducts an additional DHCS-required facility audit for American with Disabilities Act compliance for ~~seniors and persons with disabilities (~~SPD~~)~~ members, which includes access evaluation criteria to determine compliance with ADA requirements.

- Parking
- Exterior ramps
- Exterior stairways
- Entrances

- Interior circulation
- Interior doors
- Interior ramps
- Interior stairways
- Elevators
- Controls
- Sanitary facilities
- Reception and waiting areas
- Diagnostic and treatment areas

Medical Record Documentation Standards

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

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

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

CORRECTIVE ACTION PLAN(S) TO IMPROVE CARE, SERVICE

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

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

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

Performance Improvement Evaluation Criteria for Effectiveness

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

COMMUNICATION OF QUALITY IMPROVEMENT ACTIVITIES

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

- Practitioner participation in the QIC and its subcommittees
- Health Network Forums, Medical Director meeting, and other ongoing ad-hoc meetings
- Annual synopsized QI report (both web-site and hardcopy availability for both practitioners and members) shall be posted on CalOptima's website, in addition to the annual article in both practitioner and member newsletter. The information includes a QI Program Executive Summary or outline of highlights applicable to the Quality Program, its goals, processes and outcomes as they relate to member care and service. Notification

on how to obtain a paper copy of QI Program information is posted on the web, and is made available upon request
- Annual PCP pamphlet
- Member Advisory Committee (MAC), OCC Member Advisory Committee (OCC MAC) and Provider Advisory Committee (PAC).

ANNUAL PROGRAM EVALUATION

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

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

IN SUMMARY

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

APPENDIX A — 2017 QI WORK PLAN

APPENDIX B — 2017 DELEGATION GRID

"Attachment A"

CalOptima
20176 Quality Improvement Work Plan
OneCare Connect/OneCare and Medi-Cal
February, 2016 7

I. Program Oversight

- **A. Program Sscope- 2017 QI Annual oversight of programs and work plans 2/9/16**
- **B. Program Scope- 20156 QI Program Annual Evaluation**
- **C. Program Scope- 2017 UM Program and UM Work Plan annual oversight**
- **D. Program Scope- 20176 5 UM Program Annual Evaluation**
- **E. Quality of Care- 2017 Case Management Program annual oversight**
- **F. Quality of Ccare- 20156 Case Management Program Evaluation**
- **G. Quality of Care- 2017 Disease Management Program annual oversight**
- **H. Quality of Care- 20156 Disease Management Program Evaluation**
- **I. Quality of Care- Credentialing Peer Review Committee (CPRC) Oversight**
- **J. NCQA Monitoring & Compliance**

INITIAL WORK PLAN AND APPROVAL:

Submitted and approved by QIC _____ Date: _____

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

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

Quality Assurance Committee (QAC)

Quality Improvement Committee Chairperson:

_____

Medical Director _____ Date: _____

II. Case Management

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

Board of Directors' Quality Assurance Committee Chairperson:

Board of Directors' Quality Assurance Committee Chairperson:

_____

Paul Yost, Viet Van Dang, MD _____ _____

III. Behavioral Health

Date:

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

IV. LTSS

- **A. Safety of Clinical Care and Quality of Clinical Care- Review and assess LTSS placement for members participating with each organization/program**
- **B. Safety of Clinical Care and Quality of Clinical Care- Review and assess emergency department visits for LTSS members participating with each organization/program**
- **C. Safety of Clinical Care and Quality of Clinical Care- Review and assess readmissions for LTSS members participating with each organization/program: Hospital Readmissions**
- **D. Safety of Clinical Care and Quality of Clinical Care-Review and Assess Readmissions for LTSS members participating with each organization/program: Long Term Care Admissions**

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

~~F.~~

V. Health Education & Disease Management
- ~~A.~~ Quality of Care-~~-~~All new members will complete the
- A. Initial Health Assessment and related IHEBA/SHAs
- ~~B.~~ Quality of Clinical Care-R~~, r~~eview of Disease Management Programs ~~(Asthma)~~
- ~~C. Quality of Clinical Care, review of Disease Management Program (Diabetes)~~
- ~~D.~~B. ~~Quality of Clinical Care, review of Disease Management Program (CHF)~~
- ~~E.~~ Quality of Care-~~-~~Clinical Practice Guidelines ~~-~~adoption ~~-~~for Medi-Cal line of business
- ~~F.~~C. ~~Quality of Clinical Care, review of member satisfaction with DM programs~~
- ~~G.~~D. Quality of Clinical Care-~~-~~Review of C~~c~~ardiovascular Disease
- ~~H. Quality of clinical Care- Review of Diabetes and All Cause Readmissions~~
- ~~I. Implementation of the Childhood Obesity (Shape Your Life) Program~~
- ~~J. Implement Weight Watchers (WW) for Medi-Cal Members~~
- ~~K. Implement Home Assessments for member participating in Care Management Programs~~
- ~~L. Conduct 2016 Group Needs Assessment (GNA)~~
- E. Implementation of Population Health & Wellness Programs
- F. Quality of Clinical Care-Quality and Performance Improvement Projects

VI. Access & Availability
- A. Quality of Service and Quality of Clinical Care-~~-~~Review of notification to members
- B. Access to Care-~~-~~Credentialing of provider network is monitored
- C. Access to Care-~~-~~Recredentialing of provider network is monitored
- D. Accessibility: Review of access to care
- E. Availability: Review of availability of practitioners

VII. Patient Safety
- A. Safety of Clinical Care-~~-~~Providers shall have timely and complete facility site reviews
- B. Safety of Clinical Care-~~-~~Review and follow-up on member's potential Quality of Care Complaints
- C. Safety of Clinical Care and Quality of Clinical Care-~~-r~~Reviewed through Pharmacy Management
- D. Safety of Clinical care and Quality of Clinical Care-~~-~~R~~r~~eview of Specialty Drug Utilization
- E. Patient Safety-~~-~~Review and assessment of CBAS Quality Monitoring
- F. Patient Safety-~~-~~Review and assessment of SNF Quality Monitoring
- G. Safety of Clinical Care-~~-~~Review of antibiotic usage
- H. Pharmacy Benefit~~r~~ Manager (PBM) Oversight Management ~~Implementation of the new PBM~~

VIII. Member Experience
- A. Quality of Service-~~-~~Review of Member Satisfaction
- B. Quality of Service-~~-~~Reviewed through customer service first call resolution
- C. Quality of Service-~~-~~Reviewed through customer service access
- D. Quality of Care & Service reviewed through GARS & PQI (MOC)

IX. HEDIS/STARS Improvement
- A. Improve identified HEDIS Measures listed on "Measures" worksheet
- B. Improve identified STARS ~~m~~Measures listed on "Measures" worksheet
- ~~C.~~ Improve CAHPS ~~m~~Measures listed on "Measures" worksheet
- ~~D.~~C. ~~HEDIS: Launch pediatric wellness clinic~~
- ~~E.~~D. STARS Medication Related Measures~~improvement- Medication Adherence Measures~~

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

X. Delegation Oversight
- **A. Delegation Oversight of CM**
- **B. Quality of Care & Ss~~s~~ervice of UM through d~~D~~Delegation o~~O~~versight r~~R~~eviews**
- **C. Delegation Oversight of BH Services**

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

Previously identified issues to be monitored

I. Program Oversight

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

Owner: Medical Director, Quality & Analytics

1. Activity

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

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

2. Goals

- Annual Adoption

B. Program Scope- 201~~6~~6 QI Program Annual Evaluation

Owner: Medical Director, Quality & Analytics

1. Activity

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

2. Goals

- Annual Evaluation

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

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

Owner: ~~Terrie Stanley~~Tracy Hitzeman, Interim ED Clinical Operations

1. Activity

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

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

2. Goals

- Annual Adoption

D. Program Scope- 201~~6~~6 UM Program Annual Evaluation

Owner: ~~Terrie Stanley~~Tracy Hitzeman, Interim~~interim~~ ED ~~Clinical Operations~~CO

1. Activity

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

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

2. Goals

- Annual Evaluation

E. Quality of Care – 2016 Case Management Program Annual Oversight

Owner: Tracy Hitzeman Sloane Petrillo, Interim Director, Case Management

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

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

2. **Goals**
   - Annual Adoption

F. Quality of Care – 2016 Case Management Program Evaluation

Owner: Sloane Tracy Hitzeman Petrillo, Interim Director Dtr, CM

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

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

2. **Goals**
   - Annual Evaluation

G. Quality of Care – 2016 Disease Management Program Annual Oversight

Owner: Pshyra Jones, Dir Director, of Health Education & Disease Management

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

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

2. **Goals**
   - Annual Adoption

H. Quality of Care – 2016 Disease Management Program Evaluation

Owner: Pshyra Jones, Dtr. Health Ed HE and & DM

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

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

2. **Goals**
   - Annual Evaluation

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

Owner: Medical Director, Quality

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

Approved by QIC:
Q1
Q2
Q3
QI 4/13/16
Q4Q2
Q3
Q4

2. **Goals**
   - **Quarterly Adoption of Report**

J. NCQA Monitoring & Compliance

Owner: ~~Kelly Rex-Kimmet~~Esther Okajima, Director, Quality ImprovementA

1. **Activity**
   - Evaluate NCQA standards, HEDIS & CAHPS for improvement opportunities to achieve Commendable status

Approved by QIC:
Q1
Q2
Q3
Q4

~~Approved by QIC~~

2. **Goals**

Q1
Q2
Q3
Q4

2. **Annual HIP ~~Ranking~~Rating**

II. Case Management

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

A. Owner: ~~Tracy Hitzeman~~Sloane Petrillo, Interim ~~Director~~Dtr, CM

The Approach

1. Objective

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

2. Activity

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

2. Administer the annual HRA to the beneficiary

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

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

3. Goals

- **Completion of Outreach**

~~**Completion of outreach**~~

~~OCC-100% of eligible population~~

- ~~**OCCC-**-100% of eligible population~~
- **OC~~SPD~~**-1~~-~~100% of eligible population
- **SPD**-100% of eligible population

- **Collection**

- **OCC**-Collect 56% of high risk OCC HRAs
- **OCC**-Collect 43% of low risk OCC HRAs
- **OC**-Collect 78% of initial OC HRAs
- **OC**-Collect 34% of annual OC HRAs
- **SPD**-Collect 63% of initial SPD HRAs

~~**Collectio n**~~

~~OCC-Collect 56% of high risk OCC HRAs~~

- **OCC** Collect 43% of low risk OCC HRAs
- **OC** Collect 78% of initial OC HRAs
- **OC** Collect 34% of annual OC HRAs
- **SPD** Collect 63% of initial SPD HRAs

The Approach

1. Objective

- **OCC** Health Risk Assessment Outreach Appraisals for members in the OneCare Connect Program monitored for completeness
- **OC** Health Risk Assessment Outreach for members in the OneCare Program monitored for completion
- **SPD** Health Risk Assessment Outreach for Seniors and Persons with Disabilities monitored for completion

2. Activity

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

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

3. Goals

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

2201~~6~~7 Quality Improvement Work Plan- Case Management Owner: ~~Tracy Hitzeman~~Sloane Petrillo, Interim ~~Director~~Dtr, CM

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

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

II. Case Management

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

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

Edwin Poon, Director, Behavioral Health Services (BHS)

The Approach

~~1. Objective~~

~~• Continuity and Coordination between Medical & Behavioral Health~~

~~2. Activity~~

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

~~3. Goals~~

~~• 85%~~

1. Objective

- Continuity and Coordination between Medical & Behavioral Health

2. Activity

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

3. Goals

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

"Attachment A"

2016~~6~~7 Quality Improvement Work Plan- Case Management **Owners: ~~Tracy Hitzeman~~Sloane Petrillo, Interim ~~Director~~Dtr, CM; ~~,~~Edwin Poon, D~~irector~~tr, BHS**

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

II. Case Management

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

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

The Approach

1. Objective

- Evaluation and intervention for ongoing review of high ER utilizers

2. Activity

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

3. Goals

- 5% reduction in ER visits among intervention cohort

~~C. *Quality of Clinical Care-Review of emergency department communications with PCPs~~

~~Owner: Tracy Hitzeman Director, CM~~

~~The Approach~~

~~1. Objective~~

- ~~Continuity and Coordination of Care reviewed and assessed~~

~~2. Activity~~

- ~~Assessment of medical records for communication from emergency department to primary care providers~~

~~3. Goals~~

- ~~85%~~

2016~~6~~7 Quality Improvement Work Plan- Case Management Owner: ~~Tracy Hitzeman~~Sloane Petrillo, Interim ~~Director~~Dtr, CM

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

II. Case Management

D. Quality of Clinical Care-Review of member satisfaction with CM programs **Owner: Sloane Petrillo, Interim ~~Director~~Dtr, CM**

The Approach

1. Objective

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

2. Activity

- Review annual satisfaction survey results, define areas for improvement and implement interventions to improve member experience with CM programs
- Revise methodology to increase sample size of responses

3. Goals

- Satisfaction with Case Management - 88%

~~**D. Patient Safety, Quality of Care Case Management- High ER utilization** **Owner: Tracy Hitzeman Director, CM; Novella Quesada, Manager, QI**~~

~~**The Approach**~~

~~**1. Objective**~~

- ~~Evaluation and intervention for ongoing review of high ER utilizers~~

~~**2. Activity**~~

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

~~**3. Goals**~~

- ~~35%~~

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

~~The Approach~~

~~1. Objective~~

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

~~2. Activity~~

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

~~3. Goals~~

- ~~Satisfaction with Case Management - 85%~~

2016~~6~~7 Quality Improvement Work Plan- Case Management Owner: ~~Tracy Hitzeman, Director, CM; Novella Quesada, Manger QI~~Sloane Petrillo, Interim ~~Director~~Dtr, CM

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

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

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

II. Case Management

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

The Approach

1. Objective

- Improve adherence to NCQA standards for all Health Networks

2. Activity

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

3. Goals

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

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

~~The Approach~~

~~1. Objective~~

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

~~2. Activity~~

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

~~3. Goals~~

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

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

Monitoring	Assessments, Findings, Monitoring of Previous Issues	Next Steps	Target Completion
Q1			
Q2			
Q3			
Q4			

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

III. Behavioral Health

~~**A. *Quality of Clinical Care: Integration of BH Services** **Owner: Dr. Donald Sharps, Medical Director, BHI**~~

~~**The Approach**~~

~~**1. Objective**~~

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

~~**2. Activity**~~

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

~~**3. Goals**~~

- ~~10% improvement over 2015~~

A. *Quality of Clinical Care: HEDIS Measures for M/C & OCC **Owner: Dr. Donald Sharps, Medical Director, BHI**

The Approach

1. Objective

- Behavioral Health HEDIS measures will be monitored and measured

2. Activity

- Design and implement activities to improve HEDIS measures relating to Behavioral Health

3. Goals

- At or above the 50th Percentile
-

20172~~2~~[01]~~6~~7 Quality Improvement Work Plan- Behavioral Health Owner: ~~Terrie Stanley, ED Clinical Operations~~Dr. Donald Sharps, Medical ~~Director~~Dtr, BHI

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

III. Behavioral Health

B. *Quality of Clinical Care: Interdisciplinary Care Treatment Team Participation ~~——~~**Owner: Dr. Donald Sharps, Medical ~~Director~~Dtr, BH~~I~~**

~~— Medical Director, BH~~

~~T~~The Approach

1. **Objective**
   - BH Services, integration & coordination of care will be monitored and measured
2. **Activity**
   - Monitor and ~~i~~identify opportunities to improve integration and coordination of care across settings and~~-~~/or transitions of care through ICT/ICP
3. **Goals**
   - 10% Improvement over 2016

~~**B. *Quality of Care-Clinical BH Practice Guidelines adoption for Medi-Cal Line of business —— Owner: Dr. Donald Sharps, Medical Director, BH**~~

~~**The Approach**~~

1. ~~**Objective**~~
   - ~~BH Clinical Practice Guidelines will be reviewed and adopted~~
2. ~~**Activity**~~
   - ~~Adoption of Clinical Practice Guidelines, at least two (2) behavioral health will be reviewed and adopted~~
   - ~~Depression & Autism CPGs reviewed annually~~
3. ~~**Goals**~~
   - ~~100%~~

20167 Quality Improvement Work Plan- Behavioral Health Owner: DRr. Donald Sharps, Medical DirectorDtr, BHI

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

III. Behavioral Health

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

~~The Approach~~

~~1. Objective~~
- ~~Continuity and Coordination of Care reviewed and assessed for medical care with behavioral health care~~

~~2. Activity~~
- ~~Assessment of medical records for communication between primary care providers and behavioral health providers~~

~~3. Goals~~
- ~~85%~~

C. *Quality of Care- Clinical Behavioral Health Practice Guidelines Owner: Dr. Donald Sharps, Medical D~~irec~~tor, BHI

The Approach

1. Objective
- BH Clinical Practice Guidelines will be reviewed and adopted

2. Activity
- Adoption of Clinical Practice Guidelines, at least two (2) behavioral health guidelines will be reviewed and adopted

3. Goals
- 100%

2016~~6~~7 Quality Improvement Work Plan- Behavioral Health Owner: Dr. Donald Sharps, Medical D~~irect~~or, BH~~I~~

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

Q4			
Year End			

III. Behavioral Health

D. *Access and Coordination of Care ~~(NEW)~~ Owner: Dr. Donald Sharps, Medical D~~irec~~tor, BHI

The Approach

1. Objective

- Appropriate, timely, and effective access for BB~~B~~ehavioral ~~H~~HHealth services in LTC/SNF facilities
- Explore opportunities for coordination of care with PCPs

2. Activity

- Identify and survey existing LTC/SNF facilities,
- conduct analysis~~; and~~
- P~~p~~ropose interventions to address barriers to access Behavioral Health services

3. Goals

- Maintain amount of encounters from previous MBHO
- Establish gap analysis and needs for Behavioral Health support to PCPs
- Establish gap analysis and needs for Behavioral Health in LTC
- Develop uniform process for accessing Behavioral Health in LTC

2017 Quality Improvement Work Plan–Behavioral Health Owner: Dr. Donald Sharps, Medical Director, BHI

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

Q4			
Year End			

IV. LTSS

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

Owner: ~~Suzanne Harvey~~Marie ~~Earvoline~~Tracy Hitzeman, Interim ~~Director, LTSS~~ED, ~~Clinical~~ CO~~Operations~~

~~Clinical Operations~~

The Approach

1. **Objective**
   - Member review of Hospital Admissions (for each organization/program)

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

3. **Goals**
   - ~~2% CBAS;~~ Establishing goals in 2016 for IHSS, LTC & MSSP

2016~~7~~ Quality Improvement Work Plan- LTSS Owner: ~~Suzanne Harvey~~Marie ~~Earvolino~~Tracy Hitzeman, Interim ~~Director, LTSS~~ED, C~~linical O~~perations

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

IV. LTSS

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

Owner: ~~Suzanne Harvey~~Marie Earvolino Tracy Hitzeman, Interim ~~Director, LTSS~~ED, C~~linical~~O ~~Operations~~ ~~Operations~~

The Approach

1. **Objective**
   - Member review of Emergency Department Visits (for each organization/program)

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

3. **Goals**
   - 9% CBAS~~;~~
   - R~~Establishing goals in~~Review 2016 data to establish goals for IHSS, LTC, MSSP
   - Monitor progress towards goals quarterly

2016~~7~~ Quality Improvement Work Plan- LTSS Owner: ~~Suzanne Harvey~~~~Marie Earvolino~~Tracy Hitzeman, Interim ~~Director, LTSS~~ED, C~~linical~~ Operations

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

IV. LTSS

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

Owner: ~~Suzanne Harvey~~Marie ~~Earvolino~~Tracy Hitzeman, Interim ~~Director, LTSS~~ED, CO ~~Clinical Operations~~ ~~Operations~~

The Approach

1. **Objective**
   - Members reviewed for Hospital Readmissions (for each organization/program)

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

3. **Goals**
   - 2.5% CBAS~~;~~
   - Review 2016 data to establish goals for IHSS, LTC, MSSP
   - ~~Establishing goals in 2016 for IHSS, LTC, MSSP~~

2016~~6~~7 Quality Improvement Work Plan- LTSS **Owner: ~~Suzanne Harvey~~Marie ~~Earvolino~~Tracy Hitzeman, Interim ~~Director, LTSS~~ED, C~~linical O~~perations**

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

IV. LTSS

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

Owner: ~~Marie Earvolino~~Tracy Hitzeman, Interim ~~Director, LTSSED~~, CO~~Clinical Operations~~

~~Clinical Operations~~

The Approach

1. Objective

- Members reviewed for Long Term Care Admissions (LTC) (for each organization/program)

2. Activity

- Measure and assess admissions to LTC ~~ong Term Care~~ for members in each program to drive interventions to minimize hospital readmissions~~:~~
  1. CBAS
  2. IHSS
  3. MSSP

3. Goals

- 2% CBAS
- ~~; Establishing goals in~~Review data from 2016 and establish goals for ~~for~~ IHSS, LTC, MSSP

2017 Quality Improvement Work Plan- LTSS Owner: ~~Marie Earvolino~~Tracy Hitzeman, Interim ~~Director, LTSS~~ED, C~~linical O~~perations~~

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

IV. LTSS

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

Owner: Suzanne HarveyMarie Earvolino, Interim Director, LTSS

The Approach

1. **Objective**
   - Health risk assessment for members in the OCC line of business monitored for completeness

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

3. **Goals**
   - 100%

~~2016~~7 Quality Improvement Work Plan- LTSS ~~Owner: Suzanne Harvey~~Marie Earvolino, ~~Interim~~ ~~Director, LTSS~~

	~~Assessments, Findings, Monitoring of Previous Issues~~	~~Next Steps~~	
	~~Results / Metrics~~	~~Next Steps~~	

IV. LTSS

~~E.~~ CBAS Member Satisfaction

Owner: ~~Novella Quesada~~Esther Okajima, ~~Manager~~Director, QI~~I~~

~~E.~~

The Approach

1. **Objective**
   - **Monitor and/or improve member satisfaction in CBAS/LTSS**
2. **Activity**
   - **Measur**e, assess and identify areas for improvement and implement
   - interventions to assure high member satisfaction
3. **Goals**
   - ~~-~~5% Improvement over previous year

2016~~6~~7 Quality Improvement Work Plan- LTSS Owner: ~~Novella Quesada~~Esther Okajima, ~~Manager~~Di~~rec~~tor, QI

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

IV. LTSS

A. SNF Member Satisfaction

Owner: ~~Novella Quesada~~Esther Okajima, ~~Manager~~Director~~or~~, QI

The Approach

1. **Objective**
   - Monitor and/or improve member satisfaction in SNF
2. **Activity**
   - Measure~~s~~, assess and identify areas for improvement and implement interventions
   - to assure high member satisfaction
3. **Goals**
   - 5% Improvement over previous year

2016~~6~~7 Quality Improvement Work Plan- LTS S Owner: ~~Novella Quesada~~Esther Okajima, ~~Manager~~D~~irect~~or, QI

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

V. Health Education & Disease Management

~~A. *Quality of Care-All new members will complete the Initial Health Assessment and related IHEBA/SHAs~~ ~~Owner: Pshyra Jones, Director, Health ED and DM~~

~~The Approach~~

~~1. Objective~~
- ~~To assure all new members are connected with a PCP and their health risks are assessed~~

~~2. Activity~~
- ~~IHA/IHEBA [Staying Healthy Assessment(SHA)] will be completed with 120 days of enrollment~~
- ~~Reports will be available for Health Networks on IHA/SHA completion~~
- ~~Facility Site Reviews will review sample of medical records for compliance with completing appropriate age level IHA/SHA~~
- ~~If use of alcohol or drugs, the member will have an SBIRT documented (Screening, Brief intervention, and Referral to Treatment)~~

~~3. Goals~~
- ~~Improve plan performance over 2015 by 10%~~

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

Owner: Pshyra Jones, Director, Health ~~E~~Education & ~~and~~ Disease Management

The Approach

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

2. Activity
- IHA/IHEBA [Staying Healthy Assessment(SHA)] will be completed

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

3. Goals

- Improve plan performance over 2016 by 10%

2016~~6~~7 Quality Improvement Work Plan- ~~Health Education & Disease Management~~HE & DM _Owner: Pshyra Jones, D~~irect~~or, H~~ealth~~ Ed~~d~~D & DM

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

V. Health Education & Disease Management

~~**B. Quality of Clinical Care, review of Disease Management Program (Asthma) Owner: Pshyra, Jones, Director, Health Ed and DM**~~

~~**The Approach**~~

~~**1. Objective**~~

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

~~**2. Activity**~~

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

~~**3. Goals**~~

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

B. Quality of Clinical Care, Rreview of Disease Management Programs Owner: Pshyra, Jones, ~~Director, Health Ed & and DM~~Dtr, HE & DM

The Approach

1. Objective

- Disease Management activity reviewed to assess clinical care delivered to members with Asthma, ~~Diabetes,~~Diabetes and Heart Failure

2. Activity

- Incorporate HEDIS improvement into DM program interventions
- Assure DM programs are implemented across all populations

- Conduct annual member satisfaction of DM programs
- Evaluate the overall effectiveness of the Program-Participation Member Rates, ED, IP and RX related utilization

3. Goals

Medi-Cal

- Increase to 75th percentile for Asthma Medication Ratio (AMR) Ages 5-11
- Increase to 75th percentile for Medication Management for People with Asthma (MMA), ages 5-85
- Increase to 50th percentile for HbA1c Testing
- Increase to 90th percentile for HbA1c Poor Control
- Increase to 75th percentile for Eye Exams
- Increase to 50th percentile for Annual Monitoring for Patients on Persistent Medications (MPM) Ace Inhibitors or ARBSs - Increase to 50th percentile for HbA1c Testing - Medicare
- Increase to 50th percentile for Controlling High Blood Pressure (CBPC) - Medicare
- 85% satisfaction with DM Programs

2016~~7~~ Quality Improvement Work Plan- ~~Health Education & Disease Management~~HE & DM _____-Owner: Pshyra Jones, ~~Dir~~Dtr~~.ector~~ H~~ealth~~ E~~d~~ & DM

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

V. Health Education & Disease Management

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

~~**The Approach**~~

~~**1. Objective**~~

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

~~**2. Activity**~~

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

~~**3. Goals**~~

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

C. *Quality of Care-Clinical Practice Guidelines adoption for Medi-Cal line of business **Owner: Pshyra Jones, D~~irector~~tr, HE & DM**

~~**Health Ed & DM**~~

The Approach

1. Objective

- Clinical Practice Guidelines will be reviewed and adopted

2. Activity

- Adoption of Clinical Practice Guidelines, as least three (3) will be

- reviewed and adopted (linked to DM: Diabetes, Asthma, CHF)

3. Goals

- 100%

"Attachment A"

2016~~6~~7 Quality Improvement Work Plan- ~~Health Education & Disease Management~~ HE & DM ~~—~~Owner: Pshyra Jones, D~~irect~~or H~~ealth E~~d & DM

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

V. Health Education & Disease Management

~~**D. Quality of Clinical Care-Review of Disease Management Program (CHF)** **Owner: Pshyra Jones, Director, Health ED and DM**~~

~~**The Approach**~~

~~**1. Objective**~~

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

~~**2. Activity**~~

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

~~**3. Goals**~~

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

D. Quality of Clinical Care-Review of Cardiovascular Disease **Owner: Pshyra Jones, D~~irect~~or, H~~ealth Ed~~ &~~and~~ DM**

The Approach

1. Objective

- CCIP Chronic Care Improvement Projects

2. Activity

- CCIP-CMS m~~M~~andatory topic New Goal

Achieve high BP control or improvement among 50% of the members

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

3. Goals

- As determined by CMS

2016~~6~~7 Quality Improvement Work Plan- ~~Health Education & Disease Management~~ ManagementHE & DM
Owner: Pshyra Jones, D~~irec~~tor H~~ealth~~ E~~d~~ & ~~____~~ DM

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

Q4			
Year End			

V. Health Education & Disease Management

E. Implementation of Population Health & Wellness Programs **Owner: Pshyra Jones, Director, Health EdD &and DM**

The Approach

1. Objective

- Expand child and adolescent components for the Shape Your Life/Weight Management Program
- Implement Weight Watchers benefit for Shape Your Life CalOptima Medi-Cal members age 15 years or greater
- Design and implement a comprehensive Perinatal Health Program

2. Activity

- Establish program goals, objectives and interventions
- Develop clinical and operational components to expand the reach and capability
- Identify program resources and vendor support (Provider, Health EdD/RD linkages, Community Based Organizations)
- Implementation of revised program design

3. Goals

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

~~**E. *Quality of Care-Clinical Practice Guidelines adoption for Medi-Cal line of business** **Owner: Pshyra Jones, Director Health Ed & DM**~~

~~**The Approach**~~

~~**1. Objective**~~

- ~~Clinical Practice Guidelines will be reviewed and adopted~~

~~**2. Activity**~~

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

~~**3. Goals**~~

- ~~100%~~

2016~~7~~ Quality Improvement Work Plan- ~~HE & DM~~~~Health Education & Disease Management~~ Owner: Pshyra Jones, D~~irect~~~~o~~r H~~ealth~~ E~~d~~ & DM

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

V. Health Education & Disease Management

F. Quality of Clinical Care-Review of member satisfaction with DM programs Owner: Pshyra Jones, Director, Health ED and DM

The Approach

1. Objective

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

2. Activity

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

3. Goals

- 90% satisfaction with the DM program

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

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

~~V. Health Education & Disease Management~~

~~G. Quality of Clinical Care-Review of Cardiovascular Disease~~ ~~Owner: Pshyra Jones, Director, Health Ed and DM~~

~~The Approach~~

~~1. Objective~~

- ~~CCIP Chronic Care Improvement Projects~~

~~2. Activity~~

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

~~3. Goals~~

- ~~As determined by CMS~~

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

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

V. Health Education & Disease Management

~~**H. Quality of Clinical Care-Review of Diabetes and All Cause Readmissions** **Owner: Kelly Rex-Kimmet, Director, QA PIPS**~~

~~**The Approach**~~

~~**1. Objective**~~
- ~~PIP Performance Improvement Projects~~

~~**2. Activity**~~
- ~~PIP-DHCS Mandatory Projects-Readmission & Diabetes~~

~~**3. Goals**~~
- ~~As determined by CMS& DHCS~~

H. Quality of Clinical Care – Quality and Performance Improvement Projects **Owner: Kelly Rex-Kimmet, Director, Quality Analytics, ~~PIPS~~Pshyra Jones, Dtr, HE & DM**

The Approach

1. Objective
- Implement DHCS and CMS Quality and Performance Improvement Projects (QIPs and PIPs)

2. Activity
- QIPs
  - OneCare Diabetes QIP to Improve HbA1c Testing
  - OneCare Connect QIP to Improve 30-day Readmission Rate
- PIPs
  - Medi-Cal Diabetes PIP to Improve HbA1c Testing
  - Medi-Cal PIP to Improve Initial Health Assessments
  - OneCare Connect LTSS PIP to Improve In-Home Support Services Care Coordination

3. Goals

- HbA1c Testing rate at the 50th percentile based on the 2016~~5~~ NCQA Quality Compass
- 16.8% readmissions rate
- 80% HbA1c Testing
- 25% IHA rate
- 35% IHSS Participation rate

2016~~7~~ Quality Improvement Work Plan- ~~Health Education & Disease Management~~HE & DM Owner~~s~~: Kelly Rex-Kimmet, D~~irect~~t~~o~~r, QA~~;~~

Pshyra Jones, Dtr, HE & DM ~~PIPS~~

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

V. Health Education & Disease Management

I. Implementation of the Childhood Obesity (Shape your Life) Program — Owner: Pshyra Jones, Director, Health ED and DM

The Approach

1. Objective

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

2. Activity

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

3. Goals

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

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

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

V. Health Education & Disease Management

J. Implement Weight Watchers (WW) for Medi-Cal members — Owner: Pshyra Jones, Director, Health ED and DM

The Approach

1. Objective

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

2. Activity

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

3. Goals

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

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

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

V. Health Education & Disease Management

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

Owner: Pshyra Jones, Director, Health ED and DM

The Approach

1. Objective

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

2. Activity

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

3. Goals

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

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

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

V. Health Education & Disease Management

L. Conduct 2016 Group Needs assessment (GNA) — Owner: Pshyra Jones, Director, Health ED and DM

The Approach

1. Objective

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

2. Activity

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

3. Goals

- Complete GNA requirement for 2016

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

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

VI. Access & Availability

A. *Quality of Service and Quality of Clinical Care- Review of Nnotification to mMembers Owners: Laura Grigoruk, Director Provider Relations; Belinda Abeyta

~~A.~~ The Approach Director, Customer Service ~~Dir. Provider Relations~~

~~Belinda Abeyta, Director, Customer Service~~

~~The Approach~~

1. **Objective**
   - Continuity and Ccoordination of Care reviewed and assessed

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

3. **Goals**
   - 85%

2016~~6~~7 Quality Improvement Work Plan- Access & Availability
Owner~~s~~: Laura Grigoruk, D~~irect~~o~~r~~, P~~rovider R~~elations~~;~~
~~s &~~ Belinda Abeyta, D~~irect~~o~~r~~, C~~ustomer S~~ervice~~

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

VI. Access & Availability

B. *Access to Care: Credentialing of Pprovider ~~n~~Network is ~~m~~Monitored — Owner: Esther Okajima, Di~~rect~~or, QI

The Approach

1. **Objective**
   - Credentialing program activities monitored for volume and timeliness
2. **Activity**
   - New applicants processed within 180 calendar days of receipt of application
   - Report of initial credentialing file activity to CPRC
3. **Goals**
   - 90~~% of~~% of initial credentialing applications are processed within 120 days of receipt of application~~.~~

~~**B. *Access to Care: Credentialing of provider network is monitored — Owner: Novella Quesada, Manager, QI**~~

~~**The Approach**~~

~~1. **Objective**~~
   - ~~Credentialing program activities monitored for timeliness~~

~~2. **Activity**~~
   - ~~New applicants processed within 180 calendar days of receipt of application~~
   - ~~**Report from CPRC~~

~~3. **Goals**~~
   - ~~100%~~

C. Access to Care-Recredentialing of Pprovider N~~n~~etwork is M~~m~~onitored — Owner: Esther Okajima, Di~~rect~~or, QI

The Approach

1. **Objective**
   - Recredentialing of practitioners is completed timely

2. **Activity**
   - Recredentialing is processed everywith 36 months
   - Report of Admin term due to missed recredentialing cycle
   -
   - Report of re-credentialing activity to CPRC

3. **Goals**
   - 100% of all recredentialing files are processed within 36 months of last credentialing date.

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

~~**The Approach**~~

1. ~~**Objective**~~
   - ~~Recredentialing of practitioners is completed timely~~

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

3. ~~**Goals**~~
   - ~~100%~~

2016~~6~~7 Quality Improvement Work Plan- Access & Availability Owner: ~~Novella Quesada~~Esther Okajima, ~~Manager~~Director, QI

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

VI. Access and Availability

~~**D. *Accessibility: Review of access to care** **Owner: Esther Okajima, Manager, QA**~~

~~**The Approach**~~

~~**1. Objective**~~

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

~~**2. Activity**~~

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

- ~~Health Networks will be issued Corrective Action Plans for their areas of non-compliance~~
  ~~1. Urgent Care appointments with 48 hours of request~~
  ~~2. Appointments with specialist within 15 business days~~
  ~~3. Member services, by telephone ASA 30 seconds with abandonment rate <5%~~
  ~~4. Non-urgent acute care within 3 days of request~~

~~**3. Goals**~~

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

D. *Accessibility: Review of access to care **Owner: Marsha Choo, Manager, QA**

The Approach

1. Objective

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

2. Activity

- Data against goals will be measured and analyzed for the following through the implementation of our annual Timely Access study and Customer Service monitoring of wait time
  1. Urgent care appointments without prior authorization within 48 hours of request
  2. Urgent appointments with prior authorization with 96 hours of request
  3. Non-urgent primary care appointments within 10 business days of request
  4. Appointment with specialist within 15 business days of request
  5. Non-urgent mental health appointment within 10 business days of request
  6. Non-urgent appointment for ancillary services within 15 business days of request
  7. First pre-natal visit within 10 business days
  8. Member services, by telephone ASA 30 seconds with abandonment rate <5%

- Health Networks will be issued Corrective Action Plans in accordance with CalOptima's Access and Availability Policies: GG.1600 and MA.7007

3. Goals

- Appointment: 90% minimum performance level
- Phone: ASA 30 seconds; Abandonment rate <5%

2016~~6~~7 Quality Improvement Work Plan- Access & Availability Owner: ~~Esther Okajima~~Marsha Choo, M~~ana~~g~~e~~r, QA

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

VI. Access and Availability

E. *Availability: Review of Availability of Practitioners

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

The Approach

1. Objective

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

2. Activity

- Practitioner network to determine how the network is meeting the needs and preferences of he plans membership will be measured and analyzed and adjusted as necessary. Each type of PCP and high volume specialist' geographic distribution performance will be measured against set standards
  1. Members within ten (10) miles or thirty (30) minutes of a practitioner
  2. Member within thirty (30) miles or forty0five (45) minutes of a high volume specialist

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

- Availability of practitioners against goals will be measured and analyzed and adjusted as necessary
  1. Practitioner to Member
  2. Ratio of PCP to Members
  3. Ratio Specialists to Members (Neurology 1:10,000)

~~3. Goals~~

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

E. *Availability: Review of Availability of Practitioners

Owners: Marsha Choo, Manager, QA; Dr. Donald Sharps, Medical Director, BHI

The Approach

1. Objective

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

2. Activity

- Data against goals will be measured and analyzed for the following through the implementation of our provider data pull from FACETS and GeoAccess Software
  1. Practitioner network by practitioner type (i.e., PCP, high volume specialists, high impact specialists, ancillary providers, health delivery organizations, ~~etc~~etc.)~~.~~ will be measured for minimum number of providers against goals, assessed and adjusted as necessary
  2. Practitioner network on the cultural, ethnic, racial and linguistic needs of membership minimum number of providers will be measured against goals, assessed and adjusted as necessary~~.~~
  3. Practitioner network by practitioner type (i.e., PCP, high volume specialists, high impact specialists, ancillary providers, health delivery organizations, ~~etc~~etc.)~~.~~ will be measured for geographic distribution performance against set standards

4. Practitioner network by BH practitioner type (i.e., psychiatrist, psychologist, marriage and family therapist and licensed clinical social worker, ~~etc~~etc.)~~.~~ will be measured for minimum number of providers against goals, assessed and adjusted as necessary
5. Practitioner network by BH practitioner type (i.e., psychiatrist, psychologist, marriage and family therapist and licensed clinical social worker, ~~etc~~etc.)~~.~~ will be measured for geographic distribution performance against set standards

3. Activity (cont.)

- Health Networks will be issued Corrective Action Plans in accordance with CalOptima's Access and Availability Policies: GG.1600 and MA.7007

4. Goals

- Minimum performance levels in CalOptima's Access and Availability Policies: GG.1600 and MA.7007

2016~~6~~7 Quality Improvement Work Plan- Access & Availability Owners: ~~Esther Okajima~~Marsha Choo, Manager, QA;

Donald Sharps, MD, Medical Di~~rec~~tor, BHI

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

VII. Patient Safety

A. *Safety of Clinical Care-Providers shall have timely and complete facility site reviews — **Owner: Esther Okajima, Director, QI**

The Approach

1. Objective

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

2. Activity

- Facility Site Reviews (FSR), Medical Record Reviews (MRR) and Physical Accessibility Review Surveys (PARS) are completed as part of initial and re-credentialing cycles
- Report of FSR/MRR/PARS activity to CPRC

3. Goals

- 100% of FSR/MRR/PARS Initial or Full Scope Surveys are completed within initial and re-credentialing timeframes.

~~**A. *Safety of Clinical Care-Providers shall have timely and complete facility site reviews** — **Owner: Novella Quesada, Manager, QI**~~

~~**The Approach**~~

~~**1. Objective**~~

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

~~**2. Activity**~~

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

~~**3. Goals**~~

- ~~80%~~

2016~~6~~7 Quality Improvement Work Plan- Patient Safety Owner: ~~Novella Quesada~~Esther Okajima, ~~Manager~~D~~irect~~or, QI

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

VII. Patient Safety

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

~~**The Approach**~~

~~**1. Objective**~~

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

~~**2. Activity**~~

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

~~**3. Goals**~~

- ~~80%~~

B. Timeliness of Clinical Care R~~care r~~eview and F~~f~~ollow-up on Potential Quality of Care Issues Owner: Esther Okajima, D~~irec~~t~~o~~r, QI

The Approach

1. Objective

To assure patient safety and enhance patient experience by timeliness of clinical care reviews~~.~~

2. Activity

- QI Nurse Specialists and Medical Directors review cases and provide determination~~.~~
- Report all case results to CPRC for discussion~~,~~
- ~~any~~Present cases that have a severity rating of ~~-~~ 1 ~~exceed the threshold level of 1~~ (one) or higher will be presented to CPRC for action~~.~~

Follow through on Medical Director determination, when applicable, to ensure

- closure and compliance of all cases
- Conduct a PQI trend analysis at least two times a year ~~of all cases.~~

~~Conduct a PQI trend analysis at least two times/year~~

3. Goals

- ~~To achieve~~Achieve a turnaround time of 90 days on 90% of cases received
- Review data for trends and~~&~~ patterns for potential further actions~~.~~

2016~~6~~7 Quality Improvement Work Plan- Patient Safety_____ Owner: ~~Novella Quesada~~Esther Okajima, ~~Manager~~D~~irect~~or, QI

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

VII. Patient Safety

~~C. *Safety of Clinical Care and Quality of Clinical Care reviewed through Pharmacy Management~~ ~~Owner: Kris Gericke,PharmD, Director, Pharmacy Management~~

~~The Approach~~

~~1. Objective~~
- ~~To promote access to clinically sound, cost-effective pharmaceutical care for all CalOptima Members.~~

~~2. Activity~~
- ~~Review and update the CalOptima Plan Formularies on an ongoing basis in order to ensure access to quality pharmaceutical care which is consistent with the program's scope of benefits~~
- ~~Review anticipated and actual utilization trends including specialty medications~~
- ~~Review and evaluate pharmacy related issues related to delivery of health care to CalOptima's members~~
- ~~Report on medication recalls and process for informing members and providers~~
- ~~Report on Underutilization of Asthmatics not receiving long term controllers, Diabetics not receiving statins, Diabetics with Hypertension not receiving ACE/ARB~~
- ~~Overutilization/PolyPharmacy-Report on interventions for preventing opiod overuse to include Pharmacy home, Monthly RX limit, Opiod overutilization (MED over 120mg.)~~

~~3. Goals~~
- ~~100%~~

C. *Safety of Clinical Care and Quality of Clinical Care reviewed through Pharmacy Management **Owner: Kris Gericke, Pharm.D., Director, Pharmacy Management**

The Approach

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

2. Activity

Monitor for underutilization of pharmaceuticals and provide education to providers.
- Underutilization of long-term controllers for members diagnosed with asthma.
- Underutilization of osteoporosis therapies for members receiving corticosteroids.
- Underutilization of calcium for members with a diagnosis of osteoporosis.
- Underutilization of statins for members with diabetes.

- Programs to prevent overutilization include:
  - Monthly prescription limit.
  - Pharmacy Home Pprogram.
  - Prescriber Restriction Pprogram.
  - Opioid overutilization monitoring.

3. Goals

- Reductions in underutilization and overutilization measures

2016~~6~~7 Quality Improvement Work Plan- Patient Safety_____ _____Owner: Kris Gericke, Pharm.D., D~~irect~~ir, Pharm~~ana~~acy M~~anag~~anag~~emen~~emnt

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

VII. Patient Safety

D. *Safety of Clinical Care and Quality of Clinical Care- Review of Specialty Drug Utilization — **Owner: Kris Gericke,PharmD, Director, Pharmacy Services**

The Approach

1. Objective

- Provide ongoing monitoring of specialty drug trends

2. Activity

- Review and reporting of Specialty Drug trends, identify any actions necessary with the member or provider/HN

3. Goals

- TBD

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

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

VII. Patient Safety

D. *Patient Safety-Review and assessment of CBAS Quality Monitoring

Owner: Esther Okajima, Director, QI

The Approach

1. Objective

- Review of CBAS Quality monitoring of services provided

2. Activity

- CBAS Quality Assurance - continue to assess compliance of contracted CBAS centers.
- Report to LTSS QI SubcommitteeC
- Report Member Satisfaction Survey Results
- Report CDA audit results in comparison to past results

3. Goals

- 100% CDA Audit Results

E. Patient Safety-Review and Aassessment of SNF Quality Monitoring

Owner: Esther Okajima, Director, QI

The Approach

1. Objective

- Review of SNF Quality monitoring of services provided

2. Activity

- SNF Quality Assurance - continue to assess compliance of contracted SNF centers.
- Report to LTSS QIC
- Report on progress of on-siresite visits and CAPs issued
- Report on Member Satisfaction Survey Results

3. Goals

- 100% DHCS Audit results

~~E. *Patient Safety-Review and assessment of CBAS Quality Monitoring Owner: Novella Quesada, Manager, QI~~

~~The Approach~~

~~1. Objective~~

- ~~Review of CBAS Quality monitoring of services provided~~

~~2. Activity~~

- ~~CBAS Quality Assurance-continue to assess compliance of contracted CBAS centers.~~
- ~~Report to LTSS QIC~~
- ~~Report Member Satisfaction Survey Results~~
- ~~Report CDA audit results in comparison to past results~~

~~3. Goals~~

- ~~100% CDA Audit Results~~

~~F. Patient Safety-Review and assessment of SNF Quality Monitoring~~

~~The Approach~~

~~1. Objective~~

- ~~Review of SNF Quality monitoring of services provided~~

~~2. Activity~~

- ~~SNF Quality Assurance-continue to assess compliance of contracted SNF centers.~~
- ~~Report to LTSS QIC~~
- ~~Report on progress of on-sire visits and CAPs issued~~
- ~~Report on Member Satisfaction Survey Results~~

~~3. Goals~~

- ~~100% DHCS Audit results~~

2016~~6~~7 Quality Improvement Work Plan- Patient Safety Owner: ~~Novella Quesada~~Esther Okajima, ~~Manager~~Director, QI

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

VII. Patient Safety

~~G.~~**F. *Safety of Clinical Care-Review of antibiotic usage** **Owner: Kelly Rex-Kimmet ~~Dir~~Dir.tr, ~~of Quality Analytics~~QA**

The Approach

1. **Objective**
   - Increase the appropriate testing for children with Pharyngitis rate (CWP)
   - Appropriate treatment for children with upper respiratory infection (URI) to meet goals
   - Improve appropriate use of antibiotics in Adults with Acute Bronchitis (AAB)

2. **Goals**
   - Appropriate Testing for Children with Pharyngitis~~-~~: 63.24% (25th percentile)~~68.53%~~
   - Appropriate treatment for Children with URI~~:L~~ 93.2~~3~~8% (75th percentile)
   - Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB) 22.25% (25th percentile)~~91.21%~~

20167 Quality Improvement Work Plan- Patient Safety Owner: Kelly Rex-Kimmet, Director, QA

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

VII. Patient Safety

~~**H. Implementation of the new PBM** **Owner: Kris Gericke, Dir of Pharmacy**~~

~~**The Approach**~~

~~**1. Objective**~~

- ~~Provide ongoing monitoring of the implementation of the new PBM: quality of care, service, clinical metrics~~

~~**2. Activity**~~

- ~~Review and report on clinical and service metrics for Med Impact, as it relates to STARS, HEDIS, Quality of care, Quality of Service~~

~~**3. Goals**~~

- ~~TBD~~

G. Pharmacy Benefit Manager (PBM) Oversight Management **Owner: Kris Gericke, Pharm.D., D~~irect~~or, Pharm~~acy Manag~~e~~m~~ent~~**

The Approach

1. Objective

- Provide ongoing monitoring of the PBM: quality of care, service, timeliness

2. Activity

- Review and report on clinical and service metrics for MedImpact~~,~~ as it relates to performance guarantees

3. Goals

- Meet performance guarantees per the contract

20167 Quality Improvement Work Plan- Patient Safety Owner: Kris Gericke, Director, Pharmacy

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

VIII. Member Experience

~~A. Quality of Service-Review of Member Satisfaction~~ ~~Owner: Kelly Rex-Kimmet, Director, Quality Analytics~~

~~The Approach~~

~~1. Objective~~
- ~~Annual review of member feedback (CAHPS, complaints & grievances); identification of areas for improvement~~

~~2. Activity~~
- ~~Identify key areas of concern and implement related activities to improve Member Experience (CAHPS)~~
- ~~Work in conjunction with the Health Networks and other Delegates to monitor and improve the Member Experience~~

~~3. Goals~~
- ~~Annual CAHPS results~~

A. Quality of Service-Review of Member Satisfaction Owner: Kelly Rex-Kimmet, ~~Director~~, ~~Quality Analytics~~

The Approach

1. Objective
- Annual review of member feedback (CAHPS, complaints & grievances); identification of areas for improvement

2. Activity
- Identify key areas of concern and implement related activities to improve Member Experience (CAHPS)
- Work in conjunction with the Health Networks and other Delegates to monitor and improve the Member Experience

3. Goals
- Annual CAHPS results

20167 Quality Improvement Work Plan- Member Experience Owner: Kelly Rex-Kimmet, Director, QA

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

VIII. Member Experience

B. *Quality of Service-Reviewed through customer service first call resolution **Owner: Belinda Abeyta, Director, Customer Service**

The Approach

1. **Objective**
   - Gather data and information from members after interface with Customer Service
   - to assure expectations/reason for call was resolved

2. **Activity**
   - Monitor port call information and determine key strategies to assure first call
   - resolution/member satisfaction with customer service

3. **Goals**
   - 85% of calls resolved at first call

20167 Quality Improvement Work Plan- Member Experience Owner: Belinda Abeyta, Director, Customer Service

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

VIII. Member Experience

C. *Quality of Service - -Reviewed through Customer Service access

Owner: Belinda Abeyta, Director, Customer Service

The Approach

1. **Objective**
   - Customer Service call lines evaluated for average speed to answer
   - Customer Service call line evaluated for call abandonment rate
   - ~~Customer Service call lines evaluated for hold times~~

2. **Activity**
   - Customer Service lines monitored for average speed to answer
   - Customer service lines monitored for abandonment rate
   - ~~Customer service lines monitored for hold time~~

3. **Goals**
   - ASA 30 seconds
   - <3%
   - ~~Hold time under 30 seconds~~
   - First Call Resolution 85%

20167 Quality Improvement Work Plan- Member Experience Owner: Belinda Abeyta, Director, Customer Service

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

VIII. Member Experience

D. Quality of Care and ~~&~~ Service Reviewed through GARS & PQI (MOC)

Owners: Janine Kodama, Director, ~~D.~~ & Appeals; ; ~~Novella Quesada, Manager~~Laura Guest, Supervisor, QI

The Approach

1. **Objective**
   - Global review of member "pain points" (Grievances, Complaints and Quality of Care);
   - assure appropriate actions are taken to assist the member experience

2. **Activity**
   - Quarterly review of all GARS and PQI data to identify issues and trends; implement any necessary corrections
   - Report QIC
   - HN quarterly totals ~~by PMPM oo~~f grievance and PQI ~~and steps taken to address with HN~~
   - Conduct a GARS trend analysis at least two times per y~~y~~ear

3. **Goals**
   - Improve over 2015 performance

2016~~6~~7 Quality Improvement Work Plan- Member Experience ~~__~~ ~~—~~Owners: Janine Kodama, Director, GARS; ~~Novella Quesada, Manager~~Laura Guest, Super~~vis~~or, QI

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

IX. HEDIS/STARS Improvement

A. Improve identified HEDIS Measures listed on "Measure" worksheet — Owner: Kelly Rex-Kimmet Director, Quality Analytics

The Approach

1. **Objective**
   - Regain "Commendable" NCQA accreditation rating
   - Maintain or exceed NCQA 4.0 health plan rating
2. **Activity**
   - See measures worksheet for specific activities
3. **Goals**
   - See measures worksheet

B. Improve identified STARS measures listed on "Measures" worksheet

The Approach

1. **Objective**
   - Maintain or exceed 4.0 CMS STAR rating
2. **Activity**
   - See measures worksheet for specific activities
3. **Goals**
   - See measures worksheet

~~IX. HEDIS/STARS Improvement~~

~~C. Improve CAHPS measures listed on “Measures” worksheet~~

~~The Approach~~

~~1. Objective~~
- ~~Achieve 3.0 CAHPS score~~

~~2. Activity~~
- ~~See Measures worksheet for specific activities~~

~~3. Goals~~
- ~~See Measures worksheet~~

~~D. HEDIS: Launch pediatric wellness clinic~~

~~The Approach~~

~~1. Objective~~
- ~~Improve child and adolescent HEDIS measures (i.e. adolescent immunizations, childhood immunizations, adolescent well care)~~

~~2. Activity~~
- ~~Evaluate options to deliver pediatric preventive care, including immunizations in unique settings to achieve higher adherence~~
- ~~Work in conjunction with the HN and CCN providers on this initiative~~

~~3. Goals~~
- ~~Improve HEDIS rates per measure worksheet~~

~~IX. HEDIS/STARS Improvement~~

~~E. STARS Improvement-Medication Adherence Measures~~ ~~Owner: Kris Gericke, Director, Pharmacy~~

~~The Approach~~

~~1. Objective~~
- ~~Improve the 3 Medication Adherence Measures to achieve 4 Star Performance in each measure~~

~~2. Activity~~
- ~~Comprehensive member & provider outreach to identified members who appear non-compliant with medication management (interventions based on unique member characteristics)~~

~~3. Goals~~
- ~~See measures worksheet~~

~~F. HEDIS: Health Network support of HEDIS & CAHPS improvement~~ ~~Owner: Kelly Rex-Kimmet, Director, Quality Analytics~~

~~The Approach~~

~~1. Objective~~
- ~~Provider regular reporting to the Health Networks to ensure HEDIS improvement for expected measures~~

~~2. Activity~~
- ~~Provide ongoing reports to Health Networks on their specific HEDIS & CAHPS performance, including patient lists for intervention~~
- ~~Gather feedback from Health Networks on tools to assist in HEDIS & CAHPS improvement activities~~

~~3. Goals~~
- ~~24.33%~~

HEDIS Measures Worksheet

Scope	Objective	Activity	Goals or Baseline	Target Completion
**HEDIS/STARS: Review and assessment Comprehensive Diabetes Care (CDC)	Increase the comprehensive diabetes care measures MC and OC members - in conjunction with Diabetes Disease Management Program	Comprehensive diabetes care will increase through member education to identified members with diabetes and collaboration with targeted providers to better outreach to their patients for comprehensive screening and care. Also explore the use of member engagement technologies to improve rates. These measures are also incentivized through our P4V program. (interventions based on unique member characteristics)	90th percentile for all subsmeasures	2016 April, July, October
**HEDIS/STARS Improvement: Review and assessment Controlling Blood Pressure*	Increase the BP control for MC and OC members to meet goal	Blood pressure control will increase through member outreach and education with member diagnosed with hypertension.	MC: 70.32% (90th percentile) OC 79.15% (75th percentile)	2016 April, July, October
**HEDIS/STARS Improvement: Review all-cause hospital readmissions with Medi-Cal & OneCare Connect members (PCR)	Reduce 30 day All Cause Readmissions (PCR)	Readmission Rate will be minimized through member education and Quality Incentive Program. A reporting mechanism will be established followed by analysis of data.	Medi-Cal <15% Readmission rate Medicare <14% Readmission rate	2016 April, July, October
**HEDIS/STARS Improvement: Review of flu and pneumococcal immunization rates*	Increase the flu and pneumococcal screening rate in: 1. MC members 18-64 years old and 2. OC members 65 years old and older to meet goal	Compliance with flu and pneumococcal immunizations will increase through flu reminders and education.	90%	2016 April, July, October

Scope	Objective	Activity	Goals or Baseline	Target Completion
HEDIS: Review of prenatal & postpartum care services (PPC)	Increase the prenatal and postpartum care rate for all Medi-Cal deliveries to meet goal	The number of prenatal and postpartum care visits will increase through provider education to submit Prenatal Notification Reports, member and provider education and sharing of provider data. Utilize Text For Baby custom messages to encourage member compliance.	MC Prenatal: 85.19% (50th percentile) MC Postpartum: 68.85% (75th percentile)	2016 April, July, October
HEDIS: Review and assessment prescribed ADHD medication (ADHD)	Increase the follow-up care for children prescribed ADHD medication rate in MC children who were newly prescribed an ADHD medication to meet goal	Follow-up care for children with newly prescribed ADHD medication will increase through member and provider education and reminder letter to members.	Initiation Phase: 40.79% (50th percentile) Maintenance Phase: 50.61% (50th percentile)	2016 April, July, October
HEDIS: Review and assessment of antidepressant medication management (AMM)	Increase the antidepressant medication management rate in MC and OC members with a diagnosis of major depression to meet goal	Antidepressant medication management rates will increase with the distribution of member health education material.	Acute Phase Treatment: MCAL 62.56% (90th percentile) Continuation Phase Treatment: 33.93% OneCare: Effective Phase Treatment 66.67% Continuation Phase Treatment 52.87%	2016 Mar Jun Sep Dec
****HEDIS/STARS**: Review and assessment of osteoporosis management (OMW)	Increase the osteoporosis management in women who had a fracture rate in OC women who suffered a fracture to meet goal	Osteoporosis management in women who had a fracture will increase through improved member identification using claims and pharmacy data and provider education.	OC: 49.48% (75th percentile)	2016 April, July, October
HEDIS: Review and assessment of treatment of bronchitis (AAB)	Increase the avoidance of antibiotic treatment in adults with acute bronchitis rate in MC members with a diagnosis of acute bronchitis to meet goal	Avoidance of antibiotic treatment in adults with a diagnosis of acute bronchitis rate in MC members 18-64 years old will increase through member and provider education.	MC: 26.30% (50th percentile)	2016 April, July, October

Scope	Objective	Activity	Goals or Baseline	Target Completion
HEDIS: Review and assessment of childhood immunization rates	Increase the childhood immunization status rate in children 2 years old (combo 10) to meet goal	Immunization in children by their 2nd birthday will increase through member reminders and education (Combo 10) This measure is also incentivized in our P4V program.	MC: Combo 10: 49.63% (90th percentile)	2016 April, July, October
HEDIS: Review and assessment of adolescent Immunization rates	Increase the adolescent immunization rate to meet goal	Adolescent immunizations will improve through a adolescent focused event that will provide immunization opportunities, member education and member resources.	75th percentile (or above) 59.98%	2016 April, July, October
HEDIS: Review and assessment of appropriate testing for pharyngitis rates - - -	Increase the appropriate testing of pharyngitis in children 2-18 years of age to meet goal - - -	Appropriate testing for pharyngitis will improve through the distribution of strep A tests and provider education.	MC: 71.48% (50th percentile)	2016 April, July, October - - -
HEDIS: Review and assessment of use of imaging studies for low back pain - - -	Increase the use of appropriate treatment for low back pain (decrease the use of imaging studies for persons with low back pain) - - -	Imaging studies will decrease for persons diagnosed with low back pain through provider outreach and education	MC: 74.95% (50th percentile) - - -	2016 April, July, October - - -
***STARS Improvement** Medication Adherence Measures	Improve the 3 Medication Adherence Measures to achieve 4 Star performance in each measure	Comprehensive member & provider outreach to identified members who appear non-compliant with medication management (interventions based on unique member characteristics)	4 Stars	2016 Mar Jun Sep Dec
CAHPS: Rating of Health Plan	Increase CAHPS score on Rating of Health Plan	Utilize results from CalOptima's supplemental survey and explorations of other methods to "hear" our member will assist in developing strategies to improve Rating of Health Plan.	50th Percentile or higher	2016 Mar Jun Sep Dec

~~Scope~~	~~Objective~~	~~Activity~~	~~Goals or Baseline~~	~~Target Completion~~
~~CAHPS: Getting Needed Care~~	~~Increase CAHPS score on Getting Needed Care~~	~~Sharing of HN specific CAHPS reports, member education on referrals and prior authorization processes, and review and monitoring of provider capacity and geoaccess standards will improve rating of Getting Needed Care.~~	~~50th Percentile or higher (2.52)~~	~~2016 Mar Jun Sep Dec~~
~~CAHPS: Getting Care Quickly~~	~~Increase CAHPS score on Getting Care Quickly~~	~~Sharing of HN specific CAHPS reports, member education on referrals and prior authorization processes, and review and monitoring of provider capacity and geoaccess standards will improve rating of Getting Care Quickly.~~	~~50th Percentile or higher~~	~~2016 Mar Jun Sep Dec~~
~~CAHPS: How Well Doctors Communicate~~	~~Increase CAHPS score on How Well Doctors Communicate~~	~~Tips on "Preparing for your Dr. Visit," toolkits/decision tools for PCPs, and provider and office staff in-service on customer service will improve rating on How Well Doctors Communicate.~~	~~50th percentile or higher~~	~~2016 Mar Jun Sep Dec~~
~~CAHPS: Customer Service~~	~~Increase CAHPS score on Customer Service~~	~~Customer service post-call survey and evaluation and trending of member pain points will improve rating of Customer Service.~~	~~50th percentile or higher~~	~~2016 Mar Jun Sep Dec~~
~~HOS: Health Outcome Survey Measures~~	~~Improve HOS measures for Star Rating~~	~~Develop and implement activities around: 1)Reducing Risk of Falls 2)Improving Physical Health Status 3)Improving Mental Health Status~~	~~50th percentile or higher~~	~~2016 Mar Jun Sep Dec~~

A. Improve identified HEDIS ~~HEDIS~~ Measures listed on "Measures" worksheet **Owners: Kelly Rex-Kimmet ~~Director~~, Quality ~~Analytics~~**

The Approach

1. Objective

- Maintain "Commendable" NCQA accreditation rating

- Maintain or exceed NCQA 4.0 health plan rating
- Earn Quality Withhold Dollars back for OneCare Connect for all HEDIS measures in OCC QW program~~Maintain "Commendable" NCQA accreditation rating~~
- ~~Maintain or exceed NCQA 4.0 health plan rating~~

2. Activity

- See M~~m~~easures worksheet for specific activities

3. Goals

- See M~~m~~easures worksheet

HEDIS Measures Worksheet

Scope	Objective	Activity	Goals or Baseline	Target Completion (Proposed reporting months to QIC)
**HEDIS/STARS: Review and assessment Comprehensive Diabetes Care (CDC)	Increase the comprehensive diabetes care measures MC and OC members - in conjunction with Diabetes Disease Management Program	Comprehensive diabetes care will increase through member education to identified members with diabetes and collaboration with targeted providers to better outreach to their patients for comprehensive screening and care. Also explore the use of member engagement technologies to improve rates. These measures are also incentivized through our P4V program. (interventions based on unique member characteristics)	Medicaid: • A1C Screening: ~~86.0%~~85.95% (50th percentile) • A1C Control <8.0%: ~~55.47%~~52.55% (~~Between~~ 75th ~~and 90th~~ percentile) • A1C Control >9.0%: ~~33.05%~~36.87% (lower score is better) ~~Between~~ (75th ~~and 90th~~ percentile) • Eye Exams: ~~65.1%~~61.5 (75th percentile) • Nephropathy Screening: 90.51% (50th percentile) • BP Control: ~~72.17%~~68.61% (~~between~~ 75th ~~and 90th~~ percentile) Medicare: • A1C Screening: 91.4% • A1C Control <8.0%: 72.8% • A1C Control >9.0 18.8% (lower score is better) • Eye Exams: 82% Nephropathy Screening: 95.8% • BP Control: 79.3%	2017 April, July, October
**HEDIS/STARS Improvement: Review all-cause hospital readmissions with Medi-Cal & OneCare Connect	Reduce 30 day All Cause Readmissions (PCR)	Readmission Rate will be minimized through member education and Quality Incentive Program.	Medi-Cal <14~~5~~% Readmission rate Medicare <14% Readmission rate OCC <11% readmission Rate (Quality Withhold goal)	2017 April, July, October

Scope	Objective	Activity	Goals or Baseline	Target Completion (Proposed reporting months to QIC)
members (PCR)		A reporting mechanism will be established followed by analysis of data.		
**HEDIS/STARS Improvement: Review of flu and pneumococcal immunization rates*	Increase the flu and pneumococcal screening rate in: 1. MC members 18-64 years old and 2. OC members 65 years old and older to meet goal	Compliance with flu and pneumococcal immunizations will increase through flu reminders and education.	90%	2017 April, July, October
HEDIS: Review of prenatal & postpartum care services (PPC)	Increase the prenatal and postpartum care rate for all Medi-Cal deliveries to meet goal	The number of prenatal and postpartum care visits will increase through provider education to submit Prenatal Notification Reports, member and provider education and sharing of provider data. Utilize Text-For-Baby custom messages to encourage member compliance.	MC Prenatal: 82.25% (50th percentile) MC Postpartum: ~~65.96~~67.53% (~~66th~~75th -percentile)	2017 April, July, October

Scope	Objective	Activity	Goals or Baseline	Target Completion (Proposed reporting months to QIC)
~~**Cervical Cancer Screening**~~**Lead Screening (Monitoring Measure)**	Increase lead screening rate~~Increase the cervical cancer screening rate for Medi-Cal to meet DHCS MPL of 25th percentile~~	~~Cervical cancer screening rate will increase through office staff, provider and member incentives as well as planned campaigns for women's health preventive screenings.~~Analyze data to determine low performing HN. Implement initiatives to address identified barriers to better performance (data strategy as well as provider outreach)	MC: 75.7% (66th percentile)~~MC:~~	
HEDIS: Review and assessment prescribed ADHD medication (ADHD)	Increase the follow-up care for children prescribed ADHD medication rate in MC children who were newly prescribed an ADHD medication to meet goal	Follow-up care for children with newly prescribed ADHD medication will increase through member and provider education and reminder letter to members.	Initiation Phase: 42.19% (50th percentile) Maintenance Phase: ~~40.91~~52.47% (~~25~~50th percentile)	2017 April, July, October
HEDIS: Review and assessment of antidepressant medication management (AMM)	Increase the antidepressant medication management rate in MC and OC members with a diagnosis of major depression to meet goal	Antidepressant medication management rates will increase with the distribution of member health education material.	MC: Acute Phase Treatment: ~~56.65%~~59.52 (~~66~~75th percentile) MC: Continuation Phase Treatment: 41.46% (66th percentile) OC: Effective Phase Treatment 68.66% (50th percentile) OC: Continuation Phase Treatment 54.76% (50th percentile)	2017 Mar Jun Sep Dec
HEDIS/STARS: Review and assessment of	Increase the osteoporosis management in women	Osteoporosis management in women who had a	OC: 47.6% (66th percentile)	2017 April, July, October

Scope	Objective	Activity	Goals or Baseline	Target Completion (Proposed reporting months to QIC)
osteoporosis management (OMW)	who had a fracture rate in OC women who suffered a fracture to meet goal	fracture will increase through improved member identification using claims and pharmacy data and provider education.		- -
~~**HEDIS**: Review and assessment of treatment of bronchitis (AAB)~~	~~Increase the avoidance of antibiotic treatment in adults with acute bronchitis rate in MC members with a diagnosis of acute bronchitis to meet goal~~	~~Avoidance of antibiotic treatment in adults with a diagnosis of acute bronchitis rate in MC members 18-64 years old will increase through member and provider education.~~	~~MC: 22.25% (25th percentile)~~	~~2017 April, July, October~~
HEDIS: Review and assessment of childhood immunization rates	Increase the childhood immunization status rate in children 2 years old (combo 10) to meet goal	Immunization in children by their 2nd birthday will increase through member reminders and education (Combo 10) This measure is also incentivized in our P4V program.	MC: Combo 10: 40.9% (75th percentile)	2017 April, July, October
-	-			-
HEDIS: Review and assessment of use of imaging studies for low back pain ~~**HEDIS:** Review and assessment of adult's access to preventive/ambulatory health (AAP)~~	Increase the use of appropriate treatment for low back pain (decrease the use of imaging studies for persons with low back pain) ~~Increase MC and OC adult's access to preventive/ambulatory health to meet goal~~	Imaging studies will decrease for persons diagnosed with low back pain through provider outreach and education ~~Comprehensive member and provider outreach with reminders to increase access for adults~~	MC: ~~77.09~~73.71% (~~75~~50th percentile) ~~MC: 83.84% (50th percentile)~~ ~~OC: 95.56% (50th percentile)~~	2017 April, July, October ~~2017 April, July, October~~
HEDIS: Review and	Increase MC and OC	Comprehensive member	MC: 82.15% (50th percentile)	2017 April,

Scope	Objective	Activity	Goals or Baseline	Target Completion (Proposed reporting months to QIC)
assessment of adult's access to preventive/ambulatory health (AAP)	adult's access to preventive/ambulatory health to meet goal	and provider outreach with reminders to increase access for adults	OC: 95.56% (50th percentile)	July, October
HEDIS: Review and assessment of children's access to primary care practitioners (CAP)	Increase children's access to primary care practitioners to meet goal	Comprehensive member and provider outreach with reminders to increase access for children	MC: 1) 12-24 months ~~96.28%~~95.74% (50th percentile) 2) 25 months -6 years ~~91.22%~~90.98% (75th percentile) 3) 7-11 years 93.~~90~~25% (75th percentile) 4) 12-19 years ~~90.06%~~89.37% (50th percentile)	2017 April, July, October
HEDIS: Review and assessment of cervical cancer screening (CCS)	Increase the cervical cancer screening in our MC female members 21-64 to meet goal	Increase cervical cancer screening through member and provider outreach and education with reminders.	MC: ~~67.88~~55.94% (~~75~~50th percentile)	2017 April, July, October
HEDIS: Review and assessment of well child visits in the first 15 months of life (W15)	Increase the well care visits for MC children in their first 15 months of life to meet goal	Increase of well care visit for children in their first 15 months of life through member and provider outreach and education with reminders	MC: 59.~~76~~57% (6 or more visits) (50th percentile)	2017 April, July, October
HEDIS: Review and assessment of breast cancer screening (BCS)	Increase the breast cancer screening for MC and OC female members to meet goal	Increase the breast cancer screening through member and provider education and outreach with reminders as ways to decrease barriers to screening	MC: 71.~~41~~52% (90th percentile) OC: 71.36% (50th percentile)	2017 April, July, October
HEDIS/STARS: Review and assessment of colorectal cancer screening (COL)	Increase the colorectal cancer screening for OC members to meet goal	Increase colorectal cancer screening through member and provider outreach as well as ways to decrease barriers to screening	OC: 67.27% (50th percentile) Monitor for Medicaid population. Develop internal benchmark as National Medicaid Benchmark does not exist.	2017 April, July, October
HOS/STARS: Health Outcome Survey Measures	Improve HOS measures for Star Rating	Develop and implement activities around: ~~1~~)Reducing Risk of Falls 2)Improving Physical Health Status		2017 Mar Jun Sep Dec

Scope	Objective	Activity	Goals or Baseline	Target Completion (Proposed reporting months to QIC)

~~Scope~~	~~Objective~~	~~Activity~~	~~Goals or Baseline~~	~~Target Completion (Proposed reporting months to QIC)~~
~~**HEDIS/STARS: Review and assessment Comprehensive Diabetes~~	~~Increase the comprehensive diabetes care measures MC and OC~~	~~Comprehensive diabetes care will increase through member education to~~	~~Medicaid: A1C Screening: 86.0% (50th percentile) A1C Control <8.0%: 55.47% (Between 75th and 90th percentile)~~	~~20167 April, July, October~~

Scope	Objective	Activity	Goals or Baseline	Target Completion (Proposed reporting months to QIC)
Care (CDC)	members - in conjunction with Diabetes Disease Management Program	identified members with diabetes and collaboration with targeted providers to better outreach to their patients for comprehensive screening and care. Also explore the use of member engagement technologies to improve rates. These measures are also incentivized through our P4V program. (interventions based on unique member characteristics)	A1C Control >9.0%: 33.05% (lower score is better) Between 75th and 90th percentile Eye Exams: 65.1% (75th percentile) Nephropathy Screening: 90.51% (50th percentile) BP Control: 72.17% (between 75th and 90th) Medicare: A1C Screening: 91.4% A1C Control <8.0%: 72.8% A1C Control >9.0 18.8% (lower score is better) Eye Exams: 82% Nephropathy Screening: 95.8% BP Control: 79.3%	
**HEDIS/STARS Improvement: Review all-cause hospital readmissions with Medi-Cal & OneCare Connect members (PCR)	Reduce 30 day All Cause Readmissions (PCR)	Readmission Rate will be minimized through member education and Quality Incentive Program. A reporting mechanism will be established followed by analysis of data.	Medi-Cal <15% Readmission rate Medicare <14% Readmission rate OCC <11% readmission Rate (Quality Withhold goal)	20167 April, July, October
**HEDIS/STARS Improvement: Review of flu and pneumococcal immunization rates*	Increase the flu and pneumococcal screening rate in: 1. MC members 18-64 years old and	Compliance with flu and pneumococcal immunizations will increase through flu reminders and education.	90%	20167 April, July, October

Scope	Objective	Activity	Goals or Baseline	Target Completion (Proposed reporting months to QIC)
	2. OC members 65 years old and older to meet goal			
HEDIS: Review of prenatal & postpartum care services (PPC)	Increase the prenatal and postpartum care rate for all Medi-Cal deliveries to meet goal	The number of prenatal and postpartum care visits will increase through provider education to submit Prenatal Notification Reports, member and provider education and sharing of provider data. Utilize Text For Baby custom messages to encourage member compliance.	MC Prenatal: 82.25% (50th percentile) MC Postpartum: 65.96% (66th percentile)	20167 April, July, October
Cervical Cancer Screening	Increase the cervical cancer screening rate for Medi-Cal to meet DHCS MPL of 25th percentile	Cervical cancer screening rate will increase through office staff, provider and member incentives as well as planned campaigns for women's health preventive screenings.	MC:	
HEDIS: Review and assessment prescribed ADHD medication (ADHD)	Increase the follow-up care for children prescribed ADHD medication rate in MC children who were newly prescribed an ADHD medication to meet goal	Follow-up care for children with newly prescribed ADHD medication will increase through member and provider education and reminder letter to members.	Initiation Phase: 42.19% (50th percentile) Maintenance Phase: 40.91% (25th percentile)	20167 April, July, October
HEDIS: Review and assessment of antidepressant	Increase the antidepressant medication management rate in MC	Antidepressant medication management rates will increase with the	MC: Acute Phase Treatment: 56.65% (66th percentile) MC: Continuation Phase Treatment: 41.46% (66th percentile) OC: Effective Phase Treatment 68.66% (50th percentile)	20167 Mar Jun Sep Dec

Scope	Objective	Activity	Goals or Baseline	Target Completion (Proposed reporting months to QIC)
medication management (AMM)	and OC members with a diagnosis of major depression to meet goal	distribution of member health education material.	OC: Continuation Phase Treatment 54.76% (50th percentile)	
**HEDIS/STARS: Review and assessment of osteoporosis management (OMW)	Increase the osteoporosis management in women who had a fracture rate in OC women who suffered a fracture to meet goal	Osteoporosis management in women who had a fracture will increase through improved member identification using claims and pharmacy data and provider education.	OC: 47.6% (66th percentile)	20167 April, July, October - -
HEDIS: Review and assessment of treatment of bronchitis (AAB)	Increase the avoidance of antibiotic treatment in adults with acute bronchitis rate in MC members with a diagnosis of acute bronchitis to meet goal	Avoidance of antibiotic treatment in adults with a diagnosis of acute bronchitis rate in MC members 18-64 years old will increase through member and provider education.	MC: 22.25% (25th percentile)	20167 April, July, October
HEDIS: Review and assessment of childhood immunization rates	Increase the childhood immunization status rate in children 2 years old (combo 10) to meet goal	Immunization in children by their 2nd birthday will increase through member reminders and education (Combo 10) This measure is also incentivized in our P4V program.	MC: Combo 10: 40.9% (75th percentile)	20167 April, July, October

Scope	Objective	Activity	Goals or Baseline	Target Completion (Proposed reporting months to QIC)
HEDIS: Review and assessment of appropriate testing for pharyngitis rates	Increase the appropriate testing of pharyngitis in children 2-18 years of age to meet goal	Appropriate testing for pharyngitis will improve through the distribution of strep A tests and provider education.	MC: 63.24% (25th percentile)	20167 April, July, October
HEDIS: Review and assessment of use of imaging studies for low back pain	Increase the use of appropriate treatment for low back pain (decrease the use of imaging studies for persons with low back pain)	Imaging studies will decrease for persons diagnosed with low back pain through provider outreach and education	MC: 77.09% (75th percentile)	20167 April, July, October
HEDIS: Review and assessment of adult's access to preventive/ambulatory health (AAP)	Increase MC and OC adult's access to preventive/ambulatory health to meet goal	Comprehensive member and provider outreach with reminders to increase access for adults	MC: 83.84% (50th percentile) OC: 95.56% (50th percentile)	20167 April, July, October
HEDIS: Review and assessment of children's access to primary care practitioners (CAP)	Increase children's access to primary care practitioners to meet goal	Comprehensive member and provider outreach with reminders to increase access for children	MC: 1) 12-24 months 96.28% (50th percentile) 2) 25 months -6 years 91.22% (75th percentile) 3) 7-11 years 93.90% (75th percentile) 4) 12-19 years 90.06% (50th percentile)	20167 April, July, October
HEDIS: Review and assessment of cervical cancer screening (CCS)	Increase the cervical cancer screening in our MC female members 21-64 to meet goal	Increase cervical cancer screening through member and provider outreach and education with reminders.	MC: 67.88% (75th percentile)	20167 April, July, October
HEDIS: Review and assessment of well child visits in the first 15 months of life (W15)	Increase the well care visits for MC children in their first 15 months of life to meet goal	Increase of well care visit for children in their first 15 months of life through member and provider outreach and education with reminders	MC: 59.76% (50th percentile)	20167 April, July, October
HEDIS: Review and assessment of breast	Increase the breast cancer screening for MC and OC	Increase the breast cancer screening through member	MC: 71.41% (90th percentile) OC: 71.36% (50th percentile)	20167 April, July, October

Scope	Objective	Activity	Goals or Baseline	Target Completion (Proposed reporting months to QIC)
cancer screening (BCS)	female members to meet goal	and provider education and outreach with reminders as ways to decrease barriers to screening		
HEDIS/STARS: Review and assessment of colorectal cancer screening (COL)	Increase the colorectal cancer screening for OC members to meet goal	Increase colorectal cancer screening through member and provider outreach as well as ways to decrease barriers to screening	OC: 67.27% (50th percentile)	20167 April, July, October
HOS/STARS: Health Outcome Survey Measures	Improve HOS measures for Star Rating	Develop and implement activities around: 1)Reducing Risk of Falls 2)Improving Physical Health Status		20167 Mar Jun Sep Dec

IX. HEDIS/STARS Improvement

B. Improve identified STARS midentified STARS measures listed on "Measures" worksheet **Owners: Kelly Rex-Kimmet Director, Quality Analytics; Kris Gericke, Pharm.D., Director, Pharmacy Management; Tracy Hitzeman, Interim Executive Director, Clinical Operations ; Kris Gericke, Pharm.D., Director, Pharmacy**

~~Management, Tracy Hitzemen, Executive Director,~~

~~Clinical Operations~~

The Approach

1. Objective

- Attain 4.0 CMS STAR rating~~ttain 4.0 CMS STAR rating~~

2. Activity

- See Mmeasures worksheet for specific activities

3. Goals

- See Mmeasures worksheet

~~STARS~~~~HEDIS~~ Measures Worksheet

~~Scope~~	~~Objective~~	~~Activity~~	~~Goals or Baseline~~	~~Target Completion~~
~~**HEDIS/STARS: Review and assessment Comprehensive Diabetes Care (CDC)~~	~~Increase the comprehensive diabetes care measures- MC and OC members - in conjunction with~~	~~Comprehensive diabetes care will increase through member education to identified members with diabetes and collaboration with targeted providers to~~	~~90th percentile for all subsmeasures~~	~~20167 April, July, October~~

Scope	Objective	Activity	Goals or Baseline	Target Completion
	Diabetes Disease Management Program	better outreach to their patients for comprehensive screening and care. Also explore the use of member engagement technologies to improve rates. These measures are also incentivized through our P4V program. (interventions based on unique member characteristics)		!
**HEDIS/STARS Improvement: Review all-cause hospital readmissions with Medi-Cal & OneCare Connect members (PCR)	Reduce 30-day All Cause Readmissions (PCR)	Readmission Rate will be minimized through member education and Quality Incentive Program. A reporting mechanism will be established followed by analysis of data.	Medicare <14% Readmission rate	20167 April, July, October - - !
**HEDIS/STARS Improvement: Review of flu and pneumococcal immunization rates*	Increase the flu and pneumococcal screening rate in: 1. MC members 18-64 years old and 2. OC members 65 years old and older to meet goal	Compliance with flu and pneumococcal immunizations will increase through flu reminders and education.	90%	20167 April, July, October
**HEDIS/STARS: Review and assessment of osteoporosis management (OMW)	Increase the osteoporosis management in women who had a fracture rate in OC women who suffered a fracture to meet goal	Osteoporosis management in women who had a fracture will increase through improved member identification using claims and pharmacy data and provider education.	OC: 49.48% (75th percentile)	20176 April, July, October
HEDIS/STARS: Review and assessment of colorectal cancer screening (COL)	Increase the colorectal cancer screening for OC members to meet goal	Increase colorectal cancer screening through member and provider outreach as well as ways to decrease barriers to screening	OC: 67.27% (50th percentile)	20167 April, July, October
HOS/STARS: Health Outcome Survey Measures	Improve HOS measures for Star Rating	Develop and implement activities around: 1)Reducing Risk of Falls 2)Improving Physical Health Status		20167 Mar Jun Sep Dec

Scope	Objective	Activity	Goals or Baseline	Target Completion
**HEDIS/STARS: Review and assessment Comprehensive Diabetes Care (CDC)	Increase the comprehensive diabetes care measures OC and OCC members - in conjunction with	Comprehensive diabetes care will increase through member education to identified members with diabetes and collaboration with	Medicare: 1) A1C Control >9:.0 16% (lower score is better;	2017 April, July, October

Scope	Objective	Activity	Goals or Baseline	Target Completion
	Diabetes Disease Management Program	targeted providers to better outreach to their patients for comprehensive screening and care. Also explore the use of member engagement technologies to improve rates. These measures are also incentivized through our P4V program. (interventions based on unique member characteristics)	CMS 5 star goal) 2) Eye Exams: 82% (maintain 2016 above CMS 5-star goal) 3) Nephropathy Screening: 96% (CMS 4 star goal)	
**HEDIS/STARS Review Adult BMI Assessment	Increase the BMI assessment in adults	Assessment of BMI will increase through provider education and dissemination of BMI assessment tools.	Medicare: 96% (CMS 5 star goal)	2017 April, July, October
**HEDIS/STARS Improvement: Review Care of Older Adult	Increase the Care of Older Adult Rate in: 1) Medication Review 2) Pain Screening 3) Functional Status Assessment	Care of Older Adult measures to increase through provider education and dissemination of provider tools.	OneCare Only: 1) Medication Review: 87% (CMS 5 star goal) 2) Pain Screening: 88% (CMS 5 star goal) 3) Functional Status Assessment: 74% (CMS 4 star goal)	2017 April, July, October
**HEDIS/STARS Improvement: Review all-cause hospital readmissions with OneCare & OneCare Connect members (PCR)	Reduce 30 day All Cause Readmissions (PCR)	Readmission Rate will be minimized through member education and Quality Incentive Program. A reporting mechanism will be established followed by analysis of data.	Medicare: <10% Readmission rate (CMS 4 star goal)	2017 April, July, October
**HEDIS/STARS Improvement: Review of flu and pneumococcal immunization rates*	Increase the flu and pneumococcal screening rate in OC and OCC members 65 years old and older to meet goal	Compliance with flu and pneumococcal immunizations will increase through flu reminders and education.	Medicare: 74% (CMS 4 star goal)	2017 April, July, October

Scope	Objective	Activity	Goals or Baseline	Target Completion
**HEDIS/STARS: Review and assessment of osteoporosis management (OMW)	Increase the osteoporosis management in women who had a fracture rate in OC and OCC women who suffered a fracture to meet goal	Osteoporosis management in women who had a fracture will increase through improved member identification using claims and pharmacy data and provider education.	Medicare: 51% (CMS 4 start goal)	2017 April, July, October
**HEDIS/STARS: Review and assessment of colorectal cancer screening (COL)	Increase the colorectal cancer screening for OC and OCC members to meet goal	Increase colorectal cancer screening through member and provider outreach as well as ways to decrease barriers to screening	Medicare: 71% (CMS 4 star goal)	2017 April, July, October
**HEDIS/STARS: Review and assessment of breast cancer screening (BCS)	Increase the breast cancer screening for OC and OCC members to meet goal	Increase breast cancer screening through member and provider outreach as well as ways to decrease barriers to screening	Medicare: 76% (CMS 5 star goal)	2017 April, July, October
**HEDIS/STARS: Review and assessment of monitoring physical activity	Increase the monitoring of physical activity for OC and OCC members to meet goal	Increase of monitoring of physical activity through provider outreach and education and dissemination of provider tools	Medicare: 57% (CMS 5 star goal)	2017 April, July, October
**HEDIS/STARS: Review and assessment of controlling blood pressure (CBP)	Increase of controlling blood pressure rate	Increase of controlling blood pressure rate through provider and member outreach and education	Medicare: 75% (CMS 5 star goal)	2017 April, July, October
**HEDIS/STARS: Improvement: Rheumatoid Arthritis Management	Increase of rheumatoid arthritis management rate	Increase of rheumatoid arthritis management through provider education	Medicare: 72% (CMS 3 star goal)	2017 April, July, October
**HEDIS: Follow-up after Hospitalization for Mental Illness (7 days / 30 days)	Increase follow-up after hospitalization for mental illness	Increase follow-up after hospitalization through collaboration with our behavioral health partner to conduct provider education and member outreach through reminders.	Medicare: 56% (Quality Withhold Goal)	2017 April, July, October
**HOS/STARS: Health Outcome Survey Measures	Improve HOS measures for Star Rating	Develop and implement activities around: 1) Reducing Risk of Falls 2) Improving Physical Health Status 3) Improving Mental Health Status	Medicare: 1) Reducing Risk of Falls: 73% (CMS 5 star goal) 2) Improving Physical Health Status: 72% (CMS 4 star goa 3) Improving Mental Health Status: 87% (CMS 5 star goa	2017 Mar Jun Sep Dec

IX. HEDIS/STARS Improvement

C. Improve CAHPS measures listed on "Measures" worksheet

Owner: Kelly Rex-Kimmet Director, Quality Analytics

The Approach

1. Objective

- Achieve 3.0 CAHPS score
- Attain 4.0 CMS STAR rating
- Meet CMS STAR Goals

2. Activity

- See Measures worksheet for specific activities

3. Goals

- See Measures worksheet

CAHPS MHEDIS Measures Worksheet

Scope	Objective	Activity	Goals or Baseline	Target Completion
CAHPS: Rating of Health Plan	Increase CAHPS score on Rating of Health Plan	Utilize results from CalOptima's supplemental survey and explorations of other methods to "hear" our member will assist in developing strategies to improve Rating of Health Plan.	50th Percentile or higher	20167 Mar Jun Sep Dec
CAHPS: Getting Needed Care	Increase CAHPS score on Getting Needed Care	Sharing of HN specific CAHPS reports, member education on referrals and prior authorization processes, and review and monitoring of provider capacity and geoaccess standards will improve rating	50th Percentile or higher (2.52)	20167 Mar Jun Sep Dec

~~Scope~~	~~Objective~~	~~Activity~~	~~Goals or Baseline~~	~~Target Completion~~
		~~of Getting Needed Care.~~		
~~CAHPS: Getting Care Quickly~~	~~Increase CAHPS score on Getting Care Quickly~~	~~Sharing of HN specific CAHPS reports, member education on referrals and prior authorization processes, and review and monitoring of provider capacity and geoaccess standards will improve rating of Getting Care Quickly.~~	~~50th Percentile or higher~~	~~20167 Mar Jun Sep Dec~~
~~CAHPS: How Well Doctors Communicate~~	~~Increase CAHPS score on How Well Doctors Communicate~~	~~Tips on "Preparing for your Dr. Visit," toolkits/decision tools for PCPs, and provider and office staff in-service on customer service will improve rating on How Well Doctors Communicate.~~	~~50th percentile or higher~~	~~20167 Mar Jun Sep Dec~~
~~CAHPS: Customer Service~~	~~Increase CAHPS score on Customer Service~~	~~Customer service post-call survey and evaluation and trending of member pain points will improve rating of Customer Service.~~	~~50th percentile or higher~~	~~20167 Mar Jun Sep Dec~~

Scope	Objective	Activity	Goals or Baseline	Target Completion
STARS: CAHPS: Rating of Health Plan	Increase CAHPS score on Rating of Health Plan	Utilize results from CalOptima's supplemental survey and explorations of other methods to "hear" our member will assist in developing strategies to improve Rating of Health Plan.	Medicaid: 50th Percentile or higher Medicare: 82% (CMS 3 star goal)	2017 Mar Jun Sep Dec
STARS:CAHPS: Getting Needed Care	Increase CAHPS score on Getting Needed Care	Sharing of HN specific CAHPS reports, member education on referrals and prior authorization processes, and review and monitoring of provider capacity and geoaccess standards will improve rating of Getting Needed Care.	Medicaid: 50th Percentile or higher (2.52) Medicare: 79% (CMS 2 star goal)	2017 Mar Jun Sep Dec
STARS:CAHPS: Getting Care Quickly	Increase CAHPS score on Getting Care Quickly	Sharing of HN specific CAHPS reports, member education on referrals and prior authorization processes, and review and monitoring of provider	Medicaid: 50th Percentile or higher	2017 Mar Jun Sep Dec

Scope	Objective	Activity	Goals or Baseline	Target Completion
		capacity and geoaccess standards will improve rating of Getting Care Quickly.	Medicare: 72% (CMS 2 star goal)	
CAHPS: How Well Doctors Communicate	Increase CAHPS score on How Well Doctors Communicate	Tips on "Preparing for your Dr. Visit," toolkits/decision tools for PCPs, and provider and office staff in-service on customer service will improve rating on How Well Doctors Communicate.	Medicaid: 50th percentile or higher	2017 Mar Jun Sep Dec
STARS:CAHPS: Customer Service	Increase CAHPS score on Customer Service	Customer service post-call survey and evaluation and trending of member pain points will improve rating of Customer Service.	Medicaid: 50th percentile or higher Medicare: 86% (CMS 3 star goal)	2017 Mar Jun Sep Dec
STARS:CAHPS: Getting Needed Prescription Drugs	Increase CAHPS score on Getting Needed Prescription Drugs		Medicare: 89% (CMS 3 star goal)	2017 Mar Jun Sep Dec
STARS:CAHPS: Care Coordination	Increase CAHPS score on Care Coordination	Provider and office staff in-service on best practices to better coordinate care for members will improve rating on Care Coordination.	Medicare: 82% (CMS 2 star goal)	2017 Mar Jun Sep Dec
STARS: CAHPS: Overall Rating of Health Care Quality	Increase CAHPS score on Overall Rating of Health Care Quality	Utilize results from CalOptima's supplemental survey and explorations of other methods to "hear" our member will assist in developing strategies to improve Rating of Health Plan.	Medicare: 82% (CMS 2 star goal)	2017 Mar Jun Sep Dec

IX. HEDIS/STARS Improvement

D. STARS-Medication Related Measures

Owner: Kris Gericke, Pharm.D., Director, Pharmacy Management

The Approach

1. Objective

- Optimal Performance in the CMS Pharmacy Star and Display Measures.

2. Activity

- Decrease utilization of high-risk medications
  - Formulary controls
  - Prior authorization criteria
  - Prescriber education
- Antipsychotic use in members with dementia in nursing homes

- Prescriber education
- LTC quality incentive program

- Appropriate dosing of oral diabetes medications
  - Formulary controls
  - Prior authorization criteria
  - Prescriber education
- Medication Adherence
  - Comprehensive member and & provider outreach to identified members who appear non-adherent with medication management (interventions based on unique member characteristics)
  - Interventions include:
    - Outreach
    - Pre-Assessment: Modified Morisky Scale (MMS) for knowledge, /motivation and confidence
    - Mailings - lL etter with member's action plan, Healthy You, medication log;
    - Ffollow--up calls as needed
  - Outcomes include:
    - Pre –and Post--PDC rates to measure program success
    - Evaluate member's improvement in knowledge, motivation (MMS) and confidence
    - Evaluate member survey results

3. Goals

- Scores above the national MA-PD average as reported by CMS

HEDIS Measures Worksheet

Scope	Objective	Activity	Goals or Baseline	Target Completion
***STARS Improvement -** Medication Adherence Measures	Improve the 3 Medication Adherence Measures to achieve 4 Star performance in each measure	Comprehensive member & provider outreach to identified members who appear non-compliant with medication management (interventions based on unique member characteristics)	4 Stars	2016~~7~~ Mar Jun Sep Dec

IX. HEDIS/STARS Improvement

E. HEDIS: Health Network support of HEDIS & CAHPS improvement

Owner: Kelly Rex-Kimmet, Director, Quality Analytics

The Approach

1. Objective

- Provider regular reporting to the Health Networks to ensure HEDIS improvement for expected measures

2. Activity

- Provide ongoing reports to Health Networks on their specific HEDIS & CAHPS performance, including patient lists for intervention
- Gather feedback from Health Networks on tools to assist in HEDIS & CAHPS improvement activities

3. Goals

- 24.33%

HEDIS Measures **Owner: Marsha Choo, Manager, QA**

	Results / Metric	Next Steps	Target Completion
Diabetes Ccare			
Controlling Blood Pressure			
30-Day ReadmmsionsReadmissions			
Flu & PheumoccalPneumococcal Rates			
Prenatal Care			
Post PartumPost-Partum			
ADMHD			
Antidepressant Medication MgmtManagement			
Osteoporosis MgmtManagement			

Antibiotics Use/ Bronchitis			
Childhood Immunizations. Combo 10			
Adolescent Immunizations	Not on HEDIS Measures worksheet		
Low Back Pain			
Adult Access to Preventive Care (AAP)			

CAHPS Measures Team — **Owner: Member Experience**

	Results / Metric	Next Steps	Target Completion
Rating of Health			
Getting Needed Care			
Getting Care Quickly			
How ~~W~~well Doctors Communicate			
Customer Service			

STARS **Owner: Kris Gericke, PharmDPharm.D, Director, Pharmacy**

	Results / Metric	Next Steps	Target Completion
Cholesterol			
Hypertension			
Diabetes			

Health Outcomes Survey **Owner: Marsha Choo, Manager, QA**

	Results / Metric	Next Steps	Target Completion
Reducing Risk of Falls			
Improving Physical Health Status			
Improving Mental Health Status			

X. Delegation Oversight

~~**A. Delegation Oversight of CM** **Owner: Tracy Hitzeman, Director, CM**~~

~~**The Approach**~~

~~**1. Objective**~~
- ~~Regular review of the Health Network's performance of CM functions~~

~~**2. Activity**~~
- ~~Assure compliance to all regulatory and accreditation delegation oversight requirements~~
- ~~**Report from DOC~~

~~**3. Goals**~~
- ~~100%~~

A. Delegation Oversight of CM **Owner: Sloane Petrillo, Interim D~~irec~~tor, CM**

The Approach

1. Objective
- Regular review of the Health Network's performance of CM functions

2. Activity
- Review of 100% of MOC files with monthly feedback provided to Health Networks
- Assure compliance to all regulatory and accreditation delegation oversight requirements
- **Report from DOC

3. Goals
- 90%

201~~6~~7 Quality Improvement Work Plan--Delegation Oversight Owner: ~~Tracy Hitzeman~~Sloane Petrillo, Interim Di~~rec~~t~~o~~r, CM

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

X. Delegation Oversight

B. Quality of Care and & Service of UM through Ddelegation oOversight rReviews ——— Owner: Solange Marvin Directo r, Audit & Oversight

The Approach

1. **Objective**
   - Delegation Oversight of Health Networks to assess compliance
2. **Activity**
   - Delegated entity oversight supports how UM delegated activities are performed
   - to expectations and compliance with standards, such as Prior Authorizations
   - **Report from DAOC
3. **Goals**
   - 98%

20167 Quality Improvement Work Plan- Delegation Oversight Owner: Solange Marvin, Director, Audit & Oversight

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

X. Delegation Oversight

C. Delegation oversight of BH Services

Owner: ~~Solange Marvin~~Dr. Edwin Poon, D~~irec~~tor, ~~Audit & Oversight~~BH~~I~~SI

The Approach

1. **Objective**
   - Regular review of the MBHO's performance of BH functions

2. **Activity**
   - Assure compliance to all regulatory and accreditation delegation oversight requirements
   - **Report from ~~D~~AOC

3. **Goals**
   - 98%

2016~~7~~ Quality Improvement Work Plan- Delegation Oversight ——— Owner: ~~Solange Marvin~~Dr. Edwin Poon, D~~irec~~t~~o~~r, ~~Audit & Oversight~~BH~~I~~SI

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

XI. Organizational Projects

A. Implementation of the 2016 Value Based P4P Program — Owner: Medical Director, Quality & Analytics

The Approach

1. Objective

- Confirm and implement the 2016 Value Based P4P Program (Medi-Cal & OCC)

2. Activity

- Complete review of 2014 & 2015; confirm measures, align with auto-assignment quality measures and define weighting for 2016
- Incentivize Health Networks via a P4P to achieve high quality scores on targeted accreditation, health plan rating and STARS measures

3. Goals

- Improve performance over 2015

~~2016~~7 Quality Improvement Work Plan- Organizational Projects ~~Owner: Medical Director, QA~~

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

XI. Organizational Projects

~~B. Value Based P4P 2016-2019~~ ~~Owner: Kelly Rex-Kimmet, Director, QA~~

~~The Approach~~

~~1. Objective~~

- ~~Design longer term Value Based P4P Program and gain board approval by 7/1/16~~

~~2. Activity~~

- ~~Design new program in conjunction with provider/ Health Network Stakeholders, PAC & MAC input; develop COBAR for presentation to board~~
- ~~Define analytics and matching resources to support new P4Value Program~~

~~3. Goals~~

- ~~National & State Benchmarks~~

A. Value Based P4P 2017- Owner: Sandeep Mital, Manager, Quality P4V

The Approach

1. Objective

- Present MY~~MY~~2017 P4V program to QAC and Board of Directors by 3/1/17
- Re-Evaluate Auto Assignment Quality Measures and Recommend Changes to measures and algorithm
- Design 2018 P4Value program based on interim measures

2. Activity

- Design new program in conjunction with provider/ Health Network s~~S~~takeholders,
- PAC & MAC input
- ~~;~~ D~~d~~evelop COBAR for presentation to board
- Define analytics and matching resources to ~~support~~define ~~new~~2018 P4Value Program

3. Goals

- Implement 2017 prospective rates by 3/1/17
- Design 2018 P4V by 4th Quarter, 2017

2016~~6~~7 Quality Improvement Work Plan- Organizational Projects Owner: ~~Kelly Rex-Kimmet~~Sandeep Mital, ~~Director~~Manager, Quality ~~QA~~P4V

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

XII. Organizational Projects

B. MOC Dashboard

Owner: Esther~~.~~ Okajima, D~~irec~~tor, Q~~uality I~~mprovement

The Approach

~~Objective~~
~~Activity~~

1. ~~Goal~~Objective
   - Present OC/OCC & SPD MOC Quality Matrix to QAC and Board of Directors by 2nd Quarter, 2017
   - Re-e~~E~~valuate measurements through data analysis

2. Activity
   - Define analytics and resources to support the Model of Care for OC/OCC & SPD members
   - Implement activities to meet or exceed measures

3. Goals
   - Meet or exceed defined MOC metrics

G:\Model of Care\CalOptima Model of Care\MOC Dashboard\Latest version\MOC Dashboard_12.12.16.xlsx

- (right click and select "open hyperlink)

"Attachment A"

	A	B	C	D	E	F	G	H	I	J
1	**OneCare Connect**	Goals	Data Source & Owner	Frequency	7/1/2015 - 12/31/2015 Results	Met Not Met	CY 2016 Results	Met Not Met	CY 2017 Results	Met Not Met
2	**Program Structure:**									
3	QI Program Description (submission date)	Date	Esther	Annual	Apr-15	Met	Apr-16	Met		
4	QI Work Plan (submission date)	Date	Esther	Annual	Apr-15	Met	Apr-16	Met		
5	QI Evaluation (submission date)	Date	Esther	Annual	Apr-16	Met				
6										
7	**Network Management**									
8	Strong Network (Access)-Survey	See report	Marsha C.	Annual	See access report	N/A				
9	Strong Network (Availability)-Quarterly Report	See report	Marsha C.	Quarterly	See availability report	N/A				
10	Behavioral Health Access (BH Access & Availability)	See report	Dr. Poon	Quarterly	See Member Satisfaction Survey Report	N/A				
11	LTSS Access & Availability	TBD	Marie E.	Quarterly						
12	Complaints associated with Network Access	%/1000	Janine	Quarterly	0%	Y				
13	Use of Dental Benefit	41.50%	Lizeth	Monthly						
14	Complaints associated with use of Dental Benefit	1.80%	Janine	Quarterly	15%	N				
15	Utilization of Taxi Benefit (Transportation Services)	29.80%	Belinda	Annual	19.43%	Y				
16	Complaints associated with Taxi Benefit (Transportation Services)	2.70%	Janine	Quarterly	8%	N				
17										

"Attachment A"

	A	B	C	D	E	F	G	H	I	J
1	**OneCare Connect**	Goals	Data Source & Owner	Frequency	7/1/2015 - 12/31/2015 Results	Met Not Met	CY 2016 Results	Met Not Met	CY 2017 Results	Met Not Met
18	**Coordination of Care**									
19	% of calls resolved at first call	85%	Belinda	Quarterly	NA					
20	Member voluntary disenrollment rate	3.00%	Belinda	Quarterly	14.25%	N				
21	Transitions of Care									
22	Sending Member's Care Plan to Next Care Setting	% sent	Denise	Quarterly						
23	Notification to PCP of Transition	% notified	Denise	Quarterly						
24	HRA Outreach Completion Rate	90%	Cecelia	Quarterly	99%	Met				
25	HRA completion rate	TBD	Cecelia	Quarterly	22.90%					
26	ICP/ICT									
27	ICP (% of members with ICP)	90%	Denise	Quarterly						
28	ICT (% of members with ICT)	TBD	Denise	Quarterly						
29	DM inclusion in ICP (CCN)	30%	Pshyra	Quarterly						
30	Over/Under-Utilization of Services (Unused Auths?)			Quarterly	See HN rpt tab					
31	In-Patient Admits/1000	Admits/1000	Debra/Solange	Semi-Annual	See HN rpt tab					
32	Readmission Rate	<9.9%	Debra/Solange	Semi-Annual	See HN rpt tab					
33	Reduction in ER Visits (visit/1000 members)	585/1000	Debra/Solange	Quarterly	See HN rpt tab					
34	ALOS	4	Debra/Solange	Monthly	See HN rpt tab					
35	Response to Key Events (Need definition)	TBD	Denise	Quarterly						
36	F/Up after MH hospitalization (7 & 30 day)	50th %tile	Paul J	Annual	7 day = 81.35% 30 day = 85.49% (One Care)					
37	LTSS:									
38	Access to LTSS (utilization of LTSS services)	TBD	Marie E.	Quarterly						
39	Inpatient Days/1000 LTSS	Days/1000	Marie E.	Quarterly	Process not finalized in 2015					

"Attachment A"

	A	B	C	D	E	F	G	H	I	J
1	**OneCare Connect**	Goals	Data Source & Owner	Frequency	7/1/2015 - 12/31/2015 Results	Met Not Met	CY 2016 Results	Met Not Met	CY 2017 Results	Met Not Met
40	ER Visits (visits/1000)	Visits/1000	Marie E.	Quarterly	Process not finalized in 2015					
41	Annual Analysis of Risk Level Classification (% Low/% High)	TBD	Cecelia	Quarterly	74%/26%					
42	Disease Mgmt penetration for Basic CM members	30%	Pshyra	Quarterly						
43	Other									
44										
45	**QIP/CCIP**									
46	Topic : Improving In-Home Supportive Services Care Coordination	% improvement	Marie E./Marsha C	Quarterly	PIP not in place for 2015; 2016 only					
47	Topic: Readmission within 30 days	baseline year	Tracy/ Marsha C	Quarterly	QIP not in place for 2015; 2016 only					
48										

"Attachment A"

	A	B	C	D	E	F	G	H	I	J
1	**OneCare Connect**	Goals	Data Source & Owner	Frequency	7/1/2015 - 12/31/2015 Results	Met Not Met	CY 2016 Results	Met Not Met	CY 2017 Results	Met Not Met
49	**Health Outcomes**									
50	HEDIS performance (Stars Measure)				One Care Results for 2015					
51	Improvement in Adult Preventive Service	94.8% (50th %tile)	Paul J	Annual	93.61%	N				
52	Measure 1 (Controlling Blood Pressure)	4 Star Goal	Paul J	Annual	69.68%					
53	Measure 2 (Diabetes Care - A1C Control)	4 Star Goal	Paul J	Annual	72.51%					
54	Measure 3 (Diabetes Care - Nephropathy Monitoring)	4 Star Goal	Paul J	Annual	95.15%					
55	Measure 4 (Breast Cancer Screening)	69.80%	Paul J	Annual	68.69%	N				
56	Measure 5 (Colorectal Cancer Screening)	54.70%	Paul J	Annual	64.36%	Y				
57	Measure 6 (Acute Phase Depression Tx)	63.40%	Paul J	Annual	55.25%	N				
58	Measure 7 (Rheumatoid Arthritis)	4 Star Goal	Paul J	Annual	66.00%					
59	Measure 8 (Osteoporosis)	4 Star Goal	Paul J	Annual	44.87%					
60	Pharmacy Measures									
61	Medication Adherence - Hypertension	4 Star Goal	Nicki	Annual	5 stars (86%)	Y				
62	Medication Adherence - Diabetes	4 Star Goal	Nicki	Annual	4 stars (82%)	Y				
63	Medication Adherence - Cholesterol	4 Star Goal	Nicki	Annual	5 stars (82%)	Y				
64	HOS performance									

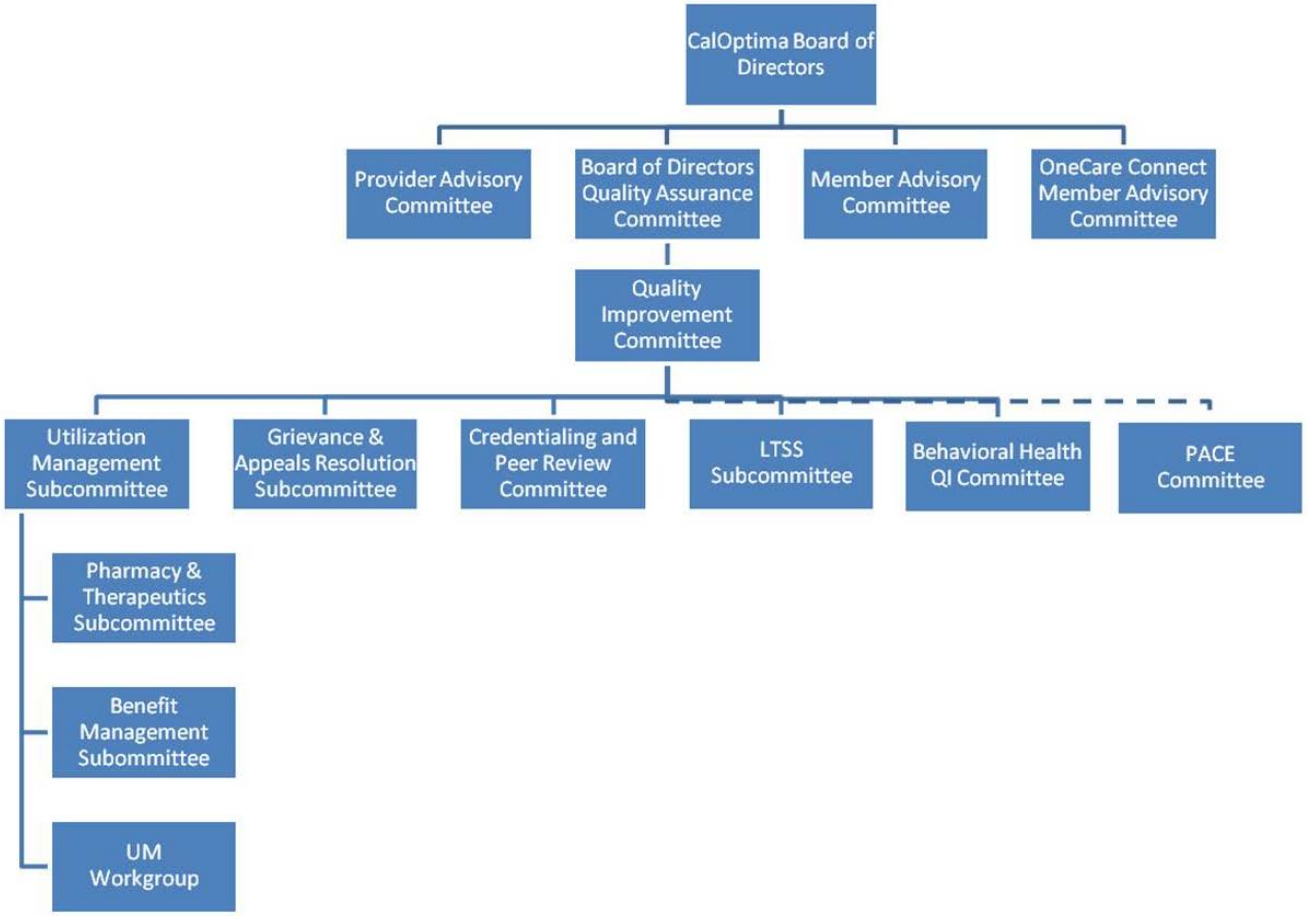
"Attachment A"

	A	B	C	D	E	F	G	H	I	J
1	**OneCare Connect**	Goals	Data Source & Owner	Frequency	7/1/2015 - 12/31/2015 Results	Met Not Met	CY 2016 Results	Met Not Met	CY 2017 Results	Met Not Met
65	Maintaining or improving physical health status	4 Star Goal	Marsha C	Annual	HOS not conducted in 2016					
66	Maintaining or improving mental health status	4 Star Goal	Marsha C	Annual	HOS not conducted in 2016					
67	Reducing the risk of falling	4 Star Goal	Marsha C	Annual	HOS not conducted in 2016					
68										
69	**Member Experience**									
70	CAHPS Performance (Stars Measures)				One Care Results for 2015					
71	Getting Needed Care	4 Star Goal	Marsha C	Annual	77%	Not Met				
72	Rating of Drug Plan	4 Star Goal	Marsha C	Annual	82%	Not Met				
73	Customer Service	4 Star Goal	Marsha C	Annual	85%	Not Met				
74	Getting Appointments & Care Quickly	4 Star Goal	Marsha C	Annual	70%	Not Met				
75	Getting Needed Prescription Drugs	4 Star Goal	Marsha C	Annual	88%	Not Met				
76	Care Coordination	4 Star Goal	Marsha C	Annual	80%	Not Met				
77	Overall Rating of Plan	4 Star Goal	Marsha C	Annual	82%	Not Met				
78	Overall Rating of Health Care Quality	4 Star Goal	Marsha C	Annual	81%	Not Met				

"Attachment A"

	A	B	C	D	E	F	G	H	I	J
1	**OneCare Connect**	Goals	Data Source & Owner	Frequency	7/1/2015 - 12/31/2015 Results	Met Not Met	CY 2016 Results	Met Not Met	CY 2017 Results	Met Not Met
79	**Medical Record Review (HN compliance to policies)**									
80	MRR results - CalOptima	Clinical Ops	Esther	Annual						
81										
82	**IRR for UM activities**									
83	Annual IRR for Staff	90%	Debra	Annual	96-100%	Y				
84	Annual IRR for RX	TBD	Solange	Annual	Completed?					
85	**Delegated functions oversight**									
86	Health Network performance	A/O Report	Solange	Quarterly						
87	MRR results - HN	A/O Report	Esther	Quarterly						
88	IRR for Delegates	A/O Report	Solange	Annual	Completed?					
89	**Clinical Practice Guidelines**									
90	Reviewed annually (linked with DM)	QIC minutes	Pshyra	Annual						

~~Quality Improvement Committee Structure~~ – 2016



Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Consent Calendar

4. Consider Approval of the 2017 CalOptima Program of All-Inclusive Care for the Elderly (PACE) Quality Assessment and Performance Improvement (QAPI) Plan

Contact

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

Recommended Action

Approve the 2017 CalOptima PACE Quality Assessment and Performance Improvement (QAPI) Plan.

Background

The Board of Directors first authorized the Chief Executive Officer to submit CalOptima's application to become a PACE Provider on October 7, 2010. The CalOptima PACE program opened its doors for operation in October of 2013. PACE is viewed as a natural extension of CalOptima's commitment to integration of acute and long-term care services for its members. This program provides the link between our healthy, elderly seniors with those seniors who need costly long-term nursing home care. PACE is a unique model of managed care service delivery in which the PACE organization is a combination of the health plan and the provider who provides direct service delivery. PACE takes care of the frail elderly by integrating acute, chronic, and long-term care for nursing home certified seniors. The goals of PACE are to prevent unnecessary institutionalization and maintain or improve the functional status of the program's participants. CalOptima's program is the first PACE program offered to Orange County residents and continues to grow. As of January 1, 2017, CalOptima PACE had 186 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. [1]

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

Discussion

The 2017 CalOptima PACE QAPI Plan updates are based on the first three full years of data collection, review and analysis with specific data driven goals and objectives. The objectives were developed based on the opportunities for quality improvement that were revealed in the 2015 CalOptima PACE QAPI Work Plan evaluation and from the preliminary 2016 CalOptima PACE QAPI

[1] Hirth, Baskins and Dever-Bumba. Program of All-Inclusive Care (PACE): Past, Present, and Future, J Am Med Dir Assoc 2009; 10: 155-160

Back to Agenda

Work Plan evaluation. The target goals are based on national benchmarks, CalPACE data, or internal CalOptima PACE metrics.

Fiscal Impact

There is no fiscal impact for the recommended action to have a written CalOptima PACE Quality Assessment and Performance Improvement (QAPI) Plan.

Rationale for Recommendation

The Centers for Medicare & Medicaid Services (CMS) requires all PACE organizations to establish a Quality Assessment and Performance Improvement (QAPI) Plan. This plan is required to be reviewed and approved annually by the CalOptima's Board of Directors to assure effective organizational oversight. CMS and the State shall review the plan during subsequent monitoring visits.

Concurrence

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

Attachment

Proposed 2017 CalOptima PACE Quality Assessment Performance Improvement (QAPI) Plan

/s/ Michael Schrader — *2/23/2017*

Authorized Signature — **Date**

Back to Agenda

CALOPTIMA PACE

QUALITY ASSESSMENT
PERFORMANCE IMPROVEMENT PLAN

20176

Quality Improvement Subcommittee Chairperson:

Richard Helmer, M.D. **Date**
Chief Medical Officer

Board of Directors' Quality Assurance Committee Chairperson:

Paul Yost~~Viet Van Dang~~, M.D. **Date**

Board of Directors Chairperson:

Mark Refowitz **Date**

Back to Agenda

Introduction

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

Overview

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

Goals

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

Objectives

- Improve the quality of health care for participants
  - Involve the physicians and other providers in establishing the most current, evidenced-based clinical guidelines to ensure standardization of care.
  - Professional standards of CalOptima PACE Staff will be measured against those outlined by their respective licensing agency in the State of California (i.e. The State Board of Nursing of California).
  - Implement population health management techniques for specific participant populations, such as immunizations.
  - Identify and address areas for improvement that arise from unusual incidents, sentinel events, and annual death review.
  - Meet or exceeds minimum levels of performance on standardized quality measures as established by the Centers for Medicare & Medicaid Services (CMS) and the State Administering Agency (SAA) w~~y CMS and the SAA w~~hich includes achieving an immunization rate for both influenza and pneumococcal vaccinations of 80% for the participant population that is appropriate.
  -
- Improve on the patient experience
  - Use the annual participant satisfaction survey, grievances and appeals, and feedback from participant committees to identify areas for improvement related to participant experience.
  - Provide education to staff on the multiple dimensions of patient experience.
  - Identify and implement ways to better engage participants in the PACE experience, i.g~~e~~., menu selection, PACE Member Advisory Committee (PMAC).
  -
- Ensure appropriate use of resources
  - Review and analyze utilization data regularly including hospital admissions,~~ns, hospital readmissions,~~ ER visits, and hospital 30-day all-cause readmission.
  -
- Provide oversight of contracted services
  - Meet or exceed community standards for credentialing of licensed providers and perform due diligence in assuring that contracted facilities meet community and regulatory standards for licensure.
  - Evaluate customer service, access, and timeliness of care provided by contracted licensed providers.
  - Review documentation and coordination of care for participants receiving care in institutional settings and perform site visits on an ongoing-basis.
  - Monitor staff and contractors to ensure that appropriate standards of care are met.
  -
- Communication of Quality and Process Improvement Activities and Outcomes
  - Communicate all QAPI activities and outcomes to the PACE staff and contractors, the PACE Member Advisory Committee, and the Board of Directors.
  - Share results of QAPI identified benchmarks with staff and contracted providers at least annually.~~Results of QAPI identified benchmarks are shared with staff and contracted providers at least annually.~~

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

Organizational and Committee Structure (See Appendix A for Organizational Chart)
CalOptima Board of Directors provides oversight and direction to CalOptima PACE Organization. The Board has the final authority to ensure that adequate resources are committed and that a culture is created that allows the QAPI Plan efforts to flourish. The Board, while maintaining ultimate authority, has delegated the duty of immediate oversight of the CalOptima quality improvement programs, including the PACE QAPI Program, to the CalOptima Board of Directors' Quality Assurance Committee (QAC). The QAC performs ~~at CalOptima. t This includes the CalOptima PACE QAPI Program, to the CalOptima Board of Director's Quality Assurance Committee (QAC), which performs t~~he functions of the Quality Improvement Committee (QIC) described in CalOptima's State and Federal contracts, and to CalOptima's Chief Executive Officer who is responsible to allocate operational resources to fulfill quality objectives.

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

CalOptima PACE Quality Improvement Committee (PQIC)
Purpose
This committee provides oversight for the overall administrative and clinical operations of the organization. The PQIC may create new committees or task forces to improve specific clinical or administrative processes that have been identified as critical to participants, families or staff. Twice a quarter, ~~On a quarterly basis,~~ the PQIC will review all QAPI Plan initiatives, review the results of monitoring activities, provide oversight for proposed changes to improve quality of service and review follow-up of all changes implemented. The PQIC may create Ad Hoc Focus Review Committees for limited time periods in order to address quality problems in any clinical or administrative process. The PQIC~~It~~ will also discuss all of the Level One reporting requirement data and any Level Two reporting incident data~~Level One data and Level Two incidents.~~ Potential areas for improvement will be identified through analysis of the data and through Level Two root cause analysis. This meeting will be facilitated by the PACE Medical Director who will report its activities up to the CalOptima Board of Director's QAC, who will then report up to the Board. The PACE Director or the PACE QA Coordinator may report up to the CalOptima Board of Director's

QAC if the PACE Medical Director is not available.

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

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

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

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

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

~~**CalOptima PACE Member Advisory Committee (PMAC)**~~

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

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

~~**CalOptima PACE Ethics Advisory Committee**~~
~~Purpose~~
~~The purpose of this committee is to provide a forum to discuss ethical dilemmas in the provision of care and to respond to participant, family member or staff requests for information on ethical aspects of participant care. It allows for a case review and non-binding recommendations to the Interdisciplinary Team (IDT). The committee or consultants will report and advise the IDT and the PQIC. In addition, it can advise the Board on policy development related to ethics.~~

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

Quality and Performance Improvement Activities, Outcomes and Reporting

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

- Utilization of Services
    - CalOptima PACE will collect, analyze and report any utilization data it deems necessary to evaluate both quality of care and fiscal well-being of the organization
    - Data analysis will allow for analyzing both over and under utilization for areas of quality improvement
    - Transportation services will be monitored through monthly metrics, grievance trending, and a transportation incident log. The monthly report generated by the transportation vendor will be reviewed at the monthly transportation leadership meeting and will be reported quarterly to the PQIC. The PACE QI department will validate the transportation data by comparing the raw GPS data and unannounced ride along data against the reports submitted.
    - Meal quality will be monitored through daily checks of food temperatures as well as

comments solicited by the CalOptima PACE Member Advisory Committee.

- Participant and Caregiver Satisfaction
  - The organization shall survey the participants and their caregivers on at least an annual basis. Additionally, we will continue to look for other opportunities for feedback in order to improve quality of services.
  - Due to the nature of the participants in PACE, caregiver feedback is an integral part of our data elements.
  - The PACE Member Advisory Committee shall provide direct feeback on satisfaction to both the PACE leadership staff and the CalOptima Board of Directors, Quality Assuarnace Committee.
- Outcome mMeasures fFrom the QAPI work plan elements as well as the clininically relavant HPMS data. Data Collected During Patient Assessments
  - This will include the CMS mandated immunization elements would include evaluations from all Interdisciplinary Team Members.
  - Physiological and clinical well-being, functional status, cognitive functioning, and emotional and mental health status assessments maywill be used. Standardized, evidenced based assessments will be used whenever available.
- Effectiveness and safety of staff-provided and contract-provided services
  - This will be measured by participants' ability to achieve treatment goals as reviewed by the Interdisciplinary Team with each reassessment, review of medical records, and success of infection control efforts
  - All clinical and certain non-clinical positions have competency profiles specific to their positions
  - CalOptima PACE staff will monitor providers by methods such as review of providers' quality improvement activities, medical record review, grievance investigations, observation of care, and interviews
  - Unannounced visits to inpatient provider sites will be made by CalOptima PACE staff as necessary
- Non-clinical areas

- The PACE PQIC has oversight to all activities offered by PACE
- Member Grievances will be forwarded to the QA Coordinator for tracking, trending and data gathering. These results will be forwarded to the PACE Director and PACE Medical Director for review and further direction on any corrective actions that may be implemented. Participants and caregivers will be informed of decisions and will be assisted with furtherment of the process as needed. Results will also be reported to the PQIC for direction on how appropriate staff should implement any corrective actions.

- Member AppealsMember Appeals will be forwarded to the QA Coordinator for tracking, trending and data gathering and the . This will be forwarded to the PACE Director and PACE Medical Director for review. If the PACE Director determines that the appeal is for clinical services, it will be forwarded to the PACE Medical Director for review. If the PACE Direcor or PACE Medical Director disagrees with decision made by the IDT, they will approve the service and communicate this decision to IDT. If the PACE Director or PACE Medical Director agree with IDT's decision, the case will be forwarded to a third party for review. The third party review's decision shall be reviewed by either the PACE Director or the PACE Medical Director and will be immediatelyand decision

~~implementation and~~ shared with the Interdisciplinary Team who will inform caregivers and participants of the decision. If the appeal is denied, the Interdisciplinary Team~~s~~ will inform the members of their additional appeal rights under Medicare and Medical and will ~~and~~ assist them with furtherment of thi~~s~~e process as needed. ~~.~~

-
- Other Monitoring Activities
    - Life safety will be monitored internally via quarterly fire drills and annual mock code and mock disaster drills as well as regulatory agency inspections.

~~- Transportation services will continue to be monitored through monthly metrics and grievance trending and reported via quarterly PQIC meetings.~~
    - ~~Meal quality will be monitored through daily checks of food temperatures as well as comments solicited by the CalOptima PACE Member Advisory Committee.~~
    - ~~Life safety will be monitored internally via quarterly fire drills and annual mock code and mock disaster drills as well as regulatory agency inspections.~~
    - ~~Plans of correction on problems noted will be implemented by center staff and reviewed by the PACE Program Director, PACE Medical Director or the PACE QA Manager.~~
    - ~~-~~The internal environment will be monitored through ongoing preventive maintenance of equipment and through repair of equipment or physical plant issues as they arise.
    -

Priority setting for performance improvement initiatives is based on

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

External Monitoring and Reporting

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

- CMS implemented changes to the Level One event reporting structure. On a quarterly basis, the following events are reports to CMS via the Health Plan Management System (HPMS):
    - Grievances
    - Appeals
    - Burnes
    - Medication Errors
    - Immunizations

- Enrollment/Disenrollment
- Falls without Injury
- ER Visits
- Kennedy Terminal Ulcer

~~Level II events, formerly known as sentinel events, are reported as they occur.~~

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

~~Level Two Reporting Indicators~~

- ~~When unusual incidents reach specified thresholds, CalOptima must notify CMS and the State Administering Agency in the required timetables, complete a Root Cause Analysis and present the results of the analysis on a conference call with both agencies as well as internally at the PACE QIC. The goal of this analysis is to identify systems failures and improvement opportunities. Examples of Level Two Events are:~~
- ~~Deaths related to suicide or homicide, unexpected and with active coroner investigation~~
- ~~Falls that result in death, a fracture or an injury requiring hospitalization related directly to the fall~~
- ~~Infectious disease outbreak that meet the threshold of three or more cases linked to the same infectious agent within the same time frame~~
- ~~Pressure ulcer acquired while enrolled in the PACE Program~~
- ~~Traumatic injuries which result in death or hospitalization of five days or more or result in permanent loss of function~~
- ~~Any elopement~~
- ~~Health Outcomes Survey Modified (HOS-M)~~
- ~~CalOptima PACE will participate in the annual HOS-M to assess the frailty of the population in our center~~
- ~~Other External Reporting Requirements~~

- Level Two Reporting Indicators
  - When unusual incidents reach specified thresholds, CalOptima must notify CMS and the State Administering Agency in the required timetables, complete a Root Cause Analysis and present the results of the analysis on a conference call with both agencies as well as internally at the PACE QIC. The goal of this analysis is to identify systems failures and improvement opportunities. Examples of Level Two Events are:
  - Deaths related to suicide or homicide, unexpected and with active coroner investigation

- F alls that result in death, a fracture or an injury requiring hospitalization related directly to the fall
- Infectious disease outbreak that meet the threshold of three or more cases linked to the same infectious agent within the same time frame
- Pressure ulcer acquired while enrolled in the PACE Program
- Traumatic injuries which result in death or hospitalization of five days or more or result in permanent loss of function
- Any elopement
- ~~Suspected elder abuse shall be reported to appropriate state agency~~
- ~~Equipment failure or serious adverse reaction to any administered medications will be reported to the FDA~~
- ~~Any infectious disease outbreak will be reported to the CDC~~

- Health Outcomes Survey-Modified (HOS-M)
  - CalOptima PACE will participate in the annual HOS-M to assess the frailty of the population in our center

- Other External Reporting Requirements
  - Suspected elder abuse shall be reported to appropriate state agency
  - Equipment failure or serious adverse reaction to any administered medications will be reported to the FDA
  - Any infectious disease outbreak will be reported to the CDC

Corrective Action Plans

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

Urgent Corrective Measures

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

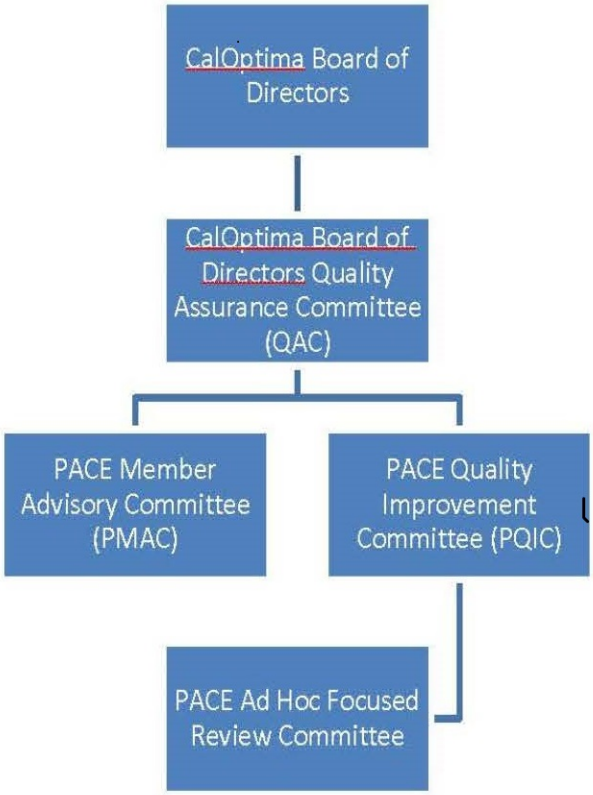
Re-Evaluation and Follow-up

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

Annual Review of PACE QAPI Plan

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

Appendix A: 2017~~6~~ CalOptima PACE QAPI Program Reporting Structure



Back to Agenda

Proposed 2017 CalOptima PACE Quality Assessment Performance Improvement (QAPI) Work Plan

QAPI Item#	Area	Description	Objective	Activity	Goal	Responsible Person	Reporting Frequency	Target completion
QAPI17.01	**Quality of Care**	**2016 PACE QAPI Plan and Work Plan Annual Evaluation**	PACE QAPI Plan and Work Plan will be evaluated annually.	PACE QAPI Plan and Work Plan will be evaluated for effectiveness on an annual basis	Annual Evaluation	PACE Medical Director	Annually	March, 2017
QAPI17.02	**Quality of Care**	**2017 PACE QAPI Plan and Work Plan Annual Oversight**	PACE QAPI Plan and Work Plan will be reviewed and updated annually	QAPI and QAPI Work Plan will be approved and adopted on an annual basis	Annual Adoption	PACE Medical Director	Annually	March, 2017
QAPI17.03	**Quality of Care**	**Influenza Immunization Rates**	Increase Influenza immunization rates for all eligible PACE participants	Improve compliance with influenza immunization recommendations	> 90% of members will have influenza vaccination	Clinical Operations Manager	Quarterly	12/31/2017
QAPI17.04	**Quality of Care**	**Pneumococcal Immunization Rates**	Increase Pneumococcal immunization rates for all eligible PACE participants	Improve compliance with pneumococcal immunization recommendations	> 90% of members will have pneumococcal vaccination	Clinical Operations Manager	Quarterly	12/31/2017
QAPI17.05	**Quality of Care**	**Infection Control**	Reduce common infections in PACE participants (Urinary and Skin)	Monitor and analyze the incidence of Urinary and Skin infectinos in the elderly at PACE and compare against national benchmark to find opportunities for quality improvement	Maintain common infection rates less than the following national benchmarks: Urinary Tract 0.46-4.4 episodes/1000 participant days. Skin and Soft Tissue 0.1-2.1 episodes/1000 participant days	Clinical Operations Manager	Quarterly	12/31/2017
QAPI17.06	**Quality of Care**	**Diabetes: Annual Diabetic Eye Exams**	Increase the percentage of PACE participants with diabetes who get their annual diabetic eye exam completed	PACE participants with diabetes will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams to develop strategies for improvement	> 90% of members with diabetes will have their annual eye exam completed	PACE Medical Director	Quarterly	12/31/2017
QAPI17.07	**Quality of Care**	**Care for Older Adults: Advance Directive Planning**	Increase POLST utilization for PACE participants	Ensure all PACE members are offered POLST upon enrollment and every six months until they have one completed in order to improve POLST utilization	>75% of members will have a POLST	PACE Center Manager	Quarterly	12/31/2017
QAPI17.08	**Quality of Care**	**Care for Older Adults: Medication Review**	Increase the percentage of PACE participants who have their medications reviewed	Ensure all PACE participants have a medication review	100%	PACE Center Manager	Quarterly	12/31/2017
QAPI17.09	**Quality of Care**	**Care for Older Adults: Functional Status Assessment**	Ensure all 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 every 6 months	100%	PACE Center Manager	Quarterly	12/31/2017
QAPI17.10	**Quality of Care**	**Care for Older Adults: Pain Screening**	Increase the percentage of PACE participants who are screened regularly for pain.	Ensure all PACE participants have a pain screening	100%	PACE Center Manager	Quarterly	12/31/2017
QAPI17.11	**Quality of Care**	**Potentially Harmful Drug/Disease Interactions in the Elderly (DAE): Dementia + tricyclic antidepressant or anticholinergic agents**	Reduce potentially harmful drug-diease interactions	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.	>38.82% (2016 HEDIS Prospective One Care Connect 90th Percentile Rate)	PACE Pharmacist	Quarterly	12/31/2017

Back to Agenda

QAPI Item#	Area	Description	Objective	Activity	Goal	Responsible Person	Reporting Frequency	Target completion
		Potentially Harmful Drug/Disease Interactions in the Elderly (DAE): Chronic Renal Failure + Nonaspirin NSAIDS or Cox2 Selective NSAIDs	Reduce potentially harmful drug-disease interactions	PACE participants with a diagnosis of Chronic Renal Failure will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams as well as the PACE pharmacist to develop strategies for improvement.	>3.93% (2016 HEDIS Prospective One Care Connect 90th Percentile Rate)	PACE Pharmacist	Quarterly	12/31/2017
		Specialty Care	Improve access to specialty practitioners	Appointments for specialty care will be scheduled within 7 business days to improve access to specialty care for initial consultations	> 80% of specialty care authorizations will be scheduled within 7 business days	PACE Clinical Operations Manager	Quarterly	12/31/2017
		Acute Hospital Day Utilization	Reduce the rate of acute hospital days by PACE participants	PACE participants hospital days will be monitored and analyzed by the PACE QI department who will work with the PACE interdisciplinary and clinical teams to develop strategies to lower that rate through preventative care and education	< 2,104 hospital days per 1000 per year (CalPACE avg in 2015)	PACE Medical Director	Quarterly	12/31/2017
		Emergency Room Utilization	Reduce the rate of ER utilization by PACE participants	ER utilization by PACE participants will be monitored and analyzed by the PACE QI department who will work with the PACE interdisciplinary and clinical teams to develop strategies to lower that rate through preventative care and education	< 458 emergency room vists per 1000 per year (CalPACE avg in 2015)	PACE Medical Director	Quarterly	12/31/2017
		30-Day All Cause Readmission Rates	Reduce the 30-day all cause readmission rates by PACE participants	30-day all cause readmission rates for hospitalized PACE participants will be monitored and analyzed by the PACE QI department who will work with PACE interdisciplinary and clinical teams to find opportunities for quality improvement	<10% 30-day all cause readdmission (CalOptima PACE avg in 2016)	PACE Medical Director	Quarterly	12/31/2017
		Long Term Care Placement	Decrease the percentage of participants who are placed in a long term care facility	PACE participants placed in long term care will be monitored and analyzed by the PACE QI department who will work with the PACE interdisciplinary and clinical teams to develop strategies to lower that rate through preventative care and education	<4% of members (CalPACE utilization in 2016) will reside in long term care	PACE Center Manager	Quarterly	12/31/2017
		Disenrollments	Reduce the percentage of participants who disenroll for controllable reasons from the PACE program within the first 90 days of enrollment.	Review and analyze the participants who disenrolled from PACE within 90 days of enrollment, excluding deaths and withdrawals, to develop strategies for improvement	Reduce the annualized rate below 50/k/year (20% reduction from 2016)	PACE Center Manager	Quarterly	12/31/2017
		Overall Satisfaction	Improve the overall satisfaction of participants and their families with the CalOptima PACE program	Review and analyze the annual satisfaction survey results, define areas for improvement and implement interventions to improve the participant and their families satisfaction with the PACE program	> 90% will answer Good, Very Good or Excellent on this question	PACE Director	Annually	12/31/2017
		Transportation	Improve response time to transportation incidents reported by staff and participants	Monitor and analyze incidents reported in the Transportation Incident Log to identify opportunities for improvement to resolve issues within 48 hours of report	>90% of incidents are resolved within 48 hours	PACE Center Manager	Quarterly	12/31/2017

Back to Agenda

QAPI Item#	Area	Description	Objective	Activity	Goal	Responsible Person	Reporting Frequency	Target completion
		Transportation	Improve PACE transportation ride times to less than 60 minutes per trip	Ensure all PACE participants are on the vehicle for less than 60 minutes per trip. Monitor and analyze one-hour violations, define areas for improvement and implement interventions to maintain compliance with regulation	0 trips > 60 minutes in duration	PACE Director	Quarterly	12/31/2017
		Transportation	Improve participant experience by providing timely transportation services	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	>90% on-time performance	PACE Director	Quarterly	12/31/2017

Back to Agenda

2017 CalOptima PACE QAPI Work Plan Measures and Definitions

QAPI measure	Description	Definition of Measure	Data Source
QAPI17.01	PACE QAPI Plan and Work Plan will be evaluated annually.	N/A	N/A
QAPI17.02	PACE QAPI Plan and Work Plan will be reviewed and updated annually	N/A	N/A
QAPI17.03	Increase Influenza immunization rates for all eligible PACE participants	Immunization rate = (Recieved immunization + Prior Immunization) / (Total Participants - Medical Contraindications - Refused)	TruChart Immunization portal
QAPI17.04	Increase Pneumococcal immunization rates for all eligible PACE participants	Immunization rate = (Recieved immunization + Prior Immunization) / (Total Participants - Medical Contraindications - Refused). Pneumococcal vaccination valid within 5 years.	TruChart Immunization portal
QAPI17.05	Reduce common infections in PACE participants (Urinary and Skin)	Infection Rate = (Espisodes per Quarter/Member Months) / 30 days x 1,000	TruChart report of ICD-10s
QAPI17.06	Increase the percentage of PACE participants with diabetes who get their annual diabetic eye exam completed	See HEDIS standard. Annual diabetic eye exam rate = # diabetic participants with completed eye exams within 12 months / # of participants with DM	TruChart report of ICD-10s (DM); TruChart service recording portal
QAPI17.07	Increase POLST utilization for PACE participants	POLST utilization rate = # of participants who are currently enrolled for at least 6 months that have a POLST / # of participants who are currently enrolled for at least 6 months	TruChart Health Wishes portal; TruChart Enrollment report
QAPI17.08	Increase the percentage of PACE participants who have their medications reviewed	See HEDIS standard. Medical Records to audit TruChart for evidence of medication review by PharmD, MD, NP or RN within 6 months. Evidence may be in the form of a progress note or assessment.	Quarterly Medical Record Review (5% of charts per quarter)
QAPI17.09	Ensure all PACE participants have a functional status assessment completed every 6 months by the disciplines required by CMS.	See HEDIS standard. Medical Records to audit TruChart for evidence of functional assessment by PCP, RN, MSW and RT every 6 months. Evidence must be in the form of an assessment.	Quarterly Medical Record Review (5% of charts per quarter)
QAPI17.10	Increase the percentage of PACE participants who are screened regularly for pain.	See HEDIS standard. Medical Records to audit TruChart for evidence of pain assessment by RN every 6 months. Evidence must be in the form of an assessment.	Quarterly Medical Record Review (5% of charts per quarter)
QAPI17.11	Reduce potentially harmful drug-disease interactions for participants with dementia diagnosis	See HEDIS standard. Rate of drug/disease interactions = # of participants on drug combination / # of participants with dementia diagnosis	TruChart report of ICD-10s (dementia); Pharmacy report of prescriptions
QAPI17.12	Reduce potentially harmful drug-disease interactions for participants with chronic renal failure diagnosis	See HEDIS standard. Rate of drug/disease interactions = # of participants on drug combination / # of participants with chronic renal failure diagnosis	TruChart report of ICD-10s (chronic renal failure); Pharmacy report of prescriptions
QAPI17.13	Improve access to specialty practitioners	Turn Around Time Rate = # of appointments scheduled within 7 business days from authorization / # of appointments scheduled	TruChart Specialty Care report
QAPI17.14	Reduce the rate of acute hospital days by PACE participants	Annualized Rate = (Number of Bed Days for a year / MM for a year) x 1000 x 12	TruChart Admit report
QAPI17.15	Reduce the rate of ER utilization by PACE participants	Annualized Rate = (#ER Visits for a year / MM for a year) x 1000 x 12	TruChart Admit report
QAPI17.16	Reduce the 30-day all cause readmission rates by PACE participants	Readmission Rate = # of readmissions / # of admits	TruChart Admit report
QAPI17.18	Decrease the percentage of participants who are placed in a long term care facility	LTC utilization rate = # participants residing in custodial SNF level of care / # of participants enrolled	TruChart Admit report
QAPI17.17	Reduce the percentage of participants who disenroll for controllable reasons from the PACE program within the first 90 days of enrollment.	Controllable Disenrollments Within 90 Days Rate = (# of controllable disenrollments within 90 days of enrollment for a year / MM for a year) x 1000 x 12	TruChart Disenrollment report; Controllable vs Non-Controllable Disenrollment report
QAPI17.18	Improve the overall satisfaction of participants and their families with the CalOptima PACE program	Annual Vital Research survey via CalPACE membership	Annual Participant Satisfaction Survey
QAPI17.19	Improve response time to transportation incidents reported by staff and participants	Response rate to incidents = # of incidents resolved within 48 hours / # of incidents	Transportation Incident Log
QAPI17.20	Improve PACE transportation ride times to less than 60 minutes per trip	Rides >60 minutes	Secure Transportation reports
QAPI17.21	Improve participant experience by providing timely transportation services	On-time performance = # of rides with actual departure +/- 15 min of scheduled time / # of rides	Secure Transportation reports

Back to Agenda

Appendix C: PACE QAPI Committee Meeting Minutes Template

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

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Consent Calendar

5. Consider Approval of the Fiscal Year (FY) 2018 (Measurement Year 2017) Pay for Value Programs for Medi-Cal and OneCare Connect

Contact

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

Recommended Action

Approve the Fiscal Year 2018 (Measurement Year 2017) "Pay for Value (P4V) Programs for Medi-Cal and OneCare Connect" which defines measures and allocations for performance, as described in Attachment 1 and 2, subject to regulatory approval, as applicable.

Background

CalOptima has implemented a comprehensive Health Network Performance Measurement System consisting of recognizing outstanding performance and supporting on-going improvement that will strengthen CalOptima's mission of providing quality health care.
The purpose of the Health Network performance measurement system, which includes both delegates and the CalOptima Community Network as previously approved by the Board on March 1, 2014, is three-fold:

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

Discussion

For the Measurement Year CY 2017 programs, staff recommends maintaining many of the elements from the prior year with some modifications. As described in the 2016 P4V program, measures and scoring methodology address the need to consider the complexity or member acuity (SPD compared to non-SPD members) and the subsequent higher consumption of physician / health network resources to care for SPD members. In addition, the scoring methodology will continue to reward performance and improvement. The program will include both Child and Adult Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures, thereby expanding our focus on the member experience. The proposed MY17 Medi-Cal and OneCare Connect Pay for Value programs are one year programs which use HEDIS 2018 specifications and for which payments will be made in 2018.

In order to sustain improvements and leverage resources that the health networks have allocated towards improvement in P4V measures, staff recommends the following modifications:

Back to Agenda

Medi-Cal Changes:

- Revise minimum denominator size from 100 to 30 eligible members for each specified quality measure to be eligible for incentive payment
- Revise CAHPS minimum performance threshold to reflect CA benchmarks

OneCare Connect Changes:

To incentivize quality care in our new OneCare Connect program and to better align with the CMS Quality Withhold program, the four clinical incentive measures below remain in the OneCare Connect P4V program:

- Plan All Cause Readmissions
- Controlling Blood Pressure
- Medication Adherence for oral anti-diabetic medications (Part D measure)
- Behavioral Health: Antidepressant Medication Management

Starting in CY 2017, a member experience survey (CAHPS) is added to the program.

Clinical measures are weighted at 60%; member experience is weighted at 40%. In the Board approved 2016 P4V program, only clinical measures were included and were weighted at 100%.

Distribution of Incentive Dollars

Performance allocations are distributed to the Health Networks, including CCN, upon final calculation and validation of each measurement rate. Payment for Medi-Cal will be paid proportional to acuity level, as determined by aid category. To qualify for payment for each of the clinical and CAHPS measures, the Health Network must have a minimum denominator, as noted.

In order to qualify for payments, a physician group must be contracted with CalOptima during the entire measurement period, period of pay for value accrual, and must be in good standing with CalOptima at the time of disbursement of payment.

Any separate OCC Quality Withhold incentive dollars earned by CalOptima will be distributed based upon a Board-approved methodology to be developed by staff and subject to any needed regulatory approvals.

Fiscal Impact

Since the distribution of incentive dollars for the MY 2017 P4V Programs for Medi-Cal and OneCare Connect will be made in FY 2017-18, there is no fiscal impact to the FY 2016-17 Operating Budget.

Staff estimates that the fiscal impact for the MY 2017 P4V Program will be no more than $2 per member per month (PMPM) for Medi-Cal, and no more than $20 PMPM for OneCare Connect. Staff will include expenses for the MY 2017 P4V Program for Medi-Cal and OneCare Connect in the upcoming FY 2017-18 CalOptima Operating Budget.

Back to Agenda

Time of Payment
Payment of any reward under the P4V program will occur after CalOptima receives official notice of HEDIS and CAHPS scores for 2017, which is anticipated to be on or around 4th quarter, 2018. The time of payment is subject to change at CalOptima's discretion.

Rationale for Recommendation
This alignment will leverage 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. FY 2018 (MY 2017) Medi-Cal Pay for Value Program
2. FY 2018 (MY 2017) OneCare Connect Pay for Value Program

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

2/23/2017 — **Date**

Back to Agenda

Attachment 1: FY 2018 (MY 2017) Medi-Cal Pay for Value Program Measurement Set

Adult Measures	**2017 Measurement Year / HEDIS 2018 Specifications** **Anticipated Payment Date: Q3 2018**	**Measurement Assessment Methodology**
Clinical Domain - HEDIS Weight: 60.00% SPD Weight 4.0 TANF Weight 1.0	<u>Prevention:</u> • Breast Cancer Screening (BCS) • Cervical Cancer Screening (CCS) <u>Diabetes:</u> • HbA1c Testing • Retinal Eye Exams <u>Access to Care</u>: • Adults Access to Preventive/Ambulatory Care <u>Respiratory</u>: • Medication Management for People with Asthma (MMA)	A relative point system by measure based on: • NCQA National HEDIS percentiles • Percentile Improvement
Patient Experience Domain - CAHPS Weight: 40%	<u>Adult Satisfaction Survey (Adult CAHPS):</u> 1. Getting appointment with a Specialist 2. Timely Care and Service 3. Rating of PCP 4. Rating of all Healthcare	A relative point system by measure based on: • NCQA California CAHPS percentiles • Percentile Improvement

Back to Agenda

Pediatric Measures	**2017 Measurement Year / HEDIS 2018 Specifications** **Anticipated Payment Date: Q3 2018**	**Measurement Assessment Methodology**
Clinical Domain - HEDIS Weight: 60.00% SPD Weight 4.0 TANF Weight 1.0	<u>Respiratory:</u> • Medication Management for People with Asthma (MMA) • Appropriate Testing for Children with Pharyngitis (CWP) • Appropriate Treatment for Children with Upper Respiratory Infection (URI) <u>Prevention:</u> • Childhood Immunization Status Combo 10 (CIS) • Well-Care Visits in the 3-6 Years of Life (W34) • Adolescent Well-Care Visits (AWC) <u>Access to Care:</u> • Children's Access to Primary Care Physician	A relative point system by measure based on: • NCQA National HEDIS percentiles • Percentile Improvement
Patient Experience Domain - CAHPS Weight: 40%	<u>Child Satisfaction Survey (Child CAHPS)</u> • Getting Appointment with a Specialist • Timely Care and Service • Rating of PCP • Rating of all Healthcare	A relative point system by measure based on: • NCQA California CAHPS percentiles • Percentile Improvement

Back to Agenda

Attachment 2: FY 2018 (MY 2017) OneCare Connect Pay for Value Program

OneCare Connect Measures	**2017 Measurement Year / HEDIS 2018 Specifications** **Anticipated Payment Date: Q3 2018**	**Measurement Assessment Methodology**
Clinical Domain - HEDIS Weight: 60.00% Each measure weighted equally	<u>Measures:</u> • Plan All Cause Readmissions • Antidepressant Medication Management Outcome Measures • Blood Pressure Control • Part D Medication Adherence for Diabetes	A relative point system by measure based on: • NCQA National HEDIS percentiles • Percent Improvement **For the Part D Medication Adherence Measure**: A relative point system by measure based on: • CMS Star Rating Percentiles • Percentile Improvement
Patient Experience Domain - CAHPS Weight: 40%	<u>Adult Satisfaction Survey (Adult CAHPS):</u> • Getting appointment with a Specialist • Timely Care and Service • Rating of PCP • Rating of all Healthcare	A relative point system by measure based on: • NCQA California CAHPS percentiles • Percentile Improvement

Back to Agenda

Participation in Quality Improvement Initiatives

For each measure in which a Health Network/medical group performs below the 50th percentile, Health Networks/medical groups must submit a Corrective Action Plan (CAP) to CalOptima which outlines, at a minimum, the following items:

- Interim measures and goals
- Measurement cycle
- Member interventions including education and outreach
- Provider interventions including education and training
- Timeline for interventions

Health networks/medical groups must submit quarterly work plans which document implementation of the corrective action plan and progress made towards goals.

In conjunction with the Health Networks, CalOptima will lead quality improvement initiatives for measures that fall below the 50th percentile. Funding for these initiatives will come from forfeited dollars.

MEASUREMENT DETAILS:

1. Clinical Domain (HEDIS measures)

Program Specific Measurement Sets
Performance measures were selected as appropriate per program based on the following criteria:

- Measures are appropriate for membership covered by the program
- Measures are based on regulatory requirements
- Measures are used by the industry for performance measurement and incentive payment

Criteria
The following criteria were considered in selecting these indicators:

- Each of these indicators measures the delivery of services that are critical to the health of the respective segments of CalOptima's membership. In addition, these measures collectively address the range of age appropriate services.
- The measures use administrative data for all except Blood Pressure only reporting since they are single point of service measures.
- CBP will be captured with a specific chart review activity for this P4V program.

  Each measure is calculated per HEDIS methodology except that continuous enrollment is assessed at the health network level instead of at the health plan level.

Incentive Measure Definition
Please refer to HEDIS 2018 Technical Specifications Volume 2 for measure definitions. For each HEDIS indicator, members will be identified according to the most recent HEDIS technical specifications updates.

Back to Agenda

II. Customer Satisfaction

Member Satisfaction

Background

CalOptima conducts annual member satisfaction surveys that are carefully designed to provide network-level satisfaction information to meet precision requirements and to support comparisons between networks and at the CalOptima agency level. The goal is to survey different subsets of the CalOptima membership (e.g. Children, Persons with disabilities, and Adults) on a rotating basis so that we develop:

- trend information over time about individual networks' performance for a specific population, and
- comparable performance information across networks both for a specific time period as well as trended over time.

Survey Methodology

The surveys are administered using the CAHPS protocol, including a mixed-mode methodology of mail and telephone contact to notify members of the study, distribute questionnaires, and encourage participation by non-respondents. Both surveys have been conducted in three threshold languages as defined by our Medi-Cal contract.

CalOptima has worked with outside technical and substantive consultants to refine its survey instruments and sampling and weighting strategies and has employed a nationally known survey research group to conduct both surveys.

The samples consisted of systematically selected Medi-Cal members who met specific requirements for inclusion as specified by the CAHPS and by our interest in targeted subgroups. The sample is a disproportionately stratified random sample with strata defined by health network. CalOptima required sample sizes and allocations across strata be developed to provide estimates of population proportions at the network level that were within 2.5 percentage points of the true value with 95% statistical confidence.

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Consent Calendar

6. Consider Authorizing Staff to Develop and Implement Medi-Cal Quality Improvement and Accreditation Activities During CalOptima Fiscal Year (FY) 2016-17 for Member and Provider Incentives

Contact

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

Recommended Action

Authorize staff to develop and implement Member and Provider incentive programs in the amounts listed on Attachment 1, subject to applicable regulatory approval and guidelines.

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.

At the December 1, 2016, meeting, the CalOptima Board of Directors approved the Medi-Cal quality improvement and accreditation activities for Fiscal Year 2016-17. Specifically, the Board:

- Directed Staff to develop member and provider incentive programs in the amounts listed in Attachment 1, subject to applicable regulatory approval and guidelines, and final approval by the Board prior to implementation; and
- Authorized unbudgeted expenditures not to exceed $1.1 million to implement a budget augmentation for current quality initiatives (i.e., Surveys & NCQA fees, Consulting services, Quality Initiatives in flight, Required Training) and new requests for quality initiatives.

Discussion

Attachment 1 provides the requested additional detail on the HEDIS measures and proposed member and provider incentives. During the development of these incentive programs, staff has been able to more precisely identify the scope and cost per incentive. Some incentives are designed as pilot programs, in order to evaluate their effectiveness prior to launching to a larger number of members or providers. As such, Attachment 2 provides further detail on the proposed revisions to the expenditures for Medi-Cal Quality Improvement and Accreditation activities from the December 1, 2016, Board action.

Member incentives will follow the guidelines in CalOptima Policy AA.1208 – Non-Monetary Member Incentives.

Back to Agenda

Fiscal Impact
There is no additional fiscal impact for the recommended action.

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
Board of Directors' Quality Assurance Committee

Attachments
1. PowerPoint Presentation: Proposed Member and Provider Incentive Plan
2. Revision to Expenditures for Medi-Cal Quality Improvement and Accreditation Activities
3. Board Action dated December 1, 2016, Consider Approval of Medi-Cal Quality Improvement and Accreditation Activities During CalOptima Fiscal Year 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

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

Back to Agenda

Proposed Member and Provider Incentive Plan

Board of Directors Meeting
March 2, 2017

Caryn Ireland
Executive Director, Quality and Analytics

Back to Agenda

Introduction

- All proposed incentives are pilot projects; results of each incentive will be brought back to the Board when analyzed
- No additional funds are requested
- Staff has refined the originally proposed costs to reflect expenditures during FY16-17 vs. through year end
- Staff has incorporated DHCS guidance on best practices for member incentives
  - Member incentives will be in the form of gift cards
- Offices/clinics identified for the Provider incentives will be based on the following criteria:
  - High Volume Providers, in good standing with CalOptima

Back to Agenda

Postpartum: Member Incentive

	Description
Objectives	To increase the number of members who had a delivery to obtain their postpartum visit within the prescribed timeframe. CalOptima's goal is to increase the HEDIS postpartum visit rate to above the 25th percentile.
Target Population	Medi-Cal members with a delivery between March 1 – June 30, 2017 (postpartum visit may occur after July 1st)
Requirements	• Voluntary participation in the postpartum incentive program. • Member must complete a postpartum visit with a provider within prescribed timeframe after delivery. • Member must complete and return required form provided by CalOptima to verify postpartum visit to obtain member incentive.
Incentive Type/Amount:	• $25 gift card per participating member •Additional entrance into a monthly opportunity drawing [50 members will be given a $100 gift card every month through opportunity drawing].
Duration:	• March 1- June 30, 2017
Total Cost:	**$90, 682** Dollars will be calculated and accrued for any incentive paid in the 2nd half of the year, 2017

Back to Agenda

Postpartum: Provider Office Staff Incentive

	Description
Objectives	Provide “just in time” training on Medical Records documentation of postpartum visits in order to improve our postpartum chart review results. Incomplete medical record documentation contributes to our declining postpartum score. Staff have analyzed postpartum medical record documentation that contributed to lack of compliance. Goal is to raise rates on Postpartum Care.
Target Population	Three PCPs, Clinics or OB/GYN offices with the highest number of members who had a delivery between January-June, 2017
Requirements	•Clinic staff must participate in a review 2016 medical record results with CalOptima staff for training on documentation which may lead to low rates. (March) •Clinic staff will implement changes within their office processes to ensure complete documentation; •Clinic staff will review sample of medical records with CalOptima team for training (April, May, June) •Requires Office Manager & Clinical Staff participation in all sessions
Incentive Type/Amount:	• $1000 per provider office or clinic for participation in the program • $1000 per provider office for demonstrated improvement
Duration:	4 months (Mar-June 30, 2017)
Total Cost:	**$10,000 (includes payments to providers and chart review resources)**

Back to Agenda

Cervical Cancer Screening: Member Incentive

	Description
Objectives	To improve cervical cancer screening HEDIS rates
Target Population	Medi-Cal members between the ages of 21-64 years old.
Requirements	• Voluntary participation in the cervical cancer screening incentive program. • Member must complete a cervical cancer screening between February 15 – August 31, 2017. • Member must complete and return required form provided by CalOptima to verify cervical cancer screening to obtain member incentive.
Incentive Type/Amount:	• $15 gift card/member for completing cervical cancer screening. • Additional entrance into a monthly opportunity drawing [75 members will be given a $100 gift card every month through opportunity drawing].
Duration:	6 months (February 15 - August 31, 2017)
Total Cost:	**$87,505 by June 30, 2017** • 4,167 members to complete cervical cancer screening by June 30, 2017 • 4,167 members x 15 = $62,505, plus $25,000 in opportunity drawing = $87,505. •Dollars will be calculated and accrued for any incentive paid in the 2nd half of the year, 2017

Back to Agenda

Cervical Cancer: Provider Office Staff Incentive

	Description
Objectives	1) To improve cervical cancer screening rates (HEDIS CCS) at targeted office sites by incentivizing staff to assist CalOptima members to get a pap test in greater volume than their current monthly average. CalOptima staff to calculate monthly average of completed pap tests for each targeted office. This may include helping to schedule appts for members, helping with transportation services, providing follow-up reminder calls, etc. 2) To understand and learn about any barriers at the provider level in an effort to provide resources and support.
Target Population	1) Target 5 High volume Medi-Cal provider offices, and 5 High volume Medi-Cal clinics, focus on office staff to help member get and keep appointments for pap tests. 2) Additional offices may be added to the campaign
Requirements	• Voluntary participation in the Provider Office Staff incentive program. • Conduct member outreach efforts (outbound calling, scheduling, record-keeping, maintaining communication with CalOptima). • Monthly communication/update with CalOptima.
Incentive Type/Amount:	• Two (2) meals will be provided at Provider Offices; Once at program launch and a second time at program completion. • $10/member above the monthly cervical cancer screening average for the office
Example for $10 incentive: Dr. John Smith	Avg. # Cervical Cancer Screenings for CalOptima Members: 25 Completed # of Cervical Cancer Screenings in February, 2017: 55 Increase over average screening rate: 30 (validated via claim/encounter submission) Total Incentive Earned for February, 2017: $300 (10 X $30=$300) Incentive may be earned for each month of the program , but amount will vary depending upon the number of members screened above the monthly average .
Duration:	6 months (February 15 – August 31, 2017)
Total Cost:	**$ Up to 72,500;** Dollars will be calculated and accrued for any incentive paid in the 2nd half of the year, 2017

Back to Agenda

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Cervical Cancer: Extended Hours Initiative

	Description
Objectives	To promote women's health (breast and cervical cancer screenings) and improve screening rates at targeted provider offices.
Target Population	Target 1-2 high volume PCP offices. * Additional offices may be added to the campaign
Requirements	• Voluntary participation in the Provider Office Extended Hours Initiative. • Extend office hours for CalOptima members at least two (2) times per month for 3 months. Extended hours could be evening or weekends; targeting 8 additional hours per month per provider office. • Conduct member outreach efforts (outbound calling, scheduling appointments, record-keeping, maintaining communication with CalOptima). • Conduct well-women exams to include pap test, exclusively for CalOptima members during extended hours.
Incentive Type/Amount:	• Each office may receive up to $200/hour (up to a maximum of 16 hours over 3 months) to cover the cost of extending office hours, staffing resources and others. • Cost may vary between offices due to staffing resources and extended hours.
Duration:	3 months (March 1 – June 30, 2017)
Total Cost:	**$10,000**

Back to Agenda

Breast Cancer Screening: Member Incentive

	Description
Objectives	To improve breast cancer screening HEDIS rates
Target Population	Medi-Cal members between the ages of 50 -74 years old.
Requirements	• Voluntary participation in the breast cancer screening incentive program. • Member must complete a breast cancer screening between February 1 – August 31, 2017. • Member must complete and return required form provided by CalOptima to verify breast cancer screening to obtain member incentive.
Incentive Type/Amount:	• $10 gift card/member for completing breast cancer screening. • Additional entrance into a monthly opportunity drawing [50 members will be given a $100 gift card every month through opportunity drawing].
Duration:	• 6 months (February 15 – August 31, 2017)
Total Cost:	**$82, 500 by June 30, 2017** • 5,750 members to complete breast cancer screening by August 31, 2017 • 5,750 x 10 = $57,000; plus $25,000 in opportunity drawing = $82,500 •Dollars will be calculated and accrued for any incentive paid in the 2nd half of the year, 2017

Back to Agenda

Attachment 2: Revision to Expenditures for Medi-Cal Quality Improvement and Accreditation Activities

	12/1/16 Board Action		Recommended Action	
Item	**Detail**	**Total Amount (Not to Exceed)**	**Detail**	**Total 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	• Prenatal/postpartum incentive: $90,682 • Breast cancer screening: $82,500 • Cervical cancer screening: $87,505	$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	• Postpartum provider office staff incentive: $10,000 • Cervical cancer provider office staff incentive: $72,500 • Cervical cancer extended hours initiative: $10,000	$92,500

Back to Agenda

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

Back to Agenda

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.

Back to Agenda

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 *11/22/2016*
Authorized Signature **Date**

Back to Agenda

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**

Back to Agenda

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**

Back to Agenda

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

Back to Agenda

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

Back to Agenda

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

Back to Agenda

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

Back to Agenda

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

Back to Agenda

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**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Consent Calendar
7. Receive and File Compliance Strategies' 2016 Compliance Program Effectiveness (CPE) Audit Report

Contact
Silver Ho, Compliance Officer, (714) 246-8400

Recommended Action
Receive and File Compliance Strategies' 2016 Compliance Program Effectiveness (CPE) Audit Report.

Background
The Centers for Medicare & Medicaid Services (CMS) requires that all Medicare Advantage (Part C) and Prescription Drug (Part D) plan sponsors conduct an audit of the effectiveness of its compliance program on at least an annual basis, and that the results must be shared with its Board of Directors ("Board"). As such, CalOptima selected Compliance Strategies, Inc. to evaluate its overall performance in administering its Compliance Program based on the seven (7) elements of an effective Compliance Program, as outlined below.

- Element I: Written Policies, Procedures and Standards of Conduct
- Element II: Compliance Officer, Compliance Committee and High Level Oversight
- Element III: Effective Training and Education
- Element IV: Effective Lines of Communication
- Element V: Well-Publicized Disciplinary Standards
- Element VI: Effective System for Routine Monitoring, Auditing and Identification of Compliance Risks
- Element VII: Procedures and System for Prompt Response to Compliance Issues

Compliance Strategies conducted the CPE audit using the 2016 CMS audit protocols.

Discussion
To conduct the audit, Compliance Strategies selected six (6) initial cases, also referred as tracers, to review during the audit performed in August 2016, and two (2) additional cases in November 2016. The tracer process requires Compliance Strategies to walk through each case to find evidence that the seven (7) elements of an effective compliance program were considered and addressed during the resolution. The tracers were selected from each of the universes and covered various areas of the organization including --- utilization management, grievances and appeals, pharmacy management, special investigations unit, customer service, as well as from CalOptima's first tier entities.

At the conclusion of the audit, Compliance Strategies determined that CalOptima demonstrated compliance with the seven (7) elements of an effective Compliance Program in reviewing and

Back to Agenda

addressing issues of non-compliance and potential fraud and abuse. In addition, Compliance Strategies commended CalOptima for two (2) best practices in the areas of tracking and communicating regulatory communications and the recently enhanced risk assessment process implemented by the Audit & Oversight Department.

Compliance Strategies also recommended two (2) areas for improvement in CalOptima's existing compliance processes.

Recommendation #1: Plan should ensure each universe is accurate based on CMS specifications. Examples of the types of errors in the universes include the following:

- One of the universes indicated an incorrect effective date for its MedImpact contract.
- One of the universes identified the PerformRx monitoring activity as monthly, but should have indicated "daily" for the frequency.
- The universe for employees and governing body was incomplete. Members of the governing body were inadvertently left out.

Corrective Action Plan (CAP): To ensure universes are compiled accurately and according to regulatory audit protocol specifications, the Office of Compliance has initiated the following short and long-term corrective action plans.

- Short-Term: Compiling universe reports using current manual processes in advance of regulatory audit engagement to allow for sufficient time to compile and validate data. Advance preparation will also allow for additional layers of review to ensure accuracy.
- Long-Term: The Office of Compliance has initiated a project with the Information Services (IS) Department to build an automated solution to collect and validate the universe data for internal business areas. By automating the process, the goal is to reduce human error with manual entry of data and to allow for staff to concentrate their time on validating the data for accuracy.

Recommendation #2: Plan should ensure the Office of Inspector General (OIG) and System for Award Management (SAM) / Government Services Administration (GSA) sanction screening is completed for all first tier, downstream, and related entities (FDRs).

- For two (2) of the five (5) FDRs selected for review, CalOptima did not provide appropriate evidence that the FDRs were verified against the OIG/GSA sanction list for certain months. For example, CalOptima did not demonstrate that Windstone was verified against the OIG/GSA sanction list for August 2015.

Corrective Action Plan (CAP):

- CAPs have been issued to the Vendor Management and Office of Compliance Departments for failure to appropriately document that all FDRs were verified against the OIG/GSA sanction list on a monthly basis.
- Desktops have been revised to ensure process is followed consistently.
- Coaching and training for responsible staff conducted.

Back to Agenda

- Audit & Oversight Department is establishing a process to conduct quarterly audits to ensure sustained compliance.

Fiscal Impact

There is no anticipated fiscal impact for the proposed receipt and file of Compliance Strategies' 2016 Compliance Program Effectiveness (CPE) audit report. To the extent that there is any fiscal impact due to increases in Compliance Program resources, such impact will be addressed in separate Board actions or in the CalOptima Fiscal Year 2017-18 Operating Budget.

Rationale for Recommendation

To ensure CalOptima meets the CMS requirement to conduct an audit of its Compliance Program on at least an annual basis, CalOptima staff recommends that the Board approve the file and receipt of Compliance Strategies' 2016 Compliance Program Effectiveness (CPE) audit report.

Concurrence

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

Attachment

Compliance Strategies' Executive Summary of Compliance Program Effectiveness Audit Findings

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

Back to Agenda

EXECUTIVE SUMMARY

Medicare Advantage and Prescription Drug Program Compliance Program Effectiveness Audit Findings

Prepared by Compliance Strategies, Inc., a Healthcare Consulting Firm, for CalOptima

December 7, 2016

INTRODUCTION:

The Medicare Advantage (Part C) and Prescription Drug (Part D) program, administered by the Centers for Medicare & Medicaid Services (CMS), requires Plan Sponsors have an independent review and audit of their performance. This may be accomplished by an internal source or external entity. Compliance Strategies, Inc. was selected to evaluate CalOptima's overall performance in administering the Compliance Program.

PURPOSE:

The purpose of this audit was to evaluate CalOptima's performance related to Medicare Part C and Part D Compliance Program Effectiveness (CPE) and to assess CalOptima ability to meet its regulatory requirements and assure beneficiaries are receiving necessary health care services in a timely and appropriate manner.

CONCLUSION:

The 2016 Compliance Program Effectiveness Audit for CalOptima provided evidence that the current Compliance Program is effective. In reviewing actual cases identified during the audit period, Compliance Strategies was able to witness the process, including reviews of supporting policies and procedures, in which the CalOptima staff handled the resolution of these as dictated in its Compliance Program. CalOptima is effectively using the seven elements of an effective Compliance Program to review and address issues of non-compliance and potential fraud and abuse.

In addition, CalOptima was commended for two *best practices* in the area of the CalOptima Regulatory Tracking System for effective communications and its new, more robust risk assessment process.

BACKGROUND:

The Medicare Advantage (Part C) and Prescription Drug (Part D) programs provide health and prescription drug benefits for eligible individuals 65 and older and eligible individuals with disabilities. CMS contracts with private companies, like CalOptima to

administer these benefits through Medicare Advantage (MA), Medicare Advantage with Prescription Drug (MA-PD), or stand alone Prescription Drug Plans (PDPs). Both One Care and One Care Connect were part of this review and audit.

PROCESS:

CalOptima submitted data consistent with CMS CY2016 audit protocols to Compliance Strategies for review. Compliance Strategies selected six initial cases, also referred as *tracers* to review during the audit performed in August 2016 and two additional cases in November 2016. The tracer process requires Compliance Strategies to walk through each case to find evidence that the seven elements of an effective compliance program were considered and addressed during the resolution.

The tracers were selected from various areas of the organization including: Utilization Management, Grievances and Appeals, Pharmacy, Special Investigations Unit, Customer Service, as well as from CalOptima's First Tier Entities: MedImpact, PerformRX, and Monarch.

RECOMMENDATIONS:

Below is a summary of Compliance Strategies' recommendations for process changes, closing gaps, and/or additional details to further refine CalOptima's existing Compliance processes.

- Universe Issues – Plan should ensure each universe is accurate based on CMS specifications.
- Element 5 –Effective Systems for Routine Monitoring and Auditing –Plan should ensure OIG and GSA sanction screening is completed for all FDRs.

FOR MORE INFORMATION:

Virgilio Florentino,
Principal
Compliance Strategies
virgilio@csteam.us
917-520-7866

CALOPTIMA FOUNDATION BOARD ACTION AGENDA REFERRAL

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

Consent Calendar
8. Consider Reappointments to the CalOptima Foundation Audit Committee

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

Recommended Action
Reappoint Lee Penrose and Victor K. Hausmaninger to the CalOptima Foundation Audit Committee for terms ending on September 30, 2018.

Background
In accordance with Article 9, Section 3 of the CalOptima Foundation's Bylaws, the Foundation Board of Directors shall appoint an Audit Committee. The primary role of the Audit Committee is to make recommendations to the Foundation Board of Directors regarding the hiring and termination of an independent auditor, and in conferring with the independent auditor to ensure the Foundation's financial affairs are in order. In addition, in the event that the auditor's firm provides non-audit services, the Audit Committee shall ensure that the auditor adheres to applicable standards for auditor independence. Audit Committee members may also provide advice and guidance on audit-related issues as the Foundation Board of Directors considers expansion of the organization's grant making role.

Members of the Committee may not include the Chairperson of the Board, the Chief Financial Officer of the Foundation, any employee of the Foundation, or any person with a material financial interest in any entity doing business with the Foundation. The Committee may be composed of one or more persons, and may include persons other than directors of the corporation. The length of terms for Audit Committee membership is generally made for approximately two years.

Discussion
Staff recommends the reappointments of the following individuals to the CalOptima Foundation Audit Committee:

- Lee Penrose
  A member of the Foundation Audit Committee since December 2012, Mr. Penrose serves as the Vice Chair of the CalOptima Board of Directors and the Chair of the CalOptima Finance and Audit Committee. He also is the Chief Operating Officer, Acute Care Services at St. Joseph Hoag Health. Mr. Penrose was appointed a CalOptima Director in November 2011.

- Victor K. Hausmaninger, CPA
  A member of the Foundation Audit Committee since October 2014, Mr. Hausmaninger is the Founding Partner of HBLA Certified Public Accountants, Inc., and has spent his entire career as a certified public accountant, serving as Audit Partner with Deloitte & Touche. In 1985, he formed HBLA where he re-engineered his "Big 4" experience and standards and offered

Back to Agenda

accounting services to privately owned businesses and their owners. His background includes extensive experience in professional service corporations, manufacturing, high technology, real estate, financial institutions, construction, and distribution. Mr. Hausmaninger's professional affiliations include the American Institute of Certified Public Accountants, California Society of Certified Public Accountants, and YMCA of Orange County.

Fiscal Impact
There is no fiscal impact.

Rationale for Recommendation
Pursuant to the Bylaws of the CalOptima Foundation, members of the Audit Committee are to be appointed by the CalOptima Foundation Board of Directors.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

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

Back to Agenda

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.

Back to Agenda

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**

Back to Agenda

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.

Back to Agenda

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**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

10. Consider Authorizing Pursuit of Proposals with Qualifying Funding Partners to Secure Medi-Cal Funds Through the Voluntary Intergovernmental Transfer (IGT) Rate Range Program for Rate Years 2015-16 (IGT 6) and 2016-17 (IGT 7)

Contact

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

Recommended Actions

1. Authorize submission of a proposal to the California Department of Health Care Services to participate in the Voluntary Intergovernmental Transfer (IGT) Rate Range Program for Rate Years 2015-16 (IGT 6) and 2016-17 (IGT 7);
2. Authorize 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 Intergovernmental Transfer (IGT) Rate Range Program for Rate Years 2015-16 (IGT 6) and 2016-17 (IGT 7); and
3. Authorize the CalOptima Board Chair and/or Vice Chair to execute agreements with these entities as necessary to seek the IGT 6 and IGT 7 funds.

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. To date, CalOptima has participated in five IGT Rate Range transactions. The resulting 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, 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.

The IGT funds that have been secured to date through IGTs 1 – 5 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 autism and adolescent depression screenings and support for members through the Personal Care Coordinator (PCC) program. With the five IGTs approved and funded to date, the net proceeds have been evenly divided between CalOptima and the respective funding partners, with all funds retained by CalOptima invested in addressing unmet community needs identified through a comprehensive and transparent stakeholder vetting process.

Discussion

In late January, CalOptima received notification from DHCS regarding the next IGT series, for the State Fiscal Years (SFY) 2015-16 (IGT 6) and 2016-17 (IGT 7) for the Voluntary IGT Rate Range Program.

Back to Agenda

The notification outlined some changes to the upcoming IGT process which include:

- Two rate years, 2015-16 (IGT 6) and 2016-17 (IGT 7), will be processed simultaneously;
- Managed Care Organization tax of 3.9375% will apply only to the 2015-16 (IGT 6) rate year increase. This does not affect the net payments to the providers, as DHCS contributes the nonfederal amount of the tax and the tax is paid to CalOptima in the form of additional rate increase.

The notification also indicates that health plans are to retain no more than a small administrative fee to cover costs of processing the IGT transaction. However, staff has received further clarification from DHCS that if health plans and providers/funding entities agree that the plan is to retain more than a reasonable administrative fee (2-3%), the health plan must submit information (i.e., purpose, services provided, etc.) in its proposal which supports the negotiated percentages and/or amounts.

Five eligible funding entities have been identified and are in the process of submitting letters of interest regarding participation in the IGT program. 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 submit a Letter of Interest proposal to participate in the Voluntary IGT Rate Range Program and to enter into agreements with the five proposed funding entities or their designated providers to secure available IGT funds. Consistent with the five prior IGT transactions and the transparent and comprehensive vetting process conducted to date, it is assumed that the net proceeds will be split evenly between the respective funding entities and CalOptima.

Notification from DHCS of the IGT Rate Range Program for Rate Year 2015-16 (IGT 6) and Rate Year 2016-17 (IGT 7) was received January 26, 2017. Proposals are typically due to DHCS within 21 calendar days from the date of the notification, but staff has secured an extension to the submission deadline in order to request Board approval, and CalOptima's response to DHCS is now due March 3, 2017. Staff will provide updates regarding the IGT 6 and 7 transactions to the Board as additional information is available.

Fiscal Impact

The recommended action to pursue a proposal with DHCS and agreements with five governmental funding entities for IGT 6 and IGT 7 is expected to generate one-time IGT revenue which will be invested in Board-approved programs and 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 and future operating budgets.

Back to Agenda

Rationale for Recommendation

Consistent with the previous five IGT transactions, authorization of the proposed funding agreements will allow the ability to maximize Orange County's available IGT funds for Rate Year 2015-16 (IGT 6) and Rate Year 2016-17 (IGT 7).

Concurrence

Gary Crockett, Chief Counsel

Attachment

Department of Health Care Services State Fiscal Years 2015-16 and 2016-17 Voluntary IGT Rate Range Program Notification Letter dated January 26, 2017

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

2/23/2017 — **Date**

Back to Agenda

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

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

JAN 26 2017

Chet Uma
Chief Financial Officer
CalOptima
505 City Parkway West
Orange, CA 92868

SUBJECT: State Fiscal Years (SFY) 2015-16 and 2016-17 Voluntary Intergovernmental Transfers (IGT) Rate Range Program – Request for Medi-Cal Managed Care Plan's (MCP) Proposal and Supporting Documentation – County Organized Health System Model

Dear Chet Uma:

Welfare and Institutions (W&I) Code, Sections 14164, 14301.4 and 14301.5, provide for a voluntary IGT program relating to the Medi-Cal managed care capitation rate ranges. The available IGT amounts are the non-federal share of the difference between the Medi-Cal MCP's contracted capitation rate and the upper bound of the MCP's actuarially sound rate range, as determined by the Department of Health Care Services (DHCS). Governmental funding entities, who are 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 14163(m). The IGT is used to fund the non-federal share of increases in Medi-Cal managed care actuarially sound capitation rates. The IGT shall be paid, together with the applicable federal financial participation (FFP), by the DHCS to the MCP as part of the MCP's capitation rates for the periods of July 1, 2015, to June 30, 2016, (SFY 2015-16), and/or July 1, 2016, to June 30, 2017, (SFY 2016-17). This funding does not replace or supplant any other amounts paid or payable to the MCP's provider(s). The IGTs must be tied to providers of health care services provided to Medi-Cal beneficiaries.

The funds transferred by the governmental entity must qualify for FFP pursuant to Title 42 Code of Federal Regulations (CFR) Part 433, Subpart B, and 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. For governmental funding entities that are also direct service providers, impermissible sources do not include patient care or other revenue received

Capitated Rates Development Division
1501 Capitol Avenue, P.O. Box 997413, MS 4413
Sacramento, CA 95899-7413
Phone (916) 449-5053 Fax (916) 650-6860
www.dhcs.ca.gov
Back to Agenda

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.

PROCESS FOR SFY 2015-16 AND SFY 2016-17:

While it is DHCS' intention to process the IGTs for SFY 2015-16 and SFY 2016-17 in the same set of agreements, a governmental funding entity's participation levels for each SFY will be based on the MCP's proposal and other submission requirements, subject to DHCS review and approval. Additionally, approved participation levels for SFY 2016-17 will not be dependent on an entity's participation in SFY 2015-16. The funds shall be transferred in accordance with a mutually agreed upon schedule between the governmental funding entity and DHCS. DHCS does not intend to collect both SFY's non-federal share amounts at the same time, since each SFY's collection schedule will be dependent on the Centers for Medicare and Medicaid Services' (CMS) approval of the corresponding capitation rate increases.

The MCP's proposal must comply with the following three tiered selection approach:

Tier 1: DHCS' pre-assignment of non-federal share amounts:

DHCS has pre-assigned the following non-federal share amounts:

- *Not Applicable*

The DHCS pre-assigned amounts must be included in the MCP's proposal; however, DHCS' final approval of these pre-assigned amounts are subject to DHCS' review of the submitted documentation (see "Submission Requirements" included below). If final approval (all or in part) is not given to the pre-assigned funding entity, the MCP may be allowed to amend their proposal at DHCS' discretion. Any non-federal share amounts above and beyond DHCS' pre-assignments will be subject to "Priority for Existing Entity(ies)" procedures (Tier 2).

Tier 2: Priority for Existing Entity(ies)

Providers and governmental funding entities that participated in SFY 2014-15 rate range IGTs will be known as an "existing entity" for purposes of the SFY 2015-16 and SFY 2016-17 IGT selection process. Any remaining IGT non-federal share amounts beyond the designated pre-assigned amounts (identified in Tier 1) for SFY 2015-16 and/or SFY 2016-17, will be available for providers and funding entities that are identified as "existing entities." The available funding for the existing entities will be limited to their participation level in SFY 2014-15, and will be subject to DHCS' review and approval.

Back to Agenda

Any DHCS pre-assigned amounts specified in Tier 1 above will decrease the base year levels subject to Tier 2 guarantees for the specified SFY(s). Any available non-federal share amounts used beyond Tiers 1 and 2 will be subject to "New Entities and Increased IGT Amounts for Existing Entities" procedures (Tier 3).

The process for soliciting interest of existing entities to participate in SFY 2015-16 and SFY 2016-17 rate range IGTs is as follows:

- Attached is the estimated SFY 2015-16 and SFY 2016-17 county/region-specific non-federal share IGT amounts for the MCP, and the SFY 2014-15 non-federal share amounts by their existing funding entity(ies) and provider(s).
    - If the estimated non-federal share IGT amount available in SFY 2015-16 and/or SFY 2016-17 is less than the aggregate SFY 2014-15 level, the MCP will be responsible for negotiating any necessary decreases from SFY 2014-15 levels with its existing entities.
- MCP's are responsible for contacting each existing entity to determine their interest, ability to participate, and any possible funding restrictions. The MCP must also notify the existing entities that if they wish to continue their IGT(s) up to SFY 2014-15 levels, they must notify the MCP by a reasonable date set by the MCP, so it is able to meet the DHCS submission requirements.
    - If an existing entity fails to express interest by the date set by the MCP, or declines interest, the MCP may offer these available funds to its other existing entity(ies) to increase their IGT amounts beyond their SFY 2014-15 levels, or to newly interested governmental funding entities, subject to the "New Entities and Increased IGT amounts for Existing Entities" procedures.
    - If an existing entity(ies) decides not to participate up to its SFY 2014-15 level in either SFY 2015-16 and/or SFY 2016-17, ***the MCP must include a description of the MCP's efforts to solicit the existing entity(ies) participation in the IGT program as part of the MCP's proposal.***

Tier 3: New Entities and Increased IGT Amounts for Existing Entities

Any available non-federal share IGT amounts beyond Tiers 1 and 2 will be subject to "New Entities and Increased IGT Amounts for Existing Entities" procedures (Tier 3). The MCP may negotiate with existing entities or newly interested governmental funding entities to fund these available amounts, subject to DHCS' review and approval. The

newly interested governmental funding entity must operate in the corresponding county/region.
The process for soliciting interest of new entities and/or increased IGT amounts for existing entities is as follows:

- The MCP should determine the remaining SFY 2015-16 and SFY 2016-17 non-federal share amounts not used under Tiers 1 and 2.

- The MCP should contact potential governmental funding entities to determine their interest, ability to participate, and any possible restrictions. All providers and governmental funding entities who express their interest to DHCS will be redirected to the MCP to facilitate negotiations. The MCP is encouraged to work with all appropriate entities in their service areas.

- The MCP will be responsible for negotiating each new or existing entities' usage of the remaining non-federal share amounts, subject to DHCS' review and approval.

- As a reminder, the IGT program is voluntary. While participation is encouraged, MCP's may not be able to obtain funding for the entire IGT amount. If that occurs, capitation rate increases relating to the IGT will be adjusted to reflect the actual transfer amounts.

Twenty (20) Percent Assessment Fee

Pursuant to W&I Code Section 14301.4, all governmental funding entities must agree to fund an additional 20 percent assessment fee (based on their IGT contribution) to reimburse DHCS for the administrative costs of operating the IGT program and for the support of the Medi-Cal program.

Allowable Health Plan Retention

The MCP shall be responsible for any Medi-Cal managed care sales tax as authorized by Senate Bill (SB) 78 (Chapter 33, Statutes of 2013) related to any SFY 2015-16 revenues. If the MCP receives any capitation rate increases based on the SFY 2015-16 IGT amounts, the MCP may retain an amount equal to sales tax that the MCP is required to pay to the state. Since SB 78 does not apply to SFY 2016-17 revenue, this allowable retention provision is only applicable to the SFY 2015-16 IGT amounts.

Unless as prohibited under W&I Code Section 14301.5, the MCP may negotiate with the governmental funding entity a reasonable administrative fee to cover the MCP's

Back to Agenda

costs for administrating the IGT program. ***The negotiated administrative cost percentage to be retained by the MCP must be included in the MCP's proposal and is subject to CMS' approval.***

MCP will not retain any other portion of the IGT payments received from DHCS other than those mentioned above.

Submission Requirements

Once all of the MCP's negotiations are complete:

- The MCP must obtain a letter of interest (refer to template in Attachment A) from each governmental funding entity participating in the MCP's rate-range IGT including DHCS' pre-assigned amounts. An individual authorized to sign the certification on behalf of the governmental entity must sign the letter of interest.
    - Each letter of interest must specify:
        1. dollar amount or percentage they will contribute for each SFY by MCP and county/region,
        2. primary contact information (name, e-mail address, mailing address, phone number), and
        3. Federal Tax Identification Number.
- As a separate attachment, the following SFY 2015-16 information must also be provided for each provider receiving funding under the IGT program. Based on the participating governmental funding entity's preference, this information can be submitted to DHCS through the MCP or directly by the governmental funding entity; however, the information must be received by DHCS by the MCP proposal due date.
    - Inpatient and outpatient charges and costs (shown separately) for Medi-Cal services provided to the MCP's Medi-Cal beneficiaries.
    - Payments made by the MCP for inpatient and outpatient (shown separately) Medi-Cal services provided to the MCP's Medi-Cal beneficiaries. For designated public hospitals participating in SB 208 (Chapter 714, Statutes of 2010), the estimated SFY 2015-16 and SFY 2016-17 SB 208 payments to be received from the MCP should be included in the payment amounts. These estimated SB 208 amounts should be clearly indicated on the worksheet.

Back to Agenda

- Estimated trend factor between SFY 2015-16 and SFY 2016-17, and the basis for this estimation. If a trend factor is not provided or is considered excessive by DHCS, the SFY 2015-16 charges, costs and payments will be used for both SFY 2015-16 and SFY 2016-17.

- Scope of services (i.e., inpatient, emergency room, outpatient) provided to Medi-Cal managed care members. Please indicate if these services were provided under a provider agreement with the MCP or non-contracted.

- Member months of Medi-Cal managed care members assigned/serviced to/by the provider (overall and specific MCP).

- The MCP must submit a proposal to DHCS.
  - This proposal must include:
    1. a cover letter signed by the MCP's Chief Executive Officer or Chief Financial Officer on MCP letterhead,
    2. MCP primary contact information (name, e-mail address, mailing address, phone number),
    3. county/region-specific summaries of the selected governmental funding entities, related providers, and participation levels specified for SFY 2015-16 and SFY 2016-17. The combined amounts or percentages for each SFY cannot exceed 100 percent of the estimated SFY's non-federal share IGT amounts provided by DHCS. If the MCP was unable to use the entire SFY's IGT amount, the MCP should indicate the unfunded amount and/or percentage.
    4. All letters of interest and supporting documents must be attached to the proposal. Please indicate if the "separate attachment" will be submitted directly by a governmental funding entity.

- The proposals, letters of interest, and supporting documents are due to DHCS ***no later than 21 calendar days after the date of this letter***. A PDF copy of these documents should be e-mailed to Sandra.Dixon@dhcs.ca.gov. ***Late submissions may result in denied participation in the SFY 2015-16 and SFY 2016-17 rate range IGT program.***

- Each proposal submitted to DHCS is subject to review and approval. Each review will include an evaluation of the proposed provider participation levels in comparison to their uncompensated contracted Medi-Cal costs and/or charges. DHCS will exercise its discretion to make changes, as it deems necessary.

Back to Agenda

- Upon DHCS' approval of the governmental funding entities and non-federal share amounts for the SFY 2015-16 and SFY 2016-17 IGT program, DHCS will submit the necessary templates, forms, and related due dates to the specified funding entities and MCP contacts. The governmental funding entities will be responsible for completing all necessary documents, responding to any inquiries necessary for obtaining approval, and obtaining the governmental funding entity, provider and MCP signatures.

If you have any questions regarding this letter, please contact Sandra Dixon at (916) 552-9460 or by email at Sandra.Dixon@dhcs.ca.gov.

Sincerely,

Rafael Davtian
Acting Division Chief
Capitated Rates Development Division

Attachments

cc: Michael Schrader, CEO
CalOptima
505 City Parkway West
Orange, CA 92868

Annabel Vaughn
Manager, Regulatory Affairs & Compliance
CalOptima
505 City Parkway West
Orange, CA 92868

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

cc: continue on next page

Back to Agenda

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

Back to Agenda

ATTACHMENT A – LETTER OF INTEREST TEMPLATE

Rafael Davtian
Acting 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 Mr. Davtian:

This letter is to confirm the interest of _Insert Participating Funding Entity Name, a governmental entity, federal I.D. Number _Insert Federal I.D. Number in working with the [Managed Care Plan's Name] (MCP) and California Department of Health Care Services (DHCS) to provide a Medi-Cal managed care rate range Intergovernmental Transfer (IGT) to be used as a portion of the non-federal share of actuarially sound Medi-Cal managed care capitation rate increases for the MCP for the periods of July 1, 2015, to June 30, 2016, and July 1, 2016, to June 30, 2017. This is a non-binding letter, stating our interest in helping to finance health improvements for Medi-Cal beneficiaries 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.

We would like to provide the SFY 2015-16 and SFY 2016-17 rate range IGT funding for the rate period of July 1, 2015, to June 30, 2016, and July 1, 2016, to June 30 2017, respectively. The MCP is in agreement with this proposal. _Insert Participating Funding Entity Name is willing to contribute up to the $_____ for the SFY 2015-16 rate period, and $_____ for the SFY 2016-17 rate period, as negotiated with the MCP. We recognize that there will be an additional 20-percent assessment fee payable to DHCS on the funding provided for the administrative costs of operating the IGT program. The MCP and funding entity have negotiated the MCP retention of _____ percent of the capitation rate increases resulting from the governmental funding entity's contributions to cover the MCP's administrative costs for administering the IGT program. Neither the assessment fee nor the MCP retention amounts for administrative costs will apply to amounts authorized under Welfare and Institutions Code Section 14301.5.

We have listed the individual from our organization who will serve as the point of communication between our organization, MCP and DHCS on this issue as follows:

Entity Contact Information:

(Please provide complete Information including name, street address, e-mail address and phone number. Our courier cannot deliver to a P.O. Box.)

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

Back to Agenda

CalOptima - Orange County (HCP 506)
IGT - 2015/16 (July 2015 - June 2016)

	Total	50% (non-MCHIP)	65% (MCHIP 7/2015-9/2015)	88% (MCHIP 10/2015 - 6/2016)
Upper Bound	$1,180,136,242	$1,055,641,094	$ 31,205,933	$ 93,289,215
Lower Bound	$1,122,813,873	$1,004,524,258	$ 29,650,455	$ 88,639,159
Total Funds Available	**$ 57,322,370**	**$ 51,116,836**	**$ 1,555,478**	**$ 4,650,056**
Federal Match	$ 30,661,528	$ 25,558,418	$ 1,011,061	$ 4,092,049
MCO Tax (SB 78) - State Portion (3.9375%)	$ 1,049,771	$ 1,006,363	$ 21,436	$ 21,972
Governmental Funding Entity's Portion	$ 25,611,071	$ 24,552,055	$ 522,981	$ 536,035
	44.7%			

*	Child - non MCHIP	Child - MCHIP	Adult & Family (19 & Over)	Aged/ Disabled NonDual	Disabled/ Dual Eligible (CCI)	Aged/ Dual Eligible (CCI)	BCCTP	Long Term Care Non-Dual	Long Term Care Dual (CCI)	Total
Jul-15	210,432	109,938	101,628	41,270	-	-	658	402	-	464,328
Aug-15	213,139	110,128	102,275	41,567	-	-	645	399	-	468,153
Sep-15	214,753	110,338	102,704	41,860	-	-	729	385	-	470,769
Oct-15	216,673	110,901	104,527	42,202	-	-	722	373	-	475,398
Nov-15	218,769	110,029	103,940	42,215	-	-	715	371	-	476,039
Dec-15	220,236	110,505	104,507	41,658	-	-	699	374	-	477,979
Jan-16	219,682	109,102	105,214	41,883	-	-	685	361	-	476,927
Feb-16	219,491	108,307	104,759	41,844	-	-	652	354	-	475,407
Mar-16	221,410	109,519	105,911	42,037	-	-	655	354	-	479,886
Apr-16	220,034	109,654	105,230	42,230	-	-	640	368	-	478,156
May-16	218,161	108,701	103,875	42,436	-	-	631	361	-	474,165
Jun-16	222,399	111,015	103,252	42,598	-	-	628	368	-	480,260
	2,615,179	1,318,137	1,247,822	503,800	-	-	8,059	4,470	-	5,697,467

7/1/2015 - 6/30/16

COHS 2015/16 base rate - annual redetermination	Member Months **	Upper Bound	Lower Bound	Upper Bound	Lower Bound	Difference
Child - non MCHIP	2,615,179	$ 94.45	$ 89.74	$ 246,997,920.42	$ 234,686,163.46	$ 12,311,756.96
Child - MCHIP 7/2015 - 9/2015	330,404	$ 94.45	$ 89.74	$ 31,205,933.09	$ 29,650,454.96	$ 1,555,478.13
Child - MCHIP 10/2015 - 6/2016	987,733	$ 94.45	$ 89.74	$ 93,289,215.36	$ 88,639,159.42	$ 4,650,055.94
Adult & Family (19& Over)	1,247,822	$ 298.68	$ 283.93	$ 372,705,452.82	$ 354,294,100.46	$ 18,411,352.36
Aged/Disabled NonDual	503,800	$ 764.72	$ 727.94	$ 385,267,550.78	$ 366,736,172.00	$ 18,531,378.78
Disabled Dual	-	$ 156.18	$ 150.23	$ -	$ -	$ -
Aged Dual	-	$ -	$ -	$ -	$ -	$ -
BCCTP	8,059	$ 1,429.08	$ 1,358.17	$ 11,516,934.78	$ 10,945,492.03	$ 571,442.75
LTC Non-Dual	4,470	$ 8,759.11	$ 8,470.32	$ 39,153,235.10	$ 37,862,330.40	$ 1,290,904.70
LTC Dual	-	$ -	$ -	$ -	$ -	$ -
	5,697,467	$ 207.13	$ 197.07	$1,180,136,242.36	$1,122,813,872.73	$ 57,322,369.63
Total	**5,697,467**			**$1,180,136,242.36**	**$1,122,813,872.73**	**$ 57,322,369.63**
			Check	**$ -**	**$ -**	**$ (0.00)**

Variance	-653	1,501	-5024

Total	**6,594,818**
CCI	893,175
	5,701,643
	(4,176)
	-0.0732%

Back to Agenda

* Member Mos as of December 1, 2016 MIS DSS
** The Adult Expansion and supplemental payments (BHT and HEP C) are not included in the rate range calculation.
Please note: The main reason for the decrease between 2014-15 and 2015-16 is the removal of the CCI population from the calculation.

2014-2015 IGTs:

Regents of the University of California on behalf of UC Irvine Medical Center	14-90583	$27,256,944	Provider: UC Irvine University Physicians & Surgeons
County of Orange	14-90584	$ 2,161,319	Provider: Orange County Health Care Agency
City of Orange	14-90585	$ 344,656	Provider: Orange County Health Authority
City of Newport Beach	14-90586	$ 221,826	Provider: City of Newport Beach
Children and Families Commission of Orange County	14-90587	$ 5,409,161	Provider: Children's Hospital of Orange County and MOMs Orange County
		$35,393,906	

CalOptima - Orange County (HCP 506)
IGT - 2016/17 (July 2016 - June 2017)

	Total	50% FMAP (Non-MCHIP)	88% FMAP (MCHIP)
Upper Bound w/o MCO Tax (SBx2 2)	$1,232,621,062	$1,099,595,970	$133,025,092
Lower Bound w/o MCO Tax (SBx2 2)	$1,166,268,983	$1,040,556,110	$125,712,873
Total Funds Available	**$ 66,352,079**	**$ 59,039,859**	**$ 7,312,219**
Federal Match	$ 35,954,683	$ 29,519,930	$ 6,434,753
Governmental Funding Entity's Portion	$ 30,397,396	$ 29,519,930	$ 877,466
	46%		

7/1/2016 - 6/30/2017

COHS 2016/17 base rate w/MCO Tax - annual redetermination	Member Months **	Upper Bound w/o MCO Tax	Lower Bound w/o MCO Tax	Upper Bound w/o MCO Tax	Lower Bound w/o MCO Tax	Difference	MCO Tax	Upper Bound w/MCO	Lower Bound w/ MCO	New Rates w/Tax (TBA based on participation)
Child - non MCHIP	2,696,753	$ 97.51	$ 92.15	$ 262,960,385.03	$ 248,505,788.95	$ 14,454,596.08	$ 13.15	$ 110.66	$ 105.30	
Child - MCHIP	1,364,220	$ 97.51	$ 92.15	$ 133,025,092.20	$ 125,712,873.00	$ 7,312,219.20	$ 13.15	$ 110.66	$ 105.30	
Adult & Family (19& Over)	1,231,378	$ 312.54	$ 295.52	$ 384,854,880.12	$ 363,896,826.56	$ 20,958,053.56	$ 13.15	$ 325.69	$ 308.67	
SPD (Aged/Disabled NonDual)	502,865	$ 790.49	$ 747.70	$ 397,509,753.85	$ 375,992,160.50	$ 21,517,593.35	$ 13.15	$ 803.64	$ 760.85	
SPD Full Dual (Disabled/Dual)	-	$ 109.30	$ 103.51	$ -	$ -	$ -	$ 13.15	$ 122.45	$ 116.66	
SPD Full Dual (Aged/Dual)	-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
BCCTP	7,561	$ 1,463.08	$ 1,383.43	$ 11,062,347.88	$ 10,460,114.23	$ 602,233.65	$ 13.15	$ 1,476.23	$ 1,396.58	
LTC NonDual	4,360	$ 9,910.23	$ 9,564.50	$ 43,208,602.80	$ 41,701,220.00	$ 1,507,382.80	$ 13.15	$ 9,923.38	$ 9,577.65	
LTC Dual	-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
	5,807,137	$ 212.26	$ 200.83	$ 1,232,621,061.88	$ 1,166,268,983.24	$ 66,352,078.64				
Total	**5,807,137**			**$ 1,232,621,061.88**	**$ 1,166,268,983.24**	**$ 66,352,078.64**				
			Check	$ -	$ -	$ (0.00)				

*	Child - non MCHIP	Child - MCHIP	Adult & Family (19& Over)	SPD (Aged/ Disabled NonDual)	SPD Full Dual (Disabled/ Dual) (CCI)	SPD Full Dual (Aged/ Dual) (CCI)	BCCTP	LTC NonDual	LTC Dual (CCI)	Total
Jul-16	223,045	111,231	102,456	41,631	-	-	633	355	-	479,351
Aug-16	222,340	111,519	101,743	41,497	-	-	628	360	-	478,087
Sep-16	222,255	112,686	101,403	41,437	-	-	621	360	-	478,762
Oct-16	222,891	113,008	101,693	41,555	-	-	623	361	-	480,131
Nov-16	223,528	113,331	101,984	41,674	-	-	625	362	-	481,504
Dec-16	224,167	113,655	102,276	41,793	-	-	627	363	-	482,881
Jan-17	224,808	113,980	102,568	41,912	-	-	629	364	-	484,261
Feb-17	225,451	114,306	102,861	42,032	-	-	631	365	-	485,646
Mar-17	226,096	114,633	103,155	42,152	-	-	633	366	-	487,035
Apr-17	226,742	114,961	103,450	42,273	-	-	635	367	-	488,428
May-17	227,390	115,290	103,746	42,394	-	-	637	368	-	489,825
Jun-17	228,040	115,620	104,043	42,515	-	-	639	369	-	491,226
	2,696,753	1,364,220	1,231,378	502,865	-	-	7,561	4,360	-	5,807,137
annual growth rate										3.43%

* Member Mos as of December 22, 2016 MIS DSS – Actual enrollment for July 2016-September 2016; 2015-16 annualized growth rate used to estimate October 2015 - June 2016 enrollment.
** The Adult Expansion and supplemental payments (BHT and HEP C) are not included in the rate range calculation.

2014-2015 IGTs:

Regents of the University of California on behalf of UC Irvine Medical Center	14-90583	$27,256,944	Provider: UC Irvine University Physicians & Surgeons
County of Orange	14-90584	$ 2,161,319	Provider: Orange County Health Care Agency
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Children and Families Commission of Orange County	14-90587	$ 5,409,161	Provider: Children's Hospital of Orange County and MOMs Orange County
		$35,393,906	

Prepared by DHCS, Capitated Rates Development Division, Financial Management Section

1/13/2017

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

11. Consider Authorizing Contract with Vendor to Assist with the Member Health Needs Assessment Activities

Contact

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

Recommended Action

Authorize the Chief Executive Officer to execute a contract with Harder+Company Community Research to assist with the Member Health Needs Assessment activities in an amount not to exceed $414,405.

Background

The CalOptima Board of Directors approved an expenditure plan for allocation of dollars from IGT 4 at the December 1, 2016 meeting. The action included approval of up to $500,000 to complete a comprehensive Member Health Needs Assessment (MHNA), the results of which will be used to understand the greatest needs of the Medi-Cal members CalOptima serves, as well as identify barriers to access, gaps in service and disparities in health among CalOptima members. The data may also be used to inform the development of a process to select and support IGT funded projects and initiatives. The MHNA will be conducted with the assistance of consultant services (procured according to CalOptima's Board-approved purchasing policy).

In selecting the recommended vendor, a Request for Proposal (RFP) process for consultant services was issued by CalOptima on December 20, 2016 and a total of five proposals were received. A proposal evaluation committee comprised of staff plus Jane Chai, County of Orange Health Care Agency, Public Health Project Manager and Sandra Finestone, CalOptima Member Advisory Committee member, two external stakeholder representatives, reviewed the submitted proposals. The top two proposals were selected to advance to a finalist round. The two finalist firms were interviewed by IGT Ad Hoc committee members (Supervisor Andrew Do and Director Alex Nguyen) and staff. After the evaluation of proposals and in-person interviews, the proposal with the highest overall score was selected.

Discussion

Harder+Company Community Research (Harder+Company) is being recommended as the selected vendor due to completeness of their proposal as well as their knowledge and experience in completing community health needs assessments with local organizations, health plans and other public health care agencies. Harder+Company, along with their subcontractor, Social Science Research Center at California State University, Fullerton (CSUF) has in-depth experience and subject matter expertise in the development and administration of multiple survey tools and methods as well as data analysis and final reporting and recommendations. The Social Science Research Center (SSRC) at CSUF will assist Harder+Company in the collection of the member survey, assist

Back to Agenda

the development of tools and support analysis. In addition, due to SSRC's local university setting and expertise, they will work with staff to connect to local community-based organizations.

Harder+Company will assist staff with the activities associated with the MHNA, including 1) development of a best practice model project plan, 2) development of survey instruments and facilitation guides, 3) administration of member and provider/key informant surveys (mail/online, telephone, in-person and facilitation at community town halls/forums and focus groups, 4) data sampling, collection and analysis combined with evaluation of internally produced clinical/survey data and external secondary data sources, and 5) development of the final health needs assessment report and recommendations. The Scope of Work is attached.

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

Rationale for Recommendation
Results of the Member Health Needs Assessment will be utilized by CalOptima's Board of Directors and executive staff to inform future strategic planning efforts, guide future grant making and program development, and support opportunities for meaningful engagement to improve the overall health of CalOptima members. The information may also guide service providers, community agencies, County departments and policy makers on the specific needs of Orange County's Medi-Cal beneficiaries.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Draft Vendor Scope of Work
2. MHNA Proposal Evaluation and Interview Scoring Sheet
3. Board Action dated December 1, 2016, Consider Authorization of the Expenditure Plan for Available IGT Funds, Including Reallocation of Dollars from IGT 1, IGT 2, and IGT 3, and Allocation of Dollars from IGT 4 and 5

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

Back to Agenda

Proposal to provide

Member Needs Assessment Services

Revised Scope of Work and Budget

CalOptima

This document outlines revised scope of work and budget for the CalOptima Member Health Needs Assessment. Changes from the original proposal are a result of conversations between Harder+Company and CalOptima.

Scope of Work

The purpose of this engagement is to conduct a comprehensive Member Health Needs Assessment (MHNA) to identify the priority needs and factors affecting the health of CalOptima's membership. In recent years, multiple health assessments have been conducted throughout Orange County but do not provide sufficient detail regarding the particular needs of Medi-Cal beneficiaries, as well as specific needs of diverse communities throughout the County. Harder+Company, in partnership with the Social Science Research Center at Cal State Fullerton, proposes to conduct a thorough member needs assessment focused on understanding the healthcare and health needs of CalOptima's member population. Our rigorous mixed-methods approach ensures broad representation of members within all key language and age groups, as well as the perspectives of health care providers and key community stakeholders. Our methods are designed to include participants in a variety of ways in order to increase engagement and yield meaningful data. Additionally, we bring deep experience designing and conducting assessments and evaluations that contextualize health needs and outcomes within a social determinants of health framework that acknowledges the role that economy, educational and environmental factors play in determining health. We work collaboratively with our clients to ensure reports and other products are accessible to a wide range of audiences and that highlight key findings that can be used to direct resources to address health disparities and promote health equity.

Based on the activities outlined in the RFP, we propose the following four project phases: (1) design and planning, (2) data collection and analysis, (3) data synthesis and reporting, and (4) project management and coordination.

Phase 1: Project Planning (March 2017 – April 2017)

A brief planning phase helps to ensure a shared understanding of program goals, objectives, and activities, as well as key evaluation questions and methods. We anticipate completing this phase within 30 days after award notification, assuming we can schedule a kick off meeting with CalOptima staff and the Member Health Needs Assessment Committee during that period. The tasks associated with this phase are outline below.

Task 1.1 Kick off meeting to refine work plan (March 2017). Our first step will be to facilitate a kick off meeting with CalOptima staff, our subcontractor Social Science Research Center (SSRC) and, if appropriate, members of the Member Health Needs Assessment Committee in order to obtain feedback on the proposed work plan. We will refine our approach, proposed tasks and timeline based on input and suggestions of the group.

- ★ Deliverable: Final Work Plan

Task 1.2 Preliminary secondary data review (March- April 2017). Harder+Company will conduct an initial review of prior assessments and reports conducted by CalOptima and the Orange County Health Care Agency, Health Improvement Partnership, as well as other relevant health needs assessments conducted throughout Orange County. The purpose of this initial review will be to assess high level health needs in the county, understand what is already known and not known about CalOptima's member population, and inform the development of data collection tools.

- ★ Deliverable: Summary of secondary data review

Task 1.3 Member Health Needs Assessment (MHNA) Committee orientation (March-April 2017). Harder+Company will convene members of the MHNA and Strategic Development staff for an in-person project orientation.

The purpose of the initial MHNA Committee meeting will be to 1) orient the MHNA Committee to the assessment process and goals; 2) review roles and responsibilities of members; and 3) invite input on the work plan, data collection activities, and best practices for recruitment of hard to reach populations. We will also determine the frequency of meetings, type of meetings (in-person versus virtual), as well as the workgroup's input and decision-making processes.

The anticipated goals of subsequent MHNA meetings are described in more detail in subsequent phases. Harder+Company will engage the MHNA Committee in two to three additional meetings following their initial orientation in person and remotely via webinar. We have successfully engaged advisory groups in this manner for several engagements, including all of our Community Health Needs Assessments.

- ★ Deliverable: Committee meeting summary

Task 1.4 Project communications and meetings (ongoing). In order to ensure the usefulness of the needs assessment data, Harder+Company will work closely with CalOptima and the SSRC throughout the data collection process, particularly during the planning and reporting phases. Initially, this will include in person meetings. We will also maintain ongoing communication as appropriate by phone, webinar and email.

- ★ Deliverable: Monthly progress report

Phase 2: Finalize Design and Develop Tools (April 2017 – May 2017)

Based on the RFP requirements, we propose three key data collection methods:

1. **Initial interviews with up to 25 key stakeholders** to understand member health needs, as well as guide both sampling and tool development for the subsequent methods;
2. **A multi-model survey** with a convenience sample as well as a random sample of 2,442 CalOptima members designed to provide a representative sample across language and age groups;

3. **An online provider survey;**
4. **Facilitation of up to eight focus groups** with target populations; and
5. **Training to CalOptima staff and volunteers** to conduct an addition 20 focus groups throughout the community.

During this phase, we will work with CalOptima and the MHNA Committee to confirm the sampling approach, tools, and analysis priorities for each method. SSRC will take the lead on all technical aspects for member survey sampling and we will work together to develop all data collection tools to ensure they build off and complement one another. The overall approach to each data collection method is described in further detail below.

Task 2.1 Finalize sampling plans (April-May 2017).
Harder+Company and SSRC will work with CalOptima to finalize a sampling frame for each data collection method that captures a breadth of perspectives as well as focuses on the specific needs of key populations. It is anticipated that the provider survey will be distribute to a broad sample of providers in the CalOptima network to obtain a cross section of feedback with regard to provider type, location, and specialty may be needed. The focus groups will focus on key target populations to be defined with input from CalOptima and the MHNA Committee.

Given that the member survey is a key focus of the needs assessment; our proposed initial approach to sampling for the survey is described below. We would expect to refine and finalize the sampling approach with CalOptima and the MHNA Committee.

The focus for the proposed study is CalOptima's member population; nearly all of Orange County's Medi-Cal beneficiaries, estimated to number 800,000 members. Although the purpose of this study is to assess the needs of Medi-Cal beneficiaries in Orange County as a whole, an emphasis is being placed on gaining a better understanding of the unique needs of members who speak one of the seven CalOptima identified "threshold" languages: English (47%), Spanish (26%), Vietnamese (9%), Korean (1%), Farsi (1%), Arabic (1%) and Chinese (1%). Therefore, it is recommended to over-sample all seven sub-groups.

The overall goal is to collect surveys from 4,000 CalOptima members. To accomplish this, a dual administration approach will be used. For the convenience sample, the survey will be first sent via mail to a random selection of CalOptima members. Members will have the option to complete the enclosed paper survey and return using a postage-paid envelope, or use a custom link to complete the survey online. The surveys will be printed and mailed by CalOptima. The final number to be sent the survey will be finalized with input from CalOptima and the MHNA Advisory Committee. Mailed surveys can be sent to SSRC for data entry; the budget currently includes data entry for up to 1,578 convenience sample surveys; any additional data entry costs will be covered by CalOptima at a unit cost of $1.50.

To ensure a representative sample for each of the seven threshold languages the survey will be completed with a random sample of an additional 2,442 survey completions. To account for the fact that CalOptima expects survey completions with those designated as "other member languages not represented within the threshold languages," a target of at least 90 survey completions with this group is expected, for a total sample size of 2,422. A sample size of 2,422 translates into a confidence level of 99%, with a confidence interval of 2.62 points. This means that for any sample estimate, CalOptima and its Stakeholders can be 99% certain that the true population parameter for members as a whole will fall between +/- 2.62 points of that estimate. The oversampling of members designated as speaking one of the seven threshold languages will ensure that CalOptima and its Stakeholders can be 95% confident that the true population parameters for any particular sub-group will fall between +/- 5.34% of the observed sample estimate. Exhibit 3 on the following provides an overview of the proposed member survey sampling frame.[1]

[1] It is anticipated that some subgroups such as languages not represented in the threshold languages or specific age groups may be smaller than the targeted threshold language groups. In an attempt to balance methodological rigor with feasibility, the confidence intervals for these groups will be larger than 5.0%. More specifically, the confidence interval for the "0 to 5 years" subgroup will be 5.29 (95% confidence level) and 5.59 for the "0 to 65 years" sub-group. If, it is easier than assumed to reach these groups, efforts will be made to sample a larger number of members from each of these two age groupings.

Exhibit 3: Projected Member Survey Sample

	English	Spanish	Vietnamese	Korean	Farsi	Arabic	Chinese	Unknown	*Totals Per Age Group*
0 to six	41	41	41	41	41	41	41	12	299
Six – 18	101	101	101	101	101	101	101	26	733
19-44	97	97	97	97	97	97	97	25	704
45-64	60	60	60	60	60	60	60	16	436
65+	37	37	37	37	37	37	37	11	270
Total by Language Group	336	336	336	336	336	336	336	90	2,422

This approach is recommended over others (such as sending the survey to all members and analyzing all returned responses) for several reasons. Specifically, this sampling approach allows for detection of statistically significant differences between the seven language sub-groups with respect to indicators of interest, including behavioral risk and protective factors as well as other determinants of health status if, in fact, they exist. In order to achieve the target number of completes for each of the seven threshold language groups, a stratified random sampling method will be utilized. In stratified random sampling, the population is divided into subgroups or strata based on specific characteristics, in this case age and language. A random selection of a target number of members from each subgroup will serve as the sample frame for the current study. Given that CalOptima has observed a return rate of 25% in previous surveys (conducted by mail and phone), it is estimated that a random selection of between 2,000 and 5,000 records from each language threshold subgroup will be needed. Within each language subgroup, the sample frame will be constructed such that the distribution of members within each

age group is roughly approximate to what is observed in the entire population: 0-5 (12%); 6-18 (30%), 19-44 (29%), 45-64 (18%) and 65+ (11%).

- ★ Deliverable: Sampling Plan for member survey, provider survey, and focus groups

Task 2.2 Finalize data collection tools (April-May 2017). The member survey, provider survey, and focus group facilitation guides will be developed by our staff and shared with MHNA Committee members and CalOptima staff for feedback and revisions. We anticipate that the tools will be based on similar needs assessment projects we have conducted, but we will tailor them to the specific focus and needs of CalOptima members based on what we learn from the secondary data review and initial stakeholder interviews. As outlined in the RFP, the member survey will be translated into Spanish, Vietnamese, Korean, Farsi, Arabic, and Chinese by CalOptima staff. We also expect CalOptima staff to assist in translation of focus group facilitation guides as needed.

- ★ Deliverable: Data Collection Tools

Phase 3: Data Collection and Analysis (May 2017 – October 2017)

The data collection methods described above are intended to ensure the final needs assessment includes input from CalOptima members, as well as providers and other key stakeholders. Below we describe the approach to successfully carry out data collection and analysis for each method.

Task 3.1 Member survey administration and analysis (May-August 2017). The following is a summary of the steps for obtaining a random sample of 2,442 surveys. As described in Task 2.1, CalOptima will also mail the survey to a select group of members to obtain an additional convenience sample of completed surveys.

We will work with CalOptima to obtain a data file that includes

member names, phone numbers, addresses, and demographic information needed to randomly select and contact members. Given the fact that members of certain ethnic subgroups have demonstrated different preferences in survey modality, a four phase multi-modal approach to data collection will be pursued. During the first phase, every member that is randomly selected into the sample frame will receive an email describing the purpose of the current study along with the request for member participation. Up to three reminders will be sent within one week of each other. During this phase, respondents may call the SSRC toll-free to request either a paper, phone or in person survey. It is estimated that approximately 1,600 members will select a paper/pencil mail-based version of the survey either because they don't have an email address, or they request one directly; these will be sent out approximately four weeks after phone calls begin. Approximately three weeks after the paper-pencil version of the survey is mailed out, reminder calls will be made to those who have not returned their survey. Up to three reminder calls will be made with members who have been mailed the paper-pencil version of the survey, at which point telephone interviewers will be trained to attempt to complete the survey over the phone or schedule a time do conduct the survey in person. Throughout this time, telephone surveys will be completed with members in the sample frame who either do not have an email or residential address or have requested to complete the survey by phone. Once the online and mail-based phases of data collection are complete, telephone surveys will be attempted with the remaining members of the sample frame. The telephone phase of the data collection will last approximately four weeks. If during this period, it is determined that the best way to complete a survey with a member is through an in person visit, one will be coordinated either with the member directly or in coordination with CalOptima or community partners. In an effort to maintain the highest standards with respect to data collection, it is recommended that surveys only be administered by trained members of the SSRC staff. If a member who is not selected as part of the sample frame wishes to be a part of the study, the SSRC will administer the survey to them but they will not be reflected in the overall response rate.

The SSRC implements Computer Assisted Telephone Interviewing (CATI) through WinCATI® software to facilitate the control of the sample, track scheduled call-backs, and monitor progress regarding the completion of sample design quotas. Programming is carried out using the CI3 scripting language which allows for the randomization of questions and question sets within a survey to eliminate response-order biases, response range limits to reduce data entry errors, and complex interview navigation commands to ensure the proper administration of survey items.

Survey questions and response options appear on a computer screen while the interviewer is speaking to the respondent. Data are entered directly into the system so coding or keying errors are reduced. SSRC supervisors are present during all interviewing shifts and "random" call-monitoring is routinely performed to verify the accuracy of the data. All SSRC supervisors previously worked as a telephone interviewer, and have received extensive training in telephone interviewing techniques and methodological considerations.

The CATI system includes a sophisticated call tracking and call-back scheduling procedure. This system assigns sample records to interviewing stations based on user configurable rules which include a randomization element, and also consider call history, and interviewer capability/training. An attempt history is maintained for each sample record which can be used to calculate productivity and other process related statistics. If no contact is made, the call record will note the time of day and the interviewer who attempted the call. The call will then be automatically reassigned at a later time based upon an algorithm that reduces the probability that the call will come up again on the same day and time. When a contact is made, but the interview is not completed, call information is recorded that includes whether a call-back has been scheduled, who the interviewer spoke with, who they should talk to if the eligible respondent is not at home, and the current disposition of the call (for example, immediate refusal, answering machine, mid-interview termination, etc.). In addition, the time of each call, the number of times the record has been called, and any interviewer-generated notes are recorded. The CATI system

allows the researcher to set the number of times a sample record is to be called before it is retired. SSRC standard operating procedure dictates 21 attempts at contact. If contact is not established after 21 calls, the number is transferred to a holding queue. Exceptions are made to this procedure in two cases. If the 21st call attempt yields a scheduled callback, then a 22nd call attempt will be made as scheduled. And, when a respondent begins a survey and cannot complete it at that time, but indicates that they will complete the survey at a later date, an indefinite number of call attempts are made to complete the survey with that individual.

SSRC policy regarding immediate refusals is to call back at random intervals no less than 72 hours after the initial refusal. Experience shows that about 30% of initial refusals can be converted simply by contacting another resident at the same number. The procedure for converting refusals by respondents whose eligibility has been established involves two steps. After the initial refusal, a call back is made at a different time. The telephone interviewer will ask for the eligible respondent, beginning by apologizing for bothering them again, and subsequently attempt to explain the scientific reason purpose for the call. This procedure converts about 20% of refusals who are known to be eligible for the survey. If this results in a second refusal, one more attempt will be made using a "please help" approach. This generally yields a conversion rate of 10%. After three refusals, the telephone number is retired and classified accordingly. This procedure is a modification of Dillman's (1978) Total Design Method.

The SSRC strives to treat all potential respondents as “clients.” As a result, all requests to speak to SSRC management staff are resolved in 24 hours. If potential respondent requires information that members of the SSRC staff do not possess, we will work with CalOptima and its stakeholders to make sure someone follows up with them.

- ★ Deliverable: Member Survey Data File

Task 3.2 Provider survey administration and analysis (May-August 2017).
The provider survey offers the opportunity to capture the unique perspective that providers bring to understand member health needs as well as understand social determinants of health, as well as existing assets and community strengths. Harder+Company will work directly with CalOptima staff to identify providers and administer the survey. The survey will be administered through Survey Gizmo, an internet survey tool that allows providers to participate in the survey online via an email link. In order to successfully engage providers, Harder+Company will draft an initial email for CalOptima to distribute to providers that will alert them that a survey will be emailed and how they can respond. Once the survey link is emailed, Harder+Company will monitor provider responses on the Survey Gizmo website. Providers who do not respond to the initial survey email will receive reminder emails. If appropriate, Harder+Company can conduct follow-up interviews via telephone with providers who do not respond to the survey email in order to increase response rates among key providers.

- ★ Deliverable: Provider Survey Data File

Task 3.3 Key informant phone interviews (April-September 2017). Harder+Company will conduct up to twenty five (25) interviews with stakeholders identified by CalOptima staff and MHNA Committee members, who can provide insight into the health needs and barriers facing CalOptima members in various regions of Orange County. These interviews will serve to complement data obtained through the member and provider surveys in order to identify the broader health needs of Orange County residents and ethnic/language population-specific needs related to health care access and utilization. Likely candidates for these interviews may include, but are not limited to CalOptima health care service providers, representatives from community based organizations that serve vulnerable and/or underrepresented populations, and MHNA Committee members. We will work with CalOptima staff and the MHNA Committee to develop the interview protocol and finalize the stakeholder list before contacting stakeholders to conduct the interviews.

★ Deliverable: Completed Interviews

Task 3.4 Stakeholder focus groups (July-September 2017). Following preliminary analysis of member and provider survey data, Harder and Company will facilitate eight (8) focus groups with key community stakeholders and members of key subpopulations with a particular focus on the needs of communities that speak Orange County threshold languages (Spanish, Vietnamese, Korean, Farsi, Arabic, and Chinese). An additional 20 focus groups will be led by CalOptima staff and volunteers (see Task 3.5). The purpose of these focus groups is to obtain in-depth, qualitative information regarding specific culturally-related barriers to health care access, ways to better engage and service hard to reach populations, and opportunities to leverage relationships with community based organizations that already have established relationships with underserved populations to improve service. We anticipate collaborating closely with CalOptima staff to recruit member participants and ensure that implementation of the focus groups is responsive to the primary languages spoken by participants. In cases, where our firm lacks relevant linguistic capacity, we will work closely with the subcontractor to co-facilitate data collection. We will summarize the focus group findings in a quote book which provides key quotes aligned with each analysis category (i.e., healthcare needs; health needs and member characteristics; social and emotional well-being; health behaviors and prevention).

We will work closely with CalOptima to determine the overall sampling plan for all focus groups and determine which should be led by Harder+Company staff and which can be led by CalOptima staff and volunteers. CalOptima staff will lead recruitment and logistics efforts, including review of recruitment materials and identifying convenient times and comfortable, safe and easy-to-access locations for the participants. We will ensure that recruitment and facilitation of the focus groups is responsive to the threshold languages. CalOptima will provide refreshments and gift card incentives for all focus groups.

★ Deliverable: Focus Group Quote Book

Task 3.5 CalOptima staff focus group facilitation training and technical assistance (June-August 2017).
Harder+Company will provide up to 3 in person or virtual trainings for CalOptima staff and volunteers to facilitate an additional 20 focus groups. This training will include a review of the evaluation plan, the focus group protocol, techniques for facilitation and managing group dynamics, and proper documentation and qualitative data management. In addition, Harder+Company will offer technical assistance to facilitators prior to and following their first focus group to ensure data quality.

- ★ Deliverable: Focus Group Training Materials

Task 3.6 Conduct Data Analysis (August-September 2017).
Harder+Company will take the lead on tabulating, coding and analyzing all survey, interview, focus group, and secondary data. We will work with CalOptima staff to develop an analysis plan that answers priority assessment questions about the health needs of the member population. Qualitative data from interviews and focus groups will be coded and analyzed using the software Atlas.ti to identify major themes. Quantitative data from the member and provider surveys will be cleaned for missing or incomplete responses and analyzed using the Statistical Package for the Social Sciences (SPSS)

- ★ Deliverable: Data Analysis Plan

Phase 4: Data Synthesis and Reporting (October-December 2017)

Task 4.1 Prepare draft report (September-October 2017).
Harder+Company will synthesis quantitative data and qualitative data collected during Phase III into a draft report. As outlined in the RFP, the report will include:

- Executive Summary
- Background and demographics of CalOptima membership;
- Healthcare Needs;
- Health needs and characteristics of membership;
- Social and Emotional Well-Being;
- Health Behaviors and Prevention.

This report will be shared with CalOptima staff and members of the MHNA Committee for feedback. We propose conducting a brief webinar or in-person meeting to review the draft report as a group and discuss feedback and steps needed to finalize the report.

- ★ Deliverable: Draft Report

Task 4.2 Prepare final report (November-December 2017). Harder+Company will incorporate feedback from CalOptima staff and members of the MHNA Committee into a final comprehensive report.

- ★ Deliverable: Final Report

Task 4.3 Prepare executive summary (November-December 2017). Concurrently with preparation of the final report, Harder+Company will synthesize key findings from the MHNA and create a concise executive summary that can be widely distributed to stakeholders.

- ★ Deliverable: Executive Summary

Task 4.4 Present key findings from MHNA (December 2017). Harder+Company will synthesis findings from the final report and prepare a final PowerPoint presentation highlighting key findings from the MHNA. These findings will be presented to CalOptima's Board of Directors and staff on December 7, 2017.

- ★ Deliverable: Data Presentation

Exhibit 2. Project Work Plan

Project Task	Deliverable	Roles			# of weeks from project start	Timeline									
		Harder+Co	SSRC	CalOptima		Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Phase I. Design and Planning															
1.1 Kick off meeting to refine work plan	Final Work Plan	Prepare and Lead meeting; refine work plan	Attend meeting	Provide input on work plan; attend meeting	4										
1.2 Preliminary secondary data review	Summary of secondary data review	Lead review	Review data summary	Send existing reports and data to Harder+Co	6										
1.3 MHNA Committee Orientation [includes meeting planning, material development, scheduling, travel, meeting time]	Committee meeting summary	Prepare and Lead meeting	Consult on agenda and materials; attend meeting	Provide Committee contact list; attend meeting	6										
1.4 Project communication and meetings	Monthly progress report	Ongoing communication and project support; attend meetings; progress reports	Bi-weekly progress reports to Harder+Co	Attend project meetings	Ongoing										
Phase II. Finalize Design and Develop Tools															
2.1 Finalize sampling plans	Sampling Plan for member survey, provider survey, and focus groups	Consult on member survey sampling; develop sampling for provider survey and focus groups	Finalize member survey sampling plan	Provide feedback on sampling plan	10										
2.2 Finalize data collection tools (member survey, provider survey, focus group, community forum) and sampling plan (includes MHNA Committee convening)	Data collection tools	Lead tool development; update based on CalOptima's input	Consult on tools, particularly member survey	Provide feedback on tools; provide translation	10										

Project Task	Deliverable	Roles	# of weeks	Timeline

			from project start													
		Harder+Co	SSRC	CalOptima		Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Phase III. Data Collection and Analysis																
3.1 Member survey administration and analysis	Member survey data file	Monitor SSRC progress; analyze findings	Lead data collection; submit data file to Harder+Co and consult on weighting analysis	Provide member contact list	24											
3.2 Provider survey administration and analysis	Provider survey data file	Lead programming of tool into Survey Gizmo, deploying email survey and collecting responses; analyze findings	N/A	Provide provider contact list	24											
3.3 Stakeholder phone interviews (n=25)	Completed Interviews	Develop questions, schedule and conduct interviews; develop summary	Provide input on questions	Provide input on stakeholder list and questions	26											
3.4 Stakeholder Focus Groups (n=8)	Focus Group Quote Book	Organize, facilitate and analyze focus groups	Co-facilitate for non-English groups	Translate facilitate guide and assist in recruitment efforts	28											
3.5 Focus Group facilitation training and technical assistance	Focus Group Training Materials	Facilitate up to three training sessions	N/A	Review training materials, organize sessions, invite staff/volunteers	28											
3.6 Conduct Data Analysis	Data analysis plan	Develop analysis plan, conduct analyses	Review analysis plan, conducting weighting analysis	Review data analysis plan	30											
Project Task	**Deliverable**	**Roles**	**# of weeks**	**Timeline**												

			from project start												
		Harder+Co	SSRC	CalOptima		Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Phase IV. Data Synthesis and Reporting (continued)															
4.1 Prepare draft report (include MHNA Committee convening)	Draft report	Lead development of report; convene webinar with CalOptima and MHNA Committee to discuss feedback	Consult on methods section; review draft, particularly synthesis of member survey findings	Provide input on draft	32										
4.2 Final report	Final report	Update report with feedback from CalOptima and MHNA Committee	Consult on revisions	N/A	36										
4.3 Executive summary	Executive Summary	Lead development	Review and provide feedback	Review and provide feedback	38										
4.4 Presentation of findings	Presentation Slide Deck	Lead development and presentation	Consult on presentation	Provide guidance on meeting format; review slides in advance of presentation	40										

Price Proposal

Our estimated budget for this project is $414,405 which can be updated once the scope of work is finalized. Exhibit 2 on the following page outlines the projected hours, rates, and costs for each phase of the project. Our hourly staff rates are comprised of salary, fringe benefits, indirect/administrative costs, and a fee. We do not charge a mark-up for project management of other service vendors. Our invoices identify the amount of hours worked by individual staff as well as any direct costs incurred, such as travel.

Exhibit 2. Proposed MHNA Budget

DIRECT LABOR COSTS	Wolpoff	Greene	Perera	Huff	RA Support
Phase I. Design and Planning					
1.1 Kick off meeting to refine work plan	16	16	16	2	2
1.2 Preliminary secondary data review	6	2	8	20	16
1.3 MHNA Committee Orientation [includes meeting planning, material development, scheduling, travel, meeting time]	16	2	16	8	8
1.4 Project communication and meetings	60	12	60	40	40
Phase II. Finalize Design and Develop Tools					
2.1 Finalize sampling plans	4	8	16	16	20
2.2 Finalize data collection tools (member survey, provider survey, focus group, community forum) and sampling plan (includes MHNA Committee convening)	20	16	40	20	32
Phase III. Data Collection and Analysis					
3.1 Member survey administration and analysis	4	12	25	40	50
3.2 Provider survey administration and analysis	15	8	20	30	40
3.3 Conduct and analyze key informant phone interviews (n=25)	6	2	22	30	20
3.4 Conduct and analyze focus groups (n=8)	20	6	40	40	80
3.5 CalOptima staff focus group facilitation trainings (up to 3) and technical assistance	2	2	16	24	24
3.6 Organize and analyze non-Harder+Co focus groups	2	0	2	30	30
Phase IV. Data Synthesis and Reporting					
4.1 Prepare draft report (include MHNA Committee convening)	40	16	60	40	80
4.2 Final report	32	8	32	32	32
4.3 Executive summary	2	2	10	20	15
4.4 Presentation of findings	20	4	30	16	10
Total Staff Hours	**265**	**116**	**413**	**408**	**499**
Hourly Rate	$175	$150	$130	$110	$90
Individual Labor Cost	$46,375	$17,400	$53,690	$44,880	$44,910
Total Direct Labor Costs:					
OTHER DIRECT COSTS					
Social Science Research Center Subcontract					$200,050
Travel (up to 14 trips/2 staff- from LA and SD/avg $75 each)					$2,100
Interview and focus group transcription (25 interviews/60 min each; 8 focus groups/2 hours each)					$4,000
Photocopies/materials					$1,000
Total Other Direct Costs:					**$207,150**
TOTAL COST					**$414,405**

Member Health Needs Assessment RFP 17-025
Vendor Evaluation Scores

Summary

All vendors were evaluated on a five point scale, 0-5.

	Proposals	**Interviews**	**Final Scores**
	(50% of the overall score)	*(50% of the overall score)*	
Harder+Company	4.07 x .50 = 2.04	4.69 x .50 = 2.35	4.39* **Recommended Vendor**
Milliman, Inc.	4.11 x .50 = 2.06	3.34 x .50 = 1.67	3.73
Germane Solutions	3.55 x .50 = 1.78		
Gary Bess & Associates	3.28 x .50 = 1.64		
Spectrum Knowledge, Inc.	3.00 x .50 = 1.50		

Back to Agenda

Interview Evaluation

(50% of the overall score)

Finalist interviews were evaluated on a five point scale, 0-5.

	Report Presentation	Question 1	Questions 2	Overall Impression	Average Total
Harder+Company	5.00	4.50	4.25	5.00	4.69
Milliman, Inc.	3.25	3.75	3.25	3.13	3.34

(Interviews conducted by Ad Hoc Committee and staff; total of 4 people.)

Proposal Evaluation

(50% of the overall score)

Proposals were evaluated on a five point scale, 0-5. Weighted scores are listed below.

	Proposal and Transmittal Letter (10% of overall score)	**Process and Scope of Work** (25% of overall score)	**Experience** (25% of overall score)	**Project Team** (25% of overall score)	**Price** (10% of overall score)	**Contract Changes** (10% of overall score)	**Grand Total**
Gary Bess & Asso.	2.15	4.75	5.75	4.5	2.3	3.5	3.28
Germane Solutions	2.80	5.625	6.875	4.10	1.95	3.50	3.55
Harder+Company	2.50	6.875	7.75	5.60	2.25	3.5	4.07
Milliman, Inc.	3.30	7.875	7.375	5.30	2.15	2.80	4.11
Spectrum Knowledge, Inc.	2.00	4.875	4.50	4.20	1.95	3.50	3.00

(Proposal evaluations conducted by external stakeholder and staff; total of 6 people.)

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

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

Contact

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

Recommended Actions

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

Background/Discussion

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

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

Back to Agenda

IGT Ad Hoc Committee

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

1. Approve $12.8 million for projects within the approved funding categories as listed below, to improve services and quality of care for Medi-Cal member, support providers, and make infrastructure investments for the benefit Medi-Cal members.

2. Complete a comprehensive Member Health Needs Assessment, results of which will be used to inform development of Community Grant RFPs.
    a. Member Health Needs Assessment to be conducted within a 3-6 month timeframe, with the assistance of a consultant (procured according to appropriate policy and RFP processes).

3. Staff will return with recommendations for Board approval on specific programs and initiatives on the expenditure of an additional $15 million in IGT funds following completion of the Member Health Needs Assessment;

Funding Allocations and Projects to be Supported

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

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

Back to Agenda

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

The details of the above recommended projects are as follows:

- Depression Screenings (up to $1,000,000): Physician incentive payment program to increase the rate of depression screenings conducted during annual wellness visits for members ages 12-18 over two years. Subject to regulator approval, as applicable, incentive payments per screening will be $30 and made directly to primary care providers. Beginning with Year 2 of the project, and again, subject to regulator approval as appropriate, a sufficient process/infrastructure must be in place to collect depression screening scores in addition to the claims from providers in order for incentive payment to be made. This project addresses the "Children's Mental Health" funding category.

- Provider Portal Communications and Interconnectivity (up to $1,500,000): Develop and implement a web-based provider portal strategy that will support real time bi-directional electronic communication between CalOptima and community partners/providers. Project includes an initial pilot with designated community agencies to evaluate and incorporate feedback prior to implementation with CCN Network Providers. This project addresses the "Pilot Program Planning and Implementation" funding category, as bi-directional data sharing and exchange between CalOptima and providers is a required component of the Whole Person Care pilot in which CalOptima is a key participant, and will be an important asset to the upcoming Health Homes Program.

- Health Homes Program (HHP) (up to $250,000): CalOptima is implementing the "Health Homes for Patients with Complex Needs Program" (HHP), a new DHCS program for Medi-Cal and Cal Medi-Connect plans. This program requires plans to engage Community-Based

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

- UCI Observation Stay Payment Pilot (up to $750,000): Assuming terms and can be reached with UCI within 90 days, funds will support a pilot project with UC Irvine Health to test cost effectiveness of emergency department observation unit (EDOU) care and demonstrate potential return on investment for such care. This project will include tracking of specific CalOptima member information, including diagnosis, protocol, time in EDOU, discharge diagnosis, discharge status and readmission rates. UCI and CalOptima will conduct monthly utilization review. If terms cannot be reached within this time period, staff will return to the Board with further recommendations. This project addresses the "Pilot Program Planning and Implementation" funding category.

- Member Health Needs Assessment (up to $500,000): Conduct a county-wide Medi-Cal member health needs assessment. Funds will support assistance from a consultant (procured according to appropriate policy and RFP processes) and associated costs for assessment activities such as surveys, focus group meetings and survey completion incentives etc. Results and recommendations from the completed assessment will inform RFP development of targeted Community Grant funding to support the needs of Medi-Cal beneficiaries in Orange County. This project addresses the "Strengthening the Safety Net" funding category by providing information that will more effectively align funding investments with the needs of our Medi-Cal members.

- Personal Care Coordinators (PCCs) (up to $7,000,000): Funds will support Health Network and CalOptima PCCs to assist members in navigating the health care system. Funding covers PCCs for the following member populations: duals (OneCare and OneCare Connect), Medi-Cal Seniors and Persons with Disabilities, and other vulnerable populations (e.g, homeless, those with serious and persistent mental illness, transitioning from Regional Center services, etc.). Funding includes support for the cost of services to complete an evaluation of the PCC program, to be completed no later than June 2018. Evaluation activities may be conducted by a consultant, temporary staff or other resource (procured according to appropriate policy and RFP processes). This project addresses the "Strengthening the Safety Net" funding category as PCCs assist members in navigating the health care system.

- Data Warehouse Expansion ($750,000): Integrate various data sources (e.g. pharmacy, claims, case management system, accounting and budget data) into the Clinical Data Warehouse to provide the capability to build complete member claims and pharmacy histories, analyze data

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

- Facets System Upgrade and Reconfiguration (up to $506,620): Improve operational efficiencies of Facets claims and member management system with additional hardware and vendor service purchases. This work supports optimizing data storage requirements and prevents data loss, adding test environments for program implementation to mitigate negative impact to production, system load balancing to support growth in membership and claims data, and improving performance and batch processing to optimize server distribution. This project addresses the "Enhance core data analysis and exchange systems" funding category, being continued from IGT 2.

- IGT Program Administration (up to $529,608): Funds will support purchase and ongoing maintenance of Grant Administration software (procured according to appropriate policy and RFP processes) to facilitate management and oversight of IGT projects and community grants. Funding will also support staffing and administrative costs to manage the IGT transaction process, and provide IGT project and expenditure oversight over two years. Administrative functions are an allowable use of IGT funds and support the funding category of "Strengthening the Safety Net" by providing oversight of the entire IGT process and ensuring that funding investments are effectively aligned with the needs of our members.

- Addressing Gaps and Barriers facing Orange County Medi-Cal members (approximately $15,000,000): $15,000,000 in anticipated funds from IGT 5 to be allocated for targeted community needs in one or more of the funding priority areas above after completion of a Member Health Needs Assessment. Staff will return to the Board with recommendations following completion of the Health Needs Assessment.

IGT 1 Project Timeline Extension

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

Fiscal Impact

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

Back to Agenda

Rationale for Recommendation

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

Concurrence

Gary Crockett, Chief Counsel

Attachments

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

Back to Agenda

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

/s/ Michael Schrader — *11/23/2016*

Authorized Signature — **Date**

Back to Agenda

IGT Update & Expenditure Plan

Board of Directors Meeting
December 1, 2016

Cheryl Meronk
Director, Strategic Development

Back to Agenda

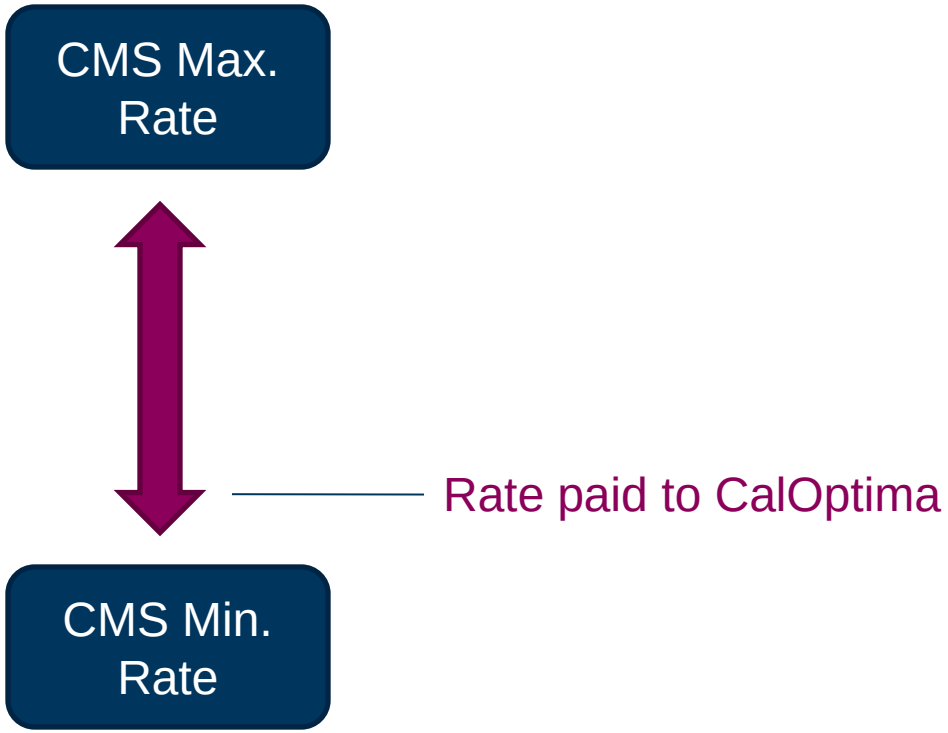
Intergovernmental Transfers (IGT) Background

- 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

Back to Agenda

Low Medi-Cal Managed Care Rates

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



Back to Agenda

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

Back to Agenda

CalOptima Share Totals for IGT 1–5

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

**Estimated total*

Back to Agenda

IGT 1 Status*

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

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

Back to Agenda

IGT 2 Status*

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

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

Back to Agenda

IGT 3 Status*

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

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

Back to Agenda

IGT 4 Status*

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

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

Back to Agenda

IGT 5 Status*

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

**Not yet received*

Back to Agenda

Total Funds to Reallocate or Allocate

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

**Estimate dependent on total IGT 5 amount*

Back to Agenda

IGT Approved Funding Categories*

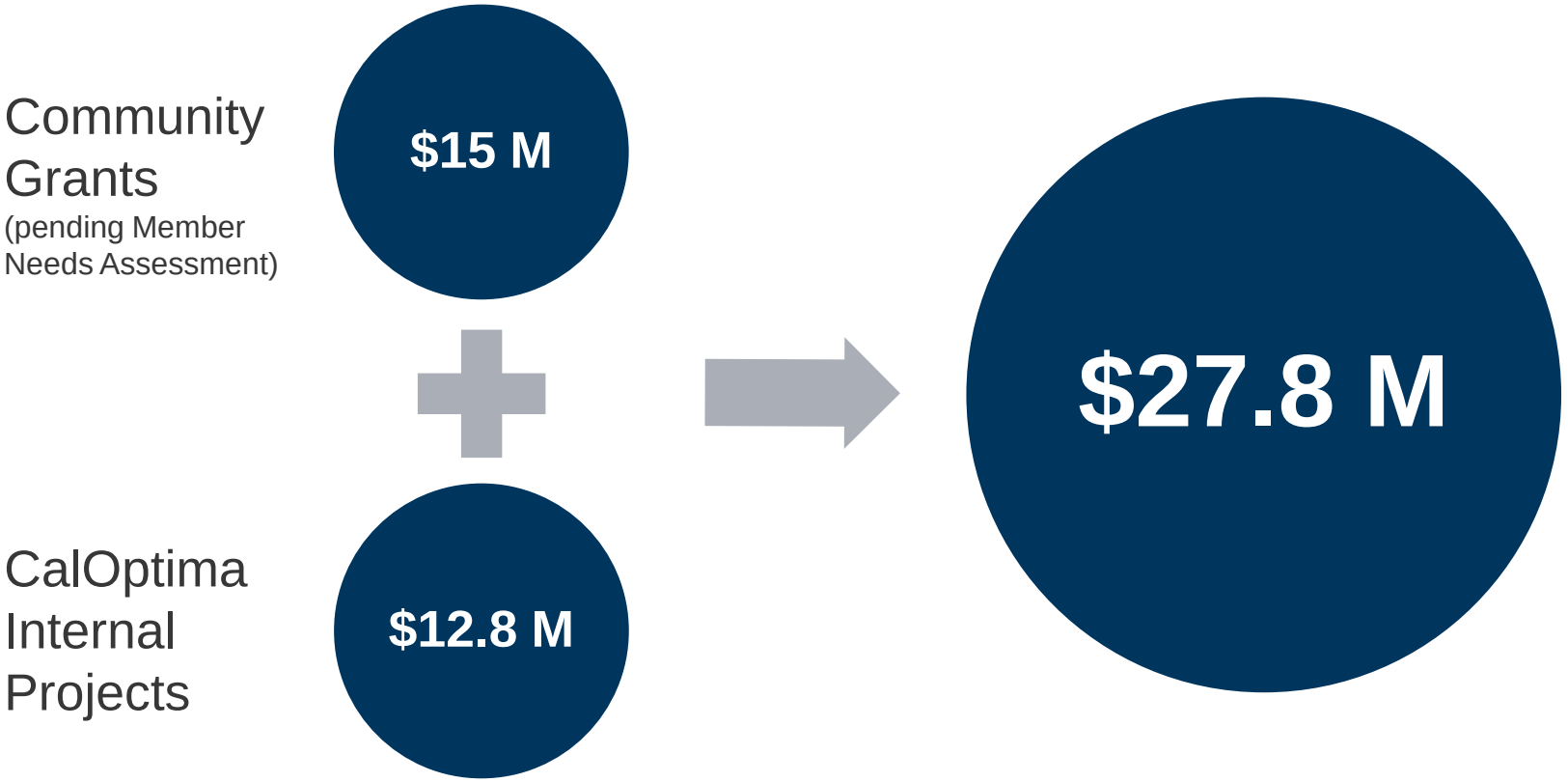
- Adult Mental Health
- Children's Mental Health
- Childhood Obesity
- Strengthening the Safety Net
- Improving Children's Health
- Pilot Program Planning & Implementation

**IGTs 4 and 5 only*

Back to Agenda

Purpose of IGT Funds

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



Back to Agenda

Recommended Internal Expenditures

Expenditures	Funding Amount
Data Warehouse Expansion	$750,000
Depression Screenings Ages 12–18	$1,000,000
Facets System Upgrade and Reconfiguration	$500,000
Health Homes Program	$250,000
Health Needs Assessment	$500,000
IGT Program Administration (grant management software, staff and administrative costs over two years)	$530,000
Personal Care Coordinators (PCCs) • Duals (OneCare and OneCare Connect) • Medi-Cal Seniors and Persons with Disabilities • Other Populations (Homeless/SPMI, RCOC, etc.)	$7,000,000
Provider Portal Communications and Interconnectivity	$1,500,000
UCI Observation Stay Payment Pilot	$750,000
Total	**$12,780,000**

Back to Agenda

External Community Grant Support

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

Back to Agenda

IGT Timeline

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

Back to Agenda

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

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

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

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

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

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

Back to Agenda

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

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

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

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

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

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

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

Back to Agenda

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

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

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

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

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

Contact

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

Recommended Actions

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

Background

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

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

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

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

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

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

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

Back to Agenda

d. e-Consult
e. Complex case management

Discussion

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

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

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

Proposed Uses	Recommended Allocation
Complex Case Management – Part 1 • Case management for high-risk members across various care settings	Year 1: $5.1M Year 2: $4.2M
Complex Case Management – Part 2 • Improved health network documentation of clinical needs	Year 1: $1.8M Year 2: $200K
Expanded Access Pilots • Pilot selected strategies with documented Return on Investment, such as e-consults, telemonitoring and alternative access points	Year 1: $450K Year 2: $650K
Total Budget	**$12.4 M**

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

Fiscal Impact

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

Rationale for Recommendation

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

Back to Agenda

Concurrence
Gary Crockett, Chief Counsel
Michael Ewing, Chief Financial Officer

Attachments
FY 2010-11 IGT Recommendations Presentation
Manatt Cost Analysis dated January 10, 2013

/s/ Michael Schrader — *3/1/2013*
Authorized Signature — **Date**

Back to Agenda

Recommendations for FY 2010-11 Intergovernmental Transfer (IGT) Funds

Board of Directors Meeting
March 7, 2013

Ilia Rolon, MPH
Manager, Strategic Operations

Back to Agenda

Planning Process

- Engaged Manatt Consulting to:
  - Estimate upfront costs, costs to sustain
  - Identify implementation barriers and opportunities
- Presented analysis to Provider Advisory Committee (PAC) and Member Advisory Committee (MAC) in January 2013
- PAC and MAC
  - Held ad hoc meetings in January to review analysis in more depth and receive staff input
  - Met in February to vote on priority of options and finalize recommendations to CalOptima Board
  - Consensus reached between PAC and MAC regarding top four priorities

Options

Previous Name	New Name
Complex case management	•Complex case management
Open access scheduling	•Extended hours
Same day appointment availability	•Combined with above
Participation in medical homes	•Medical home infrastructure support
Specialist recruitment	•Specialist recruitment and retention
24/7 clinical call center	•Clinical call center
Minute clinics	•Alternative access points
Telemedicine	•Remote visits •Telemonitoring
E-Consults	•Specialty Care Consults

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Back to Agenda

Comparison of Recommendations

Priority	Provider Advisory Committee	Member Advisory Committee
1	**Complex Case Management**	**Complex Case Management**
2	**Specialty Care Access -- Planning & Pilots**	**Extended Hours**
3	**Extended Hours Access**	**Alternative Access Points**
4	**Alternative Access Points – Planning and Pilots**	**Specialty Care Access – Planning & Pilots**
5		Remote Visits
6		Medical Home Infrastructure Support
7		Telemonitoring

* Bold type indicates consensus

Back to Agenda

Staff Recommendations

Proposed Uses	Recommended Allocation
Complex Case Management – Part 1 • Case management for high-risk members across various care settings	Year 1: $5.1M Year 2: $4.2M
Complex Case Management – Part 2 • Improved health network documentation of clinical risk	Year 1: $1.8M Year 2: $200K
Expanded Access Pilots • Pilot selected strategies with documented ROI, such as e-consults, telemonitoring and alternative access points	Year 1: $450K Year 2: $650K
Total Budget	**$12.4 M**

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Back to Agenda

Complex Case Management – Part 1

- Recommended Allocation: $9.3 Million
- Description
  - Case management and care coordination services for high-need members across various provider settings (e.g., primary and specialty care, inpatient, skilled nursing)
  - A platform for IGT-funded services: Case Management team determines which other services the member needs
- Pricing Elements
  - Approximately 15 positions (HIT staff, RNs, data analysis, patient navigators)
  - New or enhanced technology for:
    - care coordination
    - clinical decision support
    - data repository
    - electronic health record (EHR) integration
    - predictive modeling

Complex Case Management – Part 2

- Recommended Allocation: $2 Million
- Description
  - Improvement of Health Networks' ability to accurately document clinical need
- Pricing Elements
  - Gap analysis
  - Risk documentation software
  - Staffing for provider technical assistance and education

Expanded Access Pilots

- Proposed Allocation: $1.1 Million
- Objectives
  - Reduction in visits to emergency departments
  - Decreased wait times for specialty care
  - Improved member satisfaction
- Potential Pilots
  - E-Consultation: Enables PCP to meet and share information with specialist via web connection and refer electronically for treatment, thus reducing need for specialty care
  - Incentivizing providers to see patients during evening and weekend hours
  - Developing alternative access points
  - Telemonitoring

Back to Agenda

Next Steps

- Approve Staff Recommendation for use of IGT funds
- Receive implementation plan in April / May 2013

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 6, 2013
Regular Meeting of the CalOptima Board of Directors

Report Item
VII. E. Approve Work Plan and Timeline for Implementation of FY 2010-11 Intergovernmental Transfer (IGT) Funds

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

Recommended Action
Approve work plan and timeline for proposed use of $12.4 million of FY 2010-11 Intergovernmental Transfer (IGT) funds.

Background
On March 3, 2011, the CalOptima Board authorized staff to enter into agreements to secure an IGT with the Regents of the University of California/University of California, Irvine (UCI) for Fiscal Year (FY) 2010-11. CalOptima retained $12.4 million through the IGT transaction.

Subsequent to receiving the funds in late August 2012, CalOptima sought input from the Member Advisory Committee (MAC) and Provider Advisory Committee (PAC) regarding the relative priority of each CMS-approved potential use. In response to a request from both committees for a cost analysis of the potential uses, Manatt, an interdisciplinary policy and business advisory consulting firm, was engaged to research and prepare the requested analyses. The MAC and the PAC reviewed Manatt's analysis and provided recommendations for use of the funds. Based on this input, staff developed a proposal for best use of the funds.

On March 7, 2013, the CalOptima Board approved three main uses of the funds to improve the quality of care and cost effectiveness of CalOptima and its delegated network, as shown in the table below. The approved uses are expected to generate the most positive impact on members, CalOptima and its delegated networks, while also providing a sustainable return on investment for the future.

Approved Uses	Allocation
Complex Case Management – Part 1 • Case management for high-risk members across various care settings	Year 1: $5.1M Year 2: $4.2M
Complex Case Management – Part 2 • Improved health network documentation of clinical needs	Year 1: $1.8M Year 2: $200K
Expanded Access Pilots • Pilot selected strategies with documented Return on Investment, such as e-consults, telemonitoring and alternative access points	Year 1: $450K Year 2: $650K
Total Budget	**$12.4 M**

Back to Agenda

Discussion
The largest portion of FY 2010-11 IGT funds is allocated to the enhancement of complex case management services for high-risk members across various care settings. Per the medical literature, the success of such programs is highly dependent on who is targeted, the program's design, and how success is measured. To derive maximum benefit from its investment in disease and case management services, CalOptima will first seek to strengthen the existing infrastructure in the following two areas: 1) improvement of data integrity and completeness; and, 2) implementation of predictive modeling to further inform the enrollment of members in disease and complex case management programs. In Phase Two, staff will use improved data to design complex case management program enhancements and determine the optimal delegation arrangement for these services.

IGT funds were also earmarked for pilot projects that expand access to healthcare services, particularly for medically vulnerable members. In FY 2013-14, CalOptima will implement a pilot to enhance communication between primary and specialty care providers through electronic referrals and consultations. The goals of the pilot are to mitigate specialty care service capacity issues and increase the ease and efficiency with which members who need specialty care services are able to access those services.

A more detailed work plan and timeline is included in the attached presentation. Staff will provide quarterly reports on the implementation progress.

Fiscal Impact
Implementation plan is consistent with previously approved IGT for FY 2010-11.

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

Concurrence
Gary Crockett, Chief Counsel
Michael Ewing, Chief Financial Officer

Attachment
FY 2010-11 Intergovernmental Transfer (IGT) Implementation Plan

/s/ Michael Schrader — *5/31/2013*
Authorized Signature — **Date**

Back to Agenda

FY 2010-11 Intergovernmental Transfer (IGT) Implementation Plan

Board of Directors Meeting

June 6, 2013

Ilia Rolon, MPH

Director, Strategic Development

Back to Agenda

Background

March 2013 Board Actions

- Approved use of IGT funds as follows:
  - Complex Case Management (CCM) 1: Case management for high-risk members across various care settings
    - Year 1: $5.1M
    - Year 2: $4.2M
  - CCM 2: Improved health network documentation of clinical risk
    - Year 1: $1.8M
    - Year 2: $200K
  - Pilot selected expanded access strategies such as e-consults, telemonitoring, and alternative access points
    - Year 1: $450K
    - Year 2: $650K
- Directed staff to return with implementation plan

Key Planning Assumptions

- Success of case and disease management programs is highly dependent on who is targeted, how program is designed and how success is measured*
- Allocation of funding should be data-driven
    - Begin by strengthening CalOptima's ability to accurately identify patients that fall within targeted risk score range
- Resources should follow the critical mass of at-risk members

* *Source: "Complex Puzzle: How Payers are Managing Complex and Chronic Care," Issue Brief, California Healthcare Foundation, April 2013*

Back to Agenda

Work Plan and Timeline

- **Strengthen complex case management infrastructure**
  - Improve data integrity and completeness
    - **Q3 2013** Assess current CalOptima data integrity; Issue RFP for vendor to provide technical assistance to health networks (HN) and providers for improved documentation of risk (CCM 1 & 2)
    - **Q4 2013** Upon selection of vendor, enroll interested HNs and conduct assessments (CCM 2)
    - **Q1 2014** Based on assessment results, identify opportunities for improvement and offer consultative assistance to HNs (CCM 2)
    - **Q2 2014** Use improved data to design, implement CCM program enhancements and determine delegation arrangement (CCM1)
  - Implement predictive modeling to further inform enrollment in complex case management programs (CCM 1)
    - **Q2 2014** Issue RFP
    - **Q3 2014** Select vendor and begin implementation and training
    - **Q4 2014** Implement enhancements to member enrollment

Work Plan and Timeline (Cont.)

- **Enhance referral and consultation communication between primary and specialty care providers**
  - **Q3 2013** Assess current health information exchange capabilities (CalOptima web portal, OCPRHIO*) and determine buy or build
  - **Q4 2013** Issue RFP for e-consult platform, if needed
  - **Q1 2014** Install components
  - **Q2 2014** Pilot with 1 health network and select CCN providers
  - **Q2-Q3 2014** Enroll other interested health networks and CCN providers

* Orange County Partnership Regional Health Information Organization

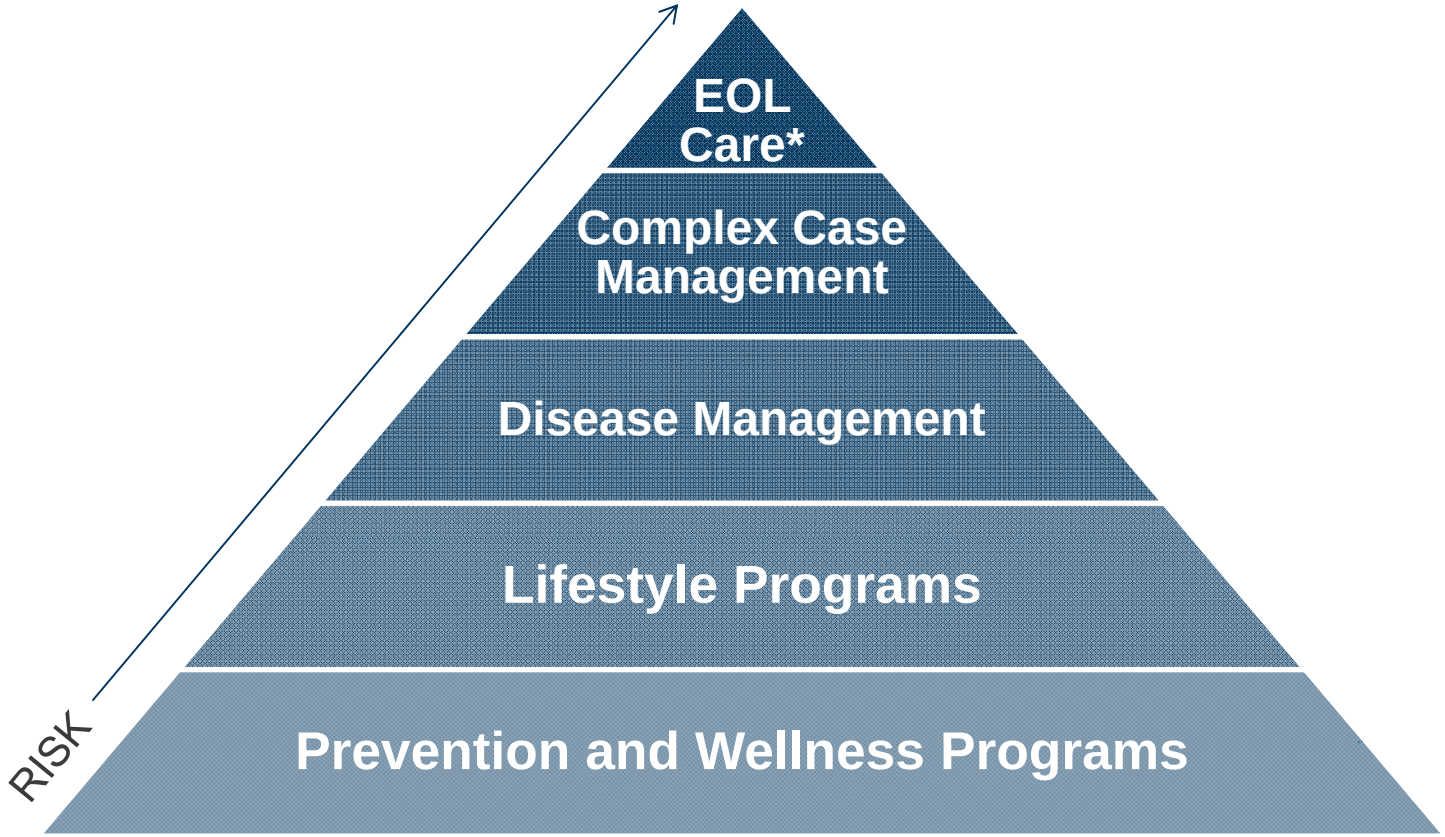
Back to Agenda

Appendix

- Types of Care Management Programs
- California Healthcare Foundation Recommendations

Back to Agenda

Types of Care Management Programs



* End-of-life care (may be considered part of complex case management or may be separate program)

Source: Booz Allen Hamilton, 2012

Back to Agenda

California Healthcare Foundation Recommendations

- Use analytic tools to better identify the population that would most benefit from interventions
  - *Predictive modeling*: Statistical technique of analyzing data to predict which members may be at greater risk for high-cost care, esp. hospitalization
- Adjust program design to engage and activate the patient by experimenting with a wide range of tools
  - "Low-touch": Tech solutions such as mobile apps, text messaging
  - "High-touch": Coaching or case management
- Better integrate disease management and complex case management programs with the treating provider or PCP
  - Use contracting arrangements to better align financial incentives and outcome measurement
  - Test a range of provider engagement tools, such as health information exchanges (HIEs), provider portals and embedding of care managers

Source: "Complex Puzzle: How Payers are Managing Complex and Chronic Care," Issue Brief, California Healthcare Foundation, April 2013

Intergovernmental Transfers (IGT)

Board of Directors Meeting
March ~~7~~ 6, 2014

Ilia Rolon
Director, Strategic Development

Back to Agenda

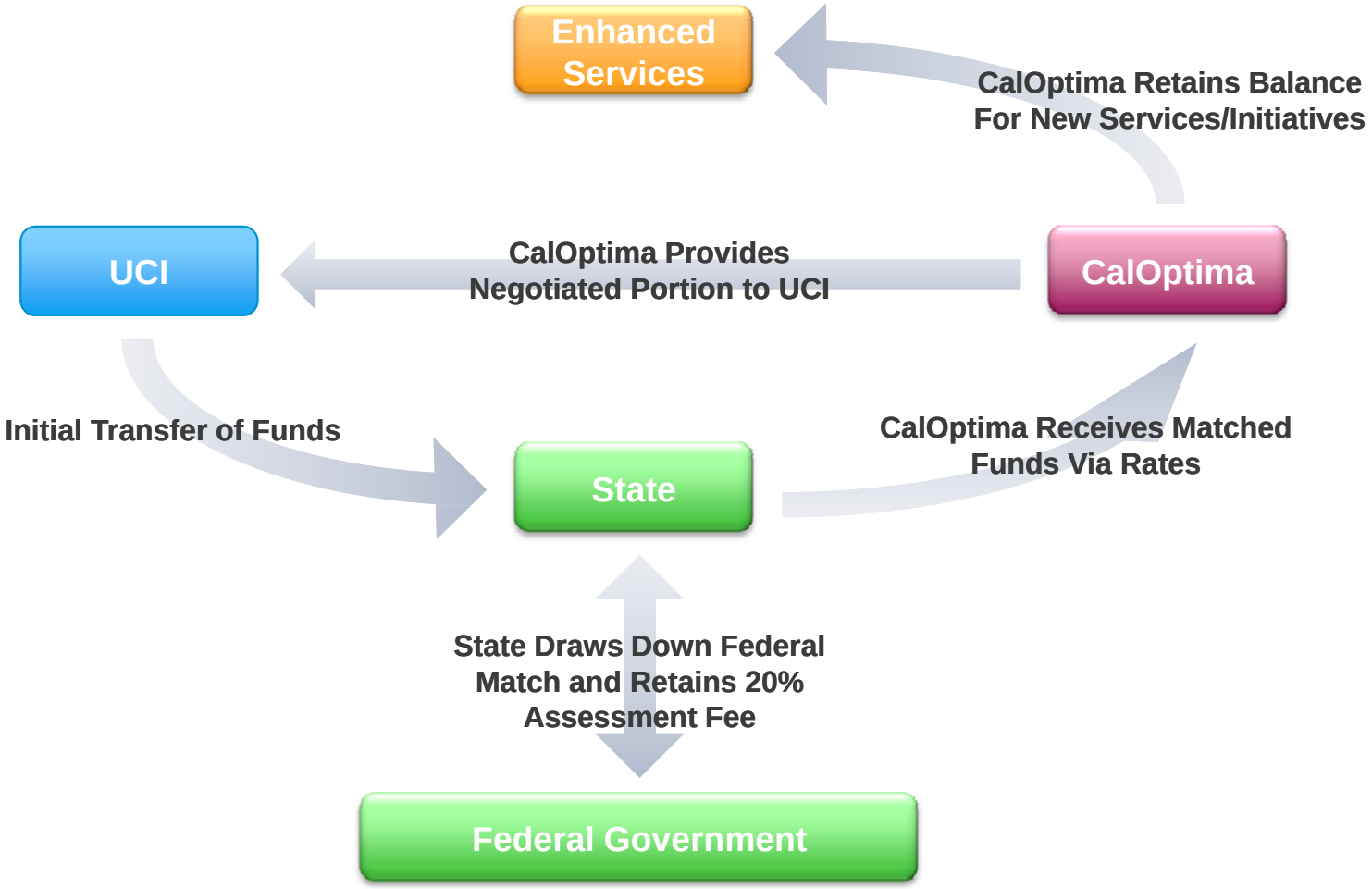
Background

Back to Agenda

About IGTs

- Intergovernmental Transfers (IGTs) are transfers of public funds between governmental entities
- Extensive precedent of IGTs among managed care plans in California
- California managed care plans have historically saved state/federal governments millions in health care costs
  - Federal Medical Assistance Percentage (FMAP): Amount of federal match for states' expenditures on social, medical services
    - California: 50%
    - Mississipi: 73%
- IGTs are a means of leveling the field and ensuring continued investment in our healthcare systems

IGT Transaction Overview



Back to Agenda

Use of Funds

- Revenue must be used to finance improvements in services for Medi-Cal beneficiaries
- No guarantee of future IGT agreements -- thus funds are best suited for one-time investments or as seed capital for new services or initiatives
- Budgeted uses for current IGTs are consistent with system improvements that will support successful response to OneCare audit
- Agreements are silent on deadline for use of funds

IGTs Received to Date

Funding Source	Claim Year	Year Received	CalOptima Amount	UCI Amount	State Amount	Total
IGT 1	FY 10-11	2012	**$12.4 M**	**$8.4 M***	$3.1 M	$23.9 M
IGT 2	FY 11-12	2013	**$7.4 M**	**$4.8 M**	$5.4 M	$17.6 M
Total Funds			**$19.8 M**	**$13.2 M**	$8.5 M	$41.5 M

- IGT 1 included a one-year community vetting process; proposed uses for IGTs 2 and 3 are consistent with results of this earlier process
- Status of IGT Year 1 expenditures: $2 M contract award for new case management system; agreements with health networks for approximately $2 M in funding for personal care coordinators pending

* UCI's net revenue was $3.4 Million due to exclusion from approximately $5.0 million in state disproportionate share (DSH) payments

Back to Agenda

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Proposal

Back to Agenda

IGT 1 Expenditure Plan

Proposed Uses	Year 1	Year 2	Impacted Programs	Timing	Description
Complex Case Management I	$5.1 M	$4.2 M	–	–	
Personal Care Coordinators	$1.85 M	$1.95 M	CMC	CY 14	Additional PMPM line item payment to networks
Case Management System	$2.0 M	$0	All	CY 14	Replace existing case management system
Strategies to Reduce Readmission	$1.0 M	$2.0 M	MC, CMC OneCare	CY 14	Post-discharge follow up; transitions of care
Program for High-Risk Children	$250 K	$250 K	MC	FY 14/15	Services for children affected by both obesity and asthma
Complex Case Management II	**$1.8 M**	**$200,000**	**N/A**	**N/A**	**Merge this category with CCM 1**
Access Strategies	$450,000	$650,000	–	–	
e-Referral/ Telemedicine	TBD	TBD	All	CY 14	Dermatology project in development
Total Funds	$7.35 M	$5.05 M			

Back to Agenda

Proposed IGT 2 Expenditure Plan

CMS and CalOptima Board Approved Categories	Proposed Allocation
Enhanced Core Systems • Facets system upgrade and reconfiguration • Provider network management solution • Security audit remediation • Funding to continue COREC services for two years	**$3.0 M**
Continued / Expanded IGT 1 Services •Personal care coordinators •Strategies to reduce hospital readmissions	**$3.0 M**
Wraparound Services & Optional Benefits • To be developed further. • May include: school-based vision and dental services for children; recuperative care for homeless members discharged from hospital; and/or backfilling Medi-Cal cuts to payments and/or benefits.	**$1.4 M**
Total Funds	**$7.4 M**

60% for direct services

Back to Agenda

Next Steps

- Execute approved expenditure plan for IGT 1
- Begin implementation of IGT 2 funded activities
- Initiate process to explore feasibility of securing third IGT
- Periodic Board updates on progress

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 6, 2014
Regular Meeting of the CalOptima Board of Directors

Report Item

VI. C. Approve Final Expenditure Plan for Use of FY 2010-11 Intergovernmental Transfer (IGT) Funds; Approve Expenditure Plan for Use of FY 2011-12 Intergovernmental Transfer (IGT) Funds; Authorize the Chief Executive Officer (CEO) to Initiate Required Process for FY 2012-13 IGT Funds and Execute the Standard Required Application Documents

Contact

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

Recommended Actions

1. Approve final expenditure plan for $12.4 Million in FY 2010-11 Intergovernmental Transfer (IGT) funds;
2. Approve expenditure plan for $7.4 Million in FY 2011-12 IGT funds;
3. Authorize the CEO to initiate the required process for FY 2012-13 IGT and execute the required application documents consistent with Board approved terms.

Background

CalOptima has partnered with the Regents of the University of California/University of California, Irvine (UCI) to secure two IGTs to date. The two transactions are summarized below:

- IGT 1 was authorized by the CalOptima Board on March 3, 2011, and covers the claiming period of Fiscal Year (FY) 2010-11. CalOptima retained $12.4 Million, UCI retained $8.4 Million, and the state disbursed the funds in August 2012.
- IGT 2 was authorized by the CalOptima Board on March 7, 2013 for the FY 2011-12 claiming period. CalOptima retained $7.4 million, UCI retained $4.8 Million, and the state disbursed the funds in June 2013.

IGTs are transfers of public funds between governmental entities. The revenue generated through the CalOptima /UCI IGTs must be used to finance improvements in services for Medi-Cal beneficiaries. Funds are potentially non-recurring, since there is no guarantee of future IGT agreements. Thus, these funds are best suited for one-time investments or as seed capital for new services or initiatives for Medi-Cal beneficiaries.

The present item seeks: 1) authorization to adjust the expenditure plan for IGT 1 to reflect the final funding distribution needed to fully implement the approved uses; 2) approval of the proposed expenditure plan for IGT 2; and 3) authorization to initiate the process to secure a third IGT.

Discussion

Final Expenditure Plan for IGT 1

On March 7, 2013, the CalOptima Board approved the following expenditure plan for IGT 1:

Back to Agenda

Table 1. Approved Expenditure Plan for IGT 1	**Budget**
Complex Case Management – Part 1 • Case management for high-risk members across various care settings	Year 1: $5.1M Year 2: $4.2M
Complex Case Management – Part 2 • Improved health network documentation of clinical needs	Year 1: $1.8M Year 2: $200K
Expanded Access Pilots • Pilot selected strategies with documented Return on Investment, such as e-consults, telemonitoring and alternative access points	Year 1: $450K Year 2: $650K
Total Budget	**$12.4 M**

As reported at the February 2014 CalOptima Board meeting, recent data analyses indicate that the need for improved health network documentation of clinical needs (i.e., Complex Case Management – Part 2 in the above table) is not consistent among the networks, and thus will not require the entire budgeted amount. At the same time, full implementation of the uses proposed under Complex Case Management – Part 1, including reimbursement of health networks for enhanced care coordination, requires more funding than originally budgeted. To allow for greater efficiency and ensure that funds are used most effectively, staff recommends merging the two Complex Case Management budget categories, as reflected in Table 2 below.

Table 2. Final Expenditure Plan for IGT 1	**Budget**
Complex Case Management • Case management for high-risk members across various care settings, including improved documentation of clinical risk	Year 1: $6.9M Year 2: $4.4M
Expanded Access Pilots • Pilot selected strategies with documented Return on Investment, such as e-consults, telemonitoring and alternative access points	Year 1: $450K Year 2: $650K
Total Budget	**$12.4 M**

Proposed Expenditure Plan for IGT 2
As previously stated, CalOptima retained $7.4 million from the second IGT. Per the state's agreement with the Centers for Medicare and Medi-Cal (CMS), funds must be used for any of three Board-approved general purposes:

Back to Agenda

1. Enhance CalOptima's core data systems and information technology infrastructure to facilitate improved member care;
2. Continue and/or expand on services and initiatives developed with FY 2010-11 IGT funds; and/or
3. Provide wraparound services and optional benefits for members in order to address critical gaps in care, including, but not limited to, behavioral health, preventive dental services and supplies, and incentives to encourage members to participate in preventive health programs.

Based on an analysis of current and emerging priorities, staff proposes the budget allocation plan presented in the attached presentation and summarized below:

Table 3. Proposed Expenditure Plan for IGT 2	**Budget**
Enhancement of Core Data Systems	$3.0 M
Continuation/Expansion of IGT 1 Initiatives	$3.0 M
Wraparound Services/Optional Benefits to Address Critical Gaps	$1.4 M
Total Budget	**$7.4 M**

Proposed FY 2012-13 IGT

UCI has notified CalOptima of its interest to secure a third IGT for FY 2012-13. The Department of Health Care Services (DHCS) is in the process of calculating the amount of funds that would be available for this transaction. Authorization is requested to begin working with UCI to determine feasibility of securing a third IGT under the same general terms as the prior two IGTs, and to initiate the process. If IGT 3 is secured, funds will be applied to uses consistent with the categories outlined in Table 3 above.

Fiscal Impact

The recommended action is to be funded from DHCS capitation receipts which are currently reserved. Expenditure of IGT funds is for restricted, one-time purposes and does not commit CalOptima to future budget allocations. It should be noted that the proposed expenditures under IGTs 1 and 2 are aligned with many of the system improvements required in response to the recent CMS audit.

Rationale for Recommendation

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

Back to Agenda

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

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

2/28/2014 — **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 4, 2014
Regular Meeting of the CalOptima Board of Directors

Report Item

VII. B. Authorize and Direct the Chairman of the Board of Directors to Enter into the Necessary Agreements with the University of California at Irvine (UCI) and the California Department of Health Care Services (DHCS) to Secure Additional Medi-Cal Funds Through an Intergovernmental Transfer (IGT) for Fiscal Year (FY) 2012-13, Including Approval of Proposed Funding Categories; Recommend Board of Directors Approval of an Updated Expenditure Plan for FY 2011-12 IGT (IGT 2) Funds; and Consider Allocation of $900,000 of IGT 2 Funds and Authorize Procurement Process for School-Based Vision and Dental Wraparound Services

Contact

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

Recommended Actions

1. Authorize the Chairman of the Board of Directors to execute an amendment to the primary agreements among DHCS, UCI, and CalOptima for the upcoming FY 2012-13 IGT (IGT 3), including approval of proposed general use categories;
2. Approve final IGT 2 budget of $8.7 million and allocate the additional $1.3 Million to children's health and/or safety net services; and
3. Consider proposal for school-based vision and dental wraparound services for children enrolled in Medi-Cal, in amounts not to exceed $500,000 for vision services and $400,000 for dental services.

Background

CalOptima has partnered with the Regents of the University of California/University of California, Irvine (UCI) to secure two IGTs to date, with a third IGT pending for FY 2012-13.

Presently staff recommends two actions related to the pending IGT 3 transaction, and two pertaining to FY IGT 2 revenue. Approval of these recommendations is requested in order to implement programmatic priorities.

Discussion

IGT 3 Application
On June 20, 2014, CalOptima and UCI submitted a proposal to DHCS for a third IGT. If approved, the proposed IGT will result in revenue of approximately $4.8 million each to UCI and CalOptima. Our understanding is that DHCS anticipates disbursement of an IGT payment to CalOptima in September 2014. At this time, staff requests authorization to amend the primary agreement between the DHCS and CalOptima for purposes of accepting an increased rate that includes IGT 3 funding. Additionally, consistent with the proposal to DHCS submitted in June 2014, staff requests approval of four general categories of uses for IGT 3 revenue as follows:

1. Services related to care coordination and case management for CalOptima members;
2. Expansion of optional benefits for CalOptima members potentially including but not limited to vision, dental, and prevention and treatment of chronic disease;

Back to Agenda

3. Innovation and enhancement of the health care delivery model;
4. Continuing improvements to information services infrastructure and applications to enhance services to CalOptima members.

A budget allocation for the proposed categories will be presented at a future Board meeting after the transaction has received federal approval and funds have been received from the state.

Additional IGT 2 Revenue
The current Board approved budget for IGT 2 is based on an original revenue estimate of $7.4 million, while actual revenue received was $8.7 million. Based upon discussion and direction provided at the August 27, 2014, Quality Assurance Committee, staff recommends allocating the additional $1.3 million for children's health and/or support of the safety net. For children's health services, priority could be given to addressing pediatric obesity and expanding access to children's health services. Safety net support could include, but not limited to, assisting safety net provider in their sustainability efforts.

Staff will present a proposed plan and recommendations for the additional funding allocation for Board consideration at a future meeting.

Plan for Wraparound Services
As discussed above, the Board-approved IGT 2 budget includes an allocation of $1.4 million for wraparound services and optional benefits for CalOptima members. The intent of these funds is to help address recognized gaps in services, as well as barriers to accessing preventive care and treatment.

The Board previously identified children's dental and vision services as priorities for this category of IGT funding, given the historically low utilization of these services. For example, only 54% of the nearly 190,000 Orange County children enrolled in Denti-Cal, which is administered directly by the state on a fee for service basis, had a dental visit in the previous year.[1] Similarly, only 52% of CalOptima's population under 19 years of age received a vision screening through a CalOptima provider in 2011. Lack of transportation; language barriers; inconvenient office hours; difficulty locating a provider that accepts Denti-Cal or Medi-Cal/Vision Services Plan (VSP); and parental beliefs regarding the timing of the first dental visit or vision screening are some reasons for the low utilization rates.

To help inform a funding plan to begin addressing these gaps, staff consulted with Kids Vision for Life, a non-profit dedicated to prevention of vision problems in children; Dr. Marc Lerner, Medical Officer, Center for Healthy Kids and Schools, Orange County Department of Education; and the

[1] "Why kids in Denti-Cal are feeling the pain," Children Now, 2013.

Children and Families Commission of Orange County, all of which have extensive expertise in these subjects, as well as deep knowledge regarding service gaps and access barriers affecting Orange County children.

At this time, staff recommends the Board consider expenditure of $900,000 for school-based children's dental and vision services, in amounts not to exceed $500,000 for vision services and $400,000 for dental. If approved, the recommended action will be accomplished in accordance with approved CalOptima Procurement Policy. Conditions for selection will include previous experience providing services at Orange County schools in high-need areas, as well as willingness to partner and coordinate with other providers for co-deployment of vision and dental services.

Children's Vision Services – $500,000

- Conduct school-based vision screening and assessment and supply eyeglasses to children with vision problems as medically recommended, with priority given to schools with the highest concentration of Medi-Cal eligible pupils;
- Provide referrals to local vision care providers and conduct follow-up to encourage families to connect with these providers for their children's ongoing vision care.

Children's Dental Services – $400,000

- Conduct school-based dental screening, education and preventive care, with priority given to schools with the highest concentration of Medi-Cal eligible pupils;
- Provide referrals to local dentists and conduct follow-up to encourage families to connect with these providers for their children's ongoing dental care.

If approved, staff anticipates selection of service providers, and inception of services, during the current (2014-15) school year. Moreover, staff will work with the selected vision and dental health partners to monitor and evaluate outcomes, and evaluation reports will be submitted to the Board's Quality Assurance Committee (QAC) for review. Upon completion of both programs, proof of concept data will be submitted to the Department of Health Care Services for its consideration of future reimbursement to providers of school-based vision and dental care.

As a separate but complementary effort, staff is also exploring opportunities to pilot incentives for pediatric primary care providers to provide basic oral health education and make timely referrals for dental care.

Another wraparound service being explored is pediatric obesity prevention and treatment. FY 2010-11 (IGT 1) funds were set aside for this purpose by prior Board action. However, given the complexity of this health issue and the dearth of effective models, staff brought this topic to the August meeting of the Board's QAC for discussion and direction. Dr. Candice Taylor Lucas, a noted expert on pediatric

obesity, provided guidelines and recommendations to the QAC. Based on input from this group, staff anticipates presenting funding recommendations for the Board's consideration in October.

Quality Assurance Committee Action
At its August meeting, the Board's Quality Assurance Committee approved the recommended Board of Directors approval of requested actions, but did not take action on proposed school-based services due to lack of consensus regarding whether schools are the most effective platform for children's vision and dental services, and whether IGT funds should be expended on these services.

Fiscal Impact
The recommended actions are consistent with the Board's previously identified funding priorities for use of IGT 2 funds. Expenditure of IGT funds is for restricted, one-time purposes, and does not commit CalOptima to future budget allocations.

Rationale for Recommendations
The final budget for IGT 2 incorporates additional funds received in a manner consistent with prior Board actions. Funding for vision and dental wraparound service was approved by prior Board action and will provide enhanced services to current CalOptima members not available through current covered benefits, a key requirement for the use of IGT funds. Proposed funding categories for IGT 3 allow for continued support of key organizational priorities and programs.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *8/29/2014*
Authorized Signature — **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 2, 2014
Regular Meeting of the CalOptima Board of Directors

Report Item
VII. E. Approve Grant Awards to Designated Organizations in Support of New and Prospective Federally Qualified Health Centers (FQHCs)

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

Recommended Actions
Approve grant awards in the aggregate amount of up to $200,000 to designated community health centers to support new and prospective Federally Qualified Health Centers (FQHCs) in Orange County, to be funded with Intergovernmental Transfer (IGT) 2 funds.

Background
Through recent discussions with representatives of Orange County's community health centers, CalOptima learned that several health centers have an urgent need for specialized technical assistance to ensure successful attainment of, and transition to, Federally Qualified Health Center (FQHC) designation. FQHCs are vital to Orange County's safety net because they provide comprehensive healthcare for low-income residents, including a significant number of current and future CalOptima Medi-Cal members. There are currently 10 FQHCs in the county, and collectively they operate 26 sites.

To qualify for FQHC designation, clinics must be located in or serve a community that has been designated a Medically Underserved Area or Population by the federal government; be governed by a community board; provide comprehensive primary health care; and provide services to all, with fees adjusted based on ability to pay. Prospective FQHCs often begin by applying to become a Non-grant-supported Health Center, more commonly known as an FQHC "look-alike." This interim designation confers many of the same benefits as full FQHC status, with the exception of the annual $650,000 grant that full FQHCs receive from the Health Resources and Services Administration (HRSA) to offset the cost of uncompensated care. Additional benefits of FQHC status are listed in the attachment to this item.

According to the Coalition of Orange County Community Health Centers, there are currently two look-alikes in the county; both are preparing to submit an application for full designation by the October 7th federal deadline. Existing FQHCs are also required to submit an application in order to expand to new sites; three Orange County FQHCs plan to apply for a New Access Points grant in October, with new sites planned for Tustin, Santa Ana and Lake Forest.

Prospective FQHCs, and those that wish to expand, must submit a successful application to HRSA's Bureau of Primary Health Care. There is typically no more than one application cycle per year. During the rigorous federal application process, prospective FQHCs often need specialized technical assistance to prepare the required application, and to conduct thorough financial analysis and planning to avoid adverse fiscal impact during the implementation period. In addition, newly-designated FQHCs derive long-term benefit from technical assistance with state and federal rate setting negotiations,

Back to Agenda

which help ensure a sustainable business model. Centers also need infrastructure support, such as information technology consultation and capital support, to meet more stringent federal guidelines.

Discussion

Five (5) Orange County health centers are preparing to submit applications by the next federal deadline of October 7, 2014. Clinics will be notified of the application outcome no later than June 30, 2015, and most likely in the Spring. A total of eight (8) grant recipients are proposed. Of those, six (6) are prospective FQHCs, applicants for new access points, or "look-alikes" upgrading to full FQHC status, as follows:

1. VNCOC Southland Health Center: FQHC "look-alike" applying for full designation;
2. North Orange County Regional Health Foundation: "look-alike" applying for full designation;
3. Camino Health Center: Full FQHC applying for a new access point in Lake Forest;
4. Friends of Family Health Center: Full FQHC applying for a new access point in Tustin;
5. Share Our Selves (SOS): Full FQHC applying for a new access point in Santa Ana; and
6. La Amistad / Puente a la Salud: New applicant.

In addition, two other clinics that received FQHC designation in 2013, Nhan Hoa Comprehensive Health Care Clinic and Serve the People, are scheduled for HRSA site visits in late 2014, which they must pass in order to successfully complete the federal designation process.

At this time, staff recommends a grant to up to eight (8) community health centers for an individual allocation not to exceed $30,000 per organization and a total aggregate amount not to exceed $200,000. In approving the staff recommendation, the Board would be making a finding that the proposed expenditures are in the public good and consistent with CalOptima's statutory purpose. The proposed grants are to be used to assist new and prospective FQHCs with consulting costs, such as for rate negotiations and HRSA site visit preparation, but shall not be used for centers' administrative costs or staff time. The proposed grants are expected to lead to enhancements to the safety net and its ability to serve the Orange County Medi-Cal population. In addition, terms of the funding agreements will require a detailed scope of services and prior approval of all contracts and subcontractors utilized for the specialized technical assistance.

CalOptima is committed to working with community health centers to explore additional opportunities to support the safety net during this period of rapid change and increased demand in the healthcare sector, and will return to the Board with recommendations at a future meeting.

Fiscal Impact

The recommended action is consistent with the Board's previously approved IGT 2 allocation of $1.3 million for children's health or support of the safety net. Expenditure of IGT funds is for restricted, one-time purposes, and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

FQHCs are vital to Orange County's safety net; the proposed support for new and prospective FQHCs has the potential to enhance access to comprehensive health services for current CalOptima Medi-Cal members.

Back to Agenda

Concurrence
Gary Crockett, Chief Counsel

Attachments
Benefits of FQHC Status

/s/ Michael Schrader — *9/26/2014*
Authorized Signature — **Date**

Back to Agenda

Benefits of Federally Qualified Health Center (FQHC) Designation

- Section 330 grant funds to offset the costs of uncompensated care and other key enabling services (Health Center Program grantees receive these grant funds. Look-alikes are eligible to compete for them.)
- Access to medical malpractice coverage under Federal Tort Claims Act (FTCA) (Look-alikes are not eligible for this benefit.)
- Prospective Payment System reimbursement for services to Medicaid patients
- Cost-based reimbursement for services to Medicare patients
- PHS Drug Pricing Discounts for pharmaceutical products under the 340B Program Federal loan guarantees for capital improvements (Look-alikes are not eligible for this benefit.)
- Access to on-site eligibility workers to provide Medicaid and Child Health Insurance Program (CHIP) enrollment services
- Reimbursement by Medicare for "first dollar" of services because deductible is waived if FQHC is providing services
- Access to Vaccines for Children Program for uninsured children
- The National Health Service Corps (NHSC) can help health centers, look-alikes, and free clinics recruit and retain qualified providers who care about communities in need and choose to work where they are needed most.

Source: U.S. Department of Health and Human Services, Health Resources and Services Administration. *Primary Care: The Health Center Program: Program Benefits*. Downloaded from http://bphc.hrsa.gov/about/benefits/.

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 4, 2014
Regular Meeting of the CalOptima Board of Directors

Report Item
VII. C. Authorize Grant Awards in Support of Prospective Federally Qualified Health Centers (FQHCs) and Funding for Expert Consultation to Manage and Ensure Satisfactory Progress on Clinic Grants

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

Recommended Actions
1. Authorize grant awards in the aggregate amount of up to $200,000 to eligible community health centers for Phase 2 of the Safety Net Program to support prospective Federally Qualified Health Centers (FQHCs) in Orange County, to be funded with Intergovernmental Transfer (IGT) 2 funds; and
2. Approve $25,000 for an expert consultant to monitor grant recipients' performance and assess progress toward FQHC designation, to be funded with Intergovernmental Transfer (IGT) 2 funds.

Background
In October 2014, the CalOptima Board of Directors approved grant awards for specified new and prospective community health centers to address clinics' need for specialized technical assistance to attain, or transition to, Federally Qualified Health Center (FQHC) designation. A total of $200,000 in FY 2012-13 Intergovernmental Transfer (IGT 2) funds was approved for eight (8) centers for Phase I of this initiative.

For Phase 2 of CalOptima's safety net support initiative, staff proposes grant awards for clinics that are interested in applying for FQHC designation, but were not ready for the 2014 cycle and would benefit from funding support to assist with costs related to feasibility analysis; FQHC application development; and/or capital improvements to meet more stringent federal requirements (such as implementation of an electronic health record system or improvements to clinics' waiting rooms).

FQHCs are vital to Orange County's safety net because they provide comprehensive healthcare for low-income residents, including a significant number of current and future CalOptima members. There are currently 10 FQHCs in the county, and collectively they operate 26 sites. To qualify for FQHC designation, clinics must be located in or serve a community that has been designated a Medically Underserved Area or Population by the federal government; be governed by a community board; provide comprehensive primary health care; and provide services to all, with fees adjusted based on ability to pay.

Prospective FQHCs must submit a successful application to HRSA's Bureau of Primary Health Care. There is typically no more than one application cycle per year. During the rigorous federal application process, prospective FQHCs often need specialized technical assistance to prepare the required application, and to conduct thorough financial analysis and planning to avoid adverse fiscal

Back to Agenda

impact during the implementation period. Centers also need infrastructure support, such as information technology consultation and capital support, to meet more stringent federal guidelines.

Discussion

Based on discussions with the Coalition of Orange County Community Health Centers, it is understood that at least three (3) Orange County health centers are interested in pursuing FQHC designation. Hence, for Phase 2 of CalOptima's safety net support initiative, staff recommends grant awards for up to four (4) community health centers for an individual allocation not to exceed $50,000 per organization, and a total aggregate amount not to exceed $200,000.

At this time, Sierra Health Center, Korean Community Services and Laguna Beach Clinic would be eligible for Phase 2 support. The final selection of health centers would be based upon a staff assessment of readiness and a commitment by the health center to undertake the necessary process for the grant award. However, community health centers currently included in Phase 1 would not be eligible for Phase 2 support.

The proposed grants are to be used to assist prospective FQHCs with consulting costs, such as for feasibility assessment and financial analysis, work plan development, and formulation of HRSA application, or for infrastructure or capital improvements that may be needed for readiness to submit a HRSA application. Funds shall not be used for general operating support. A key early deliverable for these grants will be a clinic self-assessment and written plan for moving toward FQHC designation. The proposed grants are expected to lead to enhancements to the safety net and its ability to serve the Orange County Medi-Cal population.

Staff also recommends that an additional $25,000 of IGT 2 funds be set aside for a consultant with expertise in FQHCs to assist CalOptima in monitoring grant recipients' performance toward grant objectives; assessing grantees' progress toward attainment of FQHC designation; and making recommendations for any needed future support to prospective FQHCs. Qualified consultants are currently conducting the work required for Phase I of the Safety Net FQHC support and staff would procure needed services from one or more of the current vendors consistent with CalOptima procurement policy.

In approving the staff recommendations, the Board would be making a finding that the proposed expenditures are in the public interest and consistent with CalOptima's statutory purpose.

Fiscal Impact

The recommended action is consistent with the Board's previously approved IGT 2 allocation of $1.3 million for children's health or support of the safety net. Expenditure of IGT funds is for restricted, one-time purposes, and does not commit CalOptima to future budget allocations or expenditures.

Back to Agenda

Rationale for Recommendation
FQHCs are vital to Orange County's safety net; the proposed support for prospective FQHCs has the potential to enhance access to comprehensive health services for current CalOptima Medi-Cal members.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader *11/26/2014*
Authorized Signature Date

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 4, 2014
Regular Meeting of the CalOptima Board of Directors

Report Item
VII. F. Authorize Expenditure of Intergovernmental Transfer (IGT) Funds for Post Acute Inpatient Hospital Recuperative Care for Members Enrolled in CalOptima Medi-Cal; Authorize Amendments to CalOptima Medi-Cal Hospital Contracts as Required for Implementation

Contact
Javier Sanchez, Chief Network Officer, (714) 246-8400

Recommended Actions
1. Authorize expenditures of up to $500,000 in Fiscal Year (FY) 2011- 12 Intergovernmental Transfer Funds (IGT 2) for the provision of Recuperative Care to homeless members enrolled in CalOptima Medi-Cal after discharge from an acute care hospital facility, subject to required regulator approval(s), if any; and
2. Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to amend Medi-Cal Hospital contracts covering Shared Risk Group, Physician Hospital Consortia, CalOptima Direct and CalOptima Care Network members, to include Recuperative Care services.

Revised 12/4/14

Background
At the November 6, 2014 meeting of the CalOptima Board of Directors, staff presented an overview of a proposed program to provide acute and post-acute medical care for homeless persons who are too ill or frail to recover from a physical illness or injury on the streets but who are not ill enough to be hospitalized. This program is to be funded with IGT 2 revenue.

Recuperative care currently exists in Orange County and received partial funding from the MSI program. With Medi-Cal expansion, many of the MSI members were transitioned to CalOptima and no longer have access to these services.

Proposed services to be included in the Recuperative Care Program include: housing in a motel; nurse-provided medical oversight; case management/social services; food and supplies; warm handoff to safe housing or shelters upon discharge; and communication and follow-up with referring hospitals.

Staff now requests the Board authorize the expenditure of IGT 2 funding for recuperative care services for Medi-Cal members and amending hospital contracts to facilitate referrals to and payment of this program.

Discussion
Staff requests authority by the Board of Directors to allocate up to $500,000 of IGT 2 funds to a Recuperative Care services funding pool. Funding is a continuation of IGT 1 initiatives intended to reduce hospital readmissions and reduce inappropriate emergency room use by CalOptima members experiencing homelessness.

Back to Agenda

CalOptima staff proposes to amend existing hospital contracts to allow reimbursement for hospital discharges for recuperative care services for Medi-Cal homeless members that qualify for such service. Hospitals will be required to contract and refer homeless members who can benefit from this service to a Recuperative Care provider of the hospital's choice. The hospital will facilitate the transfer of the members to the appropriate Recuperative Care provider. The referring hospital will pay the Recuperative Care provider for services rendered based on need to facilitate a safe hospital discharge as determined by the hospital and the provider.

Contracted hospitals will be required to invoice CalOptima for services rendered, CalOptima will, in turn, reimburse contracted hospitals from the Recuperative Care fund pool for services rendered. Reimbursement by CalOptima to hospitals for Recuperative Care services will stop when the $500,000 recuperative services pool has been depleted. Staff will provide oversight of the program and will implement a process to track the utilization of funds.

Fiscal Impact

A total of up to $500,000 in IGT 2 funds are proposed for this initiative. Based on an estimate of $150 per day for recuperative for up to a 10 day stay per member, this funding is expected to fund approximately 330 cases. The proposed funding level is a cap. If exhausted prior to the end of FY 2014-15, no additional funding for recuperative care will be available without further Board approval. Should the proposed IGT 2 funds not be exhausted on services provided during FY 2014-15, the remaining funds will be carried over to the following fiscal year.

The recommended actions are consistent with the Board's previously identified funding priorities for use of IGT 2 funds. Expenditure of IGT funds is for restricted, one-time purposes, and does not commit CalOptima to future budget allocations

Rationale for Recommendation

With Medi-Cal expansion, CalOptima is serving more members who are homeless. These members experience twice as many readmissions and twice as many inpatient days when discharged to the street rather than to respite or recuperative care. In addition, homeless members remain in acute care hospitals longer rather than being discharged due to a lack of residential beds.

Evaluation by the U.S. Department of Health and Human Services Agency for Healthcare Research and Quality of an existing program administered by the Illumination Foundation, showed: decreased emergency room use; reduced inpatient stays; and stable medical condition for homeless members post discharge. These results are consistent with the IGT 2, as a continuation of IGT 1 funding initiatives, to reduce readmissions to hospitals.

Concurrence

Gary Crockett, Chief Counsel

Back to Agenda

Attachments
None

/s/ Michael Schrader *11/26/2014*
Authorized Signature **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 2, 2015
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

VII. G. Authorize Reallocation of OneCare Personal Care Coordinator (PCC) Funding to Cover the Cost of the Program

Contact

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

Recommended Action

Authorize the reallocation of OneCare PCC funds from Year 2 to Year 1 in order to compensate delegated OneCare Physician Medical Groups (PMGs) for the month of March 2015.

Background

At its March 6, 2014, meeting, the CalOptima Board of Directors (Board) approved the final expenditure plan for $12.4 million in Fiscal Year (FY) 2010-11 Intergovernmental Transfer (IGT) funds. The expenditure plan included an initiative, Complex Case Management – Part 1, to provide case management for high-risk members across various care setting. As part of this initiative CalOptima and PMGs would hire PCCs for up to two (2) years. Within the PMG, PCCs would serve as a single point of contact for OneCare members and assist members in navigating the healthcare delivery system, facilitating access to care and services.

On April 3, 2014, the Board authorized the CEO, with the assistance of legal counsel, to execute OneCare PMG contract amendments to provide funding to PMGs to hire and retain PCCs. The Board authorized the expenditure of FY 2010-11 IGT funds over a two-year period, with a total of up to $1.85 million expended in Year 1, and up to $1.95 million expended in Year 2 as authorized by the Board in March 2014.

Discussion

The Board authorized $1.85 million to fund PCCs in Year 1. However, due to a higher than expected retention of membership in OneCare, the funding allocation was depleted when the February 2015 PCC capitation payment was made to contracted OneCare PMGs.

Management requests that the Board approve a budget reallocation of approximately $200,000 from the $1.95 million budget allocation in Year 2 to make the March 2015 PCC capitation payment. Staff estimates that the remaining funding for the PCC program in Year 2, which was authorized through March 31, 2016, will be sufficient since OneCare members will transition to OneCare Connect in December 2015.

Fiscal Impact

The recommended action will reallocate $200,000 in FY 2010-11 IGT funds from Year 2 to Year 1, and is consistent with the expenditure plan previously approved by the Board on March 6, 2014. Expenditure of IGT funds is for restricted, one-time purposes, and does not commit CalOptima to future budget allocations.

Back to Agenda

Rationale for Recommendation
CalOptima staff recommends this action in support the OneCare PCC program, which is an integral component of the enhanced Model of Care that has been developed for the OneCare Program and expands our ability to apply best practices in care coordination for CalOptima's Medicare members.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

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

3/27/2015 — **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 2, 2015
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

VII. H. Approve the Allocation of Intergovernmental Transfer (IGT) Funds for Personal Care Coordinators (PCC) for the OneCare Connect (OCC) Program Including for OCC Members in the CalOptima Community Network

Contact

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

Recommended Actions

1. Approve $3.6 million in Fiscal Year (FY) 2010-11 IGT funds for Complex Case Management for PCCs in the OneCare Connect Program, including for OCC members in the CalOptima Community Network:
    a. Allocate $1.15 million from 'PCC supplemental';
    b. Allocate $500,000 from 'General Contingency'; and
    c. Reallocate $1.95 million from "Strategies to Reduce Readmissions."

2. Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to execute OneCare Connect Health Network contracts that include funding to hire, train and retain PCCs for the period of July 1, 2015, through June 30, 2016.

3. Authorize CalOptima staff to hire, train and retain PCCs to support OneCare Connect members in the CalOptima Community Network during the July 1, 2015 through June 30, 2016 period.

Background

In actions taken at the January 3, 2013, February 7, 2013, and December 5, 2013, meetings, the CalOptima Board of Directors (Board) authorized the CEO to develop a provider delivery system for implementation of the Duals Demonstration, also now known in the state as the Cal MediConnect Program and branded by CalOptima as OneCare Connect.

At its March 6, 2014, meeting, the Board authorized the expenditure of IGT funds to support the hiring of PCCs by both CalOptima and Physician Medical Groups (PMGs) for up to two (2) years to provide services to OneCare members. Within the PMG, PCCs would serve as a single point of contact for OneCare members and help members navigate the healthcare delivery system, facilitating access to care and services.

Subsequently, at the April 3, 2014, meeting, the Board authorized the CEO, with the assistance of legal counsel, to execute amendments to OneCare PMG contracts to include funding for hiring, training, and retention of PCCs. The Board approved funding for the PCCs at a rate of $14.53 per member per month (PMPM). PCC payments rates are further adjusted according to performance metrics established by CalOptima and described in a CalOptima PCC Policy and Procedure.

Back to Agenda

Discussion

The Board has authorized the use of up to $3.8 million in FY 2010-11 IGT funds over a two-year period to hire PCCs to support the execution of the OneCare Model of Care by delegated PMGs. The creation of the position proved to be an integral part of the remediation of the OneCare audit findings. CMS found CalOptima's PCC Program to be a best practice among Medicare Advantage plans. The PCC program launch has exceeded expectations, and is an integral feature of the approved Model of Care for OneCare Connect, and is no longer an optional component.

Management recommends the Board to approve this action to effectuate the implementation of the successful PCC program for the Cal MediConnect Program, which CalOptima has branded as OneCare Connect. CalOptima would require OneCare Connect contracted Health Networks to hire and retain PCCs. The OneCare Connect contracts will stipulate the conditions for the funding of the PCC positions and will provide the parameters and expectations of the PCC program. Management is requesting $3.6 million in total FY 2010-11 IGT funds for PCCs for OneCare Connect Program from the following:

- Allocate $1.15 million from 'PCC supplemental';
- Allocate $500,000 from 'General Contingency'; and
- Reallocate $1.95 million from "Strategies to Reduce Readmissions."

Management requests funding the program with IGT funds for FY 2015-16, with additional funding subject to future Board approval and IGT fund availability. Funds will be used for the creation of the PCC position by the delegated health networks and the CalOptima Community Network in order to execute the OneCare Model of Care for OneCare Connect and provide ongoing funding of the PCC positions for the next year of the OneCare Connect program. After this time, CalOptima will evaluate if these positions will be self-funding following the first year based upon improved clinical outcomes and lower utilization costs. In addition, the PCCs will support preventive and chronic disease services that results in improvement in HEDIS scores and an anticipated improvement in OneCare Connect's quality rating. Finally, PCCs will improve data capture that support appropriate Hierarchical Condition Category (HCC) scores for OneCare Connect.

The PCC positions hired by CalOptima to serve OneCare Connect members in the CalOptima Community Network will be funded in the same manner as CalOptima's delegated Health Networks.

Fiscal Impact

The recommended action will result in the expenditure of IGT funds in FY 2015-16 of $3.6 million in FY 2010-11 IGT funds. Expenditure of IGT funds is for restricted, one-time purposes and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

CalOptima staff recommends this action in support of the expenditure of IGT funds as approved at the March 2014 Board Meeting. In addition, the PCCs are an integral component of the enhanced Model of Care that has been a successful program in OneCare and will an important component of the OneCare Connect Program that will expand CalOptima's ability to apply best practices in care coordination for CalOptima's members eligible for Medi-Cal and Medicare.

Back to Agenda

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader *3/27/2015*
Authorized Signature **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 7, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item

VIII. B. Authorize Agreements Necessary to Secure Additional Medi-Cal Funds Through an Intergovernmental Transfer (IGT) for Fiscal Year (FY) 2013-14 (IGT 4); Consider Approval of a Modification of Eligible Use for IGT 2 Funds Allocated to Support Federally Qualified Health Centers (FQHCs)

Contact

Lindsey Angelats, Director of Strategic Development, (714) 246-8400

Recommended Actions

1. Authorize and direct the Board Chair to execute an amendment to the primary agreements among the California Department of Health Care Services (DHCS), the Regents of the University of California on behalf of the University of California, Irvine, and CalOptima for the purpose of securing an IGT for the upcoming Rate Year 2013-14 IGT (IGT 4); and
2. Approve modification in eligible uses for IGT 2 funds designated to support Federally Qualified Health Centers in Orange County.

Background

CalOptima began participating in the rate range IGT program for its rate year that began July 1, 2010. This IGT arrangement involves an approved government entity ("funding entity") providing non-federal funds to serve as a match to allow the State to draw down the difference between the highest and lowest actuarially approved Medi-Cal reimbursement rate from the Center for Medicare and Medicaid Services (CMS). Management's understanding is that rate range IGTs are currently in place in all managed care counties in California. Eligible funding entities include but are not limited to county governments, district hospitals, and UC hospitals. Funds are potentially non-recurring, since there is no guarantee of future IGT agreements. Thus, these funds are best suited for one-time investments or as seed capital for new services or initiatives, which enhance care to Medi-Cal members.

CalOptima has partnered with the Regents of the University of California on behalf of UCI to secure three IGTs to date, and staff has started the process for a fourth proposed IGT for Rate Year 2013-14. This IGT arrangement involves UCI providing the non-federal funds for the rate increase to CalOptima and the administrative fee charged by DHCS. A high-level progress update for each of these IGTs is attached.

The CalOptima Board approves all proposed uses and authorizes the plan to participate in each available IGT. Per the State's agreement with the Centers for Medicare and Medi-Cal (CMS), funds must finance improvements in services for Medi-Cal members. The approved uses are intended to generate a positive impact on members, CalOptima and its delegated networks, while also providing a sustainable return on investment for the future.

Presently, staff recommends one action related to the proposed IGT 4 transaction and one modification to a program funded by IGT 2 revenue. Approval of these recommendations is requested in order to implement programmatic priorities.

Back to Agenda

IGT	Rate Year	IGT Funds Received by CalOptima ($)
IGT 1	2010-2011	12.4M
IGT 2	2011-2012	8.7M
IGT 3	2012-2013	4.8M
IGT 4	2013-2014	5.5M (projected)

Discussion

IGT 4 Application

On April 24, 2015, CalOptima and UCI submitted a proposal to DHCS for a fourth IGT. If approved, the proposed IGT will result in revenue of approximately $5.5 million each to UCI and CalOptima. Our understanding is that DHCS anticipates disbursement of an IGT payment to CalOptima in or about September 2015. At this time, staff requests authorization to amend the primary agreement between the DHCS and CalOptima for purposes of accepting an increased rate that includes IGT 4 funding. Additionally, consistent with the proposal to DHCS submitted in April 2015, staff recommends two general categories of use for IGT 4 revenue as follows:

1. Community health investments to improve adult mental health, children's mental health, reduce childhood obesity, strengthen the safety net, and improve children's health, consistent with the Board's March 2015 approval of these five priority areas;
2. Planning and implementing innovative programs required under the Health Homes and the 1115 Waiver initiatives. This would be one-time funding allocation for planning and to implement pilot programs as required.

Staff will develop a budget allocation for the proposed categories to be presented at a future Board meeting after the transaction has received federal approval and funds have been received from the State. Staff will continue to gather information on whether there may be additional acceptable funding entities in Orange County with the capacity to partner to participate in future rate range transfer processes. The intent is to allow CalOptima to draw down maximum available rate range eligible funding to support Medi-Cal enrollees. For example, in the most recently proposed IGT 4, the State indicated that funding entities in Orange County could provide up to $28M as the non-federal source; UCI Health was able to provide $13.7M tied to uncompensated care rendered by UCI Physicians to CalOptima members. After factoring in the available federal match and required state fees, it is possible that CalOptima could have accessed an additional $11M in net revenue to support Medi-Cal members for this rate year.

Potential IGT 4 Funding Needs/Priorities

Health Homes

The Medicaid Health Home State Plan Option, under the Affordable Care Act (Section 2703), enables states to design health homes to provide comprehensive care coordination for Medicaid beneficiaries

with chronic conditions, including homelessness and/or mental illness. California's Health Homes Program is intended to serve eligible Medi-Cal beneficiaries with multiple chronic conditions who are frequent utilizers and may benefit from enhanced care management and coordination. On April 20th, 2015, the DHCS indicated its intent to require participation from all counties effective 2016, with the benefit implemented through the managed care organizations who will then contract with community organizations. Staff is monitoring the development of final program regulations and will provide details on specific projects in the future as additional information becomes available.

1115 Waiver
California's existing Bridge to Reform 1115 Waiver expires on October 31, 2015. DHCS will seek approval of the new Waiver by November 2015 from CMS. At this time, the State's Waiver application proposes key delivery system transformations, including but not limited to changes for counties with public hospitals, regional incentives among managed care organizations, providers and counties behavioral health systems, workforce development initiatives, access to housing and supportive services, and whole person care pilots to improve and integrate physical and behavioral health. Staff will continue to monitor the development of final program regulations and will keep the Board apprised as new information becomes available.

As additional details become available, staff will return to the Board as appropriate with recommendations on the possible use of one-time IGT funded to launch potential early implementation projects to prepare for these critical programmatic changes.

Approve modification of IGT 2 funds designated to support Federally Qualified Health Centers (FQHC)
The Board approved $200,000 in funding in the *Strengthening the Safety Net* priority area at its October 2014 meeting. Specifically, the funding was designated to support engagements with qualified consultants/vendors to partner with up to eight named Orange County community clinics to support their conversion to FQHC status from FQHC "look-alike" status. To date, staff have received formal submissions from seven eligible clinics, with an additional application in progress. The ultimate goal was to contribute to a robust and sustainable system of care for vulnerable CalOptima members who access care at community clinics. Receipt of FQHC status will allow clinics to receive critical and stabilizing federal funds. A second cycle of funding (FQHC Phase 2) was designated for clinics in earlier stages of readiness to apply. The status of IGT-funded Safety Net projects is listed in the attachment.

At this time, staff recommends broadening eligible expenses to include permitting funding for one-time costs associated with merging with an existing FHQC or consulting costs associated with adding a critical new service that will facilitate greater access to care and a more robust reimbursement rate.

No funds will be used to support staff costs or recurring expenses. Currently, funds are designated for consulting services only. Specifically, staff has learned that one area clinic has elected to merge with an existing FQHC to achieve its sustainability goals. Effective May 2015, L'Amistad Health Center will be part of St. Jude Neighborhood Centers, which was not named as one of the eight clinics in the original Board approval. What is being proposed is a modification to enable St. Jude's to receive

support in lieu of L'Amistad. This funding will address the project management expense associated with bringing L'Amistad on to St. Jude Neighborhood Center existing electronic health record at a cost of $12,000, an expense within the maximum amount allowable for each clinic under the grant program. This modification is recommended as the expense is consistent with the Board's intent of accelerating sustainability and access. Likewise, a modification is recommended to enable clinics to allocate eligible consulting hours to prepare for a scope of service request in conjunction with preparation for new access point submission. This proposed change will provide an avenue for greater access to critical services such as dental or behavioral health in underserved communities.

Fiscal Impact

Fiscal Year (FY) 2013-14 IGT (IGT 4)
The recommended action to execute the FY 2013-14 IGT will provide approximately $5.5 million in one-time IGT revenue. Management will present an expenditure plan for Board approval at an upcoming meeting.

FY 2011-12 IGT (IGT 2)
The recommended action to permit St. Jude's to act as an eligible recipient under the Phase 1 FQHC program is budget neutral, as St. Jude's Neighborhood Clinic will replace L'Amistad as one of the eight eligible grantees. Expenditure of IGT funds is for restricted, one-time purposes, and does not commit CalOptima to future budget allocations.

Rationale for Recommendations

Proposed funding categories for IGT 4 would allow for continued support of key organizational priorities and programs. Modification to IGT 2 is proposed to ensure broad participation from area community clinics in the FQHC grant cycle.

Concurrence

Gary Crockett, Chief Counsel

Attachments

Presentation: IGT Progress Report

_____ _____

Authorized Signature **Date**

Back to Agenda

Intergovernmental Transfers (IGT): Progress

Board of Directors Meeting

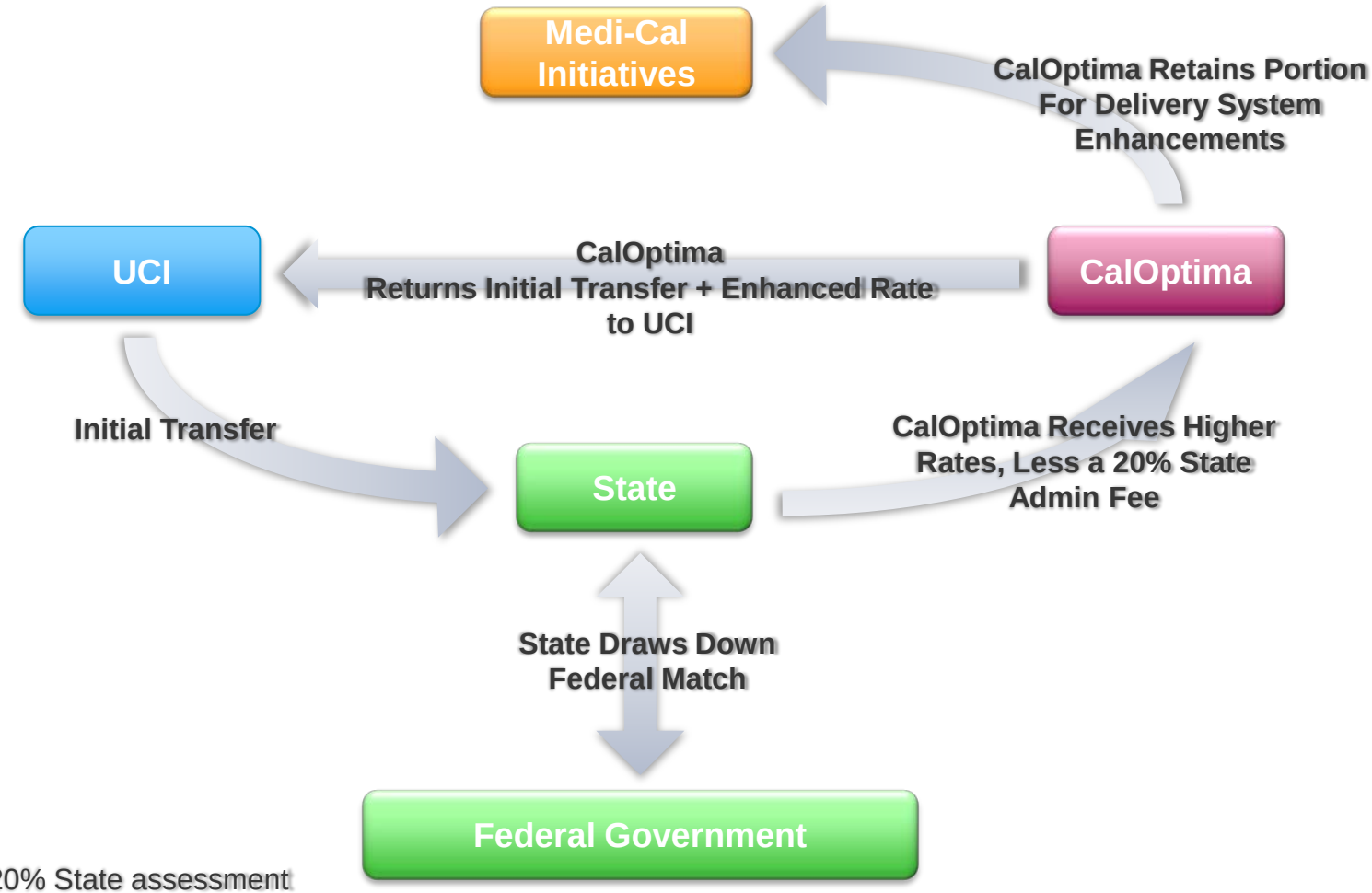
May 7, 2015

Lindsey Angelats

Director, Strategic Development

Back to Agenda

Overview of CalOptima/UC Irvine IGT



* Includes 20% State assessment fee

Back to Agenda

IGTs Purpose and Restrictions

- Revenue generated through IGTs must be used to finance enhancements in services for Medi-Cal members
  - Support enhanced Medi-Cal program
  - Enable CalOptima to pay providers designated by the funding entity (UCI is currently the only funding entity used)

- Funds are potentially non-recurring, since there is no guarantee of future IGT agreements; funds are suited for one-time investments or as seed capital for new initiatives for members

- CalOptima is only plan allowed to retain funds. This process is consistent with state and federal rules and was approved by DHCS and CMS.

Back to Agenda

IGTs Completed and In Progress

All IGTs	Fiscal Year Received	CalOptima Amount
IGT 1	12-13	$12.4 M
IGT 2	13-14	$8.7 M
IGT 3	14-15	$4.8 M
IGT 4	15-16*	(Est. $5.5 M)*
Total Funds Received		$25.9 M

* Transaction has received state and federal approval but funds have not been received yet.

Back to Agenda

IGT Presentation Timeline

	May	June	July	Aug	Sept	Oct
Board		IGT 3 Budgeting; IGT 1-2 Progress Report				IGT 3 Budgeting; IGT 1-3 Progress Report
QAC	IGT 3 Budgeting				IGT 4 Budgeting	
FAC	IGT 3 Budgeting				IGT 4 Budgeting	

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 1, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item
VIII. D. Consider Updated Revenue Expenditure Plans for Intergovernmental Transfer (IGT) 2 and IGT 3 Projects

Contact
Lindsey Angelats, Director of Strategic Development, (714) 246-8400

Recommended Actions
1. Approve updated expenditure plan for IGT 2 projects, including investments in personal care coordinators (PCC), grants to Federally Qualified Health Centers (FQHC), and autism screenings for children, and authorize expenditure of $3,875,000 in IGT 2 funds to support this purpose; and
2. Approve expenditure plan for IGT 3 projects, including investments in recuperative care and provider incentive programs, and authorize expenditure of $4,880,000 in IGT 3 funds to support this purpose.

Background / Discussion
To date, CalOptima has partnered with the University of California, Irvine (UCI) Medical Center on a total of four IGTs. These IGTs generate funds for special projects that benefit CalOptima members. A progress report detailing the use of funds is attached. Three IGTs have been successfully completed, securing $26.0 million in project funds, and a fourth IGT is pending, which is estimated to secure an additional $5.5 million in project funds. Collectively, the four IGTs represent $31.5 million in available funding. A breakdown of the total amount of IGT funds is listed below:

All IGTs	Total Amount
IGT 1	$12.4 million
IGT 2	$8.7 million
IGT 3	$4.9 million
IGT 4	*$5.5 million**
Total	$31.5 million

*The IGT 4 funds figure is an estimate. These funds have not yet been received by CalOptima.

As part of this proposed action, staff is requesting Board approval of the updated expenditure plan for IGT 2, as well as the expenditure plan for IGT 3. The allocation of these funds will be in accordance with the Board's previously approved funding categories for both IGT 2 and IGT 3, and will support staff-identified projects, as specified.

IGT 2 Updated Expenditure Plan
At its September 4, 2014, meeting, the Board approved the final expenditure plan for IGT 2. Since that time, staff has been able to identify further detailed projects to implement the Board approved allocations. Staff recommends the use of $3,875,000 in IGT 2 funds to support the following projects:

Back to Agenda

- $2,400,000 previously approved for the 'Expansion of IGT 1 Initiatives' will be used to sustain the use of PCCs in the OneCare Connect program in FY 2016-17. Current funding for PCCs expires at the end of the 2015-16fiscal year. This proposed action will extend funding for PCCs for one additional year and allow CalOptima and the health networks to better evaluate the long-term sustainability of PCCs for members.

- $100,000 previously approved for the 'Expansion of IGT 1 Initiatives' will provide IGT project administration and oversight through a full-time staff person and/or consultant for FY 2015-16.

- $875,000 previously approved for 'Children's Health/Safety Net Services' will be used for grant funding for the expansion of behavioral health and dental services at FQHCs and FQHC look-alikes. Grant funding will be awarded to up to five eligible organizations for a two-year period in order to launch the new services.

- $500,000 previously approved for 'Wraparound Services' will be used to support a provider incentive program for autism screenings for children. It is estimated that up to 3,600 screenings could be covered with this funding, in addition to costs of training for providers to deliver the screenings.

- Staff also request a modification to the Board's December 4, 2014 action, which allocated grant funding in support of community health centers. Specifically, staff requests an increase in the maximum threshold for clinic grants from $50,000 up to $100,000. No new funds will be utilized for this change, but this change will allow two existing grantees (Korean Community Services and Livingstone) to double their grant award amounts from $50,000 to $100,000. Staff recommends this modification to address the fact that while the previously approved IGT 2 expenditure plan allowed up to four clinics to receive grants, only the two aforementioned organizations formally submitted grant proposals. If the proposed increase is approved, the additional funds will be used for consulting services to finalize the clinics' FQHC Look-Alike applications as well as upgrades to their IT systems to meet FQHC requirements.

IGT 3 Expenditure Plan

For the $4,865,000 funds remaining under IGT 3, staff proposes to support ongoing projects as follows:

- $4,200,000 to support a pay-for-performance program for physicians serving vulnerable Medi-Cal members, including seniors and person with disabilities (SPD). The program will offer incentives for primary care providers to participate in interdisciplinary care teams and complete an individualized care plan for SPD members, in accordance with CalOptima's Model of Care.

  $500,000 to continue funding and broaden recuperative care for homeless Medi-Cal members. This proposed action would provide an additional investment in recuperative care in addition to the Board's previously approved funding. In addition, going forward, hospitals would be eligible to receive reimbursement for recuperative care for homeless patients following an emergency department visitor observation stay; currently, reimbursement is limited to services following an inpatient stay only. As proposed, the maximum duration for recuperative care will increase from 10 days up to 15 days to more effectively link patients to needed services.

Back to Agenda

These recuperative care services would be made available subject to required regulator approval(s), if any.

- $165,000 to provide IGT project administration and oversight through a full-time Manager, Strategic Development for FY 2016-17. The manager will project manage IGT-funded projects, complete regular progress reports, and submit required documents to DHCS.

Staff is not proposing use of IGT 4 funds at this time, but will return to the Board at a later date for approval of an expenditure plan after funds have been received from the state.

Finally, the requests outlined above have been thoroughly vetted by the CalOptima Member Advisory Committee (MAC) and Provider Advisory Committee (PAC) during their respective meetings on September 10, 2015.

Fiscal Impact
The recommended action implement an updated expenditure plan for the FY 2011-12 IGT is budget neutral. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima members, and does not commit CalOptima to future expenditures.

The recommended action to approve the expenditure plan of $4,865,000 from the FY 2012-13 IGT is consistent with the general use categories previously approved by the Board on August 7, 2014.

Rationale for Recommendation
Staff recommends approval of the proposed expenditure plans for IGT 2 and IGT 3 in order to continue critical funding support of projects that benefit CalOptima Medi-Cal members by addressing unmet needs. Approval will help ensure the success of ongoing and future IGT projects.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. IGT Expenditure Plan (PowerPoint presentation)
2. IGT Progress Report

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

9/25/2015 — **Date**

Back to Agenda

IGT Progress Report and Proposal

Board of Directors Meeting
October 1, 2015

Lindsey Angelats
Dir, Strategic Development

Back to Agenda

IGTs Completed and In Progress

All IGTs	Fiscal Year Received	CalOptima Amount	% Amount Programmed
IGT 1	12-13	$12.4 M	100%
IGT 2	13-14	$8.7 M	55%
IGT 3	14-15	$4.8 M	0%
IGT 4	15-16*	(Est. $5.5 M)*	NA
Total Funds Received or Anticipated		$31.4 M	

* Transaction has received state and federal approval but funds have not yet been received

Back to Agenda

Considerations for IGT Outstanding Funds

- **New or pending State and Federal initiatives increasingly focused on integration and coordination**
  - 1115 Waiver and Whole Person Care
  - Behavioral Health Integration
  - Health Homes
  - Capitation Pilot for Federally Qualified Health Centers

- **Value in supporting providers serving more vulnerable members with greater needs:** *(examples)*
  - Investment in ICTs for providers serving Seniors and Persons with Disabilities
  - Continuation/expansion of Personal Care Coordinators

Back to Agenda

IGT Investment Parameters and Requirements

- IGTs must be used to finance enhancements in services for Medi-Cal beneficiaries

- Projects must be one-time investments or as seed capital for new services or initiative, since there is no guarantee of future IGT agreements

Back to Agenda

Recommended Use of IGT 2 Funds ($3.875M Outstanding)

Category	Board Approval Date of Category	Proposed Project	Proposed Investment	Regulatory Driver	Anticipated Impact
Continuation of IGT 1 Initiatives	03/06/14	Sustain Personal Care Coordinators (PCCs) for the One Care Connect program in FY16-17	$2.4M	**Coordinated Care Initiative**	Providers and members receive timely support
Children's Health/Safety Net Services	10/02/14; 12/04/14	Supporting behavioral health and dental service expansion at FQHC and FQHC look-a-likes via one-time competitive grants	$875K	**Alternative Payment Pilot**	FQHCs launch critical services that can be sustained through higher PPS rates
Wraparound Services	8/7/14	Provider incentive for Autism Screening and provider training to promote access to care	$500K	**Autism Benefits in Managed Care**	Earlier identification and treatment for the 1 in 68 children with autism
Continuation of IGT 1 Initiatives	03/06/14	Full-time IGT project administrator/ benefits (pro-rated for 11/1/15 start; represents 23% admin costs)	$100K	**Intergovernmental Transfers**	Faster launch of IGT funded projects to support members and physicians

Back to Agenda

CalOptima A Public Agency Better. Together.

Recommended Use of IGT 3 Funds ($4.88M Outstanding)

Regulatory Driver	CalOptima Priority Area	Proposed Project	Proposed Investment	Anticipated Impact
1115 Waiver	**Adult Mental Health**	Continue recuperative care to reduce hospital readmissions by providing safe housing, temporary shelter, food and supplies to homeless individuals	$500K	Support for improved and integrated care for vulnerable members
Integrated Care	**Support Primary Care Access**	Support increased funding (pay for performance) for physicians serving vulnerable members, including Seniors and Persons with Disabilities (ICPs + Integrated Health Assessments for new SPDs)	$4.2M	Support for improved and integrated care for vulnerable members
Intergovernmental Transfers		Full-time IGT project administrator (represents 2% admin costs)	$165K	Faster launch of IGT funded projects to support members and physicians

Back to Agenda

Recommended Next Steps

- **Timing**
  - November: Development of project plans and launch
- **Accountability**
  - Staff provide quarterly Board reports sharing progress and outcomes for current and new projects; Jan 2016
- **Engagement**
  - Review IGT 4 with PAC/MAC in October; Staff proposes options focus on improved care for those with serious mental illness and support for providers to screen adolescents for depression
- **Maximization/Leverage**
  - ➢ In Fall 2015, staff will pursue additional Funding Entity partnerships with eligible organizations (County, Children and Families Commission, others) to draw down additional funds in 2016, based on recommendation from consultant Mr. Stan Rosenstein

Back to Agenda

Board of Directors Meeting
October 1, 2015

Intergovernmental Transfer (IGT) Funds Progress Report

Discussion

To date, CalOptima has participated in four IGT transactions with the University of California, Irvine; at this time, IGT 1 and IGT 2 funds are supporting Board-designated projects to improve care for members. Staff presented the following information on the status IGT-funded projects to the Provider Advisory Committee and Member Advisory Committee on September 10, 2015.

IGT 1 Active Projects					
Description	Objective	Budget	Board Action	Duration	% Complete
New Case Management System	To enhance management and coordination of care for vulnerable members	$2M	03/06/14	2 years	75%
Personal Care Coordinators for OneCare members	To help OneCare members navigate healthcare services and to facilitate timely access to care	$3.8M	04/03/14	3 years	50%
OneCare Connect Personal Care Coordinators	To help OneCare Connect members navigate health services and to facilitate timely access to care	$3.6M	04/02/15	1 year	25%
Strategies to Reduce Readmission	To reduce 30-day all cause (non maternity related) avoidable hospital readmissions	$1.05 M	03/06/14	2 years	25%
Complex Case Management Consulting	Staffing and data support for case management system	$350K	03/06/14	2 years	50%
Telemedicine	Expand access to specialty care	$1.1M	03/07/13	2 years	25%
Program for High Risk Children	CalOptima pediatric obesity and pediatric asthma planning and evaluation	$500K	03/06/14	3 years	25%

Back to Agenda

IGT 2 Active Projects					
Description	Objective	Budget	Board Action	Duration	% Complete
Facets System Upgrade & Reconfiguration	Upgrade and reconfigure software system used to manage key aspects of health plan operations, such as claims processing,	$1.25M	03/06/14	2 years	75%
Continuation of the CalOptima Regional Extension Center	Sustain initiative to assist in the implementation of EHRs for individual and small group local providers	$1M	04/03/14	3 years	25%
Enhancing the Safety Net	To assist health centers to apply for and prepare for Federally Qualified Health Center (FQHC) designation or expansion	$200K	10/02/14	2 years	50%
Enhancing the Safety Net	To support an FQHC readiness analysis for community health centers to enhance the Orange County safety net and its ability to serve Medi-Cal beneficiaries	$225K	12/04/14	2 years	25%
Recuperative Care	To help reduce hospital readmissions by providing safe housing, temporary shelter, food and supplies to homeless individuals	$500K	12/04/14	1 year	25%
Facets System Upgrade & Reconfiguration	Upgrade and reconfigure software system used to manage key aspects of health plan operations, such as claims processing,	$1.25M	03/06/14	2 years	75%
School-Based Vision	Increase access to school-based vision, which can be difficult for Medi-Cal beneficiaries to access	$500K	09/04/14	2 years	25%
School-Based Dental	Increase access to school-based dental, which can be difficult for Medi-Cal beneficiaries to access	$400K	09/04/14	2 years	25%
Provider Network Management Solution	Enhance CalOptima's core data systems and information technology infrastructure to facilitate improved member care	$500K	03/06/14	1 year	25%
Security Audit Remediation	To increase protection of CalOptima member data	$200K	03/06/14	1 year	85%

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 3, 2016
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

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

Contact

Richard Helmer, M.D., Chief Medical Officer, (714) 246-8400
Phil Tsunoda, Executive Director Public Policy and Public Affairs (714) 246-8400

Recommended Actions

1. Extend the authorization of expenditures of Fiscal Year (FY) 2010-11 Intergovernmental Transfer (IGT) Funds (IGT 1) for OneCare Personal Care Coordinators (PCC) from April 1, 2016 through December 31, 2016; and

2. Authorize the reallocation of $50,000 in OneCare Connect PCC funds from IGT 1 to OneCare PCC in order to compensate delegated OneCare health networks for the period of April 1, 2016, through December 31, 2016.

Background

At the March 6, 2014, meeting, CalOptima's Board of Directors approved the final expenditure plan for $12.4 million for IGT 1. The expenditure plan included an initiative, Complex Case Management – Part 1, to provide case management for high-risk members across various care settings. As part of this initiative, CalOptima and health networks would hire PCCs for up to two years. At the health network level, the PCC serves as a single point of contact for OneCare members and assist members in navigating the healthcare delivery system, facilitating access to care and services.

On April 3, 2014, the Board authorized the CEO, with the assistance of legal counsel, to execute OneCare health network PMG contract amendments to provide funding to health networks to hire and retain PCCs. The Board authorized the expenditure of IGT 1 funds over a two-year period, with a total of up to $1.85 million expended in Year 1, and up to $1.95 million expended in Year 2 as authorized by the Board in March 2014. The end date of the two-year authorization is March 31, 2016.

At the April 2, 2015, meeting, the Board authorized reallocation of $200,000 from the $1.95 million budget allocation in Year 2 to make the March 2015 OneCare PCC capitation payment.

Back to Agenda

Discussion

On January 1, 2016, the majority of OneCare members were passively enrolled into the OneCare Connect program. However, not all OneCare members were eligible for this transition, and these members still remain in OneCare. As of January 2016, there were approximately 1,238 active OneCare members. In order to maintain similar practices for OneCare and OneCare Connect, so that OneCare members receive the same quality of care as OneCare Connect members, staff proposes to continue the PCC program for the remaining OneCare members through December 31, 2016.

Staff estimates the monthly expenditures for OneCare PCCs is approximately $20,000. As of January 31, 2016, $175,401 remains in IGT 1 funds for the OneCare PCC program. Assuming the same level of funding through the rest of the calendar year, the projected shortfall for the OneCare PCC capitation payments by December 31, 2016, will be approximately is $44,599. To cover this shortfall, Management recommends that the Board approve a budget reallocation of $50,000 from OneCare Connect PCC funds from IGT 1 to OneCare PCC in order to compensate delegated OneCare health networks for the period of April 1, 2016 through December 31, 2016.

Fiscal Impact

The recommended actions to extend authorization of expenditures for the OneCare PCC program through December 31, 2016 and to reallocate $50,000 from the OneCare Connect PCC program to the OneCare PCC program is expected to have a neutral fiscal impact to CalOptima. Expenditure of IGT funds is limited to providing enhanced benefits to CalOptima Medi-Cal beneficiaries, and has been restricted to one-time purposes, and does not commit CalOptima to future funding or budget allocations.

Rationale for Recommendation

CalOptima staff recommends this action in support of the OneCare PCC program, which is an integral component of the enhanced Model of Care that has been developed for the OneCare program and expands our ability to apply best practices in care coordination for CalOptima's Medicare members.

Concurrence

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

Attachments

None

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

02/26/2016 — **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item
12. Consider Adoption of Resolution Approving Updated Human Resources Policies

Contact
Ladan Khamseh, Chief Operations Officer, (714) 246-8400
Vicki Hewlett, Interim Director Human Resources, (714) 246-8400

Recommended Action
Adopt Resolution Approving CalOptima's Updated Human Resources Policies.

Background
On November 1, 1994, the Board of Directors delegated authority to the Chief Executive Officer to promulgate employee policies and procedures, and to amend these policies from time to time, subject to annual presentation of the policies and procedures, with specific emphasis on any changes thereto, to the Board of Directors or a committee appointed by the Board of Directors for that purpose. On December 6, 1994, the Board adopted CalOptima's Bylaws, which requires, pursuant to section 13.1, that the Board of Directors adopt by resolution, and from time to time amend, procedures, practices and policies for, among other things, hiring employees and managing personnel.

Pursuant to the California Code of Regulations, Title 2, Section 570.5, CalOptima is required to adopt a publicly available pay schedule that meets the requirements set forth by the California Public Employees' Retirement System (CalPERS) to reflect recent changes, including the addition or deletion of positions and revisions to wage grades for certain positions.

The following table lists existing 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.8000 Glossary of Terms	• Minor language and formatting change. • Addition of terms and definitions • Revise definitions consistent with HR policies	-Annual review with minor updates and formatting changes. - Need to update new terms, definitions and/or revised definitions
2.	GA.8054 Injury Illness Prevention Program	• Minor language and formatting change. • Recommend that this become an Environmental Health and Safety (EHS) Policy.	-Annual review with minor formatting changes - Change to reflect EHS has jurisdiction over the Program - Update consistent with

Back to Agenda

	Policy No./Name	Summary of Changes	Reason for Change
		• Procedure and definition revisions • Revisions to Attached IIPP Program	regulatory changes - Ensure consistency with requirements under 8 CCR § 3203
3.	GA. 8058: Salary Schedule	• This policy focuses solely on CalOptima's Salary Schedule and requirements under CalPERS regulations. • Attachment 1 – Salary Schedule has been revised in order to reflect recent changes to the Salary Schedule, including changes to, and the addition and deletion of positions. A summary of the changes to the Salary Schedule is included for reference.	- Pursuant to CalPERS requirement, 2 CCR §570.5, CalOptima periodically updates the salary schedule to reflect current job titles and pay rates for each job position. - There are changes to eight positions indicated on the attached revised Salary Schedule. A change to one position is related to a change in salary grade level. New Position: Creation of a new Job Title typically due to a change in the scope of a current position or the addition of a new level in a job family. (5 positions) Replacement: Creation of a new Job Title replacing a title that is being removed. (1position) Remove Position: Elimination of a Job Title typically due to a change in the scope of a current position or the elimination of position in a job family. (1 position)

Fiscal Impact

The fiscal impact of this recommended action is budget neutral. Unspent budgeted funds for salaries and benefits approved in the CalOptima FY 2016-17 Operating Budget on June 2, 2016,

will fund the cost of the new positions. There is no fiscal impact for the salary grade level change to the Clinical Documentation Specialist (RN) since the position is currently vacant.

Rationale for Recommendation

The recommended wage grade increase is to attract and retain well qualified staff. Pursuant to the Compensation Administration Guidelines, adopted as part of CalOptima Policy GA. 8057: Compensation Program, approval by the Board of Directors is required as part of the process for market adjustments, which are not part of the regular merit process. Recommendations are made based on extensive review by CalOptima's Resources Workgroup consistent with the market adjustment process to ensure that CalOptima remains competitive with market trends and meets its ongoing obligation to provide structure and clarity on employment matters, consistent with applicable federal, state, and local laws and regulations. These policies serve as a framework for CalOptima's operations.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Resolution No. 17-0302, Approve Updated Human Resources Policies
2. Revised CalOptima Policies:
   a. GA. 8000: Glossary of Terms
   b. GA.8054 Injury and Illness Prevention Program (redlined and clean versions) – with revised Attachment
   c. GA. 8058: Salary Schedule (redlined and clean versions) – with revised Attachment
3. Summary of Changes to the Salary Schedule

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

2/23/2017 — **Date**

Back to Agenda

RESOLUTION NO. 17-0302

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.8000 Glossary of Terms; GA.8054 Injury Illness Prevention Program; and GA.8058 Salary Schedule

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a., CalOptima this 2nd day of March, 2017.

AYES:
NOES:
ABSENT:
ABSTAIN:

/s/_____
Title: Chair, Board of Directors
Printed Name and Title: Mark A. Refowitz, Chair, CalOptima Board of Directors

Attest:
/s/_____
Suzanne Turf, Clerk of the Board

Back to Agenda

Policy #:	GA.8000
Title:	**Glossary of Terms**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	Michael Schrader _____
Effective Date:	04/01/12
Last Review Date:	03/02/17
Last Revised Date:	03/02/17

I. PURPOSE~~:~~

This policy defines~~To define~~ terms as used in CalOptima Human Resources policies and procedures, unless otherwise expressly provided.

II. DEFINITIONS~~:~~

Annual Earnings: The annualized base salary of the employee as of the Separation Date, without regard to overtime, car allowances, bonus, incentive payments or commission payments.

As-Needed ~~Employee:~~: ~~-~~Employees called to work sporadically on an as-needed basis. ~~-~~These employees may not have regularly scheduled hours and do not earn any benefits.~~-~~ As-Needed employees are employed for an indefinite duration and must work less than one thousand (1,000) hours per fiscal year.

At-Will: An employment, having no specified term, may be terminated at the will of employees or employers at any time and with or without cause.

Auditing Process:~~-~~ To ensure the quality of the translation, Cultural and Linguistic (C&L) Services utilizes a multi-step process. ~~-~~All translation work is assigned a translator and a reviewer. A reviewer, different from the translator, is assigned to conduct the quality review of the translation. ~~-~~The reviewer checks for accuracy, grammar, flow, punctuation and spelling errors, and accents/diacritical marks. ~~-~~After the review is complete, the translator reviews the changes made by the reviewer to determine if the changes are appropriate and correct.~~-~~ If there is a disagreement, a second reviewer is called upon to help complete and finalize the translation.

Bilingual Certified Employee: ~~-~~An employee who has passed CalOptima's Bilingual Screening Process either upon hire or any time during his or her employment.

Bilingual Screening Process:~~-~~ Prospective staff translators are identified by Cultural and Linguistic (C&L) Services based on qualifications obtained through CalOptima's bilingual screening process.~~-~~ The screening is either conducted as part of their initial hiring process or later during their employment. All staff translators must possess a strong ability to read, write and understand the target language. Once identified as potential staff translators, they are required to take a proficiency test created by C&L Services. ~~-~~They are evaluated on their vocabulary, grammar, orthography, flow, accuracy, cultural sensitivity, as well as consistency in usage of translated terms. The selection is based on their overall score.~~-~~

Budgeting Process:~~process:~~ Payment for staff translation services is budgeted as extra compensation. ~~-~~This budget is included in the salary line item.

Business Casual Attire: Business casual attire includes suits, dress pants, dress shirts, dress shoes, dress sandals, sweaters, dresses, and skirts. Ties may be worn but are not required. All clothing should be clean, pressed, and in good repair. The height of heels should be suitable to the individual to prevent safety hazards.
~~Business Casual Attire: Business casual attire includes suits, dress pants, dress shirts, dress shoes, dress sandals, sweaters, dresses, and skirts. Ties may be worn but are not required. All clothing should be clean, pressed, and in good repair.~~

In all cases, management will define "appropriate" business attire. Business Casual Attire does not include:

1. Jeans (or any type of denim or any color jeans);
2. Spaghetti strap shirts;
3. See-through clothing;
4. Short skirts;
5. Any type of shorts (at or above the knee);
6. Casual sandals (such as flip flops or beach attire);
7. Tennis shoes;

~~8.~~ Capri pants (unless part of a professional dress suit or two piece business outfit);
~~9.~~8.
~~10.~~ Clothing ~~with writing~~displaying any written words or symbols ~~that contain profanity,~~, with the exception of CalOptima logo attire, or ~~that advocate~~brand names or ~~are associated with violence against any persons;~~ symbols;
~~11.~~9.
~~12.~~ Clothing that reveals undergarments or parts of the body incompatible with a professional setting; or
~~13.~~10.
~~14.~~11. Hats, unless prior approval from Human Resources is given.

Call Back Pay: Compensation paid to an employee who returns to the workplace after hours or on the weekends to respond to urgent business or problems. Not to be combined with On-Call Pay.

CalOptima Employees: For purposes of this policy, include, but are not limited to, all full-time and part-time regular CalOptima employees, all temporary employees, interns/volunteers, CalOptima Board members, advisory and Standing Committee members and authorized contractors and consultants.

CalOptima Logo Attire: ~~(Monday – Friday):~~ CalOptima logo attire includes dress shirts, polo shirts, or other shirts purchased through the Human Resources Department with CalOptima's logo displayed. ~~-~~Logo attire from any CalOptima program is allowed. ~~-~~These shirts must be partnered with dress pants or khaki pants in good condition. ~~-~~Logo attire is allowed Monday through Friday. ~~-~~CalOptima logo attire may~~attiremay~~ not be worn with jeans, shorts or capri pants from Monday through Thursday.

CalOptima Property: ~~-~~Any property owned or operated by CalOptima including CalOptima's administration building located at 505 City Parkway West, Orange, CA 92868 and CalOptima's PACE Center located at 13300 Garden Grove Boulevard, Garden Grove, CA 92843, inclusive of inside the facility and up to and including the perimeter of the property line.

Casual Attire: ~~(~~
~~A.~~ Casual Attire is a benefit permitted only on Fridays, unless otherwise specified.~~-~~ As with Business Casual Attire, Casual Attire should be neat in appearance and in good repair, with no tears or holes. Casual attire includes jeans, capri pants (loose and below the knee), casual sandals (no flip flops), tennis shoes or other casual clothing in good condition. ~~-~~Leggings or lycra slacks are acceptable only when worn with a dress or long shirt that falls at least below the mid-thigh level.~~-~~ In all cases, management within each respective department will define "appropriate" casual attire.

Casual attire does not include:

1. Any type of jogging or sweat suits/sweatpants;
2. Halter tops;
3. Spaghetti strap shirts;
4. See-through clothing;
5. Ripped jeans;
6. Shorts (at or above the knee)~~;)~~
7. Clothing that exposes the stomach area or other parts of the body incompatible with a professional environment;
8. Clothing displaying any written words or symbols, with the exception of CalOptima logo attire, brand names or symbols, sports teams, or university/school/club names or logos; or
9. Hats, unless prior approval from Human Resources is given.

Catastrophic Illness or Injury: A major illness or other medical condition (e.g., heart attack, cancer, etc.) of the employee or a family member of the employee that requires a prolonged absence of the employee from work, including intermittent absences that are related to the same illness or condition, and will result in a substantial loss of income to the employee because the employee will have exhausted all PTO available apart from the PTO Donation Program.~~A illness or the employee a the employee from workthe to the the PTO.~~

Central Worksite: CalOptima's primary physical location of business.

Certified Case Manager (CCM): ~~-~~ A CCM is a credential awarded by the Commission for Case Management Certification ("CCMC"). The CCMC organization is nationally accredited by the National Commission for Certifying Agencies. The CCM credential signifies a high level of proficiency, consistency, and quality in the case management practice and can be obtained by meeting eligibility criteria and passing a research-based examination.

Child-Related Activities: Participation in activities at child's school or day care facility as permitted under Labor Code section 230.8, which includes: finding, enrolling, or reenrolling a child in a school or with a licensed child care provider; child care provider or school, emergency; request for child to be picked up from school/child care or an attendance policy that prohibits the child from attending or requires the child to be picked up from the school or child care provider; behavioral/discipline problems; closure or unexpected unavailability of school (excluding planned holidays); a natural disaster; or to participate in activities of the school or licensed child care provider of his or her child, if the employee, prior to taking the time off, gives reasonable notice to CalOptima.

Continuous Service:- A period of employment with one (1) employer, which begins with the day on which the employee starts work and ends with the date of resignation or dismissal. All service, regardless of hours worked, counts toward calculating Continuous Service.

Current Retiree: Former employee of CalOptima who:

1. Was hired before January 1, 2004;
2. Completed at least five years of pensionable service (with CalOptima and/or combined with other service with a public agency that participates in CalPERS); and
3. Was already receiving retiree health benefits from CalOptima on January 1, 2014.

Designee: A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.

Discrimination:– Adverse employment action against an employee, volunteer, intern, or individual performing services pursuant to a contract on the basis of a protected class.

Documented Counseling Memo:- Discussion between supervisor and employee with the purpose of notifying/clarifying substandard employee performance/behavior or policy violation and exploration of possible causes. ~~The employee is asked to express a commitment to improve performance.~~

Eligible Dependent: The current spouse, registered domestic partner, dependent child up to age 26, and/or certified disabled dependent child over age 26, of a Current Retiree, Retired Eligible Employee, or Reinstated Eligible Retiree, who:

~~1.~~ Meets the definition of a dependent who is eligible for coverage under the employee health plan then maintained by CalOptima for its active employees; and

1.

2. Has been timely enrolled for coverage under this retiree health policy by the Eligible Retiree.

Eligible Employee: A current active employee of CalOptima meeting the following criteria:

1. The most recent date of hire was before January 1, 2004, or whose initial date of hire was before January 1, 2004, and whose most recent rehire date was on or before December 31, 2013; and
2. Completes at least five years of pensionable service (with CalOptima and/or combined with other service with a public agency that participates in CalPERS).

Eligible Retiree: Current Retiree, Retired Eligible Employee, Reinstated Eligible Retiree or Eligible Survivor Dependent.

Eligible Survivor Dependent: A Survivor Dependent who timely enrolls for Survivor Dependent health coverage within sixty (60) calendar days of the death of the Eligible Retiree.

Equal Employment Opportunity (EEO):- All individuals, irrespective of race, gender, ethnicity, disability or any other protected class set forth in this policy, have an equal opportunity for employment and advancement within the organization.

Executive Staff: ~~Any CalOptima employee whose position title is Executive Director or Chief Officer of one (1) or more departments~~Staff holding Executive level positions as designated by the Board of Directors.

Executive Team: Inclusive of all internal officers of the organization to include the Chief Executive Officer and the other members of the C-Suite. This group may or may not include the Executive Directors, as warranted by the Chief Executive Officer.

Exempt Employee: Employees who are exempt from the overtime provisions of the federal Fair Labor Standards Act (FLSA) and state regulations governing wages and salaries. Exempt status is determined by the duties and responsibilities of the position and is defined by Human Resources for each position.

Facilities Manager: For purposes of this policy ensures upkeep, maintenance, CalOptima Employee safety, building rules and regulations are adhered to in conjunction with the Property Manager.

Final Warning: Notification to an employee that his/her performance/behavior or violation(s) of CalOptima policy is at a very critical stage in their employment and that continued lack of improvement may result in termination.~~.~~

Full-Time Employee: An employee who works sixty (60) to eighty (80) hours ~~in~~ a pay period.

Gender Expression:
A person's gender-related appearance or behavior, whether or not stereotypically associated with the person's sex at birth.

Gender Identity:
A person's identification as male, female, a gender different from the person's sex at birth, or transgender.

Good Standing: The employee has at least a fully meets expectations job performance rating on their most recent evaluation and has not received written disciplinary action within the last six (6) months.

Harassment: ~~Unwelcome conduct or comments, based on a protected class, that are so severe or pervasive as to create an abusive working environment~~Conduct or actions based on protected characteristics that are severe or pervasive. The creation of a hostile work environment through unwelcomed words, actions, or physical contact not resulting in physical harm. Verbal harassment may include disparaging or derogatory comments or slurs or name calling.

Hiring Manager: Person responsible for making final hiring decision.

Injury and Illness Prevention Program (IIPP): ~~Injury and Illness Prevention Program or "Program"~~ A document that establishes ~~methods~~ guidelines for developing a structured safety program that effectively implements a safe and healthful work environment as required by Title 8, Code of California Regulations section 3203~~identifying and correcting workplace hazards, providing employee safety training, communicating safety information, and ensuring compliance with safety programs~~.

Internship Program: A program offered by CalOptima to college and graduate students to apply traditional academic classroom learning to actual work experience.

Intimidation: The intent to make a person afraid, frightened of, alarmed or scared, or the act of inducing fear by threats.

Leave of Absence (LOA): A term used to describe a scheduled period of time off longer than five (5) days that an employee is to be away from his or her primary job, while maintaining the status of employee.

Limited Term Employee: Employees who are hired to work a full-time schedule on special assignments that last a period of less than six (6) months. Limited Term employees do not become regular employees as a result of the passage of time.

Medical Record: Any single or complete record kept or required to be kept that documents all the medical services received by the Member, including, but not limited to, inpatient, outpatient, and emergency care, referral requests, authorizations, or other documentation as indicated by CalOptima policy.

Member: A beneficiary who is enrolled in a CalOptima Pprogram.

Night Shift Differential: Compensation in addition to base pay provided to employees who work shifts between the hours of 4 p.m. and 8 a.m.

Non-Exempt Employee: Includes all employees who are not identified as exempt. Non-Exempt employees are paid on an hourly basis and are eligible for overtime compensation as required by federal wage and hour laws.

On-Call Pay: Compensation provided to employees who must remain accessible after hours and/or on the weekends via pager or cell phone, and be available to fix problems or report to work, if necessary. On-Call is defined as time spent away from work during which a non-exempt employee is required to be available and to be able to come to work when requested.

Paid Interns: Paid interns are considered As-Needed employees, and should be concurrently enrolled in college or graduate courses.

Part-time Employees: Employees that regularly work at least twenty (20) hours per week and no more than thirty (30) hours per week.

Pay Differential: Additional compensation for special skills utilized on the job.

Performance Improvement Plan: A developmental coaching tool used to improve employee behavior and/or to address performance deficiencies identified in the annual performance review. The plan includes measurable expectations and accountability meetings.

Pregnancy Disability Leave (PDL): Any leave, whether paid or unpaid, taken by an employee for any period(s) during which she is disabled by pregnancy.

Promotion: Occurs when ~~an internal candidate~~a current employee advances to an open position at a higher classification and salary range ~~than~~from the employee's previous position.

Property Manager: An outside fee -based property management company, with experience at managing high rise office buildings.

Protected Health Information (PHI): Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium.

This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by Cal Optima or Business Associates and relates to:

1. The past, present, or future physical or mental health or condition of a Member;
2. The provision of health care to a Member; or
~~1.~~3. Past, present, or future Payment for the provision of health care to a Member.

Qualifying Exigency:
The military leave entitlement helps families of military service members manage their affairs while a covered military service member is on active duty or called to covered active duty status (or has been notified of an impending call or order to covered active duty). According to the FMLA, 29 C.F.R. S~~s~~ection 825.126, a qualifying exigency could include the following:

1. Short-notice deployment;

~~1.~~2. Military events and related activities;
~~2.~~3. Childcare and school activities;
~~3.~~4. Financial and legal arrangements;
~~4.~~5. Counseling;
~~5.~~6. Rest and recuperation;
~~6.~~7. Post-deployment activities;
~~7.~~ Parental care; or
8.
~~8.~~9. Additional activities not encompassed in the other categories, but agreed to by the employer and employee.
~~÷~~

~~Retires within~~
Reinstated Eligible Retiree: A Current Retiree or Retired Eligible Employee whose CalPERS retirement annuity and benefits under this Policy ended due to a reinstatement from retirement as defined in Government Code §§ 22838 and 21190 et.seq., or successor sections, and who (i) subsequently terminates employment from another state employer who does not provide retiree health benefits with a retiree share premium that is less than or equal to that being charged by CalOptima under this Policy; (ii) once again begins collecting retirement annuity payments from CalPERS within ~~120~~one hundred twenty (120) calendar days of such subsequent separation from employment; and (iii) timely enrolls for resumption of coverage under this Policy.

Remote Work Location or Remote Workplace: ~~-~~The teleworker's residence.

Required Licensure and/or Certification: Licenses and/or certificates deemed "required" in the applicable job description and/or required in the performance of an employee's job duties, including, but not limited to, professional licenses, driver's licenses, etc.

Retaliation: Adverse employment action against an employee because he or she filed a complaint or engaged in a protected activity.

Retired Eligible Employee: Eligible Employee who:

1. Retires within one hundred twenty (120) calendar days of such Eligible Employee's separation from employment with CalOptima and receives a monthly retirement allowance from CalPERS; and
2. Timely applies for retiree health benefits in accordance with this policy on and after January 1, 2014.

Retirement Date: Date Eligible Employee becomes an annuitant with CalPERS within one hundred twenty (120) calendar days of such Eligible Employee's separation from employment with CalOptima.

Safety Sensitive Employee: A position where the employee has the responsibility for his or her own safety or other people's safety, such as administering medication, handling of controlled substances and/or providing health care services or personal care services to CalOptima Members. This shall include any employee who operates a CalOptima owned or leased motor vehicle.

Second-hand Smoke: Smoke exhaled from one (1) individual unto common air, which may be inhaled by another individual, causing potentially harmful effects.

Separation Date: The last day of employment with CalOptima.

Service: All periods of employment with CalOptima, provided that service does not include periods in which an employee is on a Personal leave of absence pursuant to CalOptima Policy GA.8038: Personal Leave of Absence, and service shall not include any period of employment for which the employee has received severance pay under the RIF program or under any similar plan of CalOptima's.

Sex: Includes the same definition as provided in Government Code section 12926 and Title 42 of the United States Code section 2000 e(k), which includes, but is not limited to, pregnancy, childbirth; breastfeeding, medical conditions related to pregnancy, childbirth, or breastfeeding, gender identity, and gender expression.

Sex Stereotype:
An assumption about a person's appearance or ~~behavior,~~behavior or about an individual's ability or inability to perform certain kinds of work based on a myth, social expectation, or generalization about the individual's sex.

Smoking: The carrying or holding of any lighted pipe, cigar, or cigarettes of any kind, including electronic smoking devices (e.g. e-cigarettes and/or vaporizers), any lighted smoking equipment, or the lighting, inhaling, or exhaling of smoke from a pipe, cigar, or cigarette of any kind, including e-cigarettes and vaporizers.

Smoke-Free Environment: Prohibition of the use of cigarette, cigar, pipe tobacco, lighted pipe, or cigarettes of any kind, including e-cigarettes or any other form of substance.

Sponsoring Department: A department within CalOptima requesting a college or graduate student intern and overseeing the management and work of the interns pursuant to CalOptima Policy GA.8031: Internship Program.~~this Polic~~

Straight Time Pay:~~-~~ Pay at an employee's regular rate, not including overtime.

Subsequent Retirement Date: Date Reinstated Eligible Retiree again begins collecting retirement annuity payments from CalPERS within one hundred twenty (120) calendar days of separating from employment with the subsequent state employer described in that definition.

Survivor Dependent: Eligible Dependent who:

1. Survives an Eligible Retiree; and

2. Is collecting monthly survivor benefits from CalPERS that is attributable to a deceased Current Retiree, Retired Eligible Employee, or Reinstated Eligible Employee.

Termination: The end of the employment relationship.

Threat: A statement (verbal, written, or physical) which is intended to intimidate by expressing the intent to either harass, hurt, take the life of another person, or damage/destroy property. This includes threats made in jest or as a joke, but which others could perceive as serious.

Transfer: Occurs when an employee moves into a new position that is equivalent in its classification and salary range to the employee's previous position.

Transgender:
A general term that refers to a person whose gender identity differs from the person's sex at birth. A transgender person may or may not have a gender expression that is different from the social expectations of the sex assigned at birth. A transgender person may or may not identify as "transsexual."

~~Threat: A statement (verbal, written, or physical) which is intended to intimidate by expressing the intent to either harass, hurt, take the life of another person, or damage/destroy property. This includes threats made in jest or as a joke, but which others could perceive as serious.~~

Under the Influence of Alcohol: An employee with a blood alcohol concentration (BAC) of .04 or above.

Unusual Occurrence: Any event which jeopardizes or has the potential to jeopardize the health and/or safety of CalOptima employees, members, and/or the community, including, but not limited to, physical injury and death, and/or property damage.

Workers' Compensation: An insurance policy covering work-related injury and illness.

Workplace Violence: Any intentional act that inflicts, attempts to inflict, or threatens to inflict bodily injury on another person or that inflicts, attempts to inflict, or threatens to inflict damage to property, whether committed by a CalOptima employee or by anyone else, and which occurs in the workplace, in or on CalOptima Property, or while an employee is engaged in CalOptima business.

Written Action Plan: A written document prepared by an employee who received a Final Warning, which details actions the employee will make to correct performance/behavior.

Written Warning: ~~::~~ A Written Reminder issued to an employee documenting substandard employee performance or behavior. ~~The Supervisor communicates the seriousness of the situation and requests that the~~

~~employee submit a written commitment to improve his or her performance/behavior by the start of his or her shift on the next business day. The signed agreement will be placed in employee's Human Resource Personnel File.~~

9/80 Fair Labor Standards Act (FLSA) Workweek: Under the Fair Labor Standards Act, the workweek is defined as a fixed and regularly recurring period of seven (7) consecutive twenty-four (24)-hour periods, or one hundred sixty-eight (168) hours. The 9/80 workweek begins on the employee's eight (8) hour day, exactly four (4) hours after the scheduled start time, and ends exactly three (3) hours and fifty-nine (59) minutes after the scheduled start time on the same day the following week. This is commonly referred to as a "day divide," in which four (4) hours of the eight (8) hour day occurs in one (1) week, and four (4) hours occurs in the following week. Department supervisors/managers and Human Resources can answer questions about day divides.

9/80 Work Schedule:~~-~~ The 9/80 alternate work schedule consists of eight (8) business days of nine (9) hours per day and one (1) business day of eight (8) hours, for a total of eighty (80) hours during two (2) consecutive workweeks. The eight (8) hour work day must be on the same day of the week as the employee's regularly scheduled day off. Therefore, under the 9/80 work schedule, one (1) calendar week will consist of forty-four (44) hours (four (4) nine (9)-hour days and one (1) eight (8)-hour day) and the alternating calendar week will consist of thirty-six (36) hours (four (4) nine (9)-hour days and one (1) day off). However, each workweek will only consist of forty (40) hours, in accordance with the 9/80 Fair Labor Standards Act (FLSA) Workweek.

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~~III.~~

~~Not Applicable~~

~~IV.~~III. REGULATORY AGENCY APPROVALS

None to Date

~~V.~~IV. BOARD ACTIONS

~~None to Date~~03/02/17: Regular Meeting of the CalOptima Board of Directors

~~VI.~~V. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	04/01/2016	GA.8000	Glossary of Terms	Administrative
Revised	09/01/2013	GA.8000	Glossary of Terms	Administrative
Revised	03/02/2017	GA.8000	Glossary of Terms	Administrative

~~Version~~	~~Version Date~~	~~Policy Number~~	~~Policy Title~~

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~~Original Date~~	~~04/01/2012~~	~~GA.8000~~	~~Glossary of Terms~~
	~~09/01/2013~~	~~GA.8000~~	~~Glossary of Terms~~
		~~GA.8000~~	~~Glossary of Terms~~

Policy #:	GA.8000
Title:	**Glossary of Terms**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	Michael Schrader _____
Effective Date:	04/01/12
Last Review Date:	03/02/17
Last Revised Date:	03/02/17

I. PURPOSE

This policy defines terms as used in CalOptima Human Resources policies and procedures, unless otherwise expressly provided.

II. DEFINITIONS

Annual Earnings: The annualized base salary of the employee as of the Separation Date, without regard to overtime, car allowances, bonus, incentive payments or commission payments.

As-Needed: Employees called to work sporadically on an as-needed basis. These employees may not have regularly scheduled hours and do not earn any benefits. As-Needed employees are employed for an indefinite duration and must work less than one thousand (1,000) hours per fiscal year.

At-Will: An employment, having no specified term, may be terminated at the will of employees or employers at any time and with or without cause.

Auditing Process: To ensure the quality of the translation, Cultural and Linguistic (C&L) Services utilizes a multi-step process. All translation work is assigned a translator and a reviewer. A reviewer, different from the translator, is assigned to conduct the quality review of the translation. The reviewer checks for accuracy, grammar, flow, punctuation and spelling errors, and accents/diacritical marks. After the review is complete, the translator reviews the changes made by the reviewer to determine if the changes are appropriate and correct. If there is a disagreement, a second reviewer is called upon to help complete and finalize the translation.

Bilingual Certified Employee: An employee who has passed CalOptima's Bilingual Screening Process either upon hire or any time during his or her employment.

Bilingual Screening Process: Prospective staff translators are identified by Cultural and Linguistic (C&L) Services based on qualifications obtained through CalOptima's bilingual screening process. The screening is either conducted as part of their initial hiring process or later during their employment. All staff translators must possess a strong ability to read, write and understand the target language. Once identified as potential staff translators, they are required to take a proficiency test created by C&L Services. They are evaluated on their vocabulary, grammar, orthography, flow, accuracy, cultural sensitivity, as well as consistency in usage of translated terms. The selection is based on their overall score.

Budgeting Process: Payment for staff translation services is budgeted as extra compensation. This budget is included in the salary line item.

Business Casual Attire: Business casual attire includes suits, dress pants, dress shirts, dress shoes, dress sandals, sweaters, dresses, and skirts. Ties may be worn but are not required. All clothing should be clean,

pressed, and in good repair. The height of heels should be suitable to the individual to prevent safety hazards. In all cases, management will define "appropriate" business attire. Business Casual Attire does not include:

1. Jeans (or any type of denim or any color jeans);
2. Spaghetti strap shirts;
3. See-through clothing;
4. Short skirts;
5. Any type of shorts (at or above the knee);
6. Casual sandals (such as flip flops or beach attire);
7. Tennis shoes;
8. Capri pants (unless part of a professional dress suit or two piece business outfit);
9. Clothing displaying any written words or symbols, with the exception of CalOptima logo attire, or brand names or symbols;
10. Clothing that reveals undergarments or parts of the body incompatible with a professional setting; or
11. Hats, unless prior approval from Human Resources is given.

Call Back Pay: Compensation paid to an employee who returns to the workplace after hours or on the weekends to respond to urgent business or problems. Not to be combined with On-Call Pay.

CalOptima Employees: For purposes of this policy, include, but are not limited to, all full-time and part-time regular CalOptima employees, all temporary employees, interns/volunteers, CalOptima Board members, advisory and Standing Committee members and authorized contractors and consultants.

CalOptima Logo Attire: CalOptima logo attire includes dress shirts, polo shirts, or other shirts purchased through the Human Resources Department with CalOptima's logo displayed. Logo attire from any CalOptima program is allowed. These shirts must be partnered with dress pants or khaki pants in good condition. Logo attire is allowed Monday through Friday. CalOptima logo attire may not be worn with jeans, shorts or capri pants from Monday through Thursday.

CalOptima Property: Any property owned or operated by CalOptima including CalOptima's administration building located at 505 City Parkway West, Orange, CA 92868 and CalOptima's PACE Center located at 13300 Garden Grove Boulevard, Garden Grove, CA 92843, inclusive of inside the facility and up to and including the perimeter of the property line.

Casual Attire: Casual Attire is a benefit permitted only on Fridays, unless otherwise specified. As with Business Casual Attire, Casual Attire should be neat in appearance and in good repair, with no tears or holes. Casual attire includes jeans, capri pants (loose and below the knee), casual sandals (no flip flops), tennis shoes or other casual clothing in good condition. Leggings or lycra slacks are acceptable only when worn with a dress or long shirt that falls at least below the mid-thigh level. In all cases, management within each respective department will define "appropriate" casual attire. Casual attire does not include:

1. Any type of jogging or sweat suits/sweatpants;
2. Halter tops;
3. Spaghetti strap shirts;
4. See-through clothing;
5. Ripped jeans;
6. Shorts (at or above the knee);
7. Clothing that exposes the stomach area or other parts of the body incompatible with a professional environment;
8. Clothing displaying any written words or symbols, with the exception of CalOptima logo attire, brand names or symbols, sports teams, or university/school/club names or logos; or

9. Hats, unless prior approval from Human Resources is given.

Catastrophic Illness or Injury: A major illness or other medical condition (e.g., heart attack, cancer, etc.) of the employee or a family member of the employee that requires a prolonged absence of the employee from work, including intermittent absences that are related to the same illness or condition, and will result in a substantial loss of income to the employee because the employee will have exhausted all PTO available apart from the PTO Donation Program.

Central Worksite: CalOptima's primary physical location of business.

Certified Case Manager (CCM): A CCM is a credential awarded by the Commission for Case Management Certification ("CCMC"). The CCMC organization is nationally accredited by the National Commission for Certifying Agencies. The CCM credential signifies a high level of proficiency, consistency, and quality in the case management practice and can be obtained by meeting eligibility criteria and passing a research-based examination.

Child-Related Activities: Participation in activities at child's school or day care facility as permitted under Labor Code section 230.8, which includes: finding, enrolling, or reenrolling a child in a school or with a licensed child care provider; child care provider or school, emergency; request for child to be picked up from school/child care or an attendance policy that prohibits the child from attending or requires the child to be picked up from the school or child care provider; behavioral/discipline problems; closure or unexpected unavailability of school (excluding planned holidays); a natural disaster; or to participate in activities of the school or licensed child care provider of his or her child, if the employee, prior to taking the time off, gives reasonable notice to CalOptima.

Continuous Service: A period of employment with one (1) employer, which begins with the day on which the employee starts work and ends with the date of resignation or dismissal. All service, regardless of hours worked, counts toward calculating Continuous Service.

Current Retiree: Former employee of CalOptima who:

1. Was hired before January 1, 2004;
2. Completed at least five years of pensionable service (with CalOptima and/or combined with other service with a public agency that participates in CalPERS); and
3. Was already receiving retiree health benefits from CalOptima on January 1, 2014.

Designee: A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.

Discrimination: Adverse employment action against an employee, volunteer, intern, or individual performing services pursuant to a contract on the basis of a protected class.

Documented Counseling Memo: Discussion between supervisor and employee with the purpose of notifying/clarifying substandard employee performance/behavior or policy violation and exploration of possible causes.

Eligible Dependent: The current spouse, registered domestic partner, dependent child up to age 26, and/or certified disabled dependent child over age 26, of a Current Retiree, Retired Eligible Employee, or Reinstated Eligible Retiree, who:

1. Meets the definition of a dependent who is eligible for coverage under the employee health plan then maintained by CalOptima for its active employees; and

2. Has been timely enrolled for coverage under this retiree health policy by the Eligible Retiree.

Eligible Employee: A current active employee of CalOptima meeting the following criteria:

1. The most recent date of hire was before January 1, 2004, or whose initial date of hire was before January 1, 2004, and whose most recent rehire date was on or before December 31, 2013; and
2. Completes at least five years of pensionable service (with CalOptima and/or combined with other service with a public agency that participates in CalPERS).

Eligible Retiree: Current Retiree, Retired Eligible Employee, Reinstated Eligible Retiree or Eligible Survivor Dependent.

Eligible Survivor Dependent: A Survivor Dependent who timely enrolls for Survivor Dependent health coverage within sixty (60) calendar days of the death of the Eligible Retiree.

Equal Employment Opportunity (EEO): All individuals, irrespective of race, gender, ethnicity, disability or any other protected class set forth in this policy, have an equal opportunity for employment and advancement within the organization.

Executive Staff: Staff holding Executive level positions as designated by the Board of Directors.

Executive Team: Inclusive of all internal officers of the organization to include the Chief Executive Officer and the other members of the C-Suite. This group may or may not include the Executive Directors, as warranted by the Chief Executive Officer.

Exempt Employee: Employees who are exempt from the overtime provisions of the federal Fair Labor Standards Act (FLSA) and state regulations governing wages and salaries. Exempt status is determined by the duties and responsibilities of the position and is defined by Human Resources for each position.

Facilities Manager: For purposes of this policy ensures upkeep, maintenance, CalOptima Employee safety, building rules and regulations are adhered to in conjunction with the Property Manager.

Final Warning: Notification to an employee that his/her performance/behavior or violation(s) of CalOptima policy is at a very critical stage in their employment and that continued lack of improvement may result in termination.

Full-Time Employee: An employee who works sixty (60) to eighty (80) hours a pay period.

Gender Expression: A person's gender-related appearance or behavior, whether or not stereotypically associated with the person's sex at birth.

Gender Identity: A person's identification as male, female, a gender different from the person's sex at birth, or transgender.

Good Standing: The employee has at least a fully meets expectations job performance rating on their most recent evaluation and has not received written disciplinary action within the last six (6) months.

Harassment: Conduct or actions based on protected characteristics that are severe or pervasive. The creation of a hostile work environment through unwelcomed words, actions, or physical contact not resulting in physical harm. Verbal harassment may include disparaging or derogatory comments or slurs or name calling.

Hiring Manager: Person responsible for making final hiring decision.

Injury and Illness Prevention Program (IIPP): A document that establishes guidelines for developing a structured safety program that effectively implements a safe and healthful work environment as required by Title 8, Code of California Regulations section 3203.

Internship Program: A program offered by CalOptima to college and graduate students to apply traditional academic classroom learning to actual work experience.

Intimidation: The intent to make a person afraid, frightened of, alarmed or scared, or the act of inducing fear by threats.

Leave of Absence (LOA): A term used to describe a scheduled period of time off longer than five (5) days that an employee is to be away from his or her primary job, while maintaining the status of employee.

Limited Term Employee: Employees who are hired to work a full-time schedule on special assignments that last a period of less than six (6) months. Limited Term employees do not become regular employees as a result of the passage of time.

Medical Record: Any single or complete record kept or required to be kept that documents all the medical services received by the Member, including, but not limited to, inpatient, outpatient, and emergency care, referral requests, authorizations, or other documentation as indicated by CalOptima policy.

Member: A beneficiary who is enrolled in a CalOptima program.

Night Shift Differential: Compensation in addition to base pay provided to employees who work shifts between the hours of 4 p.m. and 8 a.m.

Non-Exempt Employee: Includes all employees who are not identified as exempt. Non-Exempt employees are paid on an hourly basis and are eligible for overtime compensation as required by federal wage and hour laws.

On-Call Pay: Compensation provided to employees who must remain accessible after hours and/or on the weekends via pager or cell phone, and be available to fix problems or report to work, if necessary. On-Call is defined as time spent away from work during which a non-exempt employee is required to be available and to be able to come to work when requested.

Paid Interns: Paid interns are considered As-Needed employees, and should be concurrently enrolled in college or graduate courses.

Part-time Employees: Employees that regularly work at least twenty (20) hours per week and no more than thirty (30) hours per week.

Pay Differential: Additional compensation for special skills utilized on the job.

Performance Improvement Plan: A developmental coaching tool used to improve employee behavior and/or to address performance deficiencies identified in the annual performance review. The plan includes measurable expectations and accountability meetings.

Pregnancy Disability Leave (PDL): Any leave, whether paid or unpaid, taken by an employee for any period(s) during which she is disabled by pregnancy.

Promotion: Occurs when a current employee advances to an open position at a higher classification and salary range from the employee's previous position.

Property Manager: An outside fee -based property management company, with experience at managing high rise office buildings.

Protected Health Information (PHI): Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium.

This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by Cal Optima or Business Associates and relates to:

1. The past, present, or future physical or mental health or condition of a Member;
2. The provision of health care to a Member; or
3. Past, present, or future Payment for the provision of health care to a Member.

Qualifying Exigency: The military leave entitlement helps families of military service members manage their affairs while a covered military service member is on active duty or called to covered active duty status (or has been notified of an impending call or order to covered active duty). According to the FMLA, 29 C.F.R. Section 825.126, a qualifying exigency could include the following:

1. Short-notice deployment;
2. Military events and related activities;
3. Childcare and school activities;
4. Financial and legal arrangements;
5. Counseling;
6. Rest and recuperation;
7. Post-deployment activities;
8. Parental care; or
9. Additional activities not encompassed in the other categories, but agreed to by the employer and employee.

Reinstated Eligible Retiree: A Current Retiree or Retired Eligible Employee whose CalPERS retirement annuity and benefits under this Policy ended due to a reinstatement from retirement as defined in Government Code §§ 22838 and 21190 et.seq., or successor sections, and who (i) subsequently terminates employment from another state employer who does not provide retiree health benefits with a retiree share premium that is less than or equal to that being charged by CalOptima under this Policy; (ii) once again begins collecting retirement annuity payments from CalPERS within one hundred twenty (120) calendar days of such subsequent separation from employment; and (iii) timely enrolls for resumption of coverage under this Policy.

Remote Work Location or Remote Workplace: The teleworker's residence.

Required Licensure and/or Certification: Licenses and/or certificates deemed "required" in the applicable job description and/or required in the performance of an employee's job duties, including, but not limited to, professional licenses, driver's licenses, etc.

Retaliation: Adverse employment action against an employee because he or she filed a complaint or engaged in a protected activity.

Retired Eligible Employee: Eligible Employee who:

1. Retires within one hundred twenty (120) calendar days of such Eligible Employee's separation from employment with CalOptima and receives a monthly retirement allowance from CalPERS; and
2. Timely applies for retiree health benefits in accordance with this policy on and after January 1, 2014.

Retirement Date: Date Eligible Employee becomes an annuitant with CalPERS within one hundred twenty (120) calendar days of such Eligible Employee's separation from employment with CalOptima.

Safety Sensitive Employee: A position where the employee has the responsibility for his or her own safety or other people's safety, such as administering medication, handling of controlled substances and/or providing health care services or personal care services to CalOptima Members. This shall include any employee who operates a CalOptima owned or leased motor vehicle.

Second-hand Smoke: Smoke exhaled from one (1) individual unto common air, which may be inhaled by another individual, causing potentially harmful effects.

Separation Date: The last day of employment with CalOptima.

Service: All periods of employment with CalOptima, provided that service does not include periods in which an employee is on a Personal leave of absence pursuant to CalOptima Policy GA.8038: Personal Leave of Absence, and service shall not include any period of employment for which the employee has received severance pay under the RIF program or under any similar plan of CalOptima's.

Sex: Includes the same definition as provided in Government Code section 12926 and Title 42 of the United States Code section 2000 e(k), which includes, but is not limited to, pregnancy, childbirth; breastfeeding, medical conditions related to pregnancy, childbirth, or breastfeeding, gender identity, and gender expression.

Sex Stereotype: An assumption about a person's appearance or behavior or about an individual's ability or inability to perform certain kinds of work based on a myth, social expectation, or generalization about the individual's sex.

Smoking: The carrying or holding of any lighted pipe, cigar, or cigarettes of any kind, including electronic smoking devices (e.g. e-cigarettes and/or vaporizers), any lighted smoking equipment, or the lighting, inhaling, or exhaling of smoke from a pipe, cigar, or cigarette of any kind, including e-cigarettes and vaporizers.

Smoke-Free Environment: Prohibition of the use of cigarette, cigar, pipe tobacco, lighted pipe, or cigarettes of any kind, including e-cigarettes or any other form of substance.

Sponsoring Department: A department within CalOptima requesting a college or graduate student intern and overseeing the management and work of the interns pursuant to CalOptima Policy GA.8031: Internship Program.

Straight Time Pay: Pay at an employee's regular rate, not including overtime.

Subsequent Retirement Date: Date Reinstated Eligible Retiree again begins collecting retirement annuity payments from CalPERS within one hundred twenty (120) calendar days of separating from employment with the subsequent state employer described in that definition.

Survivor Dependent: Eligible Dependent who:

1. Survives an Eligible Retiree; and

2. Is collecting monthly survivor benefits from CalPERS that is attributable to a deceased Current Retiree, Retired Eligible Employee, or Reinstated Eligible Employee.

Termination: The end of the employment relationship.

Threat: A statement (verbal, written, or physical) which is intended to intimidate by expressing the intent to either harass, hurt, take the life of another person, or damage/destroy property. This includes threats made in jest or as a joke, but which others could perceive as serious.

Transfer: Occurs when an employee moves into a new position that is equivalent in its classification and salary range to the employee's previous position.

Transgender: A general term that refers to a person whose gender identity differs from the person's sex at birth. A transgender person may or may not have a gender expression that is different from the social expectations of the sex assigned at birth. A transgender person may or may not identify as "transsexual."
Under the Influence of Alcohol: An employee with a blood alcohol concentration (BAC) of .04 or above.

Unusual Occurrence: Any event which jeopardizes or has the potential to jeopardize the health and/or safety of CalOptima employees, members, and/or the community, including, but not limited to, physical injury and death, and/or property damage.

Workers' Compensation: An insurance policy covering work-related injury and illness.

Workplace Violence: Any intentional act that inflicts, attempts to inflict, or threatens to inflict bodily injury on another person or that inflicts, attempts to inflict, or threatens to inflict damage to property, whether committed by a CalOptima employee or by anyone else, and which occurs in the workplace, in or on CalOptima Property, or while an employee is engaged in CalOptima business.

Written Action Plan: A written document prepared by an employee who received a Final Warning, which details actions the employee will make to correct performance/behavior.

Written Warning: A Written Reminder issued to an employee documenting substandard employee performance or behavior.

9/80 Fair Labor Standards Act (FLSA) Workweek: Under the Fair Labor Standards Act, the workweek is defined as a fixed and regularly recurring period of seven (7) consecutive twenty-four (24)-hour periods, or one hundred sixty-eight (168) hours. The 9/80 workweek begins on the employee's eight (8) hour day, exactly four (4) hours after the scheduled start time, and ends exactly three (3) hours and fifty-nine (59) minutes after the scheduled start time on the same day the following week. This is commonly referred to as a "day divide," in which four (4) hours of the eight (8) hour day occurs in one (1) week, and four (4) hours occurs in the following week. Department supervisors/managers and Human Resources can answer questions about day divides.

9/80 Work Schedule: The 9/80 alternate work schedule consists of eight (8) business days of nine (9) hours per day and one (1) business day of eight (8) hours, for a total of eighty (80) hours during two (2) consecutive workweeks. The eight (8) hour work day must be on the same day of the week as the employee's regularly scheduled day off. Therefore, under the 9/80 work schedule, one (1) calendar week will consist of forty-four (44) hours (four (4) nine (9)-hour days and one (1) eight (8)-hour day) and the alternating calendar week will consist of thirty-six (36) hours (four (4) nine (9)-hour days and one (1) day off). However, each workweek will only consist of forty (40) hours, in accordance with the 9/80 Fair Labor Standards Act (FLSA) Workweek.

III. REGULATORY AGENCY APPROVALS

None to Date

IV. BOARD ACTIONS

03/02/17: Regular Meeting of the CalOptima Board of Directors

V. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	04/01/2016	GA.8000	Glossary of Terms	Administrative
Revised	09/01/2013	GA.8000	Glossary of Terms	Administrative
Revised	03/02/2017	GA.8000	Glossary of Terms	Administrative

Policy #:	GA.8054
Title:	**Injury Illness Prevention Program**
Department:	~~Human Resources~~Facilities
Section:	~~Not Applicable~~Environmental Health & Safety

CEO Approval: Michael Schrader

	~~5/1~~
Effective Date:	05/01/14
Last Review Date:	03/02/17
Last Revised Date:	03/02/17

I. PURPOSE

~~To establish~~This policy establishes an Injury and Illness Prevention Program to provide a safe and healthy workplace for CalOptima employees.

~~II. DEFINITIONS~~

~~Not Applicable.~~

~~III.~~II. POLICY

A. CalOptima is committed to providing a safe and healthy work environment for CalOptima employees. In furtherance of this commitment, CalOptima herein adopts the attached Injury and Illness Prevention Program (IIPP or Program) to establish methods for identifying and correcting workplace hazards, providing employee safety training, communicating safety information, and ensuring compliance with safety programs.

B. All managers and supervisors are responsible for enforcing safety and health policies and procedures and shall ensure employees are provided training, where applicable, specific to employee job duties and environment.

C. All employees are expected to:

1. Use safe work practices;
2. Follow all directives, policies, and procedures;
3. Comply with the requirements of the IIPP; and
4. Actively assist in ensuring workplace safety by reporting hazards and safety issues to management.

D. Any employee who demonstrates unsafe and/or unhealthy work practices will be subject to corrective and/or disciplinary action, up to and including termination.

~~IV.~~III. PROCEDURE

A. The Manager of Environmental Health and Safety has the authority and responsibility for implementing the provisions of this Program for CalOptima.

B. Copies of the IIPP shall be posted on CalOptima's ~~Infonet, and maintained in the Human Resources Department and the Facilities Department~~Environmental Health and Safety Infonet page.

C. A Safety Committee shall be established and comprised of appointed Human Resources ~~representatives~~ and management representatives~~, and the~~

~~C.~~1. The Safety Committee shall not meet ~~not~~ less than quarterly.

D. The Human Resources Department shall inform new employees, during orientation, about site-specific safety and health policies and procedures.

~~V.~~IV. ATTACHMENTS

A. Injury and Illness Prevention Program

~~VI.~~V. REFERENCES

A. California Labor Code, §6401.7
~~A.~~ Title 8, California Code of Regulations ~~Section~~ (C.C.R.), §3203
~~B. California Labor Code Section 6401.7~~

VI. REGULATORY AGENCY APPROVALS ~~OR~~

None to Date

VII. BOARD ~~ACTION~~ACTIONS

A. ~~5/1/14:~~ 03/02/17: Regular Meeting of the CalOptima Board ~~Meeting~~of Directors
B. 05/01/14: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

~~KEYWORDS~~

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	05/01/2014	GA.8054	Injury Illness Prevention Program	Administrative
Revised	03/02/2017	GA.8054	Injury Illness Prevention Program	Administrative

IX. GLOSSARY

Term	Definition
Injury and Illness Prevention Program (IIPP)	A document that establishes guidelines for developing a structured safety program that effectively implements a safe and healthful work environment as required by Title 8, California Code of Regulations section 3203.

~~IX.~~

Policy #:	GA.8054
Title:	**Injury Illness Prevention Program**
Department:	Facilities
Section:	Environmental Health & Safety
CEO Approval:	Michael Schrader
Effective Date:	05/01/14
Last Review Date:	03/02/17
Last Revised Date:	03/02/17

I. PURPOSE

This policy establishes an Injury and Illness Prevention Program to provide a safe and healthy workplace for CalOptima employees.

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A. The Manager of Environmental Health and Safety has the authority and responsibility for implementing the provisions of this Program for CalOptima.

B. Copies of the IIPP shall be posted on CalOptima's Environmental Health and Safety Infonet page.

C. A Safety Committee shall be established and comprised of appointed Human Resources and management representatives

1. The Safety Committee shall not meet less than quarterly.

D. The Human Resources Department shall inform new employees, during orientation, about site-specific safety and health policies and procedures.

IV. ATTACHMENTS

A. Injury and Illness Prevention Program

V. REFERENCES

A. California Labor Code, §6401.7
B. Title 8, California Code of Regulations (C.C.R.), §3203

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. 03/02/17: Regular Meeting of the CalOptima Board of Directors
B. 05/01/14: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	05/01/2014	GA.8054	Injury Illness Prevention Program	Administrative
Revised	03/02/2017	GA.8054	Injury Illness Prevention Program	Administrative

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Term	Definition
Injury and Illness Prevention Program (IIPP)	A document that establishes guidelines for developing a structured safety program that effectively implements a safe and healthful work environment as required by Title 8, California Code of Regulations section 3203.

Injury~~NJURY AND~~and Illness~~LLNESS P~~~~REVENTION~~revention P~~~~ROGRAM~~rogram

~~May 1~~ March 2

~~2013~~ 2017

As required by Cal/OSHA, Title 8, CCR Section 3203

Developed by Dan Greene, Manager Environmental Health and Safety

Back to Agenda

Management Commitment and Policy Statement

CalOptima management is committed to providing a safe and healthy work environment for CalOptima employees. To accomplish this, CalOptima establishes and maintains an Injury and Illness Prevention Program (“IIPP” or “Program”), and CalOptima encourages employees to actively assist by reporting hazards and safety issues. A united effort and enthusiastic approach is critical to achieving and maintaining this goal.

CalOptima’s Program, combined with safe and healthful work practices, ~~are~~ is essential in providing a safe and healthy work environment for CalOptima’s employees. This Program establishes methods for identifying and correcting workplace hazards, providing employee safety training, communicating safety information, and ensuring compliance with safety programs.

Back to Agenda

This IIPP includes all of the following minimum elements as required in Title 8 of the California Code of Regulations (CCR) § 3203, California Labor Code section 6401.7 and other applicable OSHA standards:

- Responsibilities~~;~~
- Compliance~~;~~
- Communication~~;~~
- Hazard Assessment~~;~~
- Accident/Exposure Investigation~~;~~
- Hazard Correction~~;~~
- Training and Instruction~~; and~~
- Recordkeeping~~.~~

RESPONSIBILITIES

The Injury and Illness Prevention Program (IIPP) administrator, Dan Greene, ~~M~~manager of Environmental Health and Safety (EH&S), has the authority and responsibility for implementing the provisions of this Program for CalOptima.

All ~~C~~chiefs, executives, directors, managers, supervisors and lead personnel are responsible for:

- Communicating CalOptima's commitment to health and safety to their employees~~;~~
- Directing their employees to where the IIPP is located~~;~~
- Implementing and maintaining the IIPP in their work areas~~;~~
- Answering employee questions about the IIPP~~;~~
- Modeling and enforcing safe and healthy work practices~~;~~
- Ensuring that employees are properly trained to complete all assigned tasks~~;~~
- Periodically inspecting workspaces under their authority~~;~~
- Stopping work that poses an imminent hazard to the employee and/or others~~;~~
- Providing appropriate safety training and personal protective equipment, where applicable, to employees under their supervision~~;~~
- Reporting and investigating work related injuries and illnesses~~;~~
- Encouraging employees to report health and safety issues without fear~~;~~
- Disciplining employees ~~that~~ who do not comply with safe work practices~~; and~~
- Documenting employee safety training~~.~~

All employees are responsible for:

- Complying with all applicable health and safety regulations, policies and work practices~~;~~
- Using personal protective equipment (where required)~~;~~
- Learning about the potential hazards of assigned tasks and work areas~~;~~

- Reporting all work-related injuries and illnesses promptly to their manager or supervisor~~;~~
- Warning co-workers about defective equipment and other hazards~~;~~
- Reporting any unsafe or unhealthy conditions immediately to a manager or supervisor~~;~~
- Cooperating with incident investigations~~; and~~
- Participating in workplace safety inspections~~.~~

A copy of this IIPP is available ~~in the following locations:~~on the CalOptima InfoNet.

- ~~Human Resources~~
- ~~CalOptima InfoNet~~
- ~~Facilities~~

COMPLIANCE

Compliance is critical for the effectiveness of the IIPP. Management is responsible for ensuring that all safety, health policies and procedures are clearly communicated and understood by all employees. Managers, supervisors and lead personnel are expected to enforce the rules fairly and uniformly.

All employees, including ~~c~~cChiefs, executives, directors, managers~~,~~ and supervisors~~,~~ are responsible for complying with safe and healthful work practices. All employees are responsible for using safe work practices, for following all directives, policies and procedures, and for assisting in maintaining a safe work environment. Any employee who demonstrates unsafe and/or unhealthy work practices will be subject to corrective and/or disciplinary action, up to and including termination. Discipline of employees shall be in accordance with CalOptima's policies.

The following is CalOptima's system of ensuring that all employees comply with the Program:

- Informing employees of the provisions in our IIPP~~.~~
- Maintaining copies of the IIPP in areas accessible to employees (EH & S ~~Infonet~~InfoNet webpage)~~.~~
- Evaluating the safety performance of all employees~~.~~
- Maintaining open lines of communication to report unsafe and unhealthy work conditions~~.~~
- Providing training for all new processes with potential hazards~~.~~
- ~~Posting an up to date record of days without an injury~~
- ~~Posting an up to date record of days without a lost time injury~~
- Providing training to workers whose safety performance or work practice is deficient~~.~~
- Correcting and/or disciplining employees for failure to comply with safe and healthful work practices~~.~~
- Disciplining employees for continued practices that endanger the employee or others~~.~~

It is CalOptima's desire to provide a safe and healthful workplace; therefore, CalOptima will take immediate action to correct, mitigate~~,~~ and/or remove any unsafe or unhealthy practice that jeopardizes the safety of CalOptima employees. In the event of a credible threat of violence~~,~~ ~~A~~ the Facilities Manager will notify Legal Affairs within ~~twenty-four (24)~~24 hours in ~~in~~ accordance with CalOptima Policy GA.8053:~~:~~ ~~per the~~ Workplace Violence ~~.Policy.~~ In the

event the ~~absence of the~~ Facilities Manager is absent, the Environmental Health and Safety Manager will act as backup.

COMMUNICATION

All managers and supervisors are responsible for communicating safety and health issues in a ~~form~~ manner ~~-~~readily understandable by all employees. CalOptima's communication system encourages employees to communicate safety concerns to supervisors or managers without fear of reprisal. CalOptima ~~is required to~~ shall inform employees of their right to report work related injuries and illnesses free from retaliation. CalOptima ~~is prohibited from~~shall not discriminat~~inge~~ against employees who report work related injuries and illnesses. ~~-~~CalOptima's communication system includes the following:

- Safety Committee:
  - ~~o~~ Comprised of appointed labor/management that meets not less than quarterly.
  - ➢ Minutes are posted on CalOptima's InfoNet.
  - ~~o~~➢ The committee makes available to affected employees~~,~~ written records of the safety and health issues, key initiatives~~,~~ and safety updates discussed at the committee meetings.
  - ➢ The committee serves as the primary source of communicating health and safety issues to employees.
  - ~~o~~ The committee ~~,~~
    - ➢ ~~The committee~~ reviews the results of ~~the~~ periodic scheduled work site inspections.
    - ➢ ~~o~~ The committee reviews the investigations of occupational accidents and causes of incidents resulting in occupational injury, occupational illness~~,~~ or exposure to
      - ~~o~~ hazardous ~~-~~
      hazardous ~~-~~substances and, when appropriate, submits suggestions to management for the prevention of future incidents. The Safety Committee is responsible for communicating information concerning safety and health hazards and corrective actions.
    - ~~o~~➢ The committee reviews investigations of alleged hazardous conditions brought to the attention of any committee member. The committee may conduct its own inspection and investigation to assist in remedial solutions.
    - ~~o~~➢ The committee submits recommendations to assist in the evaluation of employee safety suggestions.
- New employee orientation, including a discussion of site-specific safety and health policies and procedures
- Safety and health policies and procedures are communicated and enforced by supervisors and managers.
- Workplace safety and health training specific to employee job duties and environment~~.~~
- ~~o~~ Posting of CalOptima's IIPP is available to all employees on the ~~central~~ InfoNet. ~~In addition, emergency procedures are also posted on CalOptima's InfoNet.~~
- ~~o~~ Emergency procedures are also posted on EH & S Info~~n~~Net web~~-~~page.
- Communication of safety and health concerns between employees and supervisors, including language translation, where appropriate, as follows:
  - o Post and distribute safety information in all appropriate languages including required postings, safety meeting minutes~~,~~ and results of periodic inspections~~; and~~
  - ~~o~~ CalOptima
    - ~~Provide a system for workers to anonymously inform management about workplace hazards.~~
    - ~~o~~ ~~CalOptima~~ encourages its employees to report any perceived hazards immediately

to their supervisor, manager or safety representative. This communication will be received and communicated without reprisal. ~~For those employees who wish to remain anonymous, CalOptima provides a suggestion box in the main lunch room~~

- Communicate changes in safety practices as needed (beginning of shifts, safety meetings, safety newsletter or safety email).

- Communicate general safe work practices with respect to hazards unique to the employee's job assignment.

HAZARD ASSESSMENT

~~CalOptima's Environmental Health and Safety Manager, along with personnel in the Facilities Department, shall perform monthly inspections using the attached *Office Inspection Checklist** to identify and evaluate workplace hazards.~~
The CalOptima Facilities ~~D~~department is responsible for repairing identified hazards, repairing faulty equipment, and doing general walkthroughs inside the ~~demised~~leased premises on a daily basis. Identification of workplace hazards will be accomplished through cooperation of all employees, managers and supervisors. Maintaining a safe and healthful work environment is the responsibility of employees at every level in CalOptima.

Periodic inspections consist of identification and evaluation of workplace hazards with the option of utilizing applicable sections of the attached Hazard Assessment and Correction Record*~~,~~ and any other effective methods used to identify and evaluate workplace hazards. CalOptima shall perform periodic inspections according to the following schedule:

- When CalOptima first establishes the IIPP~~;~~
- When new substances, processes, procedures or equipment are introduced into CalOptima's workplace that present potential new occupational safety and health hazard(s)~~;~~
- When new, previously unidentified hazards are recognized~~;~~
- When occupational injuries and illnesses occur~~;~~
- When CalOptima hires and/or reassigns permanent or intermittent employees to processes, operations~~,~~ or tasks for which a hazard evaluation has not been previously conducted~~;~~
- When potential hazards are identified during the investigation of injuries, illnesses and accidents using the Accident Investigation Form*~~;~~
- When considering suggestions made by employees~~; and~~
- Whenever workplace conditions warrant an inspection~~.~~

~~When a hazard has been identified, a record of abatement will be documented on the *Hazard Assessment and Correction Record**.~~

ACCIDENT/EXPOSURE INVESTIGATIONS

~~An affected employee's supervisor and/or manager, along with the assistance of T~~the Environmental Health and Safety Manager and, when necessary, CalOptima supervisors and managers~~the affected employee~~, will be responsible for the investigation of workplace accidents, hazardous substance exposures~~,~~ and near-~~-~~accidents.

Each investigation of an injury, illness~~,~~ or accident will be documented with:

- Detailed information about the incident~~;~~
- The investigation's findings~~;~~

- Whether a workplace hazard contributed to the incident~~;~~

- How the hazard will be abated~~; and~~
- Who the investigator was~~.~~

This investigation process is critical in identifying hazards, improving processes, mitigating risk(s) and providing follow -up. If necessary, in~~In~~ the case of extraordinary or serious injury, a team of managers will thoroughly investigate the accident. CalOptima will document investigations using the Accident Investigation Form* ~~,~~and submit to the Environmental Health and Safety Manager.

The Environmental Health & Safety Manager and, when necessary, CalOptima supervisors and/or managers, ~~with the assistance of the Environmental Health and Safety Manager,~~ will be responsible for investigating workplace accidents and hazardous substance exposures. The procedures for such investigation will include:

- Visiting the scene of the accident or hazardous substance exposure as soon as the Environmental Health and Safety ~~-~~department or supervisor and/or manager receives notification~~;~~
- Interviewing affected workers and witnesses and documenting witness statements;
- Examining the workplace for factors associated with the accident/exposure/near -accident~~;~~
- Determining the causes of the accident/exposure/near -accident~~;~~
- Reviewing established procedures to ensure they were adequate and were followed~~;~~
- Taking corrective action to prevent the accident/exposure/near- accident from reoccurring~~, and~~
- Documenting all the above steps~~,~~ and, where applicable or appropriate, provide photographs of other exhibits such as drawings~~.~~

If a reportable serious injury or illness or death results, CalOptima shall contact the local OSHA office as soon as practically possible and within 8 hours of the incident by telephone at ~~(~~714~~)~~ - 558- 4451 or 1-800-321-6742 (OSHA) and fax at ~~(~~714~~)~~ -558-2035, using the form Serious Incident Report Fax.*~~:~~ "~~"~~Serious injury or illness"~~"~~ means any injury or illness occurring in a place of employment or in connection with any employment which requires inpatient hospitalization for a period in excess of 24 hours for other than medical observation or in which an employee suffers a loss of any member of the body or suffers any serious degree of permanent disfigurement. The Serious Incident Report Fax will be kept in the affected employee's file.

HAZARD CORRECTION

Unsafe or unhealthy work conditions, practices or procedures at, on or in CalOptima ~~P~~properties will be corrected in a timely manner based on the severity of the hazards~~,~~ and according to the following procedures:

- When observed or discovered~~; and~~
- When an imminent hazard exists which cannot be immediately abated without endangering employee(s) and/or property, all exposed employees will be removed from the affected area(s) except those employees necessary to correct the existing condition. Employees necessary to correct the hazardous condition shall be provided with the necessary protective equipment.

All corrective actions taken and the dates they are completed shall be documented on the Hazard Assessment and Correction Record.*

TRAINING AND INSTRUCTION

All employees, including managers, supervisors, and lead personnel shall have training and instruction on general and job-specific safety and health practices. Training and instruction shall be provided as follows:

- When the IIPP is first established;
- To all new employees during orientation;
- To all employees given new job assignments for which training has not been previously provided;
- Whenever new substances, processes, procedures or equipment are introduced to the workplace and represent a new hazard;
- Whenever CalOptima becomes aware of a new or previously unrecognized hazard;
- To managers, supervisors, and lead personnel to familiarize them with the safety and health hazards to which employees under their immediate direction and control may be exposed; and
- To all employees with respect to hazards specific to each employee''s job aassignment.

General workplace safety and health practices include, but are not limited to:

- Implementation and maintenance of the IIPP.
- Explanation of: CalOptima's IIPP; emergency action plan and fire prevention plan; measures for reporting any unsafe conditions; work practices; potential injuries; and other information when additional instruction is needed.
- Availability of sanitary toilet, hand-washing, and drinking water facilities.
- Provisions for medical services and first aid, including emergency procedures.
- Proper housekeeping, such as keeping stairways and isles aisles clear, work areas neat and orderly, and promptly cleaning up spills.
- Prohibiting horseplay, scuffling, or other acts that adversely influence safety
- Proper storage to prevent:
  - Stacking goods in an unstable manner; and
  - Storing materials and goods against doors, exits, fire extinguishing equipment and electrical panels; and.
  -
  - Proper reporting of hazards and accidents to supervisors and/or mmanagers.

- Where applicable, CalOptima's training may also include:

- Prevention of musculoskeletal disorders, including proper lifting techniques.
- Use of appropriate clothing, including gloves, footwear, and personal protective equipment.
- Information about chemical hazards to which employees could be exposed and other hazard communication program information.

- Proper food and beverage storage to prevent them from becoming contaminated.

In addition, CalOptima provides specific instructions to all employees regarding hazards unique to specific job assignments, to the extent that such information was not already covered in other training.

- ~~All~~ When necessary, training and instruction, employee name, training dates, type of training and trainers shall be documented on the Employee Training and Instruction Record.*~~.~~

The following safety programs and procedures are also available:

- Emergency Preparedness: Fire; Earthquake; Irate Person; Bomb Threat (Located on the InfoNet and in the Floor Warden Manual)
- ~~Ergo~~nomic Assessments
  - ~~Fire*~~
  - ~~Earthquake*~~
  - ~~Irate Person*~~
  - ~~Bomb Threat*~~

  ~~* located on the InfoNet and in the Floor Warden Manual~~
- ~~Ergo~~nomics Assessment Program (request via E-Ticket)

Workplace

- ~~Workplace~~ Violence Awareness Presentation (located on ~~Environmental Health and~~EH&S ~~Safety~~ InfoNet webpage)
- ~~WPV Awareness.htm Ctrl + Click to View~~

RECORDKEEPING

~~CalOptima keeps records as follows:~~

Records of scheduled and periodic inspections are maintained by the ~~P~~property ~~M~~manager. The p~~P~~roperty ~~M~~manager conducts ~~Q~~quarterly property inspections ~~are conducted by Property Manager~~ and records any identified hazards and the action(s) taken to correct the identified unsafe conditions~~,~~ ~~are recorded~~ on the Quarterly Property Inspection Report ~~by the Property Manager~~. These records are maintained in perpetuity by the p~~P~~roperty ~~M~~manager~~.~~, ~~including the person(s) conducting the inspection, the workplace hazards (i.e., unsafe conditions and work practices that have been identified) and the action(s) taken to correct the identified unsafe conditions and work practices, are recorded on the *Hazard Assessment and Correction Record** and the *Office Inspection Checklist**. These records are maintained for at least one (1) year.~~

~~1.~~

~~2.~~ CalOptima's recordkeeping is based on California Standard Section 14300, which includes using OSHA Form 300, OSHA Form 301 and OSHA Form 300A. These records are maintained for five ~~(5)~~ years.

~~3.~~ Documentation of safety and health training for each worker, including the worker's name or other identifier, training dates, type(s) of training~~,~~ and training providers are recorded on the Worker Training and Instruction Record.*~~.~~ This documentation is maintained for at least one ~~(1)~~ year.

Documents Attached:
Office Inspection Checklist*
Hazard Assessment and Correction Record*
Employee Training and Instruction Record*
Accident Investigation Form*
Serious Incident Report Fax*
Workplace Active Shooter Response and Prevention*
Level I Ergonomic Assessment*

~~*Ergonomics Program**~~

Documents / Checklists

OFFICE INSPECTION CHECKLIST

	~~Yes~~	~~No~~	~~Comments~~
Administrative	Yes	No	Ceomments/Ddate Ceorrected
Is there a current IIPP in a known location and accessible to all employees?			
Is there a safety bulletin board or equivalent displaying emergency contact information, evacuation routes, safety information, etc.?			
Is there a departmental fire and emergency preparedness protocol in place?			
Are all employees trained on all departmental protocols?			
General Safety/Housekeeping	Yes	No	Comments/Date Corrected
Are stairwells and walkways kept clear from clutter?			
Are stairwells and handrails in good condition?			
Are doorways and exits kept clear from obstacles and clutter?			
Are step stools available for easy access to high storage areas?			
Are file cabinets kept closed when not in use to prevent contusions and/or slip/trip/fall injuries?			
Are rest rooms clean and orderly?			
Are waste materials placed in appropriate waste containers (trash, recycling, etc.)?			
Are storage rooms neatly maintained?			
Are break rooms/lunch rooms clean and free from slip/fall hazards?			
Are coffee makers and water dispensers secured to avoid scalds and/or slip fall injuries?			
Are all facility work areas properly illuminated?			
Are all exit signs properly illuminated?			
Are all panic bars on emergency exits working properly?			
Are all panic bar alarms on emergency exits operable?			
Are all emergency exits clearly marked?			

	Yes	No	Comments
Are all emergency exits clearly marked?			
Earthquake and Fire Protection	**Yes**	**No**	**comments/date**
Are filing cabinets, bookcases and other items over 5 feet tall securely bolted to the walls?			
Are shelved materials located above the chest level secured by cabinet doors or straps?			
Are evacuation procedures in place for people with disabilities?			
Are fire doors closed securely at all times?			
Are fire extinguishers properly mounted and inspected?			
Are fire drills/emergency evacuation drills conducted on a regular basis?			
Have the fire Ee-xtinguishers been checked for discharge, condition and tags initialed?			
If extinguishers are in need of service, has the contractor been notified?			
Electrical	**Yes**	**No**	**Comments/Date Corrected**
Are plugs, cords, electrical panels and receptacles in good condition (no exposed conductors or broken insulation)?			
Are extension cords and surge suppressors being used correctly and not posing safety hazards?			
Miscellaneous	**Yes**	**No**	**Comments/Date Corrected**

HAZARD ASSESSMENT AND CORRECTION RECORD

Date of Inspection Click here to enter a date.

Person(s) Conducting Inspection:

Unsafe Condition or Work Practice:

Corrective Action Taken:

Date of Inspection Click here to enter a date.

Person(s) Conducting Inspection:

Unsafe Condition or Work Practice:

Corrective Action Taken:

EMPLOYEE TRAINING AND INSTRUCTION RECORD

Training Program: **Instructor:**

Employee Name	Date Completed	Comments
	3T	

Accident/Incident Investigation Report

505 City Parkway West, Orange, CA 92868

ACCIDENT/INCIDENT INVESTIGATION REPORT

SECTION 1: EMPLOYEE INFORMATION (WHO)

Name	Home Address	DOB

Gender	Job Title	Supervisor Name

Job Location Address	Date of Report
	Click here to enter a date.

SECTION 2: ACCIDENT/ INCIDENT INFORMATION (WHEN, WHERE, WHAT)

1. **When did the accident/incident occur? (Date and Time)**

2. **Where did the accident/incident happen? (Example: in front of the sink in the 6th floor break room)**

3. **What were you doing when the accident occurred? (Example: lifting boxes from the floor to my desk)**

4. **Accident/incident Witness(s)?** ☐ **Yes** ☐ **No**

a) **If yes, witness(s) name**

(Attach a witness(s) statement if applicable)

SECTION 3: ACCIDENT/INCIDENT ROOT CAUSE (WHY, HOW)

1. **Describe exactly how the accident/injury/illness occurred**

2. **Describe the injury sustained (be specific about body part(s) affected)**

3. **Why did this accident/incident happen (consider environment, conditions, training, lack of training)**

4. **How could this accident/incident have been prevented?**

SECTION 4: —CORRECTIVE ACTION AND DISPOSITION

1. **Disposition:**

a) **First aid?** ☐ **Yes** ☐ **No**

b) **If first aid, describe**

c) **Sent to:** ☐**Clinic** ☐**Emergency room-/-hospital** ☐ **Pre-designated doctor**

d) **Returned to work?** ☐**Yes** ☐**No**

e) **Returned to work modified duty** ☐

Emergency room-/-hospital address

2. **Corrective action taken, if any, including date completed or date of anticipated completion (e.g., repairs to equipment, ergonomic assessment with reasonable accommodation resolution, employee training, etc.)**

3. **Does an unsafe condition continue to exist?** ☐**Yes** ☐**No**

If yes, please describe

4. **Employee recommendations-/-suggestions**

5. **Supervisor comments-/-recommendations**

Name-/-Title of person completing report (print) **Please print report and sign ~~in blue ink~~**

Clear All Fields

v080707

Serious Incident Report FAX

TO: **Division of Occupational Safety and Health, District Manager** ( ) - Telephone

FROM:

Company Name | Name of Person Reporting

Address | Title

City | State | Zip | ( ) - Telephone

Please be advised that there was a serious incident involving our employee(s). The circumstances of the incident and the nature of the injuries are under investigation.

Date of Incident | Time of Incident

Incident occurred:

☐ On establishment premises:

Department or Area

☐ Off establishment premises:

Location

Address

City | State | Zip

Reporting: ☐ One employee ☐ More than one employee (see attached page 2)

Employee:

Name of Employee

Home Address

City | State | Zip

Employee taken to:

Location

Address

City | State | Zip

Employee suffered: ☐ Injury ☐ Illness ☐ Death

Employee's normal work site (if different than corporate address):

Address | City | State | Zip

Other law enforcement agencies involved (police, fire, etc.):

Serious Incident Report FAX

Other employees involved in the serious incident:

Employee:

Name of Employee

Home Address

City State Zip

Employee taken to:

Location

Address

City State Zip

Employee suffered: ☐ Injury ☐ Illness ☐ Death

Employee:

Name of Employee

Home Address

City State Zip

Employee taken to:

Location

Address

City State Zip

Employee suffered: ☐ Injury ☐ Illness ☐ Death

Employee:

Name of Employee

Home Address

City State Zip

Employee taken to:

Location

Address

City State Zip

Employee suffered: ☐ Injury ☐ Illness ☐ Death

WORKPLACE ACTIVE SHOOTER RESPONSE AND PREVENTION

An active shooter as defined by the United States Department of Homeland Security is an individual actively engaged in killing or attempting to kill people in a confined and populated area~~;~~. I~~i~~n most cases, active shooters use firearms(s) and there is no pattern or method to their selection of victims. ~~is any person who has used physical force or inflicts great bodily harm to another individual. as defined by the Department of Homeland Security, is an individual actively engaged in killing or attempting to kill people in a confined and populated area; and in most cases, use firearm(s).~~ Active shooter situations are unpredictable and evolve quickly. Typically, the immediate deployment of law enforcement is required to stop the active shooter and to mitigate harm to victims. Because active shooter situations are often over within 10 to 15 minutes, before law enforcement arrives on the scene, individuals must be prepared both mentally and physically to deal with an active shooter situation.

HOW TO RESPOND WHEN AN ACTIVE SHOOTER IS IN YOUR VICINITY

1. **Evacuate**
   If there is an accessible escape path, attempt to evacuate the premises. Be sure to:

   - Have an escape route and plan in mind.
   - Evacuate regardless of whether others agree to follow.
   - Leave your belongings behind.
   - Help others escape, if possible.
   - Prevent individuals from entering an area where the active shooter may be.
   - Keep your hands visible.
   - Follow the instructions of any police officers.
   - Do not attempt to move wounded people.
   - Call 911 when you are safe.

2. **Hide ~~out~~**
   If evacuation is not possible, find a place to hide where the active shooter is less likely to find you. Your hiding place should:

   - Be out of the active shooter's view.
   - Provide protection if shots are fired in your direction (~~i.e.~~e.g., an office with a closed and locked door).
   - Not trap you or restrict your options for movement.

   To prevent an active shooter from entering your hiding place:

   - Lock the door.
   - Blockade the door with heavy furniture.

If the active shooter is nearby:

- Lock the door.
- Silence your cell phone and/or pager.

- Turn off any source of noise (~~i.e.~~e.g., radios, televisions).
- Hide behind large items (~~i.e~~e.g., cabinets, desks).
- Remain quiet.

If evacuation and hiding out are not possible:

- Remain calm.
- Dial 911, if possible, to alert police to the active shooter's location.
- If you cannot speak, leave the line open and allow the dispatcher to listen.

3. **Take action against the active shooter**
   As a last resort, and only when your life is in imminent danger, attempt to disrupt and/or incapacitate the active shooter by:

   - Acting as aggressively as possible against him/her~~.~~
   - Throwing items and improvising weapons~~.~~
   - Yelling~~.~~
   - Committing to your actions~~.~~

HOW TO RESPOND WHEN LAW ENFORCEMENT ARRIVES

Law enforcement's purpose is to stop the active shooter as soon as possible. Officers will proceed directly to the area ~~in which~~that the last shots were heard.

- Officers usually arrive in teams of four ~~(4)~~.
- Officers may wear regular patrol uniforms or external bulletproof vests, Kevlar helmets, and other tactical equipment.
- Officers may be armed with rifles, shotguns, and/or handguns.
- Officers may use pepper spray or tear gas to control the situation.
- Officers may shout commands, and may push individuals to the ground for their safety.

How to react when law enforcement arrives:

- Remain calm, and follow officers' instructions.
- Put down any items in your hands (~~i.e~~e.g., bags, jackets).
- Immediately raise hands and spread fingers.
- Keep hands visible at all times.
- Avoid making quick movements toward officers such as holding on to them for safety.
- Avoid pointing, screaming and/or yelling.
- Do not stop to ask officers for help or directions when evacuating, just proceed in the direction from which officers are entering the premises.

Information to provide to law enforcement or 911 operators:

- Location of the active shooter~~.~~
- Number of shooters, if more than one~~.~~

- Physical description of shooter(s).
- Number and type of weapons held by the shooter(s).
- Number of potential victims at the location.

The first officers to arrive to the scene will not stop to help injured persons. Expect rescue teams comprised of additional officers and emergency medical personnel to follow the initial officers. These rescue teams will treat and remove any injured persons. They may also call upon able-bodied individuals to assist in removing the wounded from the premises. Once you have reached a safe location or an assembly point, you will likely be held in that area by law enforcement until the situation is under control, and all witnesses have been identified and questioned. Do not leave until law enforcement authorities have instructed you to do so.

Additional Ways to Prepare For and Prevent an Active Shooter Situation

Preparedness

- Ensure that your facility has at least two evacuation routes.
- Post evacuation routes in conspicuous locations throughout your facility.
- Include local law enforcement and first responders during training exercises.

Prevention

- Foster a respectful workplace.
  Be aware of indications of workplace violence and take remedial actions accordingly.

Humanscale Consulting

Levell Ergonomic Assessment

Pre-Assessment												
Name:		Age: 20-30 31-40 41-50 50+						Work computer use:				hrs/day
Date:		Gender: Female Male						Home computer use:				hrs/day
Company:		Height:						Average phone use:				hrs/day
Length of employment:		Dominant hand: Left Right Both						Proficient typist:			Y	N
Location:		Corrective lenses: Y N						Uses numeric keypad:			Y	N
Discomfort Area		**Discomfort Area**	**L**	**R**	**Discomfort Area**	**L**	**R**	**Discomfort Area**			**L**	**R**
Neck	☐	Shoulder	☐	☐	Wrist	☐	☐	Knee			☐	☐
Upper back	☐	Upper arm	☐	☐	Hand	☐	☐	Foot			☐	☐
Lower back	☐	Elbow	☐	☐	Hip	☐	☐	Other:				
Eyes	☐	Forearm	☐	☐	Thigh	☐	☐					
Risk Factors		**Source**			**Risk Factors**			**Source**				
Neck flexion	☐				Forearm pronation	☐						
Neck extension	☐				Elbow extension	☐						
Neck rotation	☐				Trunk flexion	☐						
Shoulder abduction	☐				Trunk rotation	☐						
Shoulder adduction	☐				Feet usupported	☐						
Shoulder shrugging	☐				Inappropriate light level	☐						
Wrist extension	☐				**Contact Stress**			**Source**				
Wrist flexion	☐				Wrists	☐						
Ulnar deviation	☐				Forearm/Elbow	☐						
Radial deviation	☐				Thighs/Knees	☐						
Equipment Audit												
Adequate task chair	☐	Task light	☐		Inline document holder	☐		Footrest		☐		
Keyboard support	☐	Laptop holder	☐		Alternative mouse	☐		Palm support		☐		
Flat panel monitor arm	☐	Sit to stand workstation	☐		Alternative keyboard	☐		Telephone headset		☐		
Workstation Assessment												
Keyboard Support		**Chair**			**Monitor / Documents / Phone**							
If yes, is it being used?	☐	Chair height adjustable?	☐		Multiple monitors in use?	☐						
KB tray height adjustable?	☐	Seat pan adjustable?	☐		Monitor(s) aligned with body?	☐						
KB tray tilts negatively?	☐	Armrests adjust adequately?	☐		Monitor(s) at appropriate height?	☐						
Adequate mouse platform?	☐	Backrest height adjustable?	☐		Monitor(s) at appropriate distance?	☐						
Adequate knee clearance?	☐	Is backrest dynamic?	☐		Documents aligned with body?	☐						
Action Level: *No change*	☐	Backrest unlocked?	☐		Telephone within arms reach?	☐						
Consider replacement	☐	**Action Level:** *No change*	☐		Telephone on dominant side?	☐						
Replacement recommended	☐	*Consider replacement*	☐		Task light in use?	☐						
Installation recommended	☐	*Replacement recommended*	☐		Task light opposite dominant side?	☐						
Actions Performed					**Corrected onsite**			**Further Action Required**				
Chair properly fitted to employee					☐							
Keyboard and mouse appropriately positioned					☐							
Monitor position adjusted					☐							
Light level made appropriate for tasks					☐							
Organized desk & documents more appropriately					☐							
Recommendations												
Keyboard support	☐	Inline document holder	☐		Laptop holder	☐		More frequent rest breaks		☐		
Corner sleeve	☐	Dynamic footrest	☐		Monitor riser	☐		Follow-up assessment		☐		
Ergonomic task chair	☐	Alternative keyboard	☐		CPU holder	☐		Seek medical attention		☐		
Flat panel monitor arm	☐	Alternative mouse	☐		Telephone headset	☐		Other:				
Task light	☐	Palm support	☐		Sit to stand workstation	☐						
Assessment Summary												
No further changes required	☐	Tool upgrade recommended	☐		Tools required for further improvement	☐						

Notes:

Injury and Illness Prevention Program

March 2

2017

As required by Cal/OSHA, Title 8, CCR Section 3203

Developed by Dan Greene, Manager Environmental Health and Safety

Back to Agenda

Management Commitment and Policy Statement

CalOptima management is committed to providing a safe and healthy work environment for CalOptima employees. To accomplish this, CalOptima establishes and maintains an Injury and Illness Prevention Program (IIPP or Program), and CalOptima encourages employees to actively assist by reporting hazards and safety issues. A united effort and enthusiastic approach is critical to achieving and maintaining this goal.

CalOptima's Program, combined with safe and healthful work practices, is essential in providing a safe and healthy work environment for CalOptima's employees. This Program establishes methods for identifying and correcting workplace hazards, providing employee safety training, communicating safety information, and ensuring compliance with safety programs.

This IIPP includes all of the following minimum elements as required in Title 8 of the California Code of Regulations (CCR) § 3203, California Labor Code section 6401.7 and other applicable OSHA standards:

- Responsibilities
- Compliance
- Communication
- Hazard Assessment
- Accident/Exposure Investigation
- Hazard Correction
- Training and Instruction
- Recordkeeping

RESPONSIBILITIES

The Injury and Illness Prevention Program (IIPP) administrator, Dan Greene, manager of Environmental Health and Safety (EH&S), has the authority and responsibility for implementing the provisions of this Program for CalOptima.

All chiefs, executives, directors, managers, supervisors and lead personnel are responsible for:

- Communicating CalOptima's commitment to health and safety to their employees
- Directing their employees to where the IIPP is located
- Implementing and maintaining the IIPP in their work areas
- Answering employee questions about the IIPP
- Modeling and enforcing safe and healthy work practices
- Ensuring that employees are properly trained to complete all assigned tasks
- Periodically inspecting workspaces under their authority
- Stopping work that poses an imminent hazard to the employee and/or others
- Providing appropriate safety training and personal protective equipment, where applicable, to employees under their supervision
- Reporting and investigating work related injuries and illnesses
- Encouraging employees to report health and safety issues without fear
- Disciplining employees who do not comply with safe work practices
- Documenting employee safety training

All employees are responsible for:

- Complying with all applicable health and safety regulations, policies and work practices
- Using personal protective equipment (where required)
- Learning about the potential hazards of assigned tasks and work areas

- Reporting all work-related injuries and illnesses promptly to their manager or supervisor
- Warning co-workers about defective equipment and other hazards
- Reporting any unsafe or unhealthy conditions immediately to a manager or supervisor
- Cooperating with incident investigations
- Participating in workplace safety inspections

A copy of this IIPP is available on the CalOptima InfoNet.

COMPLIANCE

Compliance is critical for the effectiveness of the IIPP. Management is responsible for ensuring that all safety, health policies and procedures are clearly communicated and understood by all employees. Managers, supervisors and lead personnel are expected to enforce the rules fairly and uniformly.

All employees, including chiefs, executives, directors, managers and supervisors are responsible for complying with safe and healthful work practices. All employees are responsible for using safe work practices, for following all directives, policies and procedures, and for assisting in maintaining a safe work environment. Any employee who demonstrates unsafe and/or unhealthy work practices will be subject to corrective and/or disciplinary action, up to and including termination. Discipline of employees shall be in accordance with CalOptima's policies.

The following is CalOptima's system of ensuring that all employees comply with the Program:

- Informing employees of the provisions in our IIPP
- Maintaining copies of the IIPP in areas accessible to employees (EH & S InfoNet webpage)
- Evaluating the safety performance of all employees
- Maintaining open lines of communication to report unsafe and unhealthy work conditions
- Providing training for all new processes with potential hazards
- Providing training to workers whose safety performance or work practice is deficient
- Correcting and/or disciplining employees for failure to comply with safe and healthful work practices
- Disciplining employees for continued practices that endanger the employee or others

It is CalOptima's desire to provide a safe and healthful workplace; therefore, CalOptima will take immediate action to correct, mitigate and/or remove any unsafe or unhealthy practice that jeopardizes the safety of CalOptima employees. In the event of a credible threat of violence the Facilities Manager will notify Legal Affairs within 24 hours in accordance with CalOptima Policy GA.8053: Workplace Violence. In the event the Facilities Manager is absent, the Environmental Health and Safety Manager will act as backup.

COMMUNICATION

All managers and supervisors are responsible for communicating safety and health issues in a manner readily understandable by all employees. CalOptima's communication system encourages employees to communicate safety concerns to supervisors or managers without fear of reprisal. CalOptima shall inform employees of their right to report work related injuries and illnesses free from retaliation. CalOptima shall not discriminate against employees who report work related injuries and illnesses. CalOptima's communication system includes the following:

- Safety Committee:
  - Comprised of appointed labor/management that meets not less than quarterly. Minutes are posted on CalOptima's InfoNet.
  - The committee makes available to affected employees written records of the safety and health issues, key initiatives and safety updates discussed at the committee meetings.
  - The committee serves as the primary source of communicating health and safety issues to employees.
  - The committee reviews the results of periodic scheduled work site inspections.
  - The committee reviews the investigations of occupational accidents and causes of incidents resulting in occupational injury, occupational illness or exposure to hazardous substances and, when appropriate, submits suggestions to management for the prevention of future incidents. The Safety Committee is responsible for communicating information concerning safety and health hazards and corrective actions.
  - The committee reviews investigations of alleged hazardous conditions brought to the attention of any committee member. The committee may conduct its own inspection and investigation to assist in remedial solutions.
  - The committee submits recommendations to assist in the evaluation of employee safety suggestions.
- New employee orientation, including a discussion of site-specific safety and health policies and procedures
- Safety and health policies and procedures are communicated and enforced by supervisors and managers.
- Workplace safety and health training specific to employee job duties and environment
- Posting of CalOptima's IIPP is available to all employees on the InfoNet. Emergency procedures are also posted on EH & S InfoNet webpage.
- Communication of safety and health concerns between employees and supervisors, including language translation, where appropriate, as follows:
  - Post and distribute safety information in all appropriate languages including required postings, safety meeting minutes and results of periodic inspections
  - CalOptima encourages its employees to report any perceived hazards immediately to their supervisor, manager or safety representative. This communication will be received and communicated without reprisal.
- Communicate changes in safety practices as needed (beginning of shifts, safety meetings, safety newsletter or safety email).

- Communicate general safe work practices with respect to hazards unique to the employee's job assignment.

HAZARD ASSESSMENT

The CalOptima Facilities department is responsible for repairing identified hazards, repairing faulty equipment, and doing general walkthroughs inside the premises on a daily basis. Identification of workplace hazards will be accomplished through cooperation of all employees, managers and supervisors. Maintaining a safe and healthful work environment is the responsibility of employees at every level in CalOptima.

Periodic inspections consist of identification and evaluation of workplace hazards with the option of utilizing applicable sections of the attached Hazard Assessment and Correction Record* and any other effective methods used to identify and evaluate workplace hazards. CalOptima shall perform periodic inspections according to the following schedule:

- When CalOptima first establishes the IIPP
- When new substances, processes, procedures or equipment are introduced into CalOptima's workplace that present potential new occupational safety and health hazard(s)
- When new, previously unidentified hazards are recognized
- When occupational injuries and illnesses occur
- When CalOptima hires and/or reassigns permanent or intermittent employees to processes, operations or tasks for which a hazard evaluation has not been previously conducted
- When potential hazards are identified during the investigation of injuries, illnesses and accidents using the Accident Investigation Form*
- When considering suggestions made by employees
- Whenever workplace conditions warrant an inspection

ACCIDENT/EXPOSURE INVESTIGATIONS

The Environmental Health and Safety Manager and, when necessary, CalOptima supervisors and managers, will be responsible for the investigation of workplace accidents, hazardous substance exposures and near-accidents.

Each investigation of an injury, illness or accident will be documented with:

- Detailed information about the incident
- The investigation's findings
- Whether a workplace hazard contributed to the incident

- How the hazard will be abated
- Who the investigator was

This investigation process is critical in identifying hazards, improving processes, mitigating risk(s) and providing follow up. If necessary, in the case of extraordinary or serious injury, a team of managers will thoroughly investigate the accident. CalOptima will document investigations using the Accident Investigation Form* and submit to the Environmental Health and Safety Manager.

The Environmental Health & Safety Manager and, when necessary, CalOptima supervisors and/or managers, will be responsible for investigating workplace accidents and hazardous substance exposures. The procedures for such investigation will include:

- Visiting the scene of the accident or hazardous substance exposure as soon as the Environmental Health and Safety department or supervisor and/or manager receives notification
- Interviewing affected workers and witnesses and documenting witness statements;
- Examining the workplace for factors associated with the accident/exposure/near accident
- Determining the causes of the accident/exposure/near accident
- Reviewing established procedures to ensure they were adequate and were followed
- Taking corrective action to prevent the accident/exposure/near accident from reoccurring
- Documenting all the above steps and, where applicable or appropriate, provide photographs of other exhibits such as drawings

If a reportable serious injury or illness or death results, CalOptima shall contact the local OSHA office as soon as practically possible and within 8 hours of the incident by telephone at 714-558-4451 or 1-800-321-6742 (OSHA) and fax at 714-558-2035, using the form Serious Incident Report Fax.* “Serious injury or illness” means any injury or illness occurring in a place of employment or in connection with any employment which requires inpatient hospitalization for a period in excess of 24 hours for other than medical observation or in which an employee suffers a loss of any member of the body or suffers any serious degree of permanent disfigurement. The Serious Incident Report Fax will be kept in the affected employee’s file.

HAZARD CORRECTION

Unsafe or unhealthy work conditions, practices or procedures at, on or in CalOptima properties will be corrected in a timely manner based on the severity of the hazards and according to the following procedures:

- When observed or discovered
- When an imminent hazard exists which cannot be immediately abated without endangering employee(s) and/or property, all exposed employees will be removed from the affected area(s) except those employees necessary to correct the existing condition. Employees necessary to correct the hazardous condition shall be provided with the necessary protective equipment.

All corrective actions taken and the dates they are completed shall be documented on the Hazard Assessment and Correction Record.*

TRAINING AND INSTRUCTION

All employees, including managers, supervisors and lead personnel shall have training and instruction on general and job-specific safety and health practices. Training and instruction shall be provided as follows:

- When the IIPP is first established
- To all new employees during orientation
- To all employees given new job assignments for which training has not been previously provided
- Whenever new substances, processes, procedures or equipment are introduced to the workplace and represent a new hazard
- Whenever CalOptima becomes aware of a new or previously unrecognized hazard
- To managers, supervisors and lead personnel to familiarize them with the safety and health hazards to which employees under their immediate direction and control may be exposed
- To all employees with respect to hazards specific to each employee's job assignment.

General workplace safety and health practices include, but are not limited to:

- Implementation and maintenance of the IIPP
- Explanation of: CalOptima's IIPP; emergency action plan and fire prevention plan; measures for reporting any unsafe conditions; work practices; potential injuries; and other information when additional instruction is needed
- Availability of sanitary toilet, hand-washing and drinking water facilities
- Provisions for medical services and first aid, including emergency procedures
- Proper housekeeping, such as keeping stairways and ~~isles~~ aisles clear, work areas neat and orderly, and promptly cleaning up spills
- Prohibiting horseplay, scuffling, or other acts that adversely influence safety
- Proper storage to prevent:
    - Stacking goods in an unstable manner
    - Storing materials and goods against doors, exits, fire extinguishing equipment and electrical panels
    - Proper reporting of hazards and accidents to supervisors and/or managers

Where applicable, CalOptima's training may also include:

- Prevention of musculoskeletal disorders, including proper lifting techniques
- Use of appropriate clothing, including gloves, footwear and personal protective equipment
- Information about chemical hazards to which employees could be exposed and other hazard communication program information
- Proper food and beverage storage to prevent them from becoming contaminated

In addition, CalOptima provides specific instructions to all employees regarding hazards unique to specific job assignments, to the extent that such information was not already covered in other training.

- When necessary, training and instruction, employee name, training dates, type of training and trainers shall be documented on the Employee Training and Instruction Record.*

The following safety programs and procedures are also available:

- Emergency Preparedness: Fire; Earthquake; Irate Person; Bomb Threat (Located on the InfoNet and in the Floor Warden Manual)
- Ergonomic Assessment Program (request via E-Ticket)
- Workplace Violence Awareness Presentation (located on EH&S InfoNet webpage)

RECORDKEEPING

Records of scheduled and periodic inspections are maintained by the property manager. The property manager conducts quarterly property inspections and records any identified hazards and the action(s) taken to correct the identified unsafe conditions on the Quarterly Property Inspection Report. These records are maintained in perpetuity by the property manager.

CalOptima's recordkeeping is based on California Standard Section 14300, which includes using OSHA Form 300, OSHA Form 301 and OSHA Form 300A. These records are maintained for five years.

Documentation of safety and health training for each worker, including the worker's name or other identifier, training dates, type(s) of training and training providers are recorded on the Worker Training and Instruction Record.* This documentation is maintained for at least one year.

Documents Attached:
Office Inspection Checklist*
Hazard Assessment and Correction Record*
Employee Training and Instruction Record*
Accident Investigation Form*
Serious Incident Report Fax*
Workplace Active Shooter Response and Prevention*
Level I Ergonomic Assessment*

Documents / Checklists

Administrative	Yes	No	Comments/Date Corrected
Is there a current IIPP in a known location and accessible to all employees?			
Is there a safety bulletin board or equivalent displaying emergency contact information, evacuation routes, safety information, etc.?			
Is there a departmental fire and emergency preparedness protocol in place?			
Are all employees trained on all departmental protocols?			
General Safety/Housekeeping	**Yes**	**No**	**Comments/Date Corrected**
Are stairwells and walkways kept clear from clutter?			
Are stairwells and handrails in good condition?			
Are doorways and exits kept clear from obstacles and clutter?			
Are step stools available for easy access to high storage areas?			
Are file cabinets kept closed when not in use to prevent contusions and/or slip/trip/fall injuries?			
Are restrooms clean and orderly?			
Are waste materials placed in appropriate waste containers (trash, recycling, etc.)?			
Are storage rooms neatly maintained?			
Are break rooms/lunchrooms clean and free from slip/fall hazards?			
Are coffee makers and water dispensers secured to avoid scalds and/or slip fall injuries?			
Are all facility work areas properly illuminated?			
Are all exit signs properly illuminated?			
Are all panic bars on emergency exits working properly?			
Are all panic bar alarms on emergency exits operable?			
Are all emergency exits clearly marked?			

Earthquake and Fire Protection	Yes	No	Comments/Date Corrected
Are filing cabinets, bookcases and other items over 5 feet tall securely bolted to the walls?			
Are shelved materials located above the chest level secured by cabinet doors or straps?			
Are evacuation procedures in place for people with disabilities?			
Are fire doors closed securely at all times?			
Are fire extinguishers properly mounted and inspected?			
Are fire drills/emergency evacuation drills conducted on a regular basis?			
Have the fire extinguishers been checked for discharge, condition and tags initialed?			
If extinguishers are in need of service, has the contractor been notified?			
Electrical	**Yes**	**No**	**Comments/Date Corrected**
Are plugs, cords, electrical panels and receptacles in good condition (no exposed conductors or broken insulation)?			
Are extension cords and surge suppressors being used correctly and not posing safety hazards?			
Miscellaneous	**Yes**	**No**	**Comments/Date Corrected**

HAZARD ASSESSMENT AND CORRECTION RECORD

Date of Inspection Click here to enter a date.

Person(s) Conducting Inspection:

Unsafe Condition or Work Practice:

Corrective Action Taken:

Date of Inspection Click here to enter a date.

Person(s) Conducting Inspection:

Unsafe Condition or Work Practice:

Corrective Action Taken:

EMPLOYEE TRAINING AND INSTRUCTION RECORD

Training Program: **Instructor:**

Employee Name	Date Completed	Comments

ACCIDENT/INCIDENT INVESTIGATION REPORT

SECTION 1: EMPLOYEE INFORMATION (WHO)

Name	Home Address	DOB

Gender	Job Title	Supervisor Name

Job Location Address	Date of Report
	Click here to enter a date.

SECTION 2: ACCIDENT/ INCIDENT INFORMATION (WHEN, WHERE, WHAT)

1. **When did the accident/incident occur? (Date and Time)**

2. **Where did the accident/incident happen? (Example: in front of the sink in the 6th floor break room)**

3. **What were you doing when the accident occurred? (Example: lifting boxes from the floor to my desk)**

4. **Accident/incident Witness(s)? ☐ Yes ☐ No**

a) **If yes, witness(s) name**

(Attach a witness(s) statement if applicable)

SECTION 3: ACCIDENT/INCIDENT ROOT CAUSE (WHY, HOW)

1. **Describe exactly how the accident/injury/illness occurred**

2. **Describe the injury sustained (be specific about body part(s) affected)**

3. **Why did this accident/incident happen (consider environment, conditions, training, lack of training)**

4. **How could this accident/incident have been prevented?**

SECTION 4: CORRECTIVE ACTION AND DISPOSITION

1. **Disposition:**

a) **First aid?** ☐ **Yes** ☐ **No**

b) **If first aid, describe**

c) **Sent to:** ☐**Clinic** ☐**Emergency room/hospital** ☐ **Pre-designated doctor**

d) **Returned to work?** ☐**Yes** ☐**No**

e) **Returned to work modified duty** ☐

Emergency room/hospital address

2. **Corrective action taken, if any, including date completed or date of anticipated completion (e.g., repairs to equipment, ergonomic assessment with reasonable accommodation resolution, employee training, etc.)**

3. **Does an unsafe condition continue to exist?** ☐**Yes** ☐**No**

If yes, please describe

4. **Employee recommendations/suggestions**

5. **Supervisor comments/recommendations**

Name/Title of person completing report (print)	**Please print report and sign**

Clear All Fields

v080707

Serious Incident Report FAX

TO: Division of Occupational Safety and Health, District Manager ( ) - Telephone

FROM:

Company Name | Name of Person Reporting

Address | Title

City | State | Zip | ( ) - Telephone

Please be advised that there was a serious incident involving our employee(s). The circumstances of the incident and the nature of the injuries are under investigation.

Date of Incident | Time of Incident

Incident occurred:

☐ On establishment premises:

Department or Area

☐ Off establishment premises:

Location

Address

City | State | Zip

Reporting: ☐ One employee ☐ More than one employee (see attached page 2)

Employee:

Name of Employee

Home Address

City | State | Zip

Employee taken to:

Location

Address

City | State | Zip

Employee suffered: ☐ Injury ☐ Illness ☐ Death

Employee's normal work site (if different than corporate address):

Address | City | State | Zip

Other law enforcement agencies involved (police, fire, etc.):

Serious Incident Report FAX

Other employees involved in the serious incident:

Employee:

Name of Employee

Home Address

City State Zip

Employee taken to:

Location

Address

City State Zip

Employee suffered: ☐ Injury ☐ Illness ☐ Death

Employee:

Name of Employee

Home Address

City State Zip

Employee taken to:

Location

Address

City State Zip

Employee suffered: ☐ Injury ☐ Illness ☐ Death

Employee:

Name of Employee

Home Address

City State Zip

Employee taken to:

Location

Address

City State Zip

Employee suffered: ☐ Injury ☐ Illness ☐ Death

WORKPLACE ACTIVE SHOOTER RESPONSE AND PREVENTION

An active shooter as defined by the United States Department of Homeland Security is an individual actively engaged in killing or attempting to kill people in a confined and populated area. In most cases, active shooters use firearms(s) and there is no pattern or method to their selection of victims. Active shooter situations are unpredictable and evolve quickly. Typically, the immediate deployment of law enforcement is required to stop the active shooter and to mitigate harm to victims. Because active shooter situations are often over within 10 to 15 minutes, before law enforcement arrives on the scene, individuals must be prepared both mentally and physically to deal with an active shooter situation.

HOW TO RESPOND WHEN AN ACTIVE SHOOTER IS IN YOUR VICINITY

1. **Evacuate**
   If there is an accessible escape path, attempt to evacuate the premises. Be sure to:

   - Have an escape route and plan in mind.
   - Evacuate regardless of whether others agree to follow.
   - Leave your belongings behind.
   - Help others escape, if possible.
   - Prevent individuals from entering an area where the active shooter may be.
   - Keep your hands visible.
   - Follow the instructions of any police officers.
   - Do not attempt to move wounded people.
   - Call 911 when you are safe.

2. **Hide**
   If evacuation is not possible, find a place to hide where the active shooter is less likely to find you. Your hiding place should:

   - Be out of the active shooter's view.
   - Provide protection if shots are fired in your direction (e.g., an office with a closed and locked door).
   - Not trap you or restrict your options for movement.

   To prevent an active shooter from entering your hiding place:

   - Lock the door.
   - Blockade the door with heavy furniture.

   If the active shooter is nearby:

   - Lock the door.
   - Silence your cell phone and/or pager.

- Turn off any source of noise (e.g., radios, televisions).
- Hide behind large items (e.g., cabinets, desks).
- Remain quiet.

If evacuation and hiding out are not possible:

- Remain calm.
- Dial 911, if possible, to alert police to the active shooter's location.
- If you cannot speak, leave the line open and allow the dispatcher to listen.

3. **Take action against the active shooter**
   As a last resort, and only when your life is in imminent danger, attempt to disrupt and/or incapacitate the active shooter by:

   - Acting as aggressively as possible against him/her
   - Throwing items and improvising weapons
   - Yelling
   - Committing to your actions

HOW TO RESPOND WHEN LAW ENFORCEMENT ARRIVES

Law enforcement's purpose is to stop the active shooter as soon as possible. Officers will proceed directly to the area that the last shots were heard.

- Officers usually arrive in teams of four.
- Officers may wear regular patrol uniforms or external bulletproof vests, Kevlar helmets, and other tactical equipment.
- Officers may be armed with rifles, shotguns, and/or handguns.
- Officers may use pepper spray or tear gas to control the situation.
- Officers may shout commands, and may push individuals to the ground for their safety.

How to react when law enforcement arrives:

- Remain calm, and follow officers' instructions.
- Put down any items in your hands (e.g., bags, jackets).
- Immediately raise hands and spread fingers.
- Keep hands visible at all times.
- Avoid making quick movements toward officers such as holding on to them for safety.
- Avoid pointing, screaming and/or yelling.
- Do not stop to ask officers for help or directions when evacuating, just proceed in the direction from which officers are entering the premises.

Information to provide to law enforcement or 911 operators:

- Location of the active shooter
- Number of shooters, if more than one

- Physical description of shooter(s)
- Number and type of weapons held by the shooter(s)
- Number of potential victims at the location

The first officers to arrive to the scene will not stop to help injured persons. Expect rescue teams comprised of additional officers and emergency medical personnel to follow the initial officers. These rescue teams will treat and remove any injured persons. They may also call upon able-bodied individuals to assist in removing the wounded from the premises. Once you have reached a safe location or an assembly point, you will likely be held in that area by law enforcement until the situation is under control, and all witnesses have been identified and questioned. Do not leave until law enforcement authorities have instructed you to do so.

Additional Ways to Prepare For and Prevent an Active Shooter Situation

Preparedness

- Ensure that your facility has at least two evacuation routes.
- Post evacuation routes in conspicuous locations throughout your facility.
- Include local law enforcement and first responders during training exercises.

Prevention

- Foster a respectful workplace.
  Be aware of indications of workplace violence and take remedial actions accordingly.

Humanscale Consulting

Levell Ergonomic Assessment

Pre-Assessment												
Name:		Age: 20-30 31-40 41-50 50+						Work computer use:				hrs/day
Date:		Gender: Female Male						Home computer use:				hrs/day
Company:		Height:						Average phone use:				hrs/day
Length of employment:		Dominant hand: Left Right Both						Proficient typist:			Y	N
Location:		Corrective lenses: Y N						Uses numeric keypad:			Y	N
Discomfort Area		**Discomfort Area**	**L**	**R**	**Discomfort Area**	**L**	**R**	**Discomfort Area**	**L**	**R**		
Neck	☐	Shoulder	☐	☐	Wrist	☐	☐	Knee	☐	☐		
Upper back	☐	Upper arm	☐	☐	Hand	☐	☐	Foot	☐	☐		
Lower back	☐	Elbow	☐	☐	Hip	☐	☐	Other:				
Eyes	☐	Forearm	☐	☐	Thigh	☐	☐					
Risk Factors		**Source**			**Risk Factors**			**Source**				
Neck flexion	☐				Forearm pronation	☐						
Neck extension	☐				Elbow extension	☐						
Neck rotation	☐				Trunk flexion	☐						
Shoulder abduction	☐				Trunk rotation	☐						
Shoulder adduction	☐				Feet usupported	☐						
Shoulder shrugging	☐				Inappropriate light level	☐						
Wrist extension	☐				**Contact Stress**			**Source**				
Wrist flexion	☐				Wrists	☐						
Ulnar deviation	☐				Forearm/Elbow	☐						
Radial deviation	☐				Thighs/Knees	☐						
Equipment Audit												
Adequate task chair	☐	Task light	☐		Inline document holder	☐		Footrest	☐			
Keyboard support	☐	Laptop holder	☐		Alternative mouse	☐		Palm support	☐			
Flat panel monitor arm	☐	Sit to stand workstation	☐		Alternative keyboard	☐		Telephone headset	☐			

Workstation Assessment					
Keyboard Support		**Chair**		**Monitor / Documents / Phone**	
If yes, is it being used?	☐	Chair height adjustable?	☐	Multiple monitors in use?	☐
KB tray height adjustable?	☐	Seat pan adjustable?	☐	Monitor(s) aligned with body?	☐
KB tray tilts negatively?	☐	Armrests adjust adequately?	☐	Monitor(s) at appropriate height?	☐
Adequate mouse platform?	☐	Backrest height adjustable?	☐	Monitor(s) at appropriate distance?	☐
Adequate knee clearance?	☐	Is backrest dynamic?	☐	Documents aligned with body?	☐
Action Level: *No change*	☐	Backrest unlocked?	☐	Telephone within arms reach?	☐
Consider replacement	☐	**Action Level:** *No change*	☐	Telephone on dominant side?	☐
Replacement recommended	☐	*Consider replacement*	☐	Task light in use?	☐
Installation recommended	☐	*Replacement recommended*	☐	Task light opposite dominant side?	☐

Actions Performed	Corrected onsite	Further Action Required
Chair properly fitted to employee	☐	
Keyboard and mouse appropriately positioned	☐	
Monitor position adjusted	☐	
Light level made appropriate for tasks	☐	
Organized desk & documents more appropriately	☐	

Recommendations							
Keyboard support	☐	Inline document holder	☐	Laptop holder	☐	More frequent rest breaks	☐
Corner sleeve	☐	Dynamic footrest	☐	Monitor riser	☐	Follow-up assessment	☐
Ergonomic task chair	☐	Alternative keyboard	☐	CPU holder	☐	Seek medical attention	☐
Flat panel monitor arm	☐	Alternative mouse	☐	Telephone headset	☐	Other:	
Task light	☐	Palm support	☐	Sit to stand workstation	☐		

Assessment Summary					
No further changes required	☐	Tool upgrade recommended	☐	Tools required for further improvement	☐

Notes:

Policy #:	GA.8058
Title:	**Salary Schedule**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	Michael Schrader
Effective Date:	05/01/14
Last Review Date:	~~12/01/16~~
Last Revised Date:	03/02/17
	~~12/01/16~~
	03/02/17

~~*Board Approved Policy*~~

I. PURPOSE

A. This policy maintains a CalOptima Salary Schedule that lists all active job classifications including job title, salary grade, and salary ranges (minimum, midpoint, and maximum pay rate amounts).

B. This policy ensures the salary schedule is publicly available pursuant to the requirements of Title 2, California Code of Regulations (CCR) §570.5 so that employees who are members of the California Public Employees Retirement System (CalPERS) have their compensation considered qualified for pension calculation under CalPERS regulations.

II. POLICY

A. Pursuant to the requirements under Title 2, California Code of Regulations (CCR) §570.5, CalOptima has established the attached salary schedule for each CalOptima job position. In order for CalPERS member's pay rates to be credited by CalPERS, the Human Resources Department (HR) shall maintain a salary schedule that meets the following eight (8) separate criteria:

1. Approval and adoption by the governing body in accordance with requirements applicable to public meetings laws;

2. Identification of position titles for every employee position;

3. Listing of pay rate for each identified position, which may be stated as a single amount or as multiple amounts with a range;

4. Specifies the time base, including, but not limited to, whether the time base is hourly, daily, bi-weekly, monthly, bi-monthly, or annually;

5. Posted at the employer's office or immediately accessible and available for public review from the employer during normal business hours or posted on the employer's internet website;

6. Indicates the effective date and date of any revisions;

7. Retained by the employer and available for public inspection for not less than five (5) years; and

8. Does not reference another document in lieu of disclosing the pay rate.

B. The Chief Executive Officer (CEO) is authorized and directed to take all steps necessary and proper to implement the salary schedule for all other employees not inconsistent therewith.

III. PROCEDURE

A. The Human Resources Department (HR) will ensure that the salary schedule, meeting the requirements above, are available at CalOptima's offices and immediately accessible for public review during normal business hours or posted on CalOptima's internet website.

B. HR shall retain the salary schedule for not less than five (5) years.

C. HR shall review the salary schedule and provide recommendations to maintain the competitiveness of the salary schedule to market pay levels.

D. Any adjustments to the salary schedule requires that the Executive Director of HR make a recommendation to the CEO for approval, with the CEO taking the recommendation to the CalOptima Board of Directors for final approval. No changes to the salary schedule, or CEO compensation, shall be effective unless and until approved by the CalOptima Board of Directors.

IV. ATTACHMENTS

A. CalOptima - Salary Schedule (Revised as of ~~12/01/16~~03/02/17)

V. REFERENCES

A. Title 2, California Code of Regulations, §570.5

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. 03/02/17: Regular Meeting of the CalOptima Board of Directors
~~A.~~B. 12/01/16: Regular Meeting of the CalOptima Board of Directors
~~B.~~C. 11/03/16: Regular Meeting of the CalOptima Board of Directors
~~C.~~D. 10/06/16: Regular Meeting of the CalOptima Board of Directors
~~D.~~E. 09/01/16: Regular Meeting of the CalOptima Board of Directors
~~E.~~F. 08/04/16: Regular Meeting of the CalOptima Board of Directors
~~F.~~G. 06/02/16: Regular Meeting of the CalOptima Board of Directors
~~G.~~H. 03/03/16: Regular Meeting of the CalOptima Board of Directors
~~H.~~I. 12/03/15: Regular Meeting of the CalOptima Board of Directors
~~I.~~J. 10/01/15: Regular Meeting of the CalOptima Board of Directors
~~J.~~K. 06/04/15: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	05/01/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	08/07/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	11/06/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	12/04/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	03/05/2015	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	06/04/2015	GA.8058	Salary Schedule	Administrative
Revised	10/01/2015	GA.8058	Salary Schedule	Administrative
Revised	12/03/2015	GA.8058	Salary Schedule	Administrative
Revised	03/03/2016	GA.8058	Salary Schedule	Administrative
Revised	06/02/2016	GA.8058	Salary Schedule	Administrative
Revised	08/04/2016	GA.8058	Salary Schedule	Administrative
Revised	09/01/2016	GA.8058	Salary Schedule	Administrative
Revised	10/06/2016	GA.8058	Salary Schedule	Administrative
Revised	11/03/2016	GA.8058	Salary Schedule	Administrative
Revised	12/01/2016	GA.8058	Salary Schedule	Administrative
Revised	03/02/2017	GA.8058	Salary Schedule	Administrative

IX. GLOSSARY

Not Applicable

Policy #:	GA.8058
Title:	**Salary Schedule**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	Michael Schrader
Effective Date:	05/01/14
Last Review Date:	03/02/17
Last Revised Date:	03/02/17

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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;

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IV. ATTACHMENTS

A. CalOptima - Salary Schedule (Revised as of 03/02/17)

V. REFERENCES

A. Title 2, California Code of Regulations, §570.5

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. 03/02/17: Regular Meeting of the CalOptima Board of Directors
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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
Revised	03/02/2017	GA.8058	Salary Schedule	Administrative

IX. GLOSSARY

Not Applicable

CalOptima - Annual Base Salary Schedule - Revised March 02, 2017
Effective as of May 1, 2014

	Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
	Accountant	K	39	$47,112	$61,360	$75,504	
	Accountant Int	L	TBD	$54,288	$70,512	$86,736	
	Accountant Sr	M	68	$62,400	$81,120	$99,840	
	Accounting Clerk	I	334	$37,128	$46,384	$55,640	
	Actuarial Analyst	L	558	$54,288	$70,512	$86,736	
	Actuarial Analyst Sr	M	559	$62,400	$81,120	$99,840	
	Actuary	O	357	$82,576	$107,328	$131,976	
	Administrative Assistant	H	19	$33,696	$42,224	$50,648	
	Analyst	K	562	$47,112	$61,360	$75,504	
	Analyst Int	L	563	$54,288	$70,512	$86,736	
	Analyst Sr	M	564	$62,400	$81,120	$99,840	
	Applications Analyst	K	232	$47,112	$61,360	$75,504	
	Applications Analyst Int	L	233	$54,288	$70,512	$86,736	
	Applications Analyst Sr	M	298	$62,400	$81,120	$99,840	
	Associate Director Customer Service	O	593	$82,576	$107,328	$131,976	
	~~Associate Director Human Resources~~	~~P~~	~~638~~	~~$95,264~~	~~$128,752~~	~~$162,032~~	Remove Position
	Associate Director Information Services	Q	557	$114,400	$154,440	$194,480	
	Associate Director Provider Network	O	TBD	$82,576	$107,328	$131,976	New Position
	Auditor	K	565	$47,112	$61,360	$75,504	
	Auditor Sr	L	566	$54,288	$70,512	$86,736	
	Behavioral Health Manager	N	383	$71,760	$93,184	$114,712	
	Biostatistics Manager	N	418	$71,760	$93,184	$114,712	
	Board Services Specialist	J	435	$40,976	$53,352	$65,624	
	Business Analyst	J	40	$40,976	$53,352	$65,624	
	Business Analyst Sr	M	611	$62,400	$81,120	$99,840	
	Business Systems Analyst Sr	M	69	$62,400	$81,120	$99,840	
	Buyer	J	29	$40,976	$53,352	$65,624	
	Buyer Int	K	49	$47,112	$61,360	$75,504	
	Buyer Sr	L	67	$54,288	$70,512	$86,736	
	Care Transition Intervention Coach (RN)	N	417	$71,760	$93,184	$114,712	
	Certified Coder	K	399	$47,112	$61,360	$75,504	
	Certified Coding Specialist	K	639	$47,112	$61,360	$75,504	
	Certified Coding Specialist Sr	L	640	$54,288	$70,512	$86,736	
	Change Control Administrator	L	499	$54,288	$70,512	$86,736	
	Change Control Administrator Int	M	500	$62,400	$81,120	$99,840	
	Change Management Analyst Sr	N	465	$71,760	$93,184	$114,712	
**	Chief Counsel	T	132	$197,704	$266,968	$336,024	
**	Chief Executive Officer	V	138	$319,740	$431,600	$543,600	
**	Chief Financial Officer	U	134	$237,224	$320,216	$403,312	
**	Chief Information Officer	T	131	$197,704	$266,968	$336,024	
**	Chief Medical Officer	U	137	$237,224	$320,216	$403,312	
**	Chief Operating Officer	U	136	$237,224	$320,216	$403,312	
	Claims - Lead	J	574	$40,976	$53,352	$65,624	
	Claims Examiner	H	9	$33,696	$42,224	$50,648	
	Claims Examiner - Lead	J	236	$40,976	$53,352	$65,624	

Back to Agenda

CalOptima - Annual Base Salary Schedule - Revised March 02, 2017
Effective as of May 1, 2014

	Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
	Claims Examiner Sr	I	20	$37,128	$46,384	$55,640	
	Claims QA Analyst	I	28	$37,128	$46,384	$55,640	
	Claims QA Analyst Sr.	J	540	$40,976	$53,352	$65,624	
	Claims Recovery Specialist	I	283	$37,128	$46,384	$55,640	
	Claims Resolution Specialist	I	262	$37,128	$46,384	$55,640	
	Clerk of the Board	O	59	$82,576	$107,328	$131,976	
	Clinical Auditor	M	567	$62,400	$81,120	$99,840	
	Clinical Auditor Sr	N	568	$71,760	$93,184	$114,712	
	Clinical Documentation Specialist (RN)	O	641	$82,576	$107,328	$131,976	Pay Grade Change
	Clinical Pharmacist	P	297	$95,264	$128,752	$162,032	
	Clinical Systems Administrator	M	607	$62,400	$81,120	$99,840	
	Clinician (Behavioral Health)	M	513	$62,400	$81,120	$99,840	
	Communications Specialist	J	188	$40,976	$53,352	$65,624	
	Community Partner	K	575	$47,112	$61,360	$75,504	
	Community Partner Sr	L	612	$54,288	$70,512	$86,736	
	Community Relations Specialist	J	288	$40,976	$53,352	$65,624	
	Community Relations Specialist, Sr.	K	646	$47,112	$61,360	$75,504	
	Compliance Claims Auditor	K	222	$47,112	$61,360	$75,504	
	Compliance Claims Auditor Sr	L	279	$54,288	$70,512	$86,736	
	Contract Administrator	M	385	$62,400	$81,120	$99,840	
	Contracts Manager	N	207	$71,760	$93,184	$114,712	
	Contracts Specialist	K	257	$47,112	$61,360	$75,504	
	Contracts Specialist Int	L	469	$54,288	$70,512	$86,736	
	Contracts Specialist Sr	M	331	$62,400	$81,120	$99,840	
*	Controller	Q	464	$114,400	$154,440	$194,480	
	Credentialing Coordinator	J	41	$40,976	$53,352	$65,624	
	Credentialing Coordinator - Lead	J	510	$40,976	$53,352	$65,624	
	Customer Service Coordinator	J	182	$40,976	$53,352	$65,624	
	Customer Service Rep	H	5	$33,696	$42,224	$50,648	
	Customer Service Rep - Lead	J	482	$40,976	$53,352	$65,624	
	Customer Service Rep Sr	I	481	$37,128	$46,384	$55,640	
	Data Analyst	K	337	$47,112	$61,360	$75,504	
	Data Analyst Int	L	341	$54,288	$70,512	$86,736	
	Data Analyst Sr	M	342	$62,400	$81,120	$99,840	
	Data and Reporting Analyst - Lead	O	TBD	$82,576	$107,328	$131,976	
	Data Entry Tech	F	3	$27,872	$34,840	$41,808	
	Data Warehouse Architect	O	363	$82,576	$107,328	$131,976	
	Data Warehouse Programmer/Analyst	O	364	$82,576	$107,328	$131,976	
	Data Warehouse Project Manager	O	362	$82,576	$107,328	$131,976	
	Data Warehouse Reporting Analyst	N	412	$71,760	$93,184	$114,712	
	Data Warehouse Reporting Analyst Sr	O	522	$82,576	$107,328	$131,976	
	Database Administrator	M	90	$62,400	$81,120	$99,840	
	Database Administrator Sr	O	179	$82,576	$107,328	$131,976	
**	Deputy Chief Counsel	S	160	$164,736	$222,352	$280,072	

Back to Agenda

CalOptima - Annual Base Salary Schedule - Revised March 02, 2017
Effective as of May 1, 2014

	Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
**	Deputy Chief Medical Officer	T	561	$197,704	$266,968	$336,024	
*	Director Accounting	P	122	$95,264	$128,752	$162,032	
*	Director Applications Management	R	170	$137,280	$185,328	$233,376	
*	Director Audit & Oversight	Q	546	$114,400	$154,440	$194,480	
*	Director Behavioral Health Services	P	392	$95,264	$128,752	$162,032	
*	Director Budget and Procurement	Q	527	$114,400	$154,440	$194,480	
*	Director Business Development	P	351	$95,264	$128,752	$162,032	
*	Director Business Integration	Q	543	$114,400	$154,440	$194,480	
*	Director Case Management	Q	318	$114,400	$154,440	$194,480	
*	Director Claims Administration	P	112	$95,264	$128,752	$162,032	
*	Director Clinical Outcomes	Q	602	$114,400	$154,440	$194,480	
*	Director Clinical Pharmacy	R	129	$137,280	$185,328	$233,376	
*	Director Coding Initiatives	P	375	$95,264	$128,752	$162,032	
*	Director Communications	P	361	$95,264	$128,752	$162,032	
*	Director Community Relations	P	292	$95,264	$128,752	$162,032	
*	Director Configuration & Coding	Q	596	$114,400	$154,440	$194,480	
*	Director Contracting	P	184	$95,264	$128,752	$162,032	
*	Director COREC	Q	369	$114,400	$154,440	$194,480	
*	Director Customer Service	P	118	$95,264	$128,752	$162,032	
*	Director Electronic Business	P	358	$95,264	$128,752	$162,032	
*	Director Enterprise Analytics	Q	520	$114,400	$154,440	$194,480	
*	Director Facilities	P	428	$95,264	$128,752	$162,032	
*	Director Finance & Procurement	P	157	$95,264	$128,752	$162,032	
*	Director Financial Analysis	R	374	$137,280	$185,328	$233,376	
*	Director Financial Compliance	P	460	$95,264	$128,752	$162,032	
*	Director Fraud Waste & Abuse and Privacy	Q	581	$114,400	$154,440	$194,480	
*	Director Government Affairs	P	277	$95,264	$128,752	$162,032	
*	Director Grievance & Appeals	P	528	$95,264	$128,752	$162,032	
*	Director Health Education & Disease Management	Q	150	$114,400	$154,440	$194,480	
*	Director Health Services	Q	328	$114,400	$154,440	$194,480	
*	Director Human Resources	Q	322	$114,400	$154,440	$194,480	
*	Director Information Services	R	547	$137,280	$185,328	$233,376	
*	Director Long Term Support Services	Q	128	$114,400	$154,440	$194,480	
*	Director Medi-Cal Plan Operations	P	370	$95,264	$128,752	$162,032	
*	Director Network Management	P	125	$95,264	$128,752	$162,032	
*	Director OneCare Operations	P	425	$95,264	$128,752	$162,032	
*	Director Organizational Training & Education	P	579	$95,264	$128,752	$162,032	
*	Director PACE Program	Q	449	$114,400	$154,440	$194,480	
*	Director Process Excellence	Q	447	$114,400	$154,440	$194,480	
*	Director Program Implementation	Q	489	$114,400	$154,440	$194,480	
*	Director Project Management	Q	447	$114,400	$154,440	$194,480	
*	Director Provider Data Quality	Q	TBD	$114,400	$154,440	$194,480	
*	Director Provider Services	P	597	$95,264	$128,752	$162,032	
*	Director Public Policy	P	459	$95,264	$128,752	$162,032	

Back to Agenda

CalOptima - Annual Base Salary Schedule - Revised March 02, 2017
Effective as of May 1, 2014

	Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
*	Director Quality (LTSS)	Q	613	$114,400	$154,440	$194,480	
*	Director Quality Analytics	Q	591	$114,400	$154,440	$194,480	
*	Director Quality Improvement	Q	172	$114,400	$154,440	$194,480	
*	Director Regulatory Affairs and Compliance	Q	625	$114,400	$154,440	$194,480	
*	Director Strategic Development	P	121	$95,264	$128,752	$162,032	
*	Director Systems Development	R	169	$137,280	$185,328	$233,376	
*	Director Utilization Management	Q	265	$114,400	$154,440	$194,480	
	Disease Management Coordinator	M	70	$62,400	$81,120	$99,840	
	Disease Management Coordinator - Lead	M	472	$62,400	$81,120	$99,840	
	EDI Project Manager	O	403	$82,576	$107,328	$131,976	
	Enrollment Coordinator (PACE)	K	441	$47,112	$61,360	$75,504	
	Enterprise Analytics Manager	P	582	$95,264	$128,752	$162,032	
	Executive Assistant	K	339	$47,112	$61,360	$75,504	
	Executive Assistant to CEO	L	261	$54,288	$70,512	$86,736	
**	Executive Director, Behavioral Health Integration	S	614	$164,736	$222,352	$280,072	
**	Executive Director Clinical Operations	S	501	$164,736	$222,352	$280,072	
**	Executive Director Compliance	S	493	$164,736	$222,352	$280,072	
**	Executive Director Human Resources	S	494	$164,736	$222,352	$280,072	
**	Executive Director Network Operations	S	632	$164,736	$222,352	$280,072	
**	Executive Director Operations	S	276	$164,736	$222,352	$280,072	
**	Executive Director Program Implementation	S	490	$164,736	$222,352	$280,072	
**	Executive Director Public Affairs	S	290	$164,736	$222,352	$280,072	
**	Executive Director Quality Analytics	S	601	$164,736	$222,352	$280,072	
	Facilities & Support Services Coord - Lead	J	631	$40,976	$53,352	$65,624	
	Facilities & Support Services Coordinator	J	10	$40,976	$53,352	$65,624	
	Facilities Coordinator	J	438	$40,976	$53,352	$65,624	
	Financial Analyst	L	51	$54,288	$70,512	$86,736	
	Financial Analyst Sr	M	84	$62,400	$81,120	$99,840	
	Financial Reporting Analyst	L	475	$54,288	$70,512	$86,736	
	Gerontology Resource Coordinator	M	204	$62,400	$81,120	$99,840	
	Graphic Designer	M	387	$62,400	$81,120	$99,840	
	Grievance & Appeals Nurse Specialist	N	226	$71,760	$93,184	$114,712	
	Grievance Resolution Specialist	J	42	$40,976	$53,352	$65,624	
	Grievance Resolution Specialist - Lead	L	590	$54,288	$70,512	$86,736	
	Grievance Resolution Specialist Sr	K	589	$47,112	$61,360	$75,504	
	Health Coach	M	556	$62,400	$81,120	$99,840	
	Health Educator	K	47	$47,112	$61,360	$75,504	
	Health Educator Sr	L	355	$54,288	$70,512	$86,736	
	Health Network Liaison Specialist (RN)	N	524	$71,760	$93,184	$114,712	
	Health Network Oversight Specialist	M	323	$62,400	$81,120	$99,840	
	HEDIS Case Manager	N	443	$71,760	$93,184	$114,712	
	HEDIS Case Manager (LVN)	M	552	$62,400	$81,120	$99,840	
	Help Desk Technician	J	571	$40,976	$53,352	$65,624	
	Help Desk Technician Sr	K	573	$47,112	$61,360	$75,504	

Back to Agenda

CalOptima - Annual Base Salary Schedule - Revised March 02, 2017
Effective as of May 1, 2014

Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
HR Assistant	I	181	$37,128	$46,384	$55,640	
HR Business Partner	M	584	$62,400	$81,120	$99,840	
HR Coordinator	J	316	$40,976	$53,352	$65,624	
HR Representative	L	278	$54,288	$70,512	$86,736	
HR Representative Sr	M	350	$62,400	$81,120	$99,840	
HR Specialist	K	505	$47,112	$61,360	$75,504	
HR Specialist Sr	L	608	$54,288	$70,512	$86,736	
HRIS Analyst Sr	M	468	$62,400	$81,120	$99,840	
ICD-10 Project Manager	O	411	$82,576	$107,328	$131,976	
Infrastructure Systems Administrator	J	541	$40,976	$53,352	$65,624	
Infrastructure Systems Administrator Int	K	542	$47,112	$61,360	$75,504	
Inpatient Quality Coding Auditor	L	642	$54,288	$70,512	$86,736	
Intern	E	237	$25,272	$31,720	$37,960	
Investigator Sr	L	553	$54,288	$70,512	$86,736	
IS Coordinator	J	365	$40,976	$53,352	$65,624	
IS Project Manager	O	424	$82,576	$107,328	$131,976	
IS Project Manager Sr	P	509	$95,264	$128,752	$162,032	
IS Project Specialist	M	549	$62,400	$81,120	$99,840	
IS Project Specialist Sr	N	550	$71,760	$93,184	$114,712	
Kitchen Assistant	E	585	$25,272	$31,720	$37,960	
Legislative Program Manager	N	330	$71,760	$93,184	$114,712	
Licensed Clinical Social Worker	L	598	$54,288	$70,512	$86,736	
Litigation Support Specialist	M	588	$62,400	$81,120	$99,840	
LVN (PACE)	M	533	$62,400	$81,120	$99,840	
Mailroom Clerk	E	1	$25,272	$31,720	$37,960	
Manager Accounting	N	98	$71,760	$93,184	$114,712	
Manager Actuary	P	453	$95,264	$128,752	$162,032	
Manager Applications Management	P	271	$95,264	$128,752	$162,032	
Manager Audit & Oversight	O	539	$82,576	$107,328	$131,976	
Manager Behavioral Health	O	633	$82,576	$107,328	$131,976	
Manager Business Integration	O	544	$82,576	$107,328	$131,976	
Manager Case Management	O	270	$82,576	$107,328	$131,976	
Manager Claims	N	92	$71,760	$93,184	$114,712	
Manager Clinic Operations	O	551	$82,576	$107,328	$131,976	
Manager Clinical Pharmacist	Q	296	$114,400	$154,440	$194,480	
Manager Coding Quality	N	382	$71,760	$93,184	$114,712	
Manager Communications	N	398	$71,760	$93,184	$114,712	
Manager Community Relations	M	384	$62,400	$81,120	$99,840	
Manager Contracting	O	329	$82,576	$107,328	$131,976	
Manager Creative Branding	N	430	$71,760	$93,184	$114,712	
Manager Cultural & Linguistic	N	349	$71,760	$93,184	$114,712	
Manager Customer Service	N	94	$71,760	$93,184	$114,712	
Manager Decision Support	O	454	$82,576	$107,328	$131,976	
Manager Disease Management	O	372	$82,576	$107,328	$131,976	

Back to Agenda

CalOptima - Annual Base Salary Schedule - Revised March 02, 2017
Effective as of May 1, 2014

Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
Manager Electronic Business	O	422	$82,576	$107,328	$131,976	
Manager Employment Services	N	420	$71,760	$93,184	$114,712	
Manager Encounters	N	516	$71,760	$93,184	$114,712	
Manager Environmental Health & Safety	N	495	$71,760	$93,184	$114,712	
Manager Facilities	N	209	$71,760	$93,184	$114,712	
Manager Finance	N	148	$71,760	$93,184	$114,712	
Manager Financial Analysis	O	356	$82,576	$107,328	$131,976	
Manager Government Affairs	N	437	$71,760	$93,184	$114,712	
Manager Grievance & Appeals	N	426	$71,760	$93,184	$114,712	
Manager Health Education	N	173	$71,760	$93,184	$114,712	
Manager HEDIS	O	427	$82,576	$107,328	$131,976	
Manager Human Resources	O	526	$82,576	$107,328	$131,976	
Manager Information Services	P	560	$95,264	$128,752	$162,032	
Manager Information Technology	P	110	$95,264	$128,752	$162,032	
Manager Integration Government Liaison	N	455	$71,760	$93,184	$114,712	
Manager Long Term Support Services	O	200	$82,576	$107,328	$131,976	
Manager Marketing & Enrollment (PACE)	O	414	$82,576	$107,328	$131,976	
Manager Medical Data Management	O	519	$82,576	$107,328	$131,976	
Manager Medi-Cal Program Operations	N	483	$71,760	$93,184	$114,712	
Manager Member Liaison Program	N	354	$71,760	$93,184	$114,712	
Manager Member Outreach & Education	N	616	$71,760	$93,184	$114,712	
Manager Member Outreach Education & Provider Relations	O	576	$82,576	$107,328	$131,976	
Manager MSSP	O	393	$82,576	$107,328	$131,976	
Manager OneCare Clinical	O	359	$82,576	$107,328	$131,976	
Manager OneCare Customer Service	N	429	$71,760	$93,184	$114,712	
Manager OneCare Regulatory	N	197	$71,760	$93,184	$114,712	
Manager OneCare Sales	O	248	$82,576	$107,328	$131,976	
Manager Outreach & Enrollment	N	477	$71,760	$93,184	$114,712	
Manager PACE Center	O	432	$82,576	$107,328	$131,976	
Manager Payroll & Benefits	N	144	$71,760	$93,184	$114,712	
Manager Process Excellence	O	622	$82,576	$107,328	$131,976	
Manager Program Implementation	O	488	$82,576	$107,328	$131,976	
Manager Project Management	O	532	$82,576	$107,328	$131,976	
Manager Provider Data Management Services	N	TBD	$71,760	$93,184	$114,712	
Manager Provider Network	O	191	$82,576	$107,328	$131,976	
Manager Provider Relations	N	171	$71,760	$93,184	$114,712	
Manager Provider Services	O	TBD	$82,576	$107,328	$131,976	
Manager Purchasing	N	275	$71,760	$93,184	$114,712	
Manager QI Initiatives	N	433	$71,760	$93,184	$114,712	
Manager Quality Analytics	O	617	$82,576	$107,328	$131,976	
Manager Quality Improvement	O	104	$82,576	$107,328	$131,976	
Manager Regulatory Affairs and Compliance	O	626	$82,576	$107,328	$131,976	
Manager Reporting & Financial Compliance	O	572	$82,576	$107,328	$131,976	
Manager Strategic Development	O	603	$82,576	$107,328	$131,976	

Back to Agenda

CalOptima - Annual Base Salary Schedule - Revised March 02, 2017
Effective as of May 1, 2014

	Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
	Manager Strategic Operations	N	446	$71,760	$93,184	$114,712	
	Manager Systems Development	P	515	$95,264	$128,752	$162,032	
	Manager Utilization Management	O	250	$82,576	$107,328	$131,976	
	Marketing and Outreach Specialist	J	496	$40,976	$53,352	$65,624	
	Medical Assistant	H	535	$33,696	$42,224	$50,648	
	Medical Authorization Asst	H	11	$33,696	$42,224	$50,648	
	Medical Case Manager	N	72	$71,760	$93,184	$114,712	
	Medical Case Manager (LVN)	L	444	$54,288	$70,512	$86,736	
*	Medical Director	S	306	$164,736	$222,352	$280,072	
	Medical Records & Health Plan Assistant	G	548	$30,576	$38,272	$45,968	
	Medical Records Clerk	E	523	$25,272	$31,720	$37,960	
	Medical Services Case Manager	K	54	$47,112	$61,360	$75,504	
	Member Liaison Specialist	I	353	$37,128	$46,384	$55,640	
	MMS Program Coordinator	K	360	$47,112	$61,360	$75,504	
	Nurse Practitioner (PACE)	P	635	$95,264	$128,752	$162,032	
	Occupational Therapist	N	531	$71,760	$93,184	$114,712	
	Occupational Therapist Assistant	M	623	$62,400	$81,120	$99,840	
	Office Clerk	C	335	$21,008	$26,208	$31,408	
	OneCare Operations Manager	O	461	$82,576	$107,328	$131,976	
	OneCare Partner - Sales	K	230	$47,112	$61,360	$75,504	
	OneCare Partner - Sales (Lead)	K	537	$47,112	$61,360	$75,504	
	OneCare Partner - Service	I	231	$37,128	$46,384	$55,640	
	OneCare Partner (Inside Sales)	J	371	$40,976	$53,352	$65,624	
	Outreach Specialist	I	218	$37,128	$46,384	$55,640	
	Paralegal/Legal Secretary	K	376	$47,112	$61,360	$75,504	
	Payroll Specialist	J	554	$40,976	$53,352	$65,624	
	Performance Analyst	L	538	$54,288	$70,512	$86,736	
	Personal Care Attendant	C	485	$21,008	$26,208	$31,408	
	Personal Care Attendant - Lead	E	498	$25,272	$31,720	$37,960	
	Personal Care Coordinator	I	525	$37,128	$46,384	$55,640	
	Pharmacy Resident	K	379	$47,112	$61,360	$75,504	
	Pharmacy Services Specialist	I	23	$37,128	$46,384	$55,640	
	Pharmacy Services Specialist Int	J	35	$40,976	$53,352	$65,624	
	Pharmacy Services Specialist Sr	K	507	$47,112	$61,360	$75,504	
	Physical Therapist	N	530	$71,760	$93,184	$114,712	
	Physical Therapist Assistant	M	624	$62,400	$81,120	$99,840	
	Policy Advisor Sr	O	580	$82,576	$107,328	$131,976	
	Privacy Manager	N	536	$71,760	$93,184	$114,712	
	Privacy Officer	P	TBD	$95,264	$128,752	$162,032	New Position
	Process Excellence Manager	O	529	$82,576	$107,328	$131,976	
	Program Assistant	I	24	$37,128	$46,384	$55,640	
	Program Coordinator	I	284	$37,128	$46,384	$55,640	
	Program Development Analyst Sr	M	492	$62,400	$81,120	$99,840	
	Program Manager	M	421	$62,400	$81,120	$99,840	
	Program Manager Sr	O	594	$82,576	$107,328	$131,976	

Back to Agenda

CalOptima - Annual Base Salary Schedule - Revised March 02, 2017
Effective as of May 1, 2014

	Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
	Program Specialist	J	36	$40,976	$53,352	$65,624	
	Program Specialist Int	K	61	$47,112	$61,360	$75,504	
	Program Specialist Sr	L	508	$54,288	$70,512	$86,736	
	Program/Policy Analyst	K	56	$47,112	$61,360	$75,504	
	Program/Policy Analyst Sr	M	85	$62,400	$81,120	$99,840	
	Programmer	L	43	$54,288	$70,512	$86,736	
	Programmer Int	N	74	$71,760	$93,184	$114,712	
	Programmer Sr	O	80	$82,576	$107,328	$131,976	
	Project Manager	M	81	$62,400	$81,120	$99,840	
	Project Manager - Lead	M	467	$62,400	$81,120	$99,840	
	Project Manager Sr	O	105	$82,576	$107,328	$131,976	
	Project Specialist	K	291	$47,112	$61,360	$75,504	
	Project Specialist Sr	L	503	$54,288	$70,512	$86,736	
	Projects Analyst	K	254	$47,112	$61,360	$75,504	
	Provider Enrollment Data Coordinator	I	12	$37,128	$46,384	$55,640	
	Provider Enrollment Data Coordinator Sr	J	586	$40,976	$53,352	$65,624	
	Provider Enrollment Manager	K	190	$47,112	$61,360	$75,504	
	Provider Network Rep Sr	L	391	$54,288	$70,512	$86,736	
	Provider Network Specialist	K	44	$47,112	$61,360	$75,504	
	Provider Network Specialist Sr	L	595	$54,288	$70,512	$86,736	
	Provider Office Education Manager	L	300	$54,288	$70,512	$86,736	
	Provider Relations Rep	K	205	$47,112	$61,360	$75,504	
	Provider Relations Rep Sr	L	285	$54,288	$70,512	$86,736	
	Publications Coordinator	J	293	$40,976	$53,352	$65,624	
	QA Analyst	L	486	$54,288	$70,512	$86,736	
	QA Analyst Sr	N	380	$71,760	$93,184	$114,712	
	QI Nurse Specialist	N	82	$71,760	$93,184	$114,712	
	QI Nurse Specialist (LVN)	M	445	$62,400	$81,120	$99,840	
	Receptionist	F	140	$27,872	$34,840	$41,808	
	Recreational Therapist	L	487	$54,288	$70,512	$86,736	
	Recruiter	L	406	$54,288	$70,512	$86,736	
	Recruiter Sr	M	497	$62,400	$81,120	$99,840	
	Registered Dietitian	L	57	$54,288	$70,512	$86,736	
	Regulatory Affairs and Compliance Analyst	K	628	$47,112	$61,360	$75,504	
	Regulatory Affairs and Compliance Analyst Sr	L	629	$54,288	$70,512	$86,736	
	Regulatory Affairs and Compliance Lead	M	630	$62,400	$81,120	$99,840	
	RN (PACE)	N	480	$71,760	$93,184	$114,712	
	Security Analyst Int	N	534	$71,760	$93,184	$114,712	
	Security Analyst Sr	O	474	$82,576	$107,328	$131,976	
	Security Officer	F	311	$27,872	$34,840	$41,808	
	SharePoint Developer/Administrator Sr	O	397	$82,576	$107,328	$131,976	
	Social Worker	K	463	$47,112	$61,360	$75,504	
*	Special Counsel	R	317	$137,280	$185,328	$233,376	
	Sr Manager Human Resources	P	TBD	$95,264	$128,752	$162,032	New Position
	Sr Manager Information Services	Q	TBD	$114,400	$154,440	$194,480	New Position

Back to Agenda

CalOptima - Annual Base Salary Schedule - Revised March 02, 2017
Effective as of May 1, 2014

Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
Sr Manager Government Affairs	O	451	$82,576	$107,328	$131,976	
Sr Manager Provider Network	O	TBD	$82,576	$107,328	$131,976	New Position
Staff Attorney	P	195	$95,264	$128,752	$162,032	
Supervisor Accounting	M	434	$62,400	$81,120	$99,840	
Supervisor Audit and Oversight	N	618	$71,760	$93,184	$114,712	
Supervisor Budgeting	M	466	$62,400	$81,120	$99,840	
Supervisor Case Management	N	86	$71,760	$93,184	$114,712	
Supervisor Claims	K	219	$47,112	$61,360	$75,504	
Supervisor Coding Initiatives	M	502	$62,400	$81,120	$99,840	
Supervisor Customer Service	K	34	$47,112	$61,360	$75,504	
Supervisor Data Entry	K	192	$47,112	$61,360	$75,504	
Supervisor Day Center (PACE)	K	619	$47,112	$61,360	$75,504	
Supervisor Dietary Services (PACE)	M	643	$62,400	$81,120	$99,840	
Supervisor Disease Management	N	644	$71,760	$93,184	$114,712	
Supervisor Encounters	L	253	$54,288	$70,512	$86,736	
Supervisor Facilities	L	162	$54,288	$70,512	$86,736	
Supervisor Finance	N	419	$71,760	$93,184	$114,712	
Supervisor Grievance and Appeals	M	620	$62,400	$81,120	$99,840	
Supervisor Health Education	M	381	$62,400	$81,120	$99,840	
Supervisor Health Services	N	506	$71,760	$93,184	$114,712	
Supervisor Information Services	N	457	$71,760	$93,184	$114,712	
Supervisor Long Term Support Services	N	587	$71,760	$93,184	$114,712	
Supervisor Member Outreach and Education	L	592	$54,288	$70,512	$86,736	
Supervisor MSSP	N	348	$71,760	$93,184	$114,712	
Supervisor OneCare Customer Service	K	408	$47,112	$61,360	$75,504	
Supervisor Payroll	M	517	$62,400	$81,120	$99,840	
Supervisor Pharmacist	P	610	$95,264	$128,752	$162,032	
Supervisor Provider Enrollment	K	439	$47,112	$61,360	$75,504	
Supervisor Provider Relations	M	TBD	$62,400	$81,120	$99,840	New Position
Supervisor Quality Analytics	M	609	$62,400	$81,120	$99,840	
Supervisor Quality Improvement	N	600	$71,760	$93,184	$114,712	
Supervisor Regulatory Affairs and Compliance	N	627	$71,760	$93,184	$114,712	
Supervisor Social Work (PACE)	L	636	$54,288	$70,512	$86,736	
Supervisor Systems Development	O	456	$82,576	$107,328	$131,976	
Supervisor Therapy Services (PACE)	N	645	$71,760	$93,184	$114,712	
Supervisor Utilization Management	N	637	$71,760	$93,184	$114,712	
Systems Manager	N	512	$71,760	$93,184	$114,712	
Systems Network Administrator Int	M	63	$62,400	$81,120	$99,840	
Systems Network Administrator Sr	N	89	$71,760	$93,184	$114,712	
Systems Operations Analyst	J	32	$40,976	$53,352	$65,624	
Systems Operations Analyst Int	K	45	$47,112	$61,360	$75,504	
Technical Analyst Int	L	64	$54,288	$70,512	$86,736	
Technical Analyst Sr	M	75	$62,400	$81,120	$99,840	
Technical Writer	L	247	$54,288	$70,512	$86,736	
Technical Writer Sr	M	470	$62,400	$81,120	$99,840	

Back to Agenda

CalOptima - Annual Base Salary Schedule - Revised March 02, 2017
Effective as of May 1, 2014

Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
Therapy Aide	J	521	$40,976	$53,352	$65,624	
Training Administrator	L	621	$54,288	$70,512	$86,736	
Training Program Coordinator	K	471	$47,112	$61,360	$75,504	
Translation Specialist	G	241	$30,576	$38,272	$45,968	
Web Architect	O	366	$82,576	$107,328	$131,976	

* These positions are identified for the purposes of CalOptima Policy GA. 8042: Supplemental Compensation as Director level and above positions for which eligible employees may qualify for Employer-Paid Member Contribution.

** These positions are identified for the purposes of CalOptima Policy GA. 8042: Supplemental Compensation as Director level and above positions for which eligible employees may qualify for Employer-Paid Member Contribution and are also Chief or Executive Director level positions.

Text in red indicates new changes to the salary schedule proposed for Board approval.

Back to Agenda

Summary of Changes to Salary Schedule

For March 2017 BOD Meeting:

Title	Old Wage Grade	New Job Code / Wage Grade	Notes / Reason	Salary Adjustment (% Increase)	Month Added/Changed
Associate Director Human Resources	P	N/A	Remove title from salary schedule. Position is being eliminated.	N/A	March 2017
Associate Director Provider Network	N/A	O	This new position is responsible for directing the implementation of new programs and initiatives that impact health networks and delegates.	N/A	March 2017
Privacy Officer	N/A	P	This new position is to ensure that CalOptima and its subcontracted health networks comply with all HIPAA privacy rules and any other privacy statutes and regulations, appropriate standards, contractual provisions, and federal waivers and laws.	N/A	March 2017
Sr Manager Human Resources	N/A	P	The “Sr Manager Human Resources” job title will replace the “Associate Director Human Resources” title.	N/A	March 2017
Sr Manager Information Services	N/A	Q	This new position is responsible for providing strategic guidance, technical management oversight and direction for all IS related matters.	N/A	March 2017
Sr. Manager Provider Network	N/A	O	This new position is responsible for directing the implementation of new programs and initiatives that impact health networks and delegates.	N/A	March 2017
Supervisor Provider Relations	N/A	M	This new position will provide supervision and oversight of staff in the Provider Relations Department.	N/A	March 2017

Back to Agenda

Summary of Changes to Salary Schedule

For March 2017 Board Meeting:

Title	Old Wage Grade	New Job Code / Wage Grade	Notes / Reason	Salary Adjustment (% Increase)	Month Added/Changed
Clinical Documentation Specialist (RN)	N	O	Market competitive pay; adjusting to pay range target for position based on increased subject matter complexity and job responsibility. This position is responsible for reviewing the accuracy and appropriateness of high dollar hospital and professional claims.	N/A	March 2017

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

13. Consider Modifications to CalOptima Policy FF.2008 Health Insurance Premium Payment and Wind Down and Termination of the Program

Contact

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

Recommended Actions

1. Authorize modification of CalOptima Policy FF.2008, Health Insurance Premium Payment Program, consistent with guidance from the Department of Health Care Services (DHCS);
2. Authorize continuation of the Health Insurance Premium Payment program under the name "CalOptima Premium Payment" for current participants; and
3. Authorize the wind down and termination of the program by June 30, 2017.

Background

The Health Insurance Premium Payment (HIPP) program, established by the enactment of Assembly Bill 3328 (1986) and codified in the Welfare and Institutions Code section 14124.91, authorizes the Department of Health Care Services (DHCS), to pay private health coverage premiums for Medi-Cal beneficiaries whenever cost-effective.

In or about 1995, CalOptima developed and implemented an optional HIPP program for Medi-Cal members, modeled after DHCS's program. Claims Administration policy FF.2008 Health Insurance Premium Payment Program was approved by DHCS in August 2010 and subsequently ratified by the CalOptima Board of Directors on October 6, 2011. As of December 28, 2017 there were 22 CalOptima Medi-Cal members participating in this program.

CalOptima's policy, which has not been modified since approved by the Board, provides:

- Members must be eligible with CalOptima and:
  - Have a high cost condition (e.g., HIV/AIDS, cancer, organ transplant, etc.);
  - Have current private insurance, COBRA continuation plan or COBRA conversion plan that covers members' high cost-medical condition; and
  - Must reapply every six (6) months.
- Claims and Health Services Departments determine member eligibility;
- Claims Department issues approval or denial notices and administers premium payments; and,
- Finance Department provides annual cost analysis to Claims Department.

On June 30, 2016, DHCS issued new guidance to Medi-Cal Managed Care Plans (MCPs) on premium payment programs. The new guidance defers to plans on whether to continue offering this optional program, subject to being in compliance with State and Federal laws and regulations, and making certain "minimum" mandated changes. If the program is continued, MCPs (including CalOptima) are required to make the following mandated policy changes:

Back to Agenda

- MCPs must not reference the name "HIPP" in its program materials and must explicitly state that it is not related to the DHCS program, resulting in the renaming of the program to "CalOptima Premium Payment";
- Funding for the operation and administration of the program must come from the MCP's own profit. DHCS will not reimburse any plan costs, including premiums related to operations and administration of the program; and,
- Member enrollment in the Other Health Coverage (OHC) must predate Medi-Cal enrollment.

Subsequent to the DHCS communication received on June 30, 2016 and based on DHCS's request, CalOptima staff conducted telephonic outreach to members currently enrolled in the HIPP program informing them that the program is no longer associated with DHCS and will be renamed. Additionally, no new members have been enrolled to the program.

Discussion

While Welfare and Institutions Code section 14124.91 authorizes DHCS to pay private health coverage premiums for Medi-Cal beneficiaries whenever cost-effective, it does not specifically address whether County Organized Health System (COHS) managed care plans, including CalOptima, are authorized to operate HIPP programs. Pursuant to the June 30, 2016 guidance, DHCS now defers to the COHS plans to determine whether they want to independently operate similar programs. If COHSs plan elect to continue with similar programs, they are to modify their policies and procedures and other operational protocols to explicitly state that the programs are not in any way related to the DHCS program.

In California, CalOptima and five other COHS plans have operated HIPP programs. Of the other five COHS plans, management understands that four are currently continuing their HIPP programs and one has terminated its program. The fifth plan was challenged by a commercial plan that asserted the COHS inappropriately enrolled members into the plan for economic reasons. Although CalOptima program parameters are different, the allegations against the other plan and absence of regulatory authority could potentially expose CalOptima to challenge. Additionally, CalOptima is responsible for providing Medi-Cal benefits to eligible beneficiaries as defined in its DHCS contract. This includes providing oversight of its contracted providers to ensure that all CalOptima policies and procedures are followed in accordance with regulatory and contractual guidelines. Under the parameters of the HIPP program, and in absence of state guidance, it is possible that CalOptima may not be able to fully ensure that members' access to care and services are in complete alignment with Medi-Cal requirements. Consequently, CalOptima staff recommends winding down the CalOptima HIPP program with termination effective on June 30, 2017.

Should CalOptima proceed with the termination of the HIPP program, keeping our members informed and ensuring access to covered services remain a top priority. As such, CalOptima staff proposes the following for the wind down:

- Maintain the restriction on enrolling new members (implemented on June 30, 2016);
- Notify existing members, in writing and by phone, within 30 days of the approval of the recommendation that the program will terminate effective June 30, 2017;
- Conduct additional outreach to members three months and 30 days prior to termination of the program wind down and termination;

Back to Agenda

- Refer all members to case management for continuity of care consideration and coordinate with affected health networks; and
- Retire CalOptima policy FF.2008 once all members have been dis-enrolled from the HIPP program.

Additionally, in the interim, in order to separate the CalOptima program from the State's HIPP program, CalOptima policy FF.2008 Health Insurance Premium Payment and member facing materials will be updated according to DHCS guidance and renamed to "CalOptima Premium Payment."

Fiscal Impact

The CalOptima Fiscal Year 2016-17 Operating Budget approved by the Board on June 2, 2016, includes program expenses for the HIPP program. The recommended action to sunset the HIPP program effective June 30, 2017 will have no fiscal impact in the current fiscal year as the proposed sunset date coincides with the end of the fiscal year.

Based on current experience, the anticipated annual savings in healthcare insurance premiums in future fiscal years would be approximately $260,000. However, there will presumably be increased medical expenses for the members because the risk of providing for their health care transfers back to CalOptima or the assigned health network. Staff will project the additional medical expenses related to this population and will include these expenses in future operating budgets.

Rationale for Recommendation

Winding down the premium payment program will mitigate litigation and other risks. In order to continue the program during the wind down period, CalOptima is required to update internal policy and procedures as well as member facing materials.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated October 6, 2011, Ratify CalOptima's Health Insurance Premium Payment (HIPP) Program for Members
2. Revised CalOptima Policy FF.2008: Health Insurance Premium Payment Program (redlined and clean versions)

/s/ Michael Schrader — *2/23/2017*

Authorized Signature — **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 6, 2011
Regular Meeting of the CalOptima Board of Directors'

Report Item
VI. B. Ratify CalOptima's Health Insurance Premium Payment (HIPP) Program for Members

Contact
Michael Engelhard, Chief Financial Officer, (714) 246-8400

Recommended Action
Ratify CalOptima's Health Insurance Premium Payment (HIPP) program for Medi-Cal Members.

Background
The Health Insurance Premium Payment (HIPP) program, established by the enactment of Assembly Bill 3328 (1986) and codified in the Welfare and Institutions Code section 14124.91, authorizes the Department of Health Care Services (DHCS), to pay private health coverage premiums for Medi-Cal beneficiaries whenever cost-effective.

The DHCS HIPP Program is available to beneficiaries in the Medi-Cal Fee-for-Service system when the expected Medi-Cal program savings is 110% or greater than the premium cost.

Eligibility requirements for the program include:

- Beneficiary must have current Medi-Cal eligibility;
- Beneficiary must have a high-cost medical condition, such as asthma, cancer, cirrhosis, cystic fibrosis, diabetes, Down's Syndrome, HIV/AIDS, organ transplant and spina bifida;
- Beneficiary must have current health coverage policy, COBRA continuation coverage, a HIPAA conversion policy or coverage through another source; and
- Beneficiary's health insurance policy must cover the high-cost medical condition.

If eligibility requirements are met, a beneficiary may apply for the program.

Discussion
As a Medi-Cal managed care plan, CalOptima developed a HIPP program in or about 1995 to pay private health insurance premiums for Members with high-cost medical conditions when it is cost-effective. The application and eligibility requirements for the CalOptima HIPP program closely align with those of DHCS. CalOptima requires that Members enrolled in the CalOptima HIPP program reapply every six (6) months. CalOptima has budgeted the estimated premium cost as a Medi-Cal medical expense for at least the past ten (10) years. In the process of updating CalOptima's internal policy for

Back to Agenda

this program, staff learned that there had never been formal Board of Directors approval. The policy was submitted to DHCS, which approved it in 2010 with the expectation that the Board would provide final approval.

Fiscal Impact
Qualification for the program is based on an analysis that the cost of the other health insurance premiums is less than what DHCS or CalOptima would pay with Medi-Cal coverage. The FY 2011-12 interim Medi-Cal Budget for this program is $180,000. FY 2009-10 and FY 2010-11 actual spending were $150,609 and $193,770, respectively. Medical cost savings, especially in prescription drugs, can average $1,000 per member per month or $400,000 per year.

Participation in the HIPP program by paying Member private insurance premiums results in a lower overall cost to CalOptima and Medi-Cal as compared to having to pay for these high-cost medical services directly.

Rationale for Recommendation
Ratification of this program will allow CalOptima to continue to use its capitation dollars cost-effectively consistent with CalOptima's mission statement.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Richard Chambers — *9/30/11*
Authorized Signature — **Date**

Back to Agenda

Policy #:	FF.2008
Title:	~~Health Insurance~~CalOptima **Premium Payment Program**
Department:	Claims Administration
Section:	Not Applicable
CEO Approval:	~~Richard Chambers~~ Michael Schrader
Effective Date:	10/~~6~~06/1
Last Review Date:	1
Last Revised Date:	03/02/17 03/02/17

I. PURPOSE

~~To describe CalOptima's Health Insurance~~This policy describes the CalOptima Premium Payment (~~HIPP) Program~~CPP) program for eligible Members.

II. POLICY

A. CalOptima shall administer a ~~HIPP Program~~voluntary CalOptima Premium Payment (CPP) program by which it may pay private health insurance premiums for Members with high-cost medical conditions, as specified in this policy. A CPP program high-cost medical condition may include, but is not limited to:

1. HIV/AIDS;
2. Cancer; and
3. Organ transplantation.

B. CalOptima shall offer consideration for the ~~HIPP Program~~CPP program to Members that meet the following conditions:

1. Eligible with CalOptima;
2. Have a current private health insurance policy, Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation plan, or a COBRA conversion policy, in effect prior to enrollment in the Medi-Cal program;
3. Have a high-cost medical condition as described in Section II.A. of this policy; and
4. Be insured under a private health insurance policy that does not exclude the Member's high-cost medical condition.

C. A Member's private health insurer is considered the primary payer of health services, while CalOptima is the payer of last resort.

D. A Member's health insurance premium shall be current at the time of application. CalOptima shall not pay for premiums retroactively.

E. The CPP program is not affiliated with the Health Insurance Premium Payment (HIPP) program as administered by the California Department of Health Care Services (DHCS).

F. Enrollment, or disenrollment, from the CPP program does not affect a Member's eligibility for the Medi-Cal program.

G. Funding for the CPP program is not reimbursable by DHCS and shall be excluded from financials used to evaluate CalOptima expenses and rates.

H. Pursuant to guidance received from DHCS related to required changes to plan-administered premium payment programs, the CPP program suspended new member enrollment as of June 30, 2016.

I. Effective July 1, 2017, CalOptima shall terminate the CPP program.

1. Prior to termination of the CPP, CalOptima shall notify all affected Members no later than three (3) months prior to the termination date.

2. CalOptima shall refer all affected Members to case management for Continuity of Care and notify the Member's Health Network.

III. PROCEDURE

~~E.~~A. To apply for the ~~CalOptima HIPP Program~~CPP program, a Member shall:

1. Complete and submit the ~~CalOptima HIPP Program~~CPP program application to CalOptima;

2. Submit a health insurance policy, or description of benefits, from the Member's private health insurer, or employer;

3. Submit copies of premium payment invoices from the Member's private health insurer for the last three (3) consecutive months;

4. Submit a list from the pharmacy of all medications utilized in the last three (3) consecutive months; and

5. Submit copies of the explanation of benefits from the primary health insurance for the past six (6) consecutive months.

B. Upon receipt of the ~~CalOptima HIPP Program~~CPP program application, the CalOptima Claims Administration and ~~Health Services~~Case Management Departments shall review the Member's application and determine if the Member is eligible for the ~~Program~~CPP program.

C. If a Member is eligible for ~~the CalOptima HIPP Program~~CPP program, the Claims Department will send the Member written notification and shall pay the private health insurance premium to:

1. The Member's employer;

2. Health insurance company; or

3. Member for reimbursement.

D. If the Member is not eligible for ~~the CalOptima HIPP Program~~CPP program, the Claims Department will send the Member a Disapproval ~~letter~~Letter.

E. A Member may reapply for ~~the CalOptima HIPP Program~~CPP program every six (6) months.

F. The CalOptima Finance Department shall provide the Claims Department with a cost analysis of Members enrolled in the ~~CalOptima HIPP Program~~CPP program on an annual basis.

IV. ATTACHMENTS

A. CalOptima ~~HIPP Program~~CPP Member Evaluation and Re-evaluation Questionnaire
B. CalOptima ~~HIPP Program~~CPP Welcome Letter
~~B.~~C. CalOptima CPP Approval Letter
D. CalOptima ~~HIPP Program~~CPP Disapproval Letter
~~C.~~E. CalOptima CPP Disapproval Letter – Health Network Member
F. CalOptima ~~HIPP Program~~CPP Member Re-evaluation Reminder Letter
~~D.~~G. CalOptima CPP Termination Letter

V. REFERENCES

A. California Welfare and Institutions Code, ~~Section~~ §14124.9
~~B. Department of Health Care Services All County Welfare Directors Letter 09-02~~
~~C.~~B. CalOptima Policy AA.1000: Glossary of Terms

C. Department of Health Care Services, All County Welfare Directors Letter 09-02
D. Department of Health Care Services (DHCS) Policy Guidance on MCP Administered Premium Assistance Programs, Issued June 30, 2016

VI. REGULATORY AGENCY APPROVALS ~~OR~~

A. 08/13/10: Department of Health Care Services

~~VI.~~VII. BOARD ~~ACTION~~ACTIONS

A. ~~10/6/11:~~ 03/02/17: Regular Meeting of the CalOptima Board of Directors
~~8/13/10: Department of Health Care Services~~

B. 10/06/11: Regular Meeting of the CalOptima Board of Directors

~~VII.~~VIII. REVIEW/REVISION HISTORY

~~Not applicable~~

~~VIII. KEYWORDS~~

~~HIPP~~
~~Reimbursement~~

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	10/06/2011	FF.2008	Health Insurance Premium Payment Program	Administrative
Revised	03/02/2017	FF.2008	CalOptima Premium Payment Program	Administrative

IX. GLOSSARY

Term	Definitions
Continuity of Care	Services provided to a Member rendered by an out-of-network provider with whom the Member has pre-existing provider relationship.
Health Network	A Physician Hospital Consortium (PHC), Physician Medical Group (PMG) under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.

Policy #: FF.2008
Title: **CalOptima Premium Payment Program**
Department: Claims Administration
Section: Not Applicable

CEO Approval: Michael Schrader

Effective Date: 10/06/11
Last Review Date: 03/02/17
Last Revised Date: 03/02/17

I. PURPOSE

This policy describes the CalOptima Premium Payment (CPP) program for eligible Members.

II. POLICY

A. CalOptima shall administer a voluntary CalOptima Premium Payment (CPP) program by which it may pay private health insurance premiums for Members with high-cost medical conditions, as specified in this policy. A CPP program high-cost medical condition may include, but is not limited to:

1. HIV/AIDS;
2. Cancer; and
3. Organ transplantation.

B. CalOptima shall offer consideration for the CPP program to Members that meet the following conditions:

1. Eligible with CalOptima;
2. Have a current private health insurance policy, Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation plan, or a COBRA conversion policy, in effect prior to enrollment in the Medi-Cal program;
3. Have a high-cost medical condition as described in Section II.A. of this policy; and
4. Be insured under a private health insurance policy that does not exclude the Member's high-cost medical condition.

C. A Member's private health insurer is considered the primary payer of health services, while CalOptima is the payer of last resort.

D. A Member's health insurance premium shall be current at the time of application. CalOptima shall not pay for premiums retroactively.

E. The CPP program is not affiliated with the Health Insurance Premium Payment (HIPP) program as administered by the California Department of Health Care Services (DHCS).

F. Enrollment, or disenrollment, from the CPP program does not affect a Member's eligibility for the Medi-Cal program.

G. Funding for the CPP program is not reimbursable by DHCS and shall be excluded from financials used to evaluate CalOptima expenses and rates.

H. Pursuant to guidance received from DHCS related to required changes to plan-administered premium payment programs, the CPP program suspended new member enrollment as of June 30, 2016.

I. Effective July 1, 2017, CalOptima shall terminate the CPP program.

1. Prior to termination of the CPP, CalOptima shall notify all affected Members no later than three (3) months prior to the termination date.

2. CalOptima shall refer all affected Members to case management for Continuity of Care and notify the Member's Health Network.

III. PROCEDURE

A. To apply for the CPP program, a Member shall:

1. Complete and submit the CPP program application to CalOptima;

2. Submit a health insurance policy, or description of benefits, from the Member's private health insurer, or employer;

3. Submit copies of premium payment invoices from the Member's private health insurer for the last three (3) consecutive months;

4. Submit a list from the pharmacy of all medications utilized in the last three (3) consecutive months; and

5. Submit copies of the explanation of benefits from the primary health insurance for the past six (6) consecutive months.

B. Upon receipt of the CPP program application, the CalOptima Claims Administration and Case Management Departments shall review the Member's application and determine if the Member is eligible for the CPP program.

C. If a Member is eligible for CPP program, the Claims Department will send the Member written notification and shall pay the private health insurance premium to:

1. The Member's employer;

2. Health insurance company; or

3. Member for reimbursement.

D. If the Member is not eligible for CPP program, the Claims Department will send the Member a Disapproval Letter.

E. A Member may reapply for CPP program every six (6) months.

F. The CalOptima Finance Department shall provide the Claims Department with a cost analysis of Members enrolled in the CPP program on an annual basis.

IV. ATTACHMENTS

A. CalOptima CPP Member Evaluation and Re-evaluation Questionnaire
B. CalOptima CPP Welcome Letter
C. CalOptima CPP Approval Letter
D. CalOptima CPP Disapproval Letter
E. CalOptima CPP Disapproval Letter – Health Network Member
F. CalOptima CPP Member Re-evaluation Reminder Letter
G. CalOptima CPP Termination Letter

V. REFERENCES

A. California Welfare and Institutions Code, §14124.9
B. CalOptima Policy AA.1000: Glossary of Terms
C. Department of Health Care Services, All County Welfare Directors Letter 09-02
D. Department of Health Care Services (DHCS) Policy Guidance on MCP Administered Premium Assistance Programs, Issued June 30, 2016

VI. REGULATORY AGENCY APPROVALS

A. 08/13/10: Department of Health Care Services

VII. BOARD ACTIONS

A. 03/02/17: Regular Meeting of the CalOptima Board of Directors
B. 10/06/11: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	10/06/2011	FF.2008	Health Insurance Premium Payment Program	Administrative
Revised	03/02/2017	FF.2008	CalOptima Premium Payment Program	Administrative

IX. GLOSSARY

Term	Definitions
Continuity of Care	Services provided to a Member rendered by an out-of-network provider with whom the Member has pre-existing provider relationship.
Health Network	A Physician Hospital Consortium (PHC), Physician Medical Group (PMG) under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.

CalOptima Premium Payment (C.P.P)
Member Evaluation and Re-evaluation Questionnaire

Welcome to CalOptima! Please assist us in helping plan for your health care by filling out this form completely. This information will be used to evaluate or re-evaluate your medical needs and identify your providers of care. ***For re-evaluations, please return this form within the week of the specified date indicated in the attached letter.*** You will be contacted by a medical case manager who will review your completed questionnaire and offer assistance in coordinating your care. Completion of this form does not guarantee approval for the C.P.P.

Please note: CalOptima Premium Payment program is in no way affiliated with DHCS HIPP Program. Participation in the CalOptima Premium Payment program is strictly voluntary. Disenrollment from CPP does not affect your Medi-Cal eligibility.

Please answer the following questions:

A) MEMBER INFORMATION:

Member Name: _____

☐ New ☐ Same Address: _____

_____

Phone Number: (___) _____

Social Security Number: _____ Date of Birth: _____

Private Insurance Company: _____ Phone Number: (_____) _____

B) DIAGNOSIS:

_____

C) PHARMACY:

Name of Pharmacy you use: _____

Phone Number: (_____) _____

MEDICATIONS:
***Please attach a list from your pharmacy of medications to report to the C.P.P.**

D) HEALTH CARE ACCESS:

1. How many times in the last six (6) months did you go to the **Emergency Room**? _____

   Reason: _____

Do not write: INTERNAL USE ONLY										***Date:***
Form:	Comp	Inc	Stat:	Nw	Revl	CM:	A	P	D	Intls:

Back to Agenda

2. How many times in the last six (6) months were you **hospitalized?** _____

Reason: _____

3. Who is your **Primary/Family Doctor**? ☐ None

Primary/Family Doctor Name	Phone Number	No. of Visits for the last 6 Months

4. Who are your **Specialists**? ☐ None

Specialist's Name	Specialty	Phone Number	No. of Visits for the last 6 Months

E) EQUIPMENT:

1. What kind of **special equipment** have you used within the last six (6) months?

a) ☐ **None**

b) ☐ **Hospital Bed** **Supplier:** _____
☐ Rent ☐ Own ☐ Funded By CalOptima ☐ Funded by Private Insurance

c) ☐ **Wheel Chair** **Supplier:** _____
☐ Rent ☐ Own ☐ Funded By CalOptima ☐ Funded by Private Insurance

d) ☐ **Walker** **Supplier:** _____
☐ Rent ☐ Own ☐ Funded By CalOptima ☐ Funded by Private Insurance

e) ☐ **Other:** _____ **Supplier:** _____
☐ Rent ☐ Own ☐ Funded By CalOptima ☐ Funded by Private Insurance

F) SUPPLIES:

1. What kind of **medical supplies** have you used in the last six (6) months?

a) ☐ **None**

b) ☐ **Diapers** **Supplier:** _____
☐ Funded By CalOptima ☐ Funded by Private Insurance

Do not write: INTERNAL USE ONLY ***Date:***
Form: Comp Inc Stat: Nw Revl CM: A P D Intls:

Back to Agenda

c) ☐ **Ostomy Supplies** **Supplier:** _____
☐ Funded By CalOptima ☐ Funded by Private Insurance

d) ☐ **Special Formulas/Feeding Supplies** **Supplier:** _____

Brand: _____ **Amount Use:** _____
☐ Funded By CalOptima ☐ Funded by Private Insurance

e) ☐ **Other** _____

_____ **Supplier:** _____
☐ Funded By CalOptima ☐ Funded by Private Insurance

Comments Regarding Equipment and Supplies:

_____

_____

G) LAB/X-RAY:

1. Who do you receive **lab/x-ray** procedures from? ☐ None

_____ Phone Number: (_____) _____

H) VISION:

1. Who do you receive **vision care** from? ☐ None

_____ Phone Number: (_____) _____

I) HOME HEALTH CARE:

1. Who do you receive **home health care** from? ☐ None

_____ Phone Number: (_____) _____

J) TREATMENTS:

1. In the next six (6) months, are you **scheduled for** or **receiving** the following?
   ☐ None ☐ Radiation Therapy ☐ Speech Therapy
   ☐ Dialysis ☐ Physical Therapy ☐ Chemo Therapy

Do not write: INTERNAL USE ONLY										***Date:***	
Form:	Comp	Inc	Stat:	Nw	Revl	CM:	A	P	D		Intls:

Back to Agenda

☐ Surgery ☐ Occupational Therapy ☐ Transfusion
☐ Other: _____

Signature of Applicant/Beneficiary: _____ Date: _____

Thank you for filling out this form. Please return it to: **C.P.P.P Unit, 505 City Parkway West, Orange, California 92856.** If you have questions regarding this form, please call the **C.P.P. Unit** (714) 246-8669.

Do not write: INTERNAL USE ONLY										***Date:***	
Form:	Comp	Inc	Stat:	Nw	Revl	CM:	A	P	D		Intls:

Back to Agenda

Date

Member's name and address

Dear Member:

Thank you for your recent inquiry regarding the CalOptima Premium Payment (C.P.P.) program. Enclosed is an application for the program. As you may know, CalOptima may pay a member's private premium payment if it is determined to be cost effective and the member has a high cost medical condition.

The following documents must be provided to CalOptima for possible consideration to the CPP:

- A completed Health Member Questionnaire
- Attending physician's statement of diagnosis, date of diagnosis and treatment plan
- Medical records, treatment plan and/or progress notes from your primary physician and/or specialist
- A copy of your primary health insurance card
- Copy of the latest premium payment notice or signed Cobra election form, showing:
  - Name and Address of where premium is to be sent
  - Amount of premium
  - Date premium is due
  - Cobra effective and expiration date (if applicable)
- A list **from your pharmacy,** if applicable, of the medications you have used for the last **three (3) months**. (A handwritten or typed list **will not be accepted)**

Please submit the above documents to CalOptima to the following address:

CalOptima Premium Payment program
505 City Parkway West
Orange, CA 92868
ATTN:

We will notify you if we will require additional information from you and/or to inform you of the status of your application.

Please note that providing an application does not constitute approval for the program. Furthermore, the program does not make payments for premiums paid by the member prior to application approval, or that are past due.

Please note: CalOptima Premium Payment program is in no way affiliated with DHCS HIPP Program. Participation in the CalOptima Premium Payment program is voluntary.

If you have any questions, please call the CPP Unit at (714) 246-8669, Monday through Friday, from 9:00 a.m. to 5:00 p.m. Thank you.

Sincerely,

CalOptima Premium Payment program
Enclosure

Back to Agenda

Date

Member's name and address

Dear Member:

The CalOptima Premium Payment (CPP) program has determined, based on a review of your application and supporting documents, that it would be cost-effective for CalOptima to pay your private premium payment This letter will serve as an official notice that your health insurance premium payments will be covered by CalOptima effective from **through** on the basis of your continued Medi-Cal eligibility and CPP approved qualification status. **In the event of any changes to your primary health coverage or status, we will need to re-evaluate your case at any period of time in order to determine whether we will continue payment of your premium.**

Any change of coverage or cancellation by you of this health insurance without CalOptima Premium Payment (CPP) Unit approval can result to withdrawal of your Medi-Cal benefits and /or the CPP. **Please keep us informed about the status of your coverage.**

The CPP periodically re-evaluates your case in order to determine whether we will continue payment of your premium. To re-evaluate your case, the following items must be provided **within the week:**

- A completed Member Re-Evaluation Questionnaire
- All Explanation of Benefit (EOB) forms, if applicable, within the last **six (6) months** sent to you by your insurance carrier; or for HMO-eligible members, medical records, treatment plan and/or progress notes from your primary physician/specialist. **Please note, if you are Medicare eligible, you do not need to provide copies of your EOB forms or list of medical services.**
- A list **from your pharmacy** of the medications you have used for the last **three (3) months (A handwritten or typed list will not be accepted.)**
- Please call us immediately if you change your address or telephone # to avoid lapse in coverage.

Earlier submission of the questionnaire to CalOptima will be invalid and may delay the re-evaluation process. Furthermore, failure to provide the requested information within the specified date may result in cancellation of your eligibility from the CPP.

Please note: CalOptima Premium Payment program is in no way affiliated with DHCS HIPP Program. Participation in the CalOptima Premium Payment program is voluntary. Disenrollment from CPP does not affect your Medi-Cal eligibility.

If you have any questions, please call the **CPP** Unit at (714) 246-8669, Monday through Friday, from 8:00 a.m. to 4:00 p.m. Thank you.

Sincerely,

CalOptima Premium Payment program

Back to Agenda

Date

Member's name and address

Dear Member:

The CalOptima Premium Payment (CPP) program Unit received your application for possible consideration to the CPP on enter date. We have determined that your **coverage with (Carrier's name) ended effective____, therefore you do not meet the requirements for the (CPP) . You must have a current health insurance policy or a COBRA conversion policy in order to be eligible for the CPP.**

Your Medi-Cal eligibility and benefits are not affected by this determination. Since your other health insurance has been terminated, you will receive health care services through CalOptima Direct. **Should you require assistance regarding the CalOptima Direct Program, please call the CalOptima Member Service Department at (714) 246-8500.**

Please note: CalOptima Premium Payment program is in no way affiliated with DHCS HIPP Program. Participation in the CalOptima Premium Payment program is voluntary.

If you have any questions regarding this notice, please contact the CPP Unit at (714) 246-8669, Monday through Friday, from 9:00 a.m. to 5:00 p.m. Thank you.

Sincerely,

CalOptima Premium Payment program

Date

Member's name and address

Dear Member:

The CalOptima Premium Payment (CPP) program has determined, based upon a review of your application and supporting documents, that it would **not** be cost effective for CalOptima to pay your private health insurance premium under the CPP.

Your Medi-Cal eligibility and benefits are not affected by this determination. You will receive health care services through CalOptima's network of health plans. These health plans have joined together with CalOptima to provide health care services for Orange County Medi-Cal beneficiaries.

Our records indicate you are currently enrolled in the following CalOptima health plan:

_____

Please note: CalOptima Premium Payment program is in no way affiliated with DHCS HIPP Program. Participation in the CalOptima's Premium Payment program is voluntary.

You may remain enrolled in this health plan or you may choose to enroll in a different CalOptima health plan. If you have any questions concerning the enrollment process and need assistance in choosing a different health plan, please call the Customer Service Department at **(714) 246-8500 or (888) 587-8088.**

Sincerely,

CalOptima Premium Payment program

Date

Member's name and address

Dear Member:

This letter is a follow-up to the re-evaluation of your case. This is a courtesy reminder that the requested documents are **due within the week ending_____.** The following items must be provided.

- A completed Member-Re-Evaluation Questionnaire
- All Explanation of Benefit (EOB) forms, if applicable, within the past **six (6) months** sent to you by your insurance carrier, or for HMO members, current medical records, treatment plan and/or progress notes from your primary physician or specialist. (If you have been receiving your EOB forms through CalOptima, and were assured that CalOptima has copies of those EOB forms in your CPP file, you do not need to send copies. Please not, if you are Medicare eligible, you do not need to provide copies of your EOB forms or list of medical services.
- A list **from your pharmacy,** if applicable, of the medications you have used for the last **three (3) months** (A handwritten or typed list **will not be accepted.)**

Please send the above requested items to:

CalOptima Premium Payment program
505 City Parkway West
Orange CA 92868
ATTN:

Failure to provide the requested information within the requested date may result in cancellation of your eligibility from the CalOptima Premium Payment program and non-payment of your monthly premium for your primary health coverage.

Please note: CalOptima Premium Payment program is in no way affiliated with DHCS HIPP Program. Participation in the CalOptima Premium Payment program is voluntary. Disenrollment from CPPP does not affect your Medi-Cal eligibility.

Your attention to this matter is greatly appreciated. If you have any questions, please call the **CPP** Unit at 714-246-8669.

Sincerely,

CalOptima Premium Payment program

Enclosure

Back to Agenda

Date

Member's name and address

Dear Member:

The CalOptima Premium Payment program has determined that **your COBRA coverage period ended on___ .** You must have a current health insurance policy or a COBRA conversion policy in order to continue with the CPP. **Your participation in the program has been discontinued by CalOptima effective___.**

Your Medi-Cal eligibility and benefits are not affected by this determination. Since your other health insurance has been terminated, you will receive health care services through CalOptima Direct. Should you require assistance regarding the CalOptima Direct Program, please call the CalOptima Member Service Department at (714) 246-8500.

Please note: CalOptima Premium Payment program is in no way affiliated with DHCS HIPP Program. Participation in the CalOptima Premium Payment program is voluntary. Disenrollment from CPP does not affect your Medi-Cal eligibility.

If you have any questions regarding this notice, please contact the **CPP** Unit at (714) 246-8669, Monday through Friday, from 9:00 a.m. to 5:00 p.m. Thank you.

Sincerely,

CalOptima Premium Payment program

Continued to Future Board Meeting

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item
14. Consider Temporarily Waiving Enforcement of the Bed Day Utilization Requirement and Related Policy for Physician Hospital Consortia (PHC)

Contact
Ladan Khamseh, Chief Operating Officer, (714) 246-8400

Recommended Action
Authorize the Chief Executive Officer (CEO) to temporarily waive enforcement of the PHC Primary Hospital Bed Day Utilization Requirement commencing March 2, 2017 and continuing through June 30, 2018, unless the CEO elects to terminate the waiver sooner

Background
CalOptima's delivery model was developed to meet specific goals, including: 1) to enhance member access to health care services; 2) to promote active participation by providers and hospitals; and 3) to be innovative by maintaining a fair and equitable program that continues to evolve toward improvement and alignment with changing health care needs. To this end, CalOptima offers three health network contract models: PHC, Shared-Risk Group (SRG), and Health Maintenance Organization (HMO). These contracting options allow health networks to select their preferred means of participation that best meets their business objectives. These contracting options also allow CalOptima's delivery system to grow into a diverse landscape that supports CalOptima's mission for providing quality health care services in a cost-effective and compassionate manner. The CalOptima Board of Directors has taken an active role in ensuring the viability of CalOptima's delivery model by directing staff to monitor and make refinements to the model, as necessary.

In an action taken on June 5, 2007, the Board recognized that changes in the marketplace and a decrease in hospital participation affected the management of admissions and bed days and resulted in duplicative services and inefficient administrative costs. To address these concerns, the Board authorized the CEO to require that PHCs maintain at least 70% of Orange County hospital inpatient bed days at the PHC's primary hospital or be converted to an SRG.

In an action taken on April 2, 2009, the Board authorized the CEO to include a provision in PHC contracts to address the above referenced 70% bed day utilization requirement, with the exception of pediatric PHCs, and to allow a PHC to select an alternate hospital partner if the primary hospital has reached maximum capacity, defined as greater than 90% of the overall occupancy.

In action taken on February 4, 2010, the Board addressed feedback received from PHC hospital partners that the maximum occupancy relief was frequently unattainable due to various bed types and fluctuating capacities for each bed type. To address this concern, the Board eliminated the maximum capacity requirement and allowed PHCs to divert 10% of their bed days to an alternate hospital partner.

Back to Agenda

Discussion

At the Board's direction and to meet the Centers for Medicare & Medicaid Services' (CMS) and the California Department of Health Care Services' (DHCS) regulatory requirements, staff continually monitors and evaluates CalOptima's delivery model for any opportunities for improvement and/or enhancement that would improve access to appropriate care and provider of choice for members.

The bed day utilization requirement was implemented to address a concern that PHC primary hospitals would act as brokers, buying bed days from other hospitals rather than providing direct services, and that as a result, PHCs would be unable to meet their goal of reducing administrative cost through efficiency. That brokerage concept now appears less relevant as the reimbursement methodology for many contracted hospitals has since transitioned from per-diem or case rate to All Patient Refined, Diagnosis-Related Group or APR-DRG. Under the APR-DRG method, which promotes a more predictable and transparent payment process, hospitals are less incentivized to act as brokers.

With the recent expansion of Medi-Cal coverage and the resulting growth in both membership number and population diversity, staff recognizes the importance of allowing flexibility for health networks to manage their operations and hospital relationships directly to meet the unique health care needs of new and existing membership, including utilization of multiple hospitals. Current trends show health networks are increasingly interested in assuming greater financial risk in managing hospital services in order to achieve greater efficiency and care coordination. The current bed day utilization requirement limits PHCs' flexibility to manage their networks. Having a policy that requires PHCs to use a single hospital to maintain a minimum threshold may: 1) restrict member access to care; 2) limit a PHC's ability to direct care to other hospitals that may be better suited to meet their members' health care needs.

Members enrolled into CalOptima's programs will often select their health network based on the availability of their primary care physician and preferred hospital within the network. Review of the primary reason given by members who opted out of or disenrolled from CalOptima's OneCare Connect (OCC) program indicate that members do not want to change their providers, which may be required due to the bed day utilization requirement. Management's expectation is that temporarily waiving enforcement of the current policy will better support CalOptima's OCC outreach and marketing efforts by offering increased hospital choices that would promote member selection and retention. During the waiver period, management plans to analyze data, monitor performance, and return to the Board prior to the end of the proposed temporary waiver period with further recommendations. Depending on the results of the temporary waiver, staff anticipates recommending making the temporary waiver permanent by retiring the policy (or, alternatively, to recommending lifting the waiver in the event of unanticipated member access, network management, or other related issues).

Moreover, the current policy of requiring a PHC to change its contract model to SRG if it does meet the bed day utilization requirement may have a considerable impact on CalOptima staff and financial resources related to administering the shared-risk pools and assuming all facility risk,

instead of just inpatient services. Under the PHC model, the health network is responsible for all administrative, professional, and facility-related medical expenses. Transitioning from a PHC to SRG model shifts the facility-related expenses to CalOptima, requiring additional resources to coordinate and manage the hospital risk services. Temporarily waiving enforcement of the PHC bed day utilization requirement, on the other hand, is not expected to result in increases in resources or costs to CalOptima.

Temporarily waiving the enforcement of the bed day utilization requirement will also allow time for staff to analyze available data to confirm whether removal of this requirement would present any issues. If there are no issues, staff proposes to return to the Board no later than June 2018 with recommendation for eliminating the bed day utilization requirement.

Fiscal Impact
The recommended action to retire the bed day utilization requirement and related policy for PHCs is budget neutral to CalOptima. Provider capitation rates will not change as a result of this action, as such there is no additional fiscal impact.

Rationale for Recommendation
The bed day utilization requirement for PHCs is not related to a regulatory requirement and was originally implemented to meet a specific need at the time the policies were developed. PHCs should have the flexibility to provide services in a manner that best meets the diverse needs of their members. The bed day utilization requirement does not allow flexibility and the requirement puts CalOptima at risk for not fulfilling its mission in providing access to quality health care services.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Board Action dated June 5, 2007, Approve CalOptima Medi-Cal and CalOptima Kids Delivery System for 2008
2. Board Action dated April 2, 2009, Authorize the Chief Executive Officer (CEO) to Amend Medi-Cal and CalOptima Kids Health Network Contracts Effective July 1, 2009
3. Board Action dated February 4, 2010, Approve Modification of the Physician Hospital Consortia (PHC) Hospital Participation Policy

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

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 5, 2007
Regular Meeting of the CalOptima Board of Directors

Report Item
VI.A. Approve CalOptima Medi-Cal and CalOptima Kids Delivery System for 2008

Contact
Gregory Buchert, M.D., MPH, Chief Operating Officer, (714) 246-8400

Recommended Actions
1. Approve the CalOptima Medi-Cal and CalOptima Kids Delivery System for 2008 including the Shared Risk contracting model with the option to furnish services through continued participation as a physician hospital consortia (PHC) if the threshold 70% Orange County admissions to a primary hospital requirement is met by July 1, 2008, and allow CHOC Health Alliance a continuing choice of PHC or Shared Risk models and continuance of existing HMOs under fully capitated arrangements;

2. Authorize the Chief Executive Officer to enter into shared risk contracts if the primary medical group agrees to the shared risk model option and the medical group participating in Shared Risk (1) is currently contracted with CalOptima as part of a PHC or (2) is subcontracted with the physician group of a currently contracted PHC, subject to any necessary state approvals to implement the shared risk model;

3. Authorize the requirement that PHCs must have and maintain 70% of Orange County admissions to the PHC's primary hospital as a condition of PHC participation in CalOptima's Medi-Cal and CalOptima Kids program as of July 1, 2008 or the medical group of the PHC will be converted to Shared Risk at that time;

4. Authorize the Chief Executive Officer or authorized designee to execute HMO, PHC and Shared Risk contracts, with the assistance of legal counsel; and,

5. Authorize the Chief Executive Officer, with the assistance of legal counsel, to adopt or revise policies and procedures to implement changes to the delivery model including revisions of auto assignment policies, as necessary and appropriate.

Background
CalOptima currently provides services to a large number of its members in the Medi-Cal and CalOptima Kids programs through contracts with medical groups and hospitals through Physician Hospital Consortia (PHCs) and Health Maintenance Organizations (HMOs). Additionally, one medical group provides services to Medi-Cal members in a shared risk arrangement with CalOptima.

Back to Agenda

The CalOptima delivery model was originally developed with several goals in mind:

- A fair and equitable program for both members and providers.
- Quality health services for members.
- Enhanced access to health services.
- Innovation and cost containment.
- Establishment of a Medical Home (i.e., a Primary Care Physician).
- Member choice.
- Active participation of traditional and safety net providers.
- Maximization of health care dollars while minimizing administrative dollars.
- Appropriately aligned incentives between physicians and hospitals.

While the PHC model has served many of these goals well over the past eleven years, the execution of the model has changed significantly and remains volatile.

One of these changes is the evolution of the Broker model. In the original design, the primary hospital of the PHC was intended to serve a majority of the Health Network members' needs. Today, the number of hospitals willing to participate in a risk-bearing capitated relationship has diminished significantly. Since a medical group is currently required to have a hospital partner to participate with CalOptima, relationships have been created between two partners where there are few admissions from the medical group to the primary hospital. Second, the number of tertiary hospitals serving as primary hospitals has changed from six (6) in 2003 to two (2) today. Finally, the average number of days in a PHC primary hospital is less than 30%, causing the primary hospital to act as a broker, buying hospital days from other hospitals rather than providing direct services to members. These shifts are both a result of a changing market place and complete shift away from hospital capitation.

The one goal that the PHC model has never completely satisfied is the minimization of administrative dollars. The participation of multiple management companies performing duplicative services result in inefficient administrative costs.

For nearly two years CalOptima has engaged in extensive discussions with the CalOptima Board of Directors, the Member Advisory Committee (MAC), the Provider Advisory Committee (PAC), Health Network contractors, and various stakeholders about the delivery model. The pros and cons of the current PHC model and other model proposals have been solicited, presented, and discussed. Based on these discussions and substantial analysis by staff and external consultants, a recommendation is being made to allow the provision of covered services in the Medi-Cal and CalOptima Kids programs using a shared risk model.

Under a shared risk arrangement, contracting medical groups will remain clinically and financially responsible for all services currently defined under their capitation and existing contract. The medical group will continue to authorize inpatient and related services at CalOptima fee-for-service contracted hospitals and other hospitals as necessary. However, in

Back to Agenda

the shared risk arrangement, CalOptima will be financially responsible for all hospital related services provided to the medical group members. This is a similar arrangement to that in the OneCare program where CalOptima currently maintains shared risk relationships with medical groups. The addition of a shared risk agreement will require additional CalOptima resources and management than currently exist for the PHC model. The funds to pay for these resources will be offset by eliminating management fees previously paid to former hospital partners in PHCs. The proposed shared risk arrangement will allow the medical group members to maintain their relationships with their current Medical Group PCPs and specialists.

Discussion

In recognition of those PHCs that continue to provide a majority of hospital services through their primary contracted hospital, participation in the Shared Risk model shall be optional if the PHC demonstrates that it has and maintains at least 70% of admissions in Orange County at the primary hospital by July 1, 2008. PHC contracts will require that the PHC achieve an average of 70% of admissions to the primary hospital within that six month period or they will be converted to the Shared Risk model effective July 1, 2008. While it is anticipated that CHOC Health Alliance, as the only pediatric PHC, will admit the majority of its patients to Children's Hospital of Orange County, it will always be given choice of models for participation. Currently participating HMOs shall receive new contracts based on the existing full capitation arrangement model.

Where the primary medical group agrees to the Shared Risk model, any currently contracted Medi-Cal medical group (current PHC primary medical group or subcontracted medical group) may choose to move to shared risk on January 1, 2008. Any subcontracted medical group (not a PHC signatory) that is involuntarily terminated by the signator medical group may request to enter into a Shared Risk arrangement with CalOptima, but will be required to satisfactorily pass a readiness assessment evaluation before it may receive a shared risk contract which process and approval may delay the start date until after January 1, 2008.

Any currently contracted CalOptima Kids medical group may choose to move to the Shared Risk model on July 1, 2008. If a medical group is in shared risk in Medi-Cal, the medical group will be required to be in a shared risk agreement for CalOptima Kids.

Any realized surplus that results from transition of medical groups from a PHC to a shared risk arrangement shall be redirected for member healthcare.

Fiscal Impact

The anticipated savings are dependent on the number and mix of medical groups converted to shared risk. An estimated $2.8 Million in net savings is projected if all current medical groups with less than a 70% admission rate to the primary PHC hospital are converted to shared risk.

Back to Agenda

CalOptima staff and administrative costs will increase to replace management services provided by current Hospital contractors. The estimated cost of providing these administrative services is substantially less than the current amount allocated for management services provided by Hospital contractors through capitation.

Rationale for Recommendation
Under a Shared Risk arrangement, the money follows the member by only paying those providers actually performing services for our members. Shared Risk offers a more efficient model of healthcare delivery that is more representative of the Orange County market.

Concurrence
Procopio, Cory, Hargreaves & Savitch LLP

Attachments
None

/s/ Richard Chambers — *6/4/07*
Authorized Signature — **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 2, 2009
Regular Meeting of the CalOptima Board of Directors

Report Item

VI. C. Authorize the Chief Executive Officer (CEO) to Amend Medi-Cal and CalOptima Kids Health Network Contracts Effective July 1, 2009

Contact

Greg Buchert, MD, MPH, Chief Operating Officer, (714) 246-8400

Recommended Actions

1. Authorize CEO, with the assistance of Legal Counsel, to amend Medi-Cal Health Network (Health Maintenance Organization, Physician Hospital Consortia and Shared Risk Group) contracts to address additional terms set forth herein; and,
2. Authorize CEO, with the assistance of Legal Counsel, to amend CalOptima Kids Health Network (Physician Hospital Consortia and Shared Risk Group) contracts to address additional terms set forth herein.

Background

CalOptima provides certain services to its Medi-Cal members and all of its CalOptima Kids members through a contractual delegated relationship with Health Networks which are Physician Hospital Consortia (PHC), Shared Risk Medical Groups (SRG) or Health Maintenance Organizations (HMOs). The contracts with these Health Networks expire on June 30, 2009 and CalOptima intends to renew these relationships through either a new contract (Medi-Cal) or a contract amendment (CalOptima Kids).

On December 23, 2008, the Board authorized the CalOptima CEO, with assistance of Legal Counsel, to amend the CalOptima Kids provider contracts to incorporate changes due to the amendments in the Managed Risk Medical Insurance Board (MRMIB) contract with CalOptima covering the periods February 1, 2009 through June 30, 2009 and July 1, 2009 through June 30, 2010. On January 8, 2009, the Board authorized the CalOptima CEO, with the assistance of Legal Counsel, to enter into new or amended contracts with capitated and fee-for-service providers of Medi-Cal services to ensure that such contracts comply with the provisions of CalOptima's new Medi-Cal contract with the California Department of Health Care Services.

CalOptima seeks authority to modify and include the additional provisions discussed below in the Medi-Cal and CalOptima Kids provider contracts, some of which were the subject of prior Board actions as discussed below. Further, all of the amendments, including those imposed under the State Medi-Cal contract would be effective July 1, 2009.

Back to Agenda

Discussion

The changes for the Health Network contracts are detailed below:

1. Shared Risk Pool Reconciliation for Shared Risk Health Network Contracts
   This change will be implemented in Attachment F to the Shared Risk Medical Group contracts. The current contract specifies a quarterly reconciliation and adjustment to the Shared Risk Pool which does not accurately reflect the claims experience and may result in significant underpayment or overpayment. Therefore, CalOptima recommends changing this to a semi-annual schedule which will more accurately account for the claims lag. "Shared Risk Pool" is defined in the contract as the risk sharing program, described in Attachment F, under which the risk for the provision of Shared Risk Services to Members is shared and allocated between CalOptima and Physician. The budget for the Shared Risk Pool is determined by calculating the cost of services listed on the hospital side of the contract division of financial responsibility (called the "DOFR"). The Contract describes when and how CalOptima will reconcile and produce a written report showing all allocations, deposits, expenses and disbursements with respect to the Shared Risk Pool. As mentioned above, this is currently done on a quarterly basis and would be changed to semi-annual basis. Attachment F also provides for quarterly allocation of the surplus from the Hospital Budget Allocation which would be changed to semi-annual payment. If the amount is a deficit, it will continue to be carried forward but to the next semi-annual period, and subtracted from the computed status for that semi-annual period, before any payment is computed for that semi-annual period. If a deficit should occur in the final semi-annual period of any Shared Risk Period, however, it shall not be carried forward, and any accumulated deficit shall become part of the year-end reconciliation and settlement.

2. Prior Authorization for Off Shore Outsourcing
   The Compliance Department has requested the inclusion of a requirement for Health Networks to seek prior authorization for subcontracts that involve outsourcing of certain services to off-shore entities.

3. PHC Primary Hospital Usage Requirement
   CalOptima would include a provision in the contract that addresses the CalOptima Board's previous action to require the PHC (except exempt Pediatric PHCs) to maintain the 70% inpatient bed day threshold in order to remain a PHC. The requirement shall be evaluated per CalOptima policy for the remainder of the term of the contract.

Back to Agenda

In the situation where the primary hospital has reached maximum capacity defined as greater than 90% occupancy, CalOptima shall make the exception to allow the use of alternate hospital under the following conditions:

- One alternate hospital partner must be selected
- Less than 10% of admissions may be diverted to the alternate hospital partner
- PHC Hospital must hold a contract directly with the alternate hospital and be obligated to meet of payment and other requirements and hold CalOptima harmless.

4. Changes to the Division of Financial Responsibility (DOFR)
   - CalOptima's contract with DHCS specifies that financial risk for high cost injectables shall not be borne by the Physician Groups. Therefore, high cost injectables over $250 would be borne by CalOptima. There will be an adjustment to capitation for injectables.
   - Financial responsibility for enteral formula will change from CalOptima to the Physician Group. This change is recommended because this product is typically not provided by a pharmacy.
   - Financial responsibility for HCA furnished TB services would be moved to CalOptima. This action would result in a capitation adjustment.

5. Delegation Changes
   With the exception of the Contract with Kaiser, Health Education would be de-delegated from the Health Networks and become the responsibility of the CalOptima for the Medi-Cal program. This action would result in a capitation adjustment.

   Health Education would be de-delegated from the Health Networks and become the responsibility of CalOptima for the CalOptima Kids program. This action would result in a capitation adjustment.

6. Contract Extensions
   The new State Medi-Cal contract was effective January 1, 2009. The term of the Medi-Cal provider contracts would be extended through June 30, 2010 with two (2) additional one-year terms at CalOptima's sole discretion. CalOptima understands that DHCS has allowed COHSs through June 30, 2009 to implement the State Medi-Cal Contract changes in its provider contracts.

7. Capitation Rates
   The contracts will also include changes in the specific capitation rates for PHC Physician, PHC Hospital, HMO, SRG and CalOptima components that are currently being calculated by Milliman and shall be reflected in the final rates.

Back to Agenda

Fiscal Impact
The net results of the changes described above are budget neutral.. There will be changes in the specific capitation rates for PHC Physician, PHC Hospital, HMO, SRG and CalOptima Health Plan components that are currently being calculated by Milliman and shall be reflected in the final rates.

Rationale for Recommendation
The Health Network contracts need to be amended to reflect the above additional terms when the DHCS Medi-Cal Contract changes are implemented in the provider contracts. Additionally, changes shall be made to the CalOptima Kids contracts for operational consistency and to reflect programmatic changes.

Concurrence
Procopio, Cory, Hargreaves & Savitch LLP

Attachments
None

/s/ Richard Chambers — *3/25/09*
Authorized Signature — **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 4, 2010
Regular Meeting of the CalOptima Board of Directors

Consent Calendar
V. B. Approve Modification of the Physician Hospital Consortia (PHC) Hospital Participation Policy

Contact
Javier Sanchez, Executive Director, State Programs (714) 246-8400

Recommended Action
Modify the Physician Hospital Consortia (PHC) Participation Policy that requires 70% of admissions to be admitted to the PHC's Hospital or Hospital System's Hospitals by eliminating a requirement for 90% occupancy before diversion to a contracted Alternate Hospital.

Background
PHCs are required to maintain 70% of acute admissions (for Orange County Hospitals only) to their Primary Hospital and their Hospital System's Hospitals to maintain their status as a PHC. Up to 30% of the PHC's bed days may occur in other hospitals. The admission patterns are reviewed annually by CalOptima to assure compliance.

A Board action on April 2, 2009 included a new provision that allowed a PHC Hospital to subcontract with an Alternate Hospital in a situation where the primary hospital had reached a maximum capacity defined as greater than 90% occupancy.

CalOptima allowed the use of Alternate Hospital under the following conditions:

- One alternate hospital partner was selected;
- Less than 10% of admissions were diverted to the alternate hospital partner; and,
- PHC Hospital must hold a contract directly with the alternate hospital and be obligated to meet payment and other requirements and hold CalOptima harmless.

This was designed for a situation where the PHC Hospital is nearing bed capacity and it would not be penalized if it had to divert admissions for their Health Network members to another hospital since every diversion of a PHC Health Network member would count against it for their 70% acute admission requirement.

In the April 2, 2009 Board action, provisions were included that the PHC Hospital must contract with the Alternate Hospital to protect CalOptima from claims from the Alternate Hospital if it did not get paid by the PHC Hospital. CalOptima also limited admissions to an Alternate Hospital to 10% to keep the diversions to a minimum number.

Back to Agenda

Discussion
CalOptima has received feedback from our PHC Hospitals that the 90% occupancy relief is frequently unattainable due to the various bed types, various units and their fluctuating capacities for each bed type. For example, a Medical/Surgical bed might not be available even though the hospital is not at an overall 90% occupancy due to the fact that other bed types are available (OB, Mental Health, etc.). Thus, the PHC Hospital must divert a PHC Health Network Medical/Surgical admission to another hospital and be penalized as it tries to maintain its 70% capacity requirement. A Hospital for two PHCs has attempted to address this requirement by reserving beds for PHC members and diverting other CalOptima and other payers' patients to other potentially more costly hospitals. The unintended consequence of this requirement may be a net increase in overall hospital costs.

Fiscal Impact
Staff projects no material fiscal impact.

Rationale for Recommendation
Eliminating the 90% occupancy requirement will allow a PHC Hospital to divert 10% of its days to a contracted Alternate Hospital and provide for a more rational distribution of patients. The diverted days will be counted toward compliance with a 70% admission rate to the PHC's hospital system hospitals. Since the Alternate Hospital must be contracted and the diversion percentage of admissions is limited to 10%, these provisions support a sufficient overflow volume to keep a PHC Hospital engaged with its contracted Alternate Hospital to maintain performance requirements of the PHC contract.

Concurrence
Procopio, Cory, Hargreaves & Savitch LLP

Attachments
None

/s/ Richard Chambers — *1/28/2010*
Authorized Signature — **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

15. Consider Authorizing Issuance of Request for Proposal (RFP) for Medi-Cal Perinatal Support Services (PSS), Contracts with Qualifying RFP Responders, and Amendment of Contract with Current Vendor

Contact

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

Recommended Actions

1. Authorize the issuance of a Request for Proposal (RFP) to identify community partner(s) experienced with providing Medi-Cal-covered educational and care management services supporting pregnancies (pre and postpartum)—specifically, these services are referred to as perinatal support services (PSS) and are consistent with CPSP services, but have additional CalOptima-identified requirements;
2. Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to:
    a. Contract with qualifying RFP responders and in compliance with CalOptima's PSS program and Medi-Cal requirements established by the California Department of Health Care Services (DHCS); and
    b. Amend the contract with the current vendor to reflect per member per month and incentive payment based only on the CalOptima Classic Medi-Cal population, effective April 1, 2017 through the completion of the RFP process.

Background

The Comprehensive Perinatal Support Program (CPSP) provides a wide range of culturally competent services to Medi-Cal pregnant women, from conception through 60 days postpartum. In addition to standard obstetric services, women receive enhanced services in the areas of nutrition, psychosocial and health education. The Legislature enacted the CPSP in 1984 in response to findings from the OB Access Project which indicated that a comprehensive approach reduced both low birth weight rates and health care costs in women and infants. CPSP became a Medi-Cal benefit in 1987. Medi-Cal Managed Health Care Plans are required to provide access to CPSP-comparable services for pregnant Medi-Cal eligible recipients. In 1995, CalOptima was mandated by the State to provide CPSP- comparable services. These services were referred to as Perinatal Support Services (PSS). CalOptima, in turn, fully delegated this responsibility to its contracted health networks.

In 2006, a review of health network data revealed areas of concern due to marked variation in usage of PSS. The variation resulted from a fragmented referral process, eligibility timing issues, and challenges related to coordination of referrals between OB physicians and PSS providers. The resulting recommendation post review was to consolidate the referral process and transition responsibility from the health networks back to CalOptima. On May 6, 2008, the CalOptima Board approved a consolidated capitation contract for Comprehensive Perinatal Services Program with

[1] CA.GOV MO-07-0074 CPSP

Back to Agenda

MOMS Orange County (MOMs). CalOptima initially entered into a one year capitated agreement with MOMS in 2008, at a capitation rate of $.55 per member per month (pmpm) based on the total CalOptima Medi-Cal membership. The contract included two extension options of one year each. The contract was subsequently amended (Amendment II) effective May 1, 2011 to renew automatically on an annual basis upon Board approval. This agreement also included monetary incentives, projected at $234,000 annually, for early referrals, completed initial assessments and increased participation.

In addition to the capitated services provided by MOMs, non-MOMs CPSP-certified providers have also been providing services and are paid by CalOptima at 100% of the CalOptima Medi-Cal fee schedule. These CPSP providers include but are not limited to physicians, Ob/GYNs, certified nurse mid-wives, medical groups, clinics, and PPOs and are certified through the California Department of Public Health.

Due to Medi-Cal expansion and contract language supporting capitation for all Medi-Cal members, program costs have increased year-over-year and more recently from $2 million to $3.5 million for the 2013 - 2015 period (i.e., capitation has been paid based on total CalOptima Medi-Cal membership irrespective of the individual member's potential PSS needs). In comparison, CalOptima member births have increased more modestly during the same period, with approximately 7,000 deliveries in 2013, compared to 8,500 deliveries in 2015. Additionally, records indicate that member engagement with PSS providers decreased dramatically during the same 2013 - 2015 period, after the first encounter from 50% of identified pregnancy referrals to 15%, with continued declines reported throughout the remaining trimesters and through postpartum.

Discussion

The proposed new program will be designed to provide a more comprehensive approach, and strategically increase utilization, coordination of services and member engagement. The redesign will include program development, payment methodology, data integration and improved anticipated outcomes. Proposed program components will meet industry standards and regulatory requirements for perinatal care. The program will include additional data analysis, stratification for low, moderate and high risk, as well as engagement strategies to increase identification of need for and utilization of Perinatal Support Services.

Through an RFI process ahead of the RFP, CalOptima staff plans to seek best practices and identify potential partners and providers with the capabilities to deliver PSS to our members to inform the development of the RFP and its scope of work. CalOptima staff plans to take responsibility for the coordination of care with health network case management and OBs for members at high risk for poor pregnancy outcomes, in a similar manner to current process. CalOptima staff or identified vendor(s) from the proposed RFP process will outreach to members each trimester and provide trimester-specific coaching, nutrition education, and reassess changes in pregnancy risk status aligned with CPSP requirements. Third trimester outreach will include support and coordination of post partum visits, including member incentives for visits completed within the HEDIS-specified time period. After delivery, members will receive support resources and reminders on the importance of the Well Child Visit and Initial Health Visit during the first 15 months of life. Vendor/partner activities are expected to include real-time data-sharing and interventions consistent

Back to Agenda

with program content and will be an integral part of our efforts in providing these services and achieving optimal outcomes.

The proposed RFP could result in awarding contracts to multiple vendors and/or providers. We anticipate CPSP providers will participate in the new CalOptima perinatal program; participation will be determined (vendor or provider) as a result of the RFP process.

Staff also recommends amending the contract with the current vendor to reflect per member per month payments based only on the CalOptima Classic membership (i.e., not including the Medi-Cal Expansion (MCE) membership) at the current rate of $0.55 pmpm plus a $100 incentive payment for an initial visit completed within first 16 weeks of pregnancy, effective April 1, 2017 through the completion of the RFP process. For the COD membership, CalOptima will pay $175/assessment. (See attachment "Qualifying Aid Categories for Payment").

While it's understood that a different payment methodology may be adopted as part of the RFP process (e.g., fee-for-service or case rate), management recommends this change to the current vendor's contract to bring payments for these services made to the current vendor into closer alignment with the pre-MCE state. In the event that the current vendor is unwilling to accept such amendment, management plans to exercise CalOptima's right to terminate the contract for convenience with 60 days notice. Should this occur, management would ensure that Perinatal Support Services would be available to all qualifying members through fee-for-service providers in conjunction with CalOptima's Medical Affairs Department.

Fiscal Impact

The recommended action to initiate an RFP for a CPSP vendor(s) is expected to be budget neutral. Management anticipates that new contracts for the vendors and/or providers identified will support the revised CPSP program based on program goals and achievements (e.g. not a capitated model for all members). While the RFP process is expected to result in a more effective quality program, staff will return to the Board with a financial plan if expected expenses exceed those anticipated with the current model.

Rationale for Recommendation

As identified through CalOptima's latest HEDIS results, it is imperative for CalOptima to redefine its PSS program to increase the identification and intersection with the member and provider throughout the member's pregnancy. CalOptima staff proposes to conduct an RFP process to identify partner(s) to meet the requirements of the new program design for Perinatal Care for CalOptima members. The new program is designed to provide a more comprehensive approach, and strategically increase utilization, coordination of services and member engagement.

Concurrence

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

Back to Agenda

Attachments

1. Power Point Presentation – Perinatal Support Services (PSS)
2. Board Action dated May 6, 2008, Approve the CalOptima PSS Program and Ratify CalOptima's Contract with MOMS (Maternal Outreach Management System) for PSS
3. Qualifying Aid Categories for Payment to Current Vendor

/s/ Michael Schrader — *2/23/2017*

Authorized Signature — **Date**

Back to Agenda

Perinatal Support Services

Board of Directors Meeting

March 2, 2017

Pshyra Jones

Director, Health Education & Disease Management

Back to Agenda

Why do we need a Perinatal Support Services program?

- Pregnancy and childbirth can be a common reason for inpatient admissions.
- Perinatal care is important for the mother and the baby — and is underutilized.
- We hope to improve outcomes for mothers and babies.
- CalOptima has contractual requirements to provide members with access to a comprehensive perinatal support program.
- CalOptima is working to improve our member experience.
- We need to improve our HEDIS scores.

Back to Agenda

DHCS Perinatal Services Requirements

- Ensure the provision of all medically necessary services for pregnant members.
- Implement a comprehensive risk assessment using standards or guidelines of the American Congress of Obstetricians and Gynecologists.
  - Assessment and care plan should include health education, nutrition and psychosocial risk components.
  - Assessment should be administered at the initial prenatal visit, each trimester thereafter and postpartum.
- Ensure pregnant members at high risk of a poor pregnancy outcome are provided timely referral to specialist and delivery services.

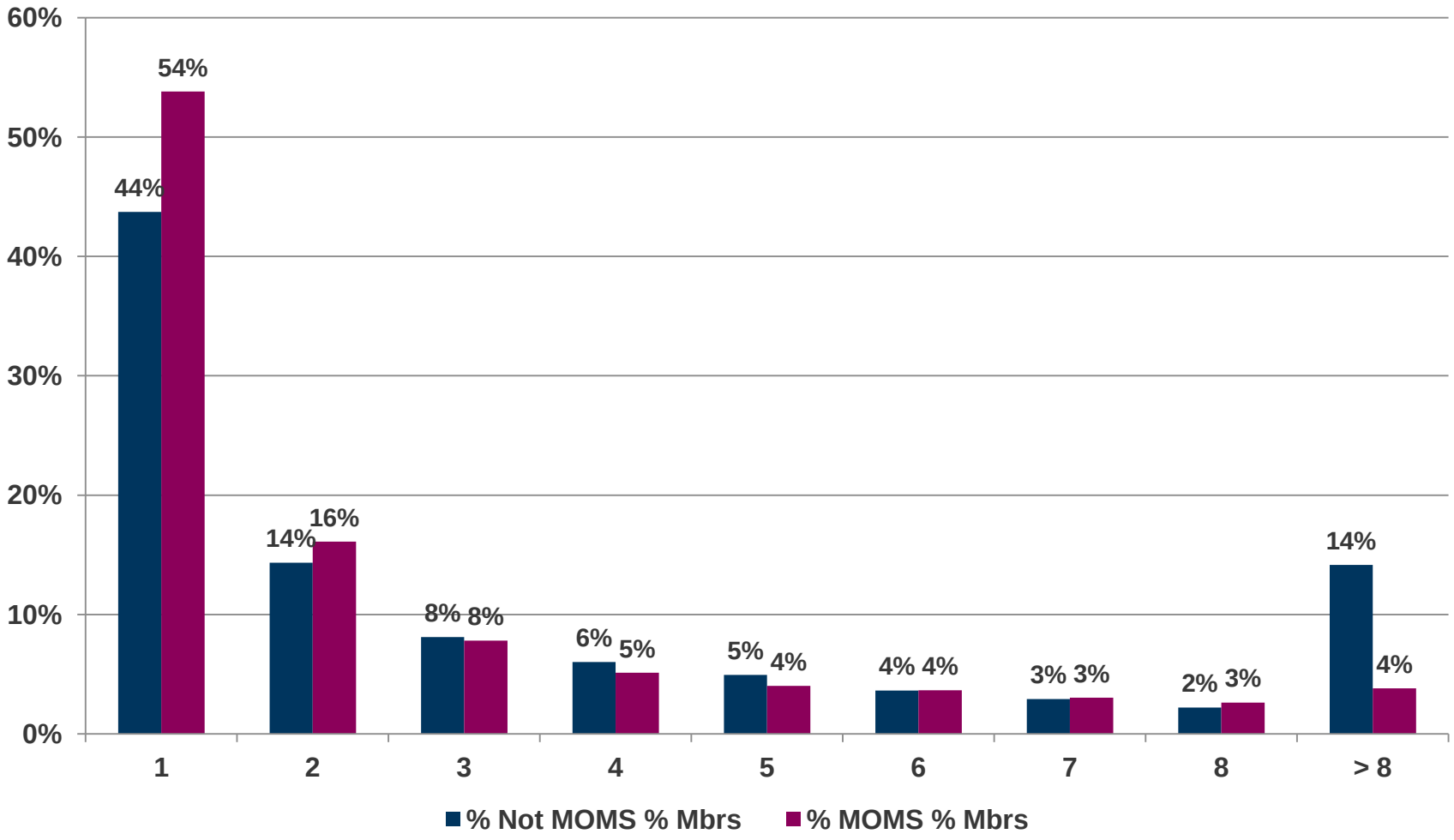
Back to Agenda

Current Fragmented Program Model

- CalOptima contracts with MOMS Orange County for perinatal support services
- Comprehensive Perinatal Services Program (CPSP) is also provided by fee-for-service OB providers
- Redundancy of services for members assigned to CPSP providers
- Existing model makes minimal contributions toward prenatal and postpartum HEDIS performance
- Single source for program entry—Pregnancy Notification Referral Form (PNR)
- PMPM based on entire CalOptima Medi-Cal membership

Back to Agenda

Average # Member Visits (2013–15)



Back to Agenda

CalOptima A Public Agency Better. Together.

CalOptima Prenatal and Postpartum Services (PPC) HEDIS Rates

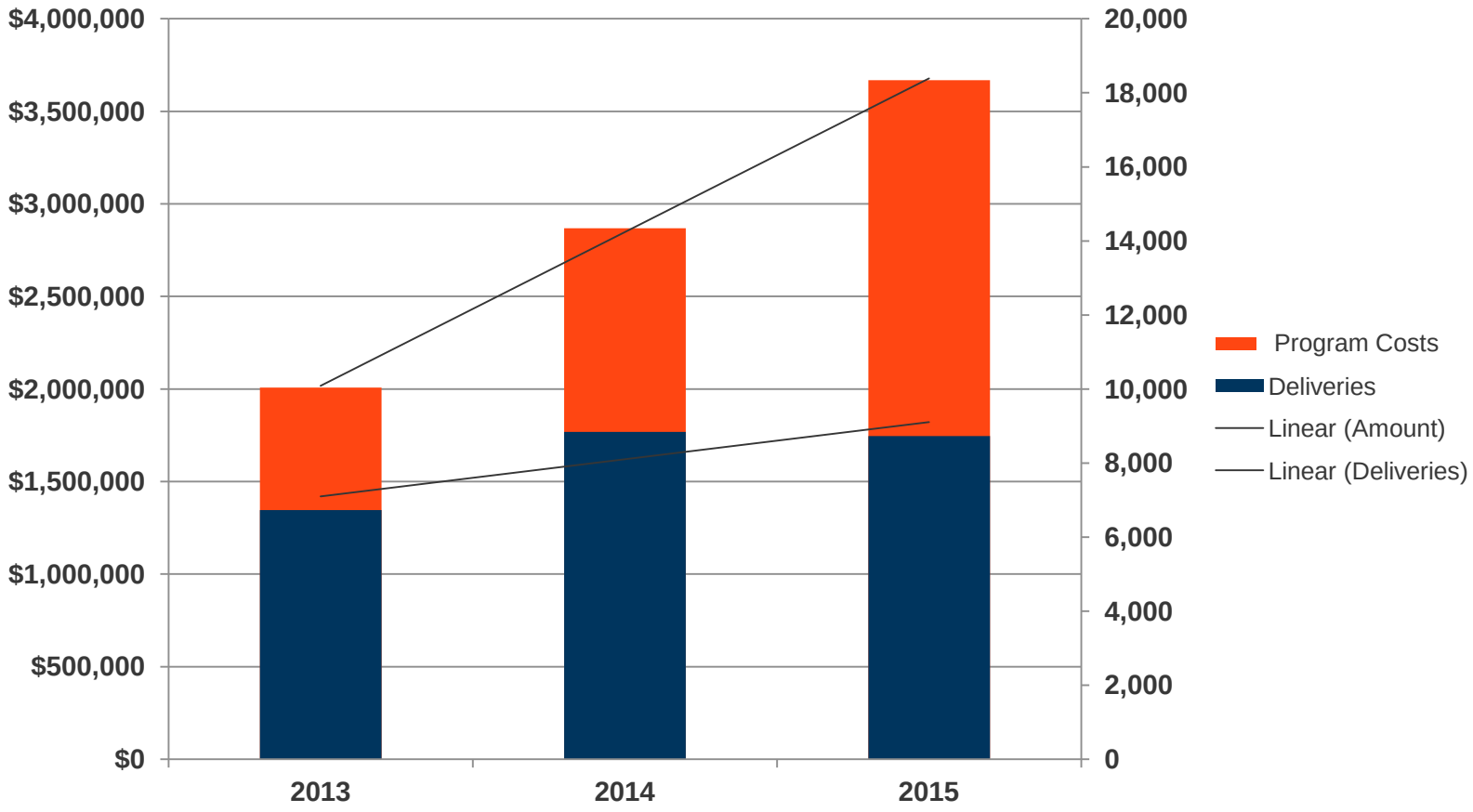
HEDIS PPC2016			
	Denominator Count	Prenatal Rate	Postpartum Rate
MOMS	1596	73.5%	48.8%*
Non-MOMS	5912	73.2%	51.7%
Total	7508	73.3%	51.1%

PPC Measure is a QIC Focus Area—CalOptima is currently below the 50th percentile and nearing the 25th percentile.

* Results are statistically significant (p= 0.040)

Back to Agenda

Deliveries vs. Program Costs



Back to Agenda

CalOptima A Public Agency Better. Together.

The New Approach

- Comprehensive, coordinated program
- More emphasis on member-initiated activity
- Coordination with CPSP providers, OB/GYNs, complex case management and community resources
- Member support with health education, nutrition and psychosocial needs
- Outreach and program marketing strategy to increase identification and member engagement

Back to Agenda

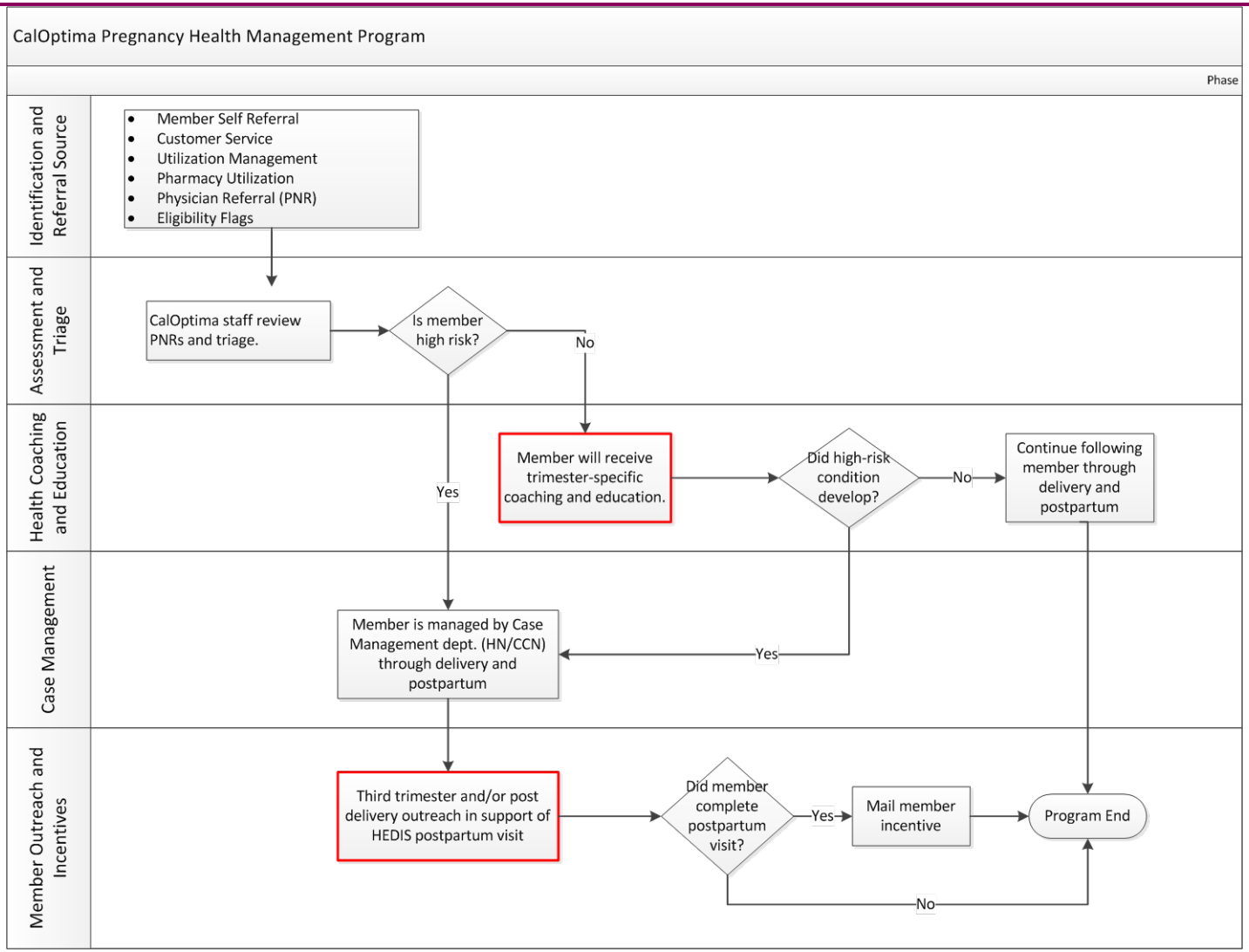
Program Components

- Identification of pregnant members
- Assessment
- Health coaching and education*
- High-risk case management
- HEDIS reminders and member outreach*
- Incentives
- Outcomes

* Program components included in RFP

Back to Agenda

New Program Model



Back to Agenda

Recommended Action

- Authorize the issuance of a Request for Proposal (RFP) to identify community partner(s) experienced with providing Medi-Cal-covered educational and care management services supporting pregnancies (pre and postpartum)—specifically, these services are referred to as perinatal support services (PSS) and are consistent with CPSP services, but have additional CalOptima-identified requirements;

Back to Agenda

Recommended Action (Cont.)

- Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to:
  - Contract with qualifying RFP responders and in compliance with CalOptima's PSS program and Medi-Cal requirements established by the California Department of Health Care Services (DHCS); and
  - Amend the contract with the current vendor to reflect per member per month and incentive payment based only on the CalOptima Classic Medi-Cal population, effective April 1, 2017 through the completion of the RFP process.

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 6, 2008
Regular Meeting of the CalOptima Board of Directors

Report Item

VI. C. Approve the CalOptima Perinatal Support Services Program and Ratify CalOptima's Contract with MOMS (Maternal Outreach Management System) for Perinatal Support Services

Contact

Gertrude S. Carter, M.D., Chief Medical Officer, (714) 246-8400

Recommended Actions

1. Approve the proposed CalOptima Perinatal Support Services Program; and
2. Ratify CalOptima's Contract with MOMS for Perinatal Support Services.

Background

The Comprehensive Perinatal Support Program (CPSP) is a Medi-Cal benefit developed in 1992 by the State of California. This benefit was designed in response to poor birth outcomes in the California Medi-Cal population. The goal of the program is to improve the overall health status of pregnant mothers and their newborn babies. CPSP services are comprised of direct OB physician services and Perinatal Support Services (PSS). The PSS services consist of health education, nutritional and psycho-social counseling and OB-focused case management. In 1995, CalOptima was mandated by the State to provide PSS services. CalOptima in turn fully delegated this responsibility to its contracted health networks.

Last year, a review of health network 2006 data revealed areas of concern with marked variation in usage of PSS services. The variation resulted from a fragmented referral process, eligibility timing issues, and coordination of referrals between OB physician and PSS provider. The resultant recommendation post review was to consolidate the referral process at the CalOptima level.

Discussion

As part of CalOptima's transfer of PSS, the established health network contractual relationships were consolidated into a CalOptima preferred capitation contract with MOMS (Maternal Outreach Management System) and the assumption of network-specific fee-for-service contracts those independent OB physician providers. It was anticipated that this re-contracting effort would recapture funds sufficient to cover the costs of the program. However, upon close review there were additional costs associated with the consolidation. Three factors have contributed to the additional costs of the program: 1) contract costs; 2) preservation of alternatives; and, 3) incentives to increase early referral.

Back to Agenda

Contract Costs It was originally anticipated that CalOptima would have an exclusive contract with MOMS on a capitated basis for all PSS services provided to CalOptima members. Outlays under this contract were expected to be equivalent to the original outlays that had been expended by the health networks for PSS services. Effective January 1, 2008, CalOptima entered into a one-year capitated agreement with MOMs with two extension options of one year each. However, upon review it was realized that some coordination activities would need to continue to be performed by the health network and accordingly, a portion of the capitation would have to remain at the health network level to pay for those functions.

Preservation of Alternatives While it was the intent of the revised program to move PSS services into an entirely capitated program under CalOptima as of January 1, 2008, it became evident in the transition planning process that doing so would create potential issues of program access, as well as interference with existing physician-patient relationships for members who had a previous history of receiving PSS services from certain traditional PSS providers. As a result, the original plan was modified to preserve the option for members to see these traditional PSS providers on a fee-for-service basis outside of the capitation arrangement with MOMS to ensure access and preserve physician-patient relationships.

Incentives to Increase Early Referrals Finally, the goals of the program are to improve member access, increase participation rates, and improve coordination. There was recognition that the earliest possible referral to the program provides the chance of the best outcome. To ensure the fastest, most effective results, the decision was made to provide an incentive for early referral. This has proven to be a successful strategy. Results from the first three months of calendar 2008 show first trimester referrals increasing from 21% to 42%, and third trimester visits decreasing from 30% to 12% over prior year levels.

Fiscal Impact

The fiscal impact of decreased health network capitation of $.55 per-member per-month in appropriate aid codes along with increased costs related to contracting, preservation of alternatives, and providing incentives to increase early referrals results in a net increase in costs of a maximum of $117,000 above the budgeted amount for FY08-09, or a projected $234,000 on an annualized basis. Going forward, these additional expenditures will be included in the budget.

Rationale for Recommendation

The Perinatal Support Services benefit was moved from the health network level to the CalOptima level in response to the identification of the need for greater coordination of PSS services. The goal for this realignment of program responsibilities is to improve utilization of PSS services through improved coordination and outreach.

Back to Agenda

Concurrence
Procopio, Cory, Hargreaves and Savitch, LLP

Attachments
None

/s/ Richard Chambers — *05/01/2008*
Authorized Signature — **Date**

Back to Agenda

Attachment 3: **Capitation**: Qualifying Aid Categories for Payment.

The following Table illustrates the aid code categories for which MOMS will receive capitation and incentive payment as referenced in the Board Action. The table also defines the populations for which MOMS will not receive capitation. The revised basis for capitation payment to the MOMS organization will become effective the first of the month following the execution of an amendment to the existing contract. The effective date is expected to be April 1, 2017.

Aid Code Categories included in Capitation	**Groups excluded from Capitation**
Family & Adult	All Kaiser members regardless of aid code category
Aged/Medi-Cal Only	All COD members
Disabled/Medi-Cal Only	All Medi-Cal Expansion Members
~~Breast and Cervical Cancer Treatment Program (BCCTP)~~	

Fee-For-Service:

Payment for COD Members only: MOMS will continue to receive one hundred seventy five dollars ($175) for each assessment completed and forwarded to CalOptima. This payment methodology is currently in place and there is no change at this time.

[1] CA.GOV MO-07-0074 CPSP

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item
16. Consider Options for Development Rights at 505 City Parkway West, Orange, California Site

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

Recommended Action
Authorize the Chief Executive Officer (CEO) to issue a Request for Information (RFI) to solicit responses regarding potential interest and options for CalOptima's development rights with results to be presented to the Board at a future date.

Background
At its January 2011 meeting, the CalOptima Board of Directors authorized the purchase of land and an office building located at 505 City Parkway West, Orange, California, and the assumption of development rights associated with the parcel pursuant to a 2004 Development Agreement with the City of Orange. The development rights include the possible construction of an office tower of up to ten stories and 200,000 square feet of office space, and a parking structure of up to five-levels and 1,528 spaces. The potential second office tower and parking structure are referred to as the "605 Building Site." At the time of CalOptima's purchase of the land and building, the expiration date for the Development Agreement was October 28, 2014.

At its October 2, 2014 meeting, the Board authorized the CEO to enter into an Amended and Restated Development Agreement with the City of Orange to extend CalOptima's development rights for up to six additional years. The extension was approved by the City of Orange Planning Commission on September 15, 2014, and the Orange City Council on November 25, 2014. Assuming CalOptima makes required public benefit fee payments to the City of Orange, the expiration date for the current development agreement is October 28, 2020.

At its August 4, 2016 meeting, the Board authorized a contract with a real estate consultant to assist in evaluating options related to CalOptima's development rights, and approved a budget allocation of $22,602 from existing reserves to fund the contract through June 30, 2017.

At the December 1, 2016 meeting, the Board authorized a contract amendment with real estate consultant, Newport Real Estate Services (NRES), to include site plan development and expenditures from existing reserves of up to $7,000 to fund the contract amendment.

Discussion
At its February 16, 2017 meeting, the Board of Directors' Finance and Audit Committee (FAC) received presentations from CalOptima management and real estate consultant, NRES. The presentation included an update on CalOptima's staffing needs and space alternatives, a review of a site plan developed by NRES, options for exercising the development rights with pros and cons of

Back to Agenda

certain options, and a preliminary timeline. In addition, FAC members discussed the need to gather more information and to gauge potential interest on the following options: Direct Sale, Ground Lease, Joint Venture, and Property Trade.

An additional option is pursuing an extension of the current Development Agreement for an additional 3 years beyond 2020. This option would require approval by the City of Orange, and would likely require CalOptima to make additional public benefit fee payments. In the event the Board elects to pursue this option, and the City of Orange is agreeable to the extension, Staff will return to the Board to present applicable proposals.

Fiscal Impact
The recommended action to issue an RFI for development rights is budget neutral.

Rationale for Recommendation
The Development Agreement with the City of Orange provides CalOptima the opportunity to provide for future space needs in the event CalOptima requires additional office space. At the same time, the development rights are a valuable asset that can be severed from the existing parcel if CalOptima finds that CalOptima's construction of a separate office building and parking structure is not practical, feasible, or otherwise in the best interest of the organization. Management recommends that the Board authorize the CEO to issue an RFI to fully explore potential interest and options available with the existing development rights.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. CalOptima Board Action dated August 4, 2016, Consider Authorizing Contract with a Real Estate Consultant to Assist in the Evaluation of Options Related to CalOptima's Development Rights and Approve Budget Allocation
2. CalOptima Board Action dated December 1, 2016, Authorize Vendor Contract(s) and/or Contract Amendment(s) for Services Related to CalOptima's Development Rights at the 505 City Parkway Site and Funding to Develop a Site Plan
3. NRES PowerPoint Presentation to the Board of Directors' Finance and Audit Committee dated February 16, 2017: Long-Range Strategic Real Estate Plan – Excess Real Estate Development or Disposition Update

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

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 4, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item

35. Consider Authorizing Contract with a Real Estate Consultant to Assist in the Evaluation of Options Related to CalOptima's Development Rights and Approve Budget Allocation

Contact

Chet Uma, Chief Financial Officer, (714) 246-8400

Recommended Actions

1. Authorize the Chief Executive Officer (CEO) to enter into a contract with a real estate consultant to assist in providing market research, evaluating development feasibility and financial feasibility, and recommend options based on CalOptima's development rights in accordance with the Board-approved procurement process; and
2. Approve allocation of $22,602 from existing reserves to fund the contract with the selected real estate consultant through June 30, 2017.

Background

In January 2011, CalOptima purchased land and an office building located at 505 City Parkway West, Orange, California, and assumed development rights for the land parcel pursuant to a 2004 Development Agreement with the City of Orange. The development rights include the possible construction of an office tower up to ten stories and 200,000 square feet of office uses, and a maximum five-level, 1,528 space parking structure which was previously approved in 2001. The second office tower and parking structure are referred to as the 605 Building Site. The expiration date for the initial 10 year Development Agreement was October 28, 2014.

At the October 2, 2014, meeting, the CalOptima Board of Directors (Board) authorized the CEO, with the assistance of legal counsel, to enter into an Amended and Restated development agreement with the City of Orange to extend CalOptima's development rights for up to six years. The extension was approved by the City of Orange Planning Commission on September 15, 2014, and the Orange City Council on November 25, 2014. The Amended and Restated Development Agreement requires CalOptima to make public benefit fee payments to the City of Orange in order to extend the termination date by two year increments. The Board approved funding of $200,000 from existing reserves to make the public benefit fee payments. The following table provides additional information on the public benefit fees.

Payment Amount	Due Date	Agreement Extension Period
First Payment: $50,000	Within forty-five (45) days of mutual execution of the Agreement	Agreement remains in effect for a period of two (2) years from the original termination date
Second Payment: $50,000	No later than fifteen (15) days prior to the expiration of the Initial Term	Extends Agreement for an additional two (2) years from the expiration of the Initial Term

Back to Agenda

Payment Amount	Due Date	Agreement Extension Period
Final Payment: $100,000	No later than fifteen (15) days prior to the expiration of the First Automatic Renewal Term	Extends Agreement for an additional two (2) years from the expiration of the First Automatic Renewal Term

Assuming all payments are made on time, the end date for the Amended and Restated Development Agreement is October 28, 2020.

Discussion

CalOptima's Development Agreement represents a significant value to CalOptima. In order to understand the best strategic use of these rights, CalOptima requires assistance of a real estate consultant who has expertise and specializes in the area of development rights. The real estate consultant will perform market research, explore options for the development rights, evaluate development feasibility and financial feasibility, and provide recommendations to CalOptima. The proposed evaluation will take into consideration options of new leased space for CalOptima, costs, compliance with internal policies and procedures, requirements of Public Works projects, and possible public-private partnerships.

In light of forthcoming development projects around the 505 City Parkway West building and the number of years remaining under the current Development Agreement, Management believes it is prudent to obtain reliable information expeditiously in order to make a well-informed decision. The CalOptima Fiscal Year (FY) 2016-17 Operating Budget included $7,398 under Professional Fees for a real estate consultant. Management proposes to make an allocation of $22,602 from existing reserves to fund the remaining expenses related to the contract with the real estate consultant through June 30, 2017.

Fiscal Impact

The recommended action to authorize the CEO to contract with a real estate consultant to assist in evaluation of options related to CalOptima's development rights will not exceed $30,000 through June 30, 2017. An allocation of $22,602 from existing reserves will fund this action.

Rationale for Recommendation

The retention of a real estate consultant to evaluate options related to CalOptima's development rights will provide reliable information to the Board and Management to make informed decisions on long term space planning.

Concurrence

Gary Crockett, Chief Counsel

Back to Agenda

Attachment

Amended and Restated Development Agreement between the City of Orange and Orange County Health Authority dated December 10, 2014

/s/ Michael Schrader — *07/29/2016*

Authorized Signature — **Date**

Back to Agenda

Ag. 4545.0C

EXEMPT FROM RECORDER'S FEES
Pursuant to Government Code §§ 6103 and 27383

Recording requested by and when recorded return to:

City Clerk
City of Orange
300 East Chapman Avenue
Orange, California 92866

Recorded in Official Records, Orange County
Hugh Nguyen, Clerk-Recorder

NO FEE

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(SPACE ABOVE FOR RECORDER'S USE)

CONFORMED COPY

AMENDED AND RESTATED DEVELOPMENT AGREEMENT

Dated as of Dec. 10 **, 2014**

By and Between

City of Orange,
a municipal corporation

and

Orange County Health Authority,
a public agency doing business as CalOptima

Back to Agenda

TABLE OF CONTENTS

Back to Agenda

Ag. 4545.OC

EXEMPT FROM RECORDER'S FEES
Pursuant to Government Code §§ 6103 and 27383

Recording requested by and when recorded return to:

City Clerk
City of Orange
300 East Chapman Avenue
Orange, California 92866

(SPACE ABOVE FOR RECORDER'S USE)

AMENDED AND RESTATED DEVELOPMENT AGREEMENT

This Amended and Restated Development Agreement (the "**Agreement**") is made in Orange County, California as of Dec. 10, 2014, by and between the CITY OF ORANGE, a municipal corporation (the "**City**") and ORANGE COUNTY HEALTH AUTHORITY, a public agency doing business as CalOptima ("**Developer**"). Together, the City and the Developer shall be referred to as the "**Parties**".

1. **Recitals**. This Agreement is made with respect to the following facts and for the following purposes, each of which is acknowledged as true and correct by the Parties:

(a) The City is authorized, pursuant to Government Code §§65864 through 65869.5 (the "**Development Agreement Statutes**") and Chapter 17.44 (Development Agreements) of the Orange Municipal Code to enter into binding agreements with persons or entities having legal or equitable interests in real property for the development of such property in order to establish certainty in the development process.

(b) Developer is the owner of certain real property located in the City and consisting of the parcel commonly referred to the "**605 Building Site**" (legally described on **Exhibit "A"**).

(c) References in this Agreement to the "**Project**" shall mean the 605 Building Site hereinabove described and the development project proposed for such property.

(d) Developer seeks to enhance the vitality of the City by developing additional office and commercial related uses.

(e) Pursuant to Government Code §65867.5 and Orange Municipal Code Section 17.44.100, the City Council finds that: (i) this Agreement and any Future Approvals of the Project implement the goals and policies of the City's General Plan, provide balanced and diversified land uses and impose appropriate standards and requirements with respect to land development and usage in order to maintain the overall quality of life and the environment within the City; (ii) this Agreement is in the best interests of and not in detriment to the public health, safety and general welfare of the residents of the City and the surrounding region; (iii) this

Back to Agenda

Agreement is compatible with the uses authorized in the zoning district and planning area in which the Project site is located; (iv) adopting this Agreement is consistent with the City's General Plan and constitutes a present exercise of the City's police power; and (v) this Agreement is being entered into pursuant to and in compliance with the requirements of Government Code §65867.

(f) Substantial public benefits (as required by Section 17.44.200 of the Orange Municipal Code) will be provided by Developer and the Project to the entire community. These substantial public benefits include, but are not limited to, the following:

(1) By and through its existence, the Project is and, at the completion of the Project, will continue to be, an enormous benefit and resource to the community;

(2) The Project will provide an expanded economic base for the City by generating substantial property tax revenue;

(3) The Project will provide temporary construction employment and permanent office-based jobs for a substantial number of workers;

(4) The Project, consisting of the 605 Building Site, will contribute traffic impact mitigation fees to the City pursuant to the West Orange Circulation Study ("**WOCS Study**"), which will partially fund the completion of traffic and circulation infrastructure in the WOCS Study area that will be needed to accommodate demand from future growth; and

(5) The Project will provide for additional sales/use taxes to the City, as provided in Section 7 hereof.

In exchange for these substantial public benefits, City intends to give Developer assurance that Developer can proceed with the development of the Project for the term and pursuant to the terms and the conditions of this Agreement and in accordance with the Applicable Rules (as hereinafter defined).

(g) The Developer has applied for and the City has approved this Agreement in order to create a beneficial project and a physical environment that will conform to and compliment the goals of the City, create a development project sensitive to human needs and values, facilitate efficient traffic circulation, and develop the Project.

(h) This Agreement will bind the City to the terms and obligations specified in this Agreement and will limit, to the degree specified in this Agreement and under the laws of the State of California, the future exercise of the City's ability to delay, postpone, preclude or regulate development on the Project, except as provided for herein.

(i) In accordance with the Development Agreement Statutes, this Agreement eliminates uncertainty in the planning process and provides for the orderly improvement of the Project. Further, this Agreement provides for appropriate further development of the Project over and above the improvements which currently exist on the Project and generally serves the public interest within the City and the surrounding region.

(j) CA-THE CITY LIMITED PARTNERSHIP (the "**Original Developer**") first filed land use applications in 2001 to entitle four (4) separate development sites which together were to consist of one million one hundred fifty-seven thousand (1,157,000) square feet of office space and a one hundred thirty-seven (137) room hotel (collectively, the "**EOP Projects**"). Those land use applications included applications for a Conditional Use Permit(s) and Major Site Plan Review(s). In addition, the Original Developer filed for negotiations and approval of that certain Development Agreement, dated as of December 13, 2004, by and between the City of Orange and the Original Developer (the "**Original Development Agreement**"). The City processed the various applications and commissioned the preparation of the Final Environmental Impact Report (FEIR) 1612-01 for the Original Development Agreement and the 2001 land use applications (the "**Final EIR**"), which was certified in accordance with the California Environmental Quality Act ("**CEQA**"). On October 9, 2001, the City certified the Final EIR and approved the various applications for the entitlements for the EOP Projects including Resolution No. 9521 with respect to the 605 Building Site.

(1) The Final EIR evaluated the EOP Projects, all of which were located in the area within or adjacent to the former "**The Block at Orange**" which has been rebranded to "**The Outlets at Orange.**" A trip generation survey was conducted and the Final EIR determined that the EOP Projects, upon completion, would generate a total of thirteen thousand eight hundred seventy-six (13,876) average daily trips. The Final EIR designated separate average daily trip generation estimates for each of the EOP Projects based upon the estimated development square footage of each of the EOP Projects.

(2) As part of its approval of the EOP Projects, the City imposed various traffic mitigation conditions, including:

(A) a "fair share" allocation of the cost of certain traffic improvements identified in the WOCS Study (the "**WOCS Improvements**");

(B) the obligation to pay one hundred percent (100%) of the cost of specific traffic improvements at three (3) designated intersections; and

(C) a "fair share" of the cost of widening the Orangewood Avenue bridge over the Santa Ana River.

The traffic improvements described in (B) and (C) are herein referred as the "**Traffic Improvement Conditions**".

(3) The WOCS Study estimated the cost of the WOCS Improvements to be approximately Three Million Five Hundred Thousand Dollars ($3,500,000.00) and assigned "fair share" costs for such improvements to the following projects:

(A) UCI Medical Center Expansion – thirty-two percent (32%);

(B) EOP Projects – thirty-eight percent (38%); and

(C) The Outlets at Orange Expansion – thirty percent (30%).

(4) On March 9, 2004, the City adopted Resolution No. 9843 in which the City determined that the "fair share" of the EOP Projects for the WOCS Improvements and the Traffic Improvement Conditions would be as set forth in Exhibit "A" to Resolution No. 9843. A copy of Resolution No. 9843 is attached hereto as **Exhibit "B"**.

(k) In 2004, in response to the Original Developer's application for the Original Development Agreement, the City felt that it would be helpful to provide the public with information updating and amplifying some of the points raised in the Final EIR as they pertain to the EOP Projects. Accordingly, and as provided in Section 15164 of the State California Environmental Quality Act Guidelines (the **"CEQA Guidelines"**), the City prepared an Addendum to the Final EIR (the "**Addendum**"). On August 16, 2004, the Planning Commission held a duly noticed public hearing on the Original Developer's application for the Original Development Agreement and the Addendum, which were approved by Resolution No. PC 33-04 and recommended to the City Council of the City approval. On September 14, 2004, the City Council held a duly noticed public hearing on the Original Developer's application for the Original Development Agreement and the Addendum, and adopted Resolution No. 9909, making certain findings under CEQA and determined that the Addendum is all that is necessary in connection with the Original Development Agreement and the approval thereof. Thereafter, at its regular meeting of September 14, 2004, the City Council adopted its Ordinance No. 19-04 approving the Original Development Agreement.

(l) In January 2006, the City and the Original Developer amended the Original Development Agreement by entering into that certain First Amendment to Development Agreement dated as of January 20, 2006, the original of which was recorded in the Official Records as Instrument No. 2006000051175 on January 24, 2006 (herein referred as the "**First Amendment**").

(m) In October 2006, the City and the Original Developer further amended the Original Development Agreement by entering into that certain Second Amendment to Development Agreement dated as of October 5, 2006, the original of which was recorded in the Official Records as Instrument No. 2006000698031 on October 17, 2006 (herein referred as the "**Second Amendment**").

(n) In January 2007, the City and the Original Developer entered into that certain Operating Memorandum dated as of January 22, 2007 (hereinafter referred as "**First Operating Memorandum**") as it relates to the amendment to certain covenants, conditions and restrictions governing the expansion of the Block at Orange (the "**Block Expansion**").

(o) In 2007, the Original Developer and Maguire Properties-City Plaza, LLC and Maguire Properties-City Parkway, LLC entered into that certain Assignment and Assumption Agreement dated April 23, 2007, the original of which was recorded in the Official Records as Instrument No. 2007000271600 on April 26, 2007 (herein referred as the "**Maguire Agreement**"). The terms of the Maguire Agreement transferred and assigned the development rights related to City Plaza Two Site and 605 Building Site (as defined in the Original Development Agreement) from the Original Developer to Maguire Properties-City Plaza, LLC and Maguire-City Parkway, LLC, respectively.

(p) In August 2008, Maguire Properties-City Plaza, LLC and HFOP City Plaza, LLC ("**HFOP**") entered into that certain Partial Assignment and Assumption of Development Agreement dated August 26, 2008, the original of which was recorded in the Official Records as Instrument No. 2008000406579 on August 27, 2008 (herein referred as the "**HFOP Agreement**"). The terms of the HFOP Agreement transferred and assigned development rights related to City Plaza Two Site from Maguire Properties-City Plaza, LLC to HFOP.

(q) In May 2009, Maguire Properties-City Parkway, LLC and AB-City Parkway, LLC entered into that certain Partial Assignment and Assumption of Development Agreement dated May 27, 2009, the original of which was recorded in the Official Records as Instrument No. 2009000268530 on May 28, 2009 (herein referred as the "**AB Agreement**"). The terms of the AB Agreement transferred and assigned development rights related to 605 Building Site from Maguire Properties-City Parkway, LLC to AB-City Parkway, LLC.

(r) In January 2011, Developer and AB-City Parkway, LLC entered into that certain Partial Assignment and Assumption of Development Agreement dated January 7, 2011, the original of which was recorded in the Official Records as Instrument No.2011000013726 on January 7, 2011 (herein referred as the "**CalOptima Agreement**"). The terms of the CalOptima Agreement transferred and assigned development rights related to 605 Building Site from AB-City Parkway, LLC to Developer. The Original Development Agreement, as amended and assigned by the First Amendment, the Second Amendment, the First Operating Memorandum, the Maguire Agreement, the HFOP Agreement, the AB Agreement, and the CalOptima Agreement, is herein referred to as the "**Amended Development Agreement**".

(s) The Developer represents to the City that, as of the date hereof, it is the owner of the Project, subject to encumbrances, easements, covenants, conditions, restrictions, and other matters of record.

(t) The Parties acknowledge and agree that the term of the Amended Development Agreement expires on October 28, 2014 (the "**Original Termination Date**"). Developer has requested, and the City has agreed, to extend the term of the Amended Development Agreement, subject to the terms hereof.

(u) In order to effectuate the extension of the term of the Amended Development Agreement, the Parties hereby agree to amend and restate in its entirety the Amended Agreement as set forth below.

2. **Definitions**. In this Agreement, unless the context otherwise requires:

(a) "**Applicable Rules**" means the development standards and restrictions set forth in Section 5 of this Agreement which shall govern the use and development of the Project and shall amend and supersede any conflicting or inconsistent provisions of zoning ordinances, regulations or other City requirements relating to development of property within the City.

(b) "**Development Agreement Statutes**" means Government Code §§ 65864 to 65869.5.

(c) **"Discretionary Actions"** and **"Discretionary Approvals"** are actions which require the exercise of judgment or a discretionary decision, and which contemplate and authorize the imposition of revisions or additional conditions, by the City, including any board, commission, or department of the City and any officer or employee of the City; as opposed to actions which in the process of approving or disapproving a permit or other entitlement merely requires the City, including any board, commission, or department of the City and any officer or employee of the City, to determine whether there has been compliance with applicable statutes, ordinances, regulations, or conditions of approval.

(d) **"Effective Date"** is the date the ordinance approving the Original Development Agreement became effective, which was October 28, 2004.

(e) **"Future Approvals"** means any action in implementation of development of the Project which requires Discretionary Approvals pursuant to the Applicable Rules, including, without limitation, parcel maps, tentative subdivision maps, development plan and site plan reviews, and conditional use permits. Upon approval of any of the Future Approvals, as they may be amended from time to time, they shall become part of the Applicable Rules, and Developer shall have a "vested right", as that term is defined under California law, in and to such Future Approvals by virtue of this Agreement.

(f) Other terms not specifically defined in this Agreement shall have the same meaning as set forth in Chapter 17.44 (Development Agreements) of the Orange Municipal Code, as the same existed on the Effective Date.

3. **Binding Effect**. This Agreement, and all of the terms and conditions of this Agreement shall, to the extent permitted by law, constitute covenants which shall run with the land comprising the Project for the benefit thereof, and the benefits and burdens of this Agreement shall be binding upon and inure to the benefit of the Parties and their respective assigns, heirs, or other successors in interest.

4. **Negation of Agency**. The Parties acknowledge that, in entering into and performing under this Agreement, each is acting as an independent entity and not as an agent of the other in any respect. Nothing contained herein or in any document executed in connection herewith shall be construed as making the City and Developer joint venturers, partners, agents of the other, or employer/employee.

5. **Development Standards for the Project, Applicable Rules**. The development standards and restrictions set forth in this Section shall govern the use and development of the Project and shall constitute the Applicable Rules, except as otherwise provided herein, and shall amend and supersede any conflicting or inconsistent provisions of existing zoning ordinances, regulations or other City requirements relating to development of the Project and any subsequent changes to the Applicable Rules as specifically described in Section 5(c).

(a) The following ordinances and regulations shall be part of the Applicable Rules:

(1) The City's General Plan as it existed on the Effective Date;

Back to Agenda

(2) The City's Municipal Code relating to Development Agreements which is set forth in Chapter 17.44 of the Orange Municipal Code, as it existed on the Effective Date; and

(3) Such other ordinances, rules, regulations, and official policies governing permitted uses of the Project, density, design, improvement, and construction standards and specifications applicable to the development of the Project in force on the Effective Date, except as they may be in conflict with the provision of Subsection (a)(4) of this Section.

(4) The terms, provisions and conditions of the following with respect to each Project as hereinafter described:

(A) Conditional Use Permit No. 2379-01 and Major Site Plan Review No. 107-99 for the 605 Building Site; and

(B) The "fair share" of the Project for the WOCS Improvements and the Traffic Improvement Conditions as set forth in Resolution No. 9843.

(b) The City acknowledges that the Original Developer sold one (1) of the EOP Projects legally described on **Exhibit "C"** attached hereto and commonly referred to as the **"City Tower Two Site"** to a third party and, the City granted approvals to allow such third party to develop a residential project on the City Tower Two Site. The City further acknowledges that the average daily trips which would be generated by the proposed residential project may be substantially less than the average daily trips that would have been generated by the original project for the City Tower Two Site as identified in the Final EIR. The City hereby agrees and acknowledges that the traffic impacts identified in the Final EIR were studied on an area-wide basis and that the Final EIR adequately studied and determined the traffic impacts and relevant mitigation measures required for such traffic impacts. Accordingly, the City hereby agrees that the difference between the average daily trips allocated to the original City Tower Two Site and the average daily trips which are determined to be generated by the residential project (or other project) located on the City Tower Two Site and approved by the City (the **"Unused Trips"**) may be "transferred" to the Project during the term of this Agreement (it being the intention of the Parties that the Unused Trips shall be reserved for the benefit of Developer and the Project and, without the prior written consent of Developer, such Unused Trips shall not be applied to or reserved for the benefit of any other project that is subject to approval by the City).

(c) The Project shall not be required to pay any portion of the "fair share" of the WOCS Improvements and/or Traffic Improvement Conditions payable by or as a result of any project approved by the City on the City Tower Two Site.

(d) The "fair share" of the Project shall not be increased as a result of the failure by the City to recover (for whatever reason) the "fair share" contributions of the UCI Medical Center Expansion and/or The Block at Orange Expansion, nor shall the cost of the WOCS Improvements and the Traffic Improvement Conditions be deemed to be increased as a result of such failure.

(e) Notwithstanding the provisions of this Agreement, the City reserves the right to apply certain other laws, ordinances and regulations under the certain limited circumstances described below:

(1) This Agreement shall not prevent the City from applying new ordinances, rules, regulations and policies relating to uniform codes adopted by City or by the State of California, such as the Uniform Building Code, National Electrical Code, Uniform Mechanical Code or Uniform Fire Code, as amended, and the application of such uniform codes to the Project at the time of application for issuance of building permits for structures on the Project including such amendments to uniform codes as the City may adopt from time to time.

(2) In the event that State or Federal laws or regulations prevent or preclude compliance with one or more of the provisions of this Agreement, such provisions of this Agreement shall be modified or suspended as may be necessary to comply with such State or Federal laws or regulations; provided, however, that this Agreement shall remain in full force and effect to the extent it is not inconsistent with such laws or regulations and to the extent such laws or regulations do not render such remaining provisions impractical to enforce. Notwithstanding the foregoing, City shall not adopt or undertake any regulation, program or action or fail to take any action which is inconsistent or in conflict with this Agreement until, following meetings and discussions with the Developer, the City Council makes a finding, at or following a noticed public hearing, that such regulation, program actions or inaction is required (as opposed to permitted) to comply with such State and Federal laws or regulations after taking into consideration all reasonable alternatives.

(3) Notwithstanding anything to the contrary in this Agreement, City shall have the right to apply City ordinances and regulations (including amendments to Applicable Rules) adopted by the City after the Effective Date, in connection with any Future Approvals, or deny, or impose conditions of approval on, any Future Approvals in City's sole discretion if such application is required to prevent a condition dangerous to the physical health or safety of existing or future occupants of the Project, or any portion thereof or any lands adjacent thereto.

6. **Right to Develop**. Subject to the terms of this Agreement, and as of the Effective Date, Developer shall have a vested right to develop the Project in accordance with the Applicable Rules.

7. **Acknowledgments, Agreements and Assurances on the Part of the Developer**.

(a) **Developer's Faithful Performance**. The Parties acknowledge and agree that Developer's performance in developing the Project and in constructing and installing certain public improvements and complying with the Applicable Rules will fulfill substantial public needs. The City acknowledges and agrees that there is good and valuable consideration to the City resulting from Developer's assurances and faithful performance thereof and otherwise in this Agreement, and that same is in balance with the benefits conferred by the City on the Project. The Parties further acknowledge and agree that the exchanged consideration hereunder is fair, just and reasonable.

Back to Agenda

(b) **Obligations to be Non-Recourse**. As a material element of this Agreement, and as an inducement to Developer to enter into this Agreement, each of the Parties understands and agrees that the City's remedies for breach of the obligations of Developer under this Agreement shall be limited as described in this Agreement.

(c) **Developer's Commitment Regarding California Sales/Use Taxes**. To the extent permitted by law, Developer will require in its general contractor construction contract that Developer's general contractor and subcontractors exercise their option to obtain a Board of Equalization sales/use tax subpermit for the jobsite at the project site and allocate all eligible use tax payments to the City. Further, to the extent permitted by law, Developer will require in its general contractor construction contract that prior to beginning construction of the project, the general contractor and subcontractors will provide the City with either a copy of the subpermit, or a statement that sales/use tax does not apply to their portion of the job, or a statement that they do not have a resale license which is a precondition to obtaining a subpermit. Further, to the extent permitted by law, Developer will use its best efforts to require in its general contractor construction contract that (1) the general contractor or subcontractor shall provide a written certification that the person(s) responsible for filing the tax return understands the process of reporting the tax to the City and will do so in accordance with the City's conditions of project approval as contained in this Agreement; (2) the general contractor or subcontractor shall, on its quarterly sales/use tax return, identify the sales/use tax applicable to the construction site and use the appropriate Board of Equalization forms and schedules to ensure that the tax is allocated to the City of Orange; (3) in determining the amounts of sales/use tax to be paid, the general contractor or subcontractor shall follow the guidelines set forth in Section 1806 of Sales and Use Tax Regulations; (4) the general contractor or subcontractor shall submit an advance copy of his tax return(s) to the City for inspection and confirmation prior to submittal to the Board of Equalization; and (5) in the event it is later determined that certain eligible sales/use tax amounts were not included on general contractor's or subcontractor's sales/use tax return(s), general contractor and subcontractor agree to amend those returns and file them with the Board of Equalization in a manner that will ensure the City receives such additional sales/use tax as City may be eligible to receive from the project for which that particular contractor and its subcontractors were responsible.

During the term of this Agreement, to the extent permitted by law, Developer shall do one of the following: (1) Developer will review the Direct Payment Permit Process established under State Revenue and Taxation Code Section 7051.3 and, if eligible, acquire and use the permit so that the local share of its sales/use tax payments is allocated to the City; Developer will provide City with either a copy of the direct payment permit or a statement certifying ineligibility to qualify for the permit; Developer will further work with the City to inform all tenants about the Direct Payment Permit Process and encourage their participation, if qualified; or (2) Developer shall make use of its resale license issued by the Board of Equalization to exempt from sales/use taxes Developer's significant equipment purchases relating to the project site from vendors and to direct pay all sales/use tax to the Board of Equalization with the City of Orange as the point of sale for such purchases; in connection with the foregoing, Developer shall provide to the City the vendor names, a description of the equipment to be purchased, the purchase amounts for any out-of-state or out-of-country purchases exceeding $500,000, and a copy of the applicable quarterly sales/use tax reflecting payment of the sales/use tax so long as the confidentiality thereof is protected in a manner consistent with the restrictions imposed by Revenue and Taxation Code Section 7056.

City agrees to cause City's sales and use tax consultant, which is presently the HdL Companies, to reasonably cooperate with Developer, Developer's general contractor(s) and the general contractors' subcontractors to maximize City's receipt of sales/use tax hereunder.

(d) **Limitation on Parking.** Developer acknowledges and agrees that the total amount of parking to be constructed by Developer in connection with the Project shall not exceed the maximum authorized parking set forth in Conditional Use Permit No. 2379-01.

8. **Acknowledgments, Agreements and Assurances on the Part of the City**. In order to effectuate the provisions of this Agreement, and in consideration for the Developer to obligate itself to carry out the covenants and conditions set forth in the preceding Section of this Agreement, the City hereby agrees and assures Developer that Developer will be permitted to carry out and complete the development of the Project in accordance with the Applicable Rules, subject to the terms and conditions of this Agreement and the Applicable Rules. Therefore, the City hereby agrees and acknowledges that:

(a) **Entitlement to Develop**. The Developer is hereby granted the vested right to develop the Project to the extent and in the manner provided in this Agreement, subject to the Applicable Rules and the **Future Approvals.**

(b) **Conflicting Enactments**. Except as provided in Subsection (e) of Section 5 above, any change in the Applicable Rules, including, without limitation, any change in any applicable general area or specific plan, zoning, subdivision or building regulation, adopted or becoming effective after the Effective Date, including, without limitation, any such change by means of a Future Approval, an ordinance, initiative, resolution, policy, order or moratorium, initiated or instituted for any reason whatsoever and adopted by the Council, the Planning Commission or any other board, commission or department of City, or any officer or employee thereof, or by the electorate, as the case may be, which would, absent this Agreement, otherwise be applicable to the Project and which would conflict in any way with or be more restrictive than the Applicable Rules ("Subsequent Rules"), shall not be applied by City to any part of the Project. Developer may give City written notice of its election to have any Subsequent Rule applied to such portion of the Project as it may own, in which case such Subsequent Rule shall be deemed to be an Applicable Rule insofar as that portion of the Project is concerned.

(c) **Permitted Conditions**. Provided Developer's applications for any Future Approvals are consistent with this Agreement and the Applicable Rules, City shall grant the Future Approvals in accordance with the Applicable Rules and authorize development of the Project for the uses and to the density and regulations as described herein. City shall have the right to impose reasonable conditions in connection with Future Approvals and, in approving tentative subdivision maps, impose dedications for rights of way or easements for public access, utilities, water, sewers, and drainage necessary for the Project or other developments on the Project; provided, however, that such conditions and dedications shall not be inconsistent with the Applicable Rules in effect prior to imposition of the new requirement nor inconsistent with the development of the Project as contemplated by this Agreement; and provided further that such conditions and dedication shall not impose additional infrastructure or public improvement obligations in excess of those identified in this Agreement or normally imposed by the City. In connection with a Future Approval, Developer may protest any conditions, dedications or fees to the City Council or as

otherwise provided by City rules or regulations while continuing to develop the Project; such a protest by Developer shall not delay or stop the issuance of building permits or certificates of occupancy unless otherwise provided in the Applicable Rules.

(d) **Timing of Development**. Because the California Supreme Court held in *Pardee Construction Co. v. City of Camarillo*, 37 Ca1.3d 465 (1984) that failure of the parties to provide for the timing of development resulted in a later adopted initiative restricting the timing of development to prevail over the parties' Agreement, it is the intent of Developer and the City to cure that deficiency by acknowledging and providing that Developer shall have the right (without the obligation) to develop the Project in such order and at such rate and at such time as it deems appropriate within the exercise of its subjective business judgment, subject to the terms of this Agreement.

(e) **Moratorium**. No City-imposed moratorium or other limitation (whether relating to the rate, timing or sequencing of the development or construction of all or any part of the Project whether imposed by ordinance, initiative, resolution, policy, order or otherwise, and whether enacted by the Council, an agency of City, the electorate, or otherwise) affecting parcel or subdivision maps (whether tentative, vesting tentative or final), building permits, occupancy certificates or other entitlements to use or service (including, without limitation, water and sewer, should the City ever provide such services) approved, issued or granted within City, or portions of City, shall apply to the Project to the extent such moratorium or other limitation is in conflict with this Agreement and/or the Applicable Rules.

(f) **Permitted Fees and Exactions**. Certain development impact and processing fees have been imposed on the Project as conditions of the Existing Project Approvals (including, by way of example but not limited to, TSIP Fees, park facility fees, library facility fees, policy facility fees and fire facility fees), which impact and processing fees are in existence on the Effective Date ("**Development Project Fees**"). Development Project Fees applicable to the Project, together with any processing fees charged by the City for the City's administrative time and related costs incurred in preparing and considering any application for the Project, shall be assessed in the amount they exist at the time Developer becomes liable to pay such fees, provided that such fees shall not exceed the fees that are charged by the City generally to all other applicants similarly situated, on a non-discriminatory basis for similar approvals, permits, or entitlements granted by City. During the term of this Agreement, the City shall be precluded from applying any development impact fee that does not exist as of the Effective Date, except for an impact fee the City may adopt on a City-wide basis for administrative facility capital improvements. This provision does not authorize City to impose fees on the Project that could not be imposed in the absence of this Agreement. Except as otherwise provided in this Agreement, City shall only charge and impose those fees and exactions, including, without limitation, dedications and any other fees or taxes (including excise, construction or any other taxes) relating to development or the privilege of developing the Project as set forth in the Applicable Rules described in Section 5 of this Agreement; provided, however, that Section 5 shall not apply to the following fees and taxes and shall not be construed to limit the authority of City to:

(1) Impose or levy general or special taxes, including but not limited to, property taxes, sales taxes, parcel taxes, transient occupancy taxes, business taxes, which may be applied to the Project or to businesses occupying the Project; provided, however, that the tax is of

general applicability citywide and does not burden the Project disproportionately to other development within the City; or

(2) Collect such fees or exactions as are imposed and set by governmental entities not controlled by City but which are required to be collected by City.

(g) **Project Mitigation**. The Developer shall undertake and complete the mitigation requirements of the Existing Project Approvals. These requirements shall be satisfied within the time established therefor in the Existing Project Approvals.

9. **Cooperation and Implementation**. The City and Developer agree that they will cooperate with one another to the fullest extent reasonable and feasible to implement this Agreement. Upon satisfactory performance by Developer of all required preliminary conditions of approval, actions and payments, the City will commence and in a timely manner proceed to complete all steps necessary for the implementation of this Agreement and the development of the Project in accordance with the terms of this Agreement. Developer shall, in a timely manner, provide the City with all documents, plans, and other information necessary for the City to carry out its obligations. Additionally:

(a) **Further Assurances: Covenant to Sign Documents**. Each party shall take all actions and do all things, and execute, with acknowledgment or affidavit, if required, any and all documents and writings, including estoppel certificates, that may be necessary or proper to achieve the purposes and objectives of this Agreement.

(b) **Reimbursement and Apportionment**. Nothing in this Agreement precludes City and Developer from entering into any reimbursement agreements for reimbursement to the Developer of the portion (if any) of the cost of any dedications, public facilities and/or infrastructure that City, pursuant to this Agreement, may require as conditions of the Future Approvals agreed to by the Parties, to the extent that they are in excess of those reasonably necessary to mitigate the impacts of the Project or development on the Project.

(c) **Processing**. Upon satisfactory completion by Developer of all required preliminary actions and payments of appropriate processing fees, if any, City shall, subject to all legal requirements, promptly initiate, diligently process, and complete all required steps, and promptly act upon any approvals and permits necessary for the development by Developer in accordance with this Agreement, including, but not limited to, the following:

(1) the processing of applications for and issuing of all discretionary approvals requiring the exercise of judgment and deliberation by City, including without limitation, the Future Approvals;

(2) the holding of any required public hearings; and

(3) the processing of applications for and issuing of all ministerial approvals requiring the determination of conformance with the Applicable Rules, including, without limitation, site plans, grading plans, improvement plans, building plans and specifications, and ministerial issuance of one or more final maps, grading permits, improvement permits, wall permits, building permits, lot line adjustments, encroachment permits, temporary use permits,

Back to Agenda

certificates of use and occupancy and approvals and entitlements and related matters as necessary for the completion of the development of the Project ("**Ministerial Approvals**").

(d) **Processing During Third Party Litigation**. The filing of any third party lawsuit(s) against City and Developer relating to this Agreement or to other development issues affecting the Project shall not delay or stop the development, processing or construction of the Project, approval of the Future Approvals, or issuance of Ministerial Approvals, unless the third party obtains a court order preventing the activity. City shall not stipulate to or fail to oppose the issuance of any such order.

(e) **Defense of Agreement**. City agrees to and shall timely take all actions which are necessary or required to uphold the validity and enforceability of this Agreement and the Applicable Rules, subject to the indemnification provisions of this Section. Developer shall indemnify, protect and hold harmless, the City and any agency or instrumentality thereof, and/or any of its officers, employees, and agents from any and all claims, actions, or proceedings against the City, or any agency or instrumentality thereof, or any of its officers, employees and agents, to attack, set aside, void, annul, or seek monetary damages resulting from an approval of the City, or any agency or instrumentality thereof, advisory agency, appeal board or legislative body including actions approved by the voters of the City, concerning this Agreement. The City shall promptly notify the Developer of any claim, action, or proceeding brought forth within this time period. The Developer and City shall select joint legal counsel to conduct such defense and which legal counsel shall represent both the City and Developer in the defense of such action. The City in consultation with Developer shall estimate the cost of the defense of the action and Developer shall deposit said amount with the City. City may require additional deposits to cover anticipated costs. City shall refund, without interest, any unused portions of the deposit once the litigation is finally concluded. Should the City fail to either promptly notify or cooperate fully, Developer shall not thereafter be responsible to indemnify, defend, protect, or hold harmless the City, any agency or instrumentality thereof, or any of its officers, employees, or agents. Should the Developer fail to post the required deposit within five (5) working days from notice by City, City may terminate this Agreement pursuant to its terms. If City elects to terminate this Agreement pursuant to this Section, it shall do so by written notice to Developer, whereupon this Agreement shall terminate, expire and have no further force or effect as to the Project. Thereafter, the terminating party's indemnity and defense obligations pursuant to this Agreement shall have no further force or effect as to acts or omissions from and after the effective date of said termination.

10. **Compliance; Termination; Modifications and Amendments**.

(a) **Review of Compliance**. The City's Director of Community Development (or designee) shall review this Development Agreement once each year, on or before each anniversary of the Effective Date ("**Periodic Review**"), in accordance with this Section, and the Applicable Rules and the City's Municipal Code in order to determine whether or not Developer is out-of-compliance with any specific term or provision of this Agreement. At commencement of each Periodic Review, the Director shall notify Developer in writing that the Periodic Review will commence or has commenced.

(b) **Prima Facie Compliance**. Within thirty (30) days after receipt of the Director's notice that the Periodic Review will commence or has commenced (and unless

Developer requests and is granted a waiver by the City), Developer shall demonstrate that it has, during the preceding twelve (12) month period, been in reasonable prima facie compliance with this Agreement. For purposes of this Agreement, the phrase "reasonable prima facie compliance" shall mean that Developer has demonstrated that it has acted in accordance with this Agreement.

(c) **Notice of Non-Compliance, Cure Rights**. If during any Periodic Review, the Director reasonably concludes that (i) Developer has not demonstrated that it is in reasonable prima facie compliance with this Agreement, and (ii) Developer is out of compliance with a specific, substantive term or provision of this Agreement, then the Director may issue and deliver to Developer a written notice of non-compliance ("**Notice of Non-Compliance**") detailing the specific reasons for non-compliance (including references to sections and provisions of this Agreement and Applicable Rules which have allegedly been breached) and a complete statement of all facts demonstrating such non-compliance. Developer shall have thirty (30) calendar days following its receipt of the Notice of Non-compliance in which to cure said failure(s); provided, however, that if any one or more of the item(s) of non-compliance set forth in the Notice of Non-compliance cannot reasonably be cured within said thirty (30) calendar day period, then Developer shall not be in breach of this Agreement if it commences to cure said item(s) within said thirty (30) day period and diligently prosecutes said cure to completion. Upon completion of each Periodic Review, the Director shall submit a report to the City Council if the Director determines that Developer has not satisfactorily demonstrated reasonable prima facie compliance with this Agreement. The Director shall submit a report to the City Council stating what steps have been taken by the Director or what steps the Director recommends that the City subsequently take with reference to the alleged non-compliance. (If the Director determines that the Developer has demonstrated reasonable prima facie compliance with this Agreement, the Director will not be required to submit a report to the City Council.) Non-performance by either party shall be excused when it is delayed unavoidably and beyond the reasonable control of the Parties as a result of any of the events identified in Section 19 of this Agreement.

(d) **Termination of Development Agreement as to Breaching Party**. If Developer fails to timely cure any item(s) of non-compliance set forth in a Notice of Non-compliance, then the City shall have the right, but not the obligation, to initiate proceedings for the purpose of terminating this Agreement. Such proceedings shall be initiated by notice to the Developer, followed by meetings between the Developer and the City for the purpose of good faith negotiations between the Parties to resolve the dispute. If the City determines to terminate this Agreement following a reasonable number of meetings and a reasonable opportunity for the Developer to cure any non-performance, the City shall give Developer written notice of its intent to so terminate this Agreement, specifying the precise grounds for termination and setting a date, time and place for a public hearing on the issue, all in compliance with the Development Agreement Statutes. At the noticed public hearing, Developer and/or its designated representative shall be given an opportunity to make a full and public presentation to the City. If, following the taking of evidence and hearing of testimony at said public hearing, the City finds, based upon a preponderance of evidence, that the Developer has not demonstrated compliance with this Agreement, and that Developer is out of material compliance with a specific, substantive term or provision of this Agreement, then the City may (unless the Parties otherwise agree in writing) terminate this Agreement.

(e) **Notice and Opportunity to Cure if City Breaches**. If at any time Developer reasonably concludes that (1) City has not acted in prima facie compliance with this Agreement, and (ii) City is out of compliance with a specific, substantive term or provision of this Agreement, then Developer may issue and deliver to City written notice of City's non-compliance, detailing the specific reasons for non-compliance (including references to sections and provisions of this Agreement which have allegedly been breached) and a complete statement of all facts demonstrating such non-compliance. Developer shall also meet with the City as appropriate to discuss any alleged non-compliance on the part of the City. City shall have thirty (30) calendar days following its receipt of the Notice of Non-compliance in which to cure said failure(s); provided, however, that if any one or more of the item(s) of non-compliance set forth in the Notice of Non-compliance cannot reasonably be cured within said thirty (30) calendar day period, then City shall not be in breach of this Agreement if it commences to cure said item(s) within said thirty (30) day period and diligently prosecutes said cure to completion.

(f) **Modification or Amendment, of Development Agreement**. Subject to the notice and hearing requirements of the applicable Development Agreement Statutes, this Agreement may be modified or amended from time to time only with the written consent of Developer and the City or their successors and assigns in accordance with the provisions of the Municipal Code and Government Code §65868.

(g) **No Cross-Default**. Notwithstanding anything set forth in this Agreement to the contrary, in no event shall the breach of or default under this Agreement by Developer with respect to the Project constitute a breach of or default under this Agreement or any other agreement with respect to any other development project. In other words, the Project identified in this Agreement shall stand alone for purposes of its compliance with the terms, provisions and requirements of this Agreement and any other agreement between the City and Developer.

11. **Operating Memoranda**. The provisions of this Agreement require a close degree of cooperation between City and Developer. The anticipated refinements to the Project and other development activity at the Project may demonstrate that clarifications to this Agreement and the Applicable Rules are appropriate with respect to the details of performance of City and Developer. If and when, from time to time during the term of this Agreement, City and Developer agree that such clarifications are necessary or appropriate, they shall effectuate such clarifications through operating memoranda approved in writing by the City and Developer which, after execution, shall be attached hereto and become a part of this Agreement, and the same may be further clarified from time to time as necessary with future written approval by City and Developer. Operating memoranda are not intended to constitute an amendment to this Agreement but mere ministerial clarifications; therefore, no public notice or hearing shall be required. The City Attorney shall be authorized, upon consultation with and approval of Developer, to determine whether a requested clarification may be effectuated pursuant to this Section or whether the requested clarification is of such a character to constitute an amendment hereof which requires compliance with the provisions of Section 10(f) above. The authority to enter into such operating memoranda is hereby delegated to the City Manager and the City Manager is hereby authorized to execute any operating memoranda hereunder without further action by the City Council.

12. **Term of Agreement**. This Agreement shall become operative and shall commence upon the date the ordinance approving this Agreement becomes effective. Subject to payment by

Back to Agenda

Developer of the "**Public Benefit Fees**" that are applicable in the amounts and at the times identified on **Exhibit "D"** attached hereto, this Agreement shall remain in effect for a period of up to six (6) years from the Original Termination Date unless this Agreement is terminated, modified or extended upon mutual written consent of the Parties hereto or as otherwise provided in this Agreement. Unless otherwise agreed to by the City and Developer, Developer's failure to pay any portion of the Public Benefit Fees within the time period set forth on **Exhibit "D"** shall be deemed Developer's election not to extend the term of this Agreement. In no event shall the Public Benefit Fees be supplemented, raised or increased above the amounts identified on **Exhibit "D"**.

(a) **First Payment of Public Benefit Fees**. Within forty-five (45) days of mutual execution of this Agreement by the Developer and the City, Developer shall pay to the City the First Public Benefit Fee (as defined on **Exhibit "D"**). Upon payment by Developer to the City of the First Public Benefit Fee, this Agreement shall remain in effect for a period of two (2) years from the Original Termination Date (such two (2) year period being the "**Initial Term**").

(b) **Second Payment of Public Benefit Fees**. If Developer elects, in its sole and absolute discretion, to extend this Agreement beyond the Initial Term, then Developer shall pay to the City the Second Public Benefit Fee (as defined on **Exhibit "D"**) no later than the time set forth on **Exhibit "D"**. Upon payment by Developer to the City of the Second Public Benefit Fee, this Agreement shall be automatically extended for an additional two (2) years from the expiration of the Initial Term (such two (2) year period being the "**First Automatic Renewal Term**").

(c) **Final Payment of Public Benefit Fees**. If Developer elects, in its sole and absolute discretion, to further extend this Agreement beyond the First Automatic Renewal Term, then Developer shall pay to the City the Third Public Benefit Fee (as defined on **Exhibit "D"**) no later than the time set forth on **Exhibit "D"**. Upon payment by Developer to the City of the Third Public Benefit Fee, this Agreement shall be automatically extended for an additional two (2) years from the expiration of the First Automatic Renewal Term.

(d) Following expiration or termination of the term hereof, this Agreement shall be deemed terminated and of no further force and effect; provided, however, that no such expiration or termination shall automatically affect any right of the City and Developer arising from City approvals on the Project prior to expiration or termination of the term hereof or arising from the duties of the Parties as prescribed in this Agreement.

13. **Administration of Agreement and Resolution of Disputes**.

(a) **Administration of Disputes**. All disputes involving the enforcement, interpretation or administration of this Agreement (including, but not limited to, decisions by the City staff concerning this Agreement and any of the projects or other matters concerning this Agreement which are the subject hereof) shall first be subject to good faith negotiations between the Parties to resolve the dispute. In the event the dispute is not resolved by negotiations, the dispute shall then be heard and decided by the City Council. Thereafter, any decision of the City Council which remains in dispute shall be appealed to, heard by, and resolved pursuant to the Mandatory Alternative Dispute Resolution procedures set forth in Section 13(b) hereinbelow.

Unless the dispute is resolved sooner, City shall use diligent efforts to complete the foregoing City Council review within thirty (30) days following receipt of a written notice of default or dispute notice. Nothing in this Agreement shall prevent or delay Developer or City from seeking a temporary or preliminary injunction in state or federal court if it believes that injunctive relief is necessary on a more immediate basis.

(b) **Mandatory Alternative Dispute Resolution**. After the provisions of Section 13(a) above have been complied with, and pursuant to Code of Civil Procedure §638, *et seq*., all disputes regarding the enforcement, interpretation or administration of this Agreement (including, but not limited to, appeals from decisions of the City Council, all matters involving Code of Civil Procedure §1094.5, all Ministerial Approvals, Discretionary Approvals, Future Approvals and the application of Applicable Rules) shall be heard and resolved pursuant to the alternative dispute resolution procedure set forth in this Section 13(b). All matters to be heard and resolved pursuant to this Section 13(b) shall be heard and resolved by a single appointed referee who shall be a retired judge from either the California Superior Court, the California Court of Appeals, the California Supreme Court, the United States District Court or the United States Court of Appeals, provided that the appointed referee shall have significant and recent experience in resolving land use and real property disputes. The Parties to this Agreement who are involved in the dispute shall agree and appoint a single referee who shall then try all issues, whether of fact or law, and report in writing to the Parties to such dispute all findings of fact and issues and decisions of law and the final judgments made thereon, in sufficient detail to inform each party as to the basis of the referee's decision. The referee shall try all issues as if he/she were a California Superior Court judge, sitting without a jury, and shall (unless otherwise limited by any term or provision of this Agreement) have all legal and equitable powers granted a California Superior Court judge. Prior to the hearing, the Parties shall have full discovery rights as provided by the California Code of Civil Procedure. At the hearing, the Parties shall have the right to present evidence, examine and cross-examine lay and expert witnesses, submit briefs and have arguments of counsel heard, all in accordance with a briefing and hearing schedule reasonably established by the referee. The referee shall be required to follow and adhere to all laws, rules and regulations of the State of California in the hearing of testimony, admission of evidence, conduct of discovery, issuance of a judgment and fashioning of remedy, subject to such restriction on remedies as set forth in this Agreement. If the Parties involved in the dispute are unable to agree on a referee, any party to the dispute may seek to have a single referee appointed by a California Superior Court judge and the hearing shall be held in Orange County pursuant to California Code of Civil Procedure §640. The cost of any proceeding held pursuant to this Section 13(b) shall initially be borne equally by the Parties involved in the dispute, and each party shall bear its own attorneys' fees. Any referee selected pursuant to this Section shall be considered a temporary judge appointed pursuant to Article 6, Section 21 of the Constitution of the State of California. The cost of the referee shall be borne equally by each party. If any party to the dispute fails to timely pay its fees or costs, or fails to cooperate in the administration of the hearing and decision process as determined by the referee, the referee shall, upon the written request of any party to the dispute, be required to issue a written notice of breach to the defaulting party, and if the defaulting party fails to timely respond or cooperate with the period of time set forth in the notice of default (which in any event may not exceed thirty (30) calendar days), then the referee shall, upon the request of any non-defaulting party, render a default judgment against the defaulting party. At the end of the hearing, the referee shall issue a written judgment (which may include an award of reasonable attorneys' fees and costs as provided elsewhere in this Agreement), which judgment shall be final and binding between the

Parties and which may be entered as a final judgment in a California Superior Court. The referee shall use his/her best efforts to finally resolve the dispute and issue a final judgment within sixty (60) calendar days from the date of his/her appointment. Pursuant to Code of Civil Procedure Section 645, the decision of the referee may be excepted to and reviewed in like manner as if made by the Superior Court.

(1) Any party to the dispute may, in addition to any other rights or remedies provided by this Agreement, seek appropriate judicial ancillary remedies from a court of competent jurisdiction to enjoin any threatened or attempted violation hereof, or enforce by specific performance the obligations and rights of the Parties hereto, except as otherwise provided herein.

(2) The Parties hereto agree that (i) the City would not have entered into this Agreement if it were to be held liable for general, special or compensatory damages for any default under or with respect to this Agreement or the application thereof, and (ii) Developer has adequate remedies, other than general, special or compensatory damages, to secure City's compliance with its obligations under this Agreement. Therefore, the undersigned agree that neither the City nor its officers, employees or agents shall be liable for any general, special or compensatory damages to Developer or to any successor or assignee or transferee of Developer for the City's breach or default under or with respect to this Agreement; and Developer covenants not to sue the City, its officers, employees or agents for, or claim against the City, its officers, employees or agents, any right to receive general, special or compensatory damages for the City's default under this Agreement. Notwithstanding the provisions of this Section 13(b)(2), City agrees that Developer shall have the right to seek a refund or return of a deposit made with the City or fee paid to the City in accordance with the provisions of the Applicable Rules.

(c) In the event Developer challenges an ordinance or regulation of the City as being outside of the authority of the City pursuant to this Agreement, Developer shall bear the burden of proof in establishing that such ordinance, rule, regulation, or policy is inconsistent with the terms of this Agreement and applied in violation thereof.

14. **Transfers and Assignments**.

(a) **Right to Assign**. Developer shall have the right to encumber, sell, transfer or assign all or any portion of the Project which it may own to any person or entity (such person or entity, a "**Transferee**") at any time during the term of this Agreement without approval of the City, provided that Developer provides the City with written notice of the applicable transfer within thirty (30) days of the transfer, along with notice of the name and address of the assignee. Nothing set forth herein shall cause a lease or license of any portion of the Project to be deemed to constitute a transfer of the Project, or any portion thereof. This Agreement may be assigned or transferred by Developer as to and in conjunction with the sale or transfer of all or a portion of the Project, as permitted by this Section 14, provided that the Transferee has agreed in writing to be subject to all of the provisions of this Agreement applicable to the portion of the Project so transferred.

(b) **Liabilities Upon Transfer**. Upon the delegation of all duties and obligations and the sale, transfer or assignment of all or any portion of the Project to a Transferee,

Back to Agenda

Developer shall be released from its obligations under this Agreement with respect to the Project or portion thereof so transferred arising subsequent to the effective date of such transfer if (1) Developer has provided to City thirty (30) days' prior written notice of such transfer and (2) the Transferee has agreed in writing to be subject to all of the provisions hereof applicable to the portion of the Project so transferred. Upon any transfer of any portion of the Project and the express assumption of Developer's obligations under this Agreement by such Transferee, the Transferee becomes a party to this Agreement, and the City agrees to look solely to the Transferee for compliance by such Transferee with the provisions of this Agreement as such provisions relate to the portion of the Project acquired by such Transferee. Any such Transferee shall be entitled to the benefits of this Agreement and shall be subject to the obligations of this Agreement, applicable to the parcel(s) transferred. A default by any Transferee shall only affect that portion of the Project owned by such Transferee and shall not cancel or diminish in any way Developer's rights hereunder with respect to any portion of the Project not owned by such Transferee. The Transferee shall be responsible for the reporting and annual review requirements relating to the portion of the Project owned by such Transferee, and any amendment to this Agreement between City and a transferee shall only affect the portion of the Project owned by such transferee. In the event that Developer retains its obligations under this Agreement with respect to the portion of the Project transferred by Developer, the Transferee in such a transaction (a "**Non-Assuming Transferee**") shall be deemed to have no obligations under this Agreement, but shall continue to benefit from all rights provided by this Agreement for the duration of the term set forth in Section 12. Nothing in this section shall exempt any Non-Assuming Transferee from payment of applicable fees and assessments or compliance with applicable permit conditions of approval or mitigation measures.

15. **Mortgage Protection**. The Parties hereto agree that this Agreement shall not prevent or limit Developer, at Developer's sole discretion, from encumbering the Project or any portion thereof or any improvement thereon in any manner whatsoever by any mortgage, deed of trust, sale/leaseback, synthetic lease or other security device securing financing with respect to the Project. City acknowledges that the lender(s) providing such financing may require certain Agreement interpretations and modifications and agrees, upon request, from time to time, to meet with Developer and representatives of such lender(s) to negotiate in good faith any such request for interpretation or modification; provided, however, that no such interpretations or modifications shall diminish the public benefits received under this Agreement unless the City agrees to the acceptance of such diminished public benefits. City will not unreasonably withhold its consent to any such requested interpretation or modification, provided such interpretation or modification is consistent with the intent and purposes of this Agreement. Any mortgagee of a mortgage or a beneficiary of a deed of trust or landlord under a sale/leaseback, synthetic lease or lender providing secured financing in any manner ("**Mortgagee**") on the Project shall be entitled to the following rights and privileges:

(a) **Mortgage Not Rendered Invalid**. Neither entering into this Agreement nor a breach of this Agreement shall defeat, render invalid, diminish, or impair the lien of any mortgage, deed of trust or other financing documents on the Project made in good faith and for value.

(b) **Request for Notice to Mortgagee**. The Mortgagee of any mortgage, deed of trust or other financing documents encumbering the Project, or any part thereof, who has submitted a request in writing to City in the manner specified herein for giving notices shall be

entitled to receive written notification from City of any default by Developer in the performance of Developer's obligations under this Agreement.

(c) **Mortgagee's Time to Cure**. If City timely receives a request from a Mortgagee requesting a copy of any notice of default given to Developer under the terms of this Agreement, City shall provide a copy of that notice to the Mortgagee within ten (10) days of sending the notice of default to Developer. The Mortgagee shall have the right, but not the obligation, to cure the default during the remaining cure period allowed Developer under this Agreement, as well as any reasonable additional time necessary to cure, including reasonable time for reacquisition of the Project or the applicable portion thereof.

(d) **Project Taken Subject to Obligations**. Any Mortgagee who comes into possession of the Project or any portion thereof, pursuant to foreclosure of the mortgage, deed of trust, or other financing documents, or deed in lieu of foreclosure, shall take the Project or portion thereof subject to the terms of this Agreement; provided, however, that in no event shall such Mortgagee be held liable for any default or monetary obligation of Developer arising prior to acquisition of title to the Project by such Mortgagee, except that no such Mortgagee (nor its successors or assigns) shall be entitled to a building permit or occupancy certificate until all delinquent and current fees and other monetary obligations due under this Agreement for the Project or portion thereof acquired by such Mortgagee have been paid to City.

16. **Notices**. All notices under this Agreement shall be in writing and shall be deemed delivered when personally received by the addressee, or within three (3) calendar days after deposit in the United States mail by registered or certified mail, postage prepaid, return receipt requested, to the following Parties and their counsel at the addresses indicated below; provided, however, if any party to this Agreement delivers a notice or causes a notice to be delivered to any other party to this Agreement, a duplicate of that Notice shall be concurrently delivered to each other party and their respective counsel.

If to City:	City of Orange 300 East Chapman Avenue Orange, CA 92866 Attention: City Manager Facsimile: (714) 744-5147
With a copy to:	Wayne Winthers, Esq. City Attorney City of Orange 300 East Chapman Avenue Orange, California 92866 Facsimile: (714) 538-7157
If to Developer:	ORANGE COUNTY HEALTH AUTHORITY, a public agency doing business as CalOptima 505 City Parkway West Orange, California 92868 Attention: Mr. Mike Ruane

Back to Agenda

Facsimile: (714) 571-2416

Notice given in any other manner shall be effective when received by the addressee. The addresses for notices may be changed by notice given in accordance with this provision.

17. **Severability and Termination**. If any provision of this Agreement is determined by a court of competent jurisdiction to be invalid or unenforceable, or if any provision of this Agreement is superseded or rendered unenforceable according to any law which becomes effective after the Effective Date, the remainder of this Agreement shall be effective to the extent the remaining provisions are not rendered impractical to perform, taking into consideration the purposes of this Agreement.

18. **Time of Essence**. Time is of the essence for each provision of this Agreement of which time is an element.

19. **Force Majeure**. Changed conditions, changes in local, state or federal laws or regulations, floods, earthquakes, delays due to strikes or other labor problems, moratoria enacted by City or by any other governmental entity or agency (subject to Sections 5 and 8 of this Agreement), third-party litigation, injunctions issued by any court of competent jurisdiction, initiatives or referenda, the inability to obtain materials, civil commotion, fire, acts of God, or other circumstances which substantially interfere with the development or construction of the Project, or which substantially interfere with the ability of any of the Parties to perform its obligations under this Agreement, shall collectively be referred to as "**Events of Force Majeure**". If any party to this Agreement is prevented from performing its obligation under this Agreement by any Event of Force Majeure, then, on the condition that the party claiming the benefit of any Event of Force Majeure, (a) did not cause any such Event of Force Majeure and (b) such Event of Force Majeure was beyond said party's reasonable control, the time for performance by said party of its obligations under this Agreement shall be extended by a number of days equal to the number of days that said Event of Force Majeure continued in effect, or by the number of days it takes to repair or restore the damage caused by any such Event to the condition which existed prior to the occurrence of such Event, whichever is longer. In addition, the termination date of this Agreement as set forth in Section 12 of this Agreement shall be extended by the number of days equal to the number of days that any Events of Force Majeure were in effect.

20. **Sole Obligation of Health Authority**. As required by County of Orange Ordinance No. 3896 and amendments thereto, any obligation of the Orange County Health Authority created by this Development Agreement shall not be an obligation of the County of Orange.

21. **Waiver**. No waiver of any provision of this Agreement shall be effective unless in writing and signed by a duly authorized representative of the party against whom enforcement of a waiver is sought.

22. **No Third Party Beneficiaries**. This Agreement is made and entered into for the sole protection and benefit of the Developer and the City and their successors and assigns. Notwithstanding anything contained in this Agreement to the contrary, no other person shall have any right of action based upon any provision of this Agreement.

23. **Attorneys' Fees**. In the event any dispute hereunder is resolved pursuant to the terms of Section 13 (b) hereof, or if any party commences any action for the interpretation, enforcement, termination, cancellation or rescission of this Agreement, or for specific performance for the breach hereof, the prevailing party shall be entitled to its reasonable attorneys' fees, litigation expenses and costs arising from the action. Attorneys' fees under this Section shall include attorneys' fees on any appeal as well as any attorneys' fees incurred in any post judgment proceedings to collect or enforce the judgment.

24. **Incorporation of Exhibits**. The following exhibits which are part of this Agreement are attached hereto and each of which is incorporated herein by this reference as though set forth in full:

(a) Exhibit "A" — Legal Description of the 605 Building Site;

(b) Exhibit "B" — Copy of Resolution No. 9843 of the City Council of the City of Orange;

(c) Exhibit "C" – Legal Description of the City Tower Two Site; and

(d) Exhibit "D" — Public Benefit Fees.

25. **Copies of Applicable Rules**. Prior to the Effective Date, the City and Original Developer prepared two (2) sets of the Applicable Rules, one each for City and Original Developer, so that if it became necessary in the future to refer to any of the Applicable Rules, there would be a common set available to the Parties. The City agrees to deliver to Developer a copy of the Applicable Rules upon request.

26. **Authority to Execute, Binding Effect**. Developer represents and warrants to the City that it has the power and authority to execute this Agreement and, once executed, this Agreement shall be final, valid, binding and enforceable against Developer in accordance with its terms. The City represents and warrants to Developer that (a) all public notices and public hearings have been held in accordance with law and all required actions for the adoption of this Agreement have been completed in accordance with applicable law; (b) this Agreement, once executed by the City, shall be final, valid, binding and enforceable on the City in accordance with its terms; and (c) this Agreement may not be amended, modified, changed or terminated in the future by the City except in accordance with the terms and conditions set forth herein.

27. **Entire Agreement; Conflicts**. This Agreement represents the entire of the Parties. This Agreement integrates all of the terms and conditions mentioned herein or incidental hereto, and supersedes all negotiations or previous s between the Parties or their predecessors in interest with respect to all or any part of the subject matter hereof. Should any or all of the provisions of this Agreement be found to be in conflict with any other provision or provisions found in the Applicable Rules, then the provisions of this Agreement shall prevail.

28. **Remedies**. Upon either party's breach hereunder, the non-breaching party shall be permitted to pursue any remedy provided for hereunder.

[SIGNATURES BEGIN ON FOLLOWING PAGE]

Back to Agenda

IN WITNESS WHEREOF, the Parties have each executed this Agreement on the date first written above.

CITY OF ORANGE:

Teresa E. Smith, Mayor

ATTEST:

chief clerk for

Mary E. Murphy, City Clerk

APPROVED AS TO FORM:

By:

Wayne W. Winthers, City Attorney

Back to Agenda

DEVELOPER:

ORANGE COUNTY HEALTH AUTHORITY,
a public agency doing business as CalOptima
By: ORANGE COUNTY HEALTH AUTHORITY,
a public agency doing business as CalOptima
_____
Print Name: Michael Schrader
its Chief Executive Officer

By: ORANGE COUNTY HEALTH AUTHORITY,
a public agency doing business as CalOptima
_____
Print Name: _____
its _____

Back to Agenda

ACKNOWLEDGMENTS

STATE OF CALIFORNIA)
) ss.
COUNTY OF ORANGE)

On Dec. 9 2014, before me, Suzanne M. Turf, Notary Public, personally appeared Michael Schrader, who proved to me on the basis of satisfactory evidence to be the person~~(s)~~ whose name~~(s)~~ is subscribed to the within instrument and acknowledged to me that ~~he/she/they~~ executed the same in ~~his/her/their~~ authorized capacity~~(ies)~~, and that by ~~his/her/their~~ signature on the instrument, the person~~(s),~~ or the entity upon behalf of which the person acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

SUZANNE M. TURF
Commission # 1921663
Notary Public - California
Orange County
My Comm. Expires Jan 14, 2015

(SEAL)

Suzanne M. Turf
Notary Public in and for said State

STATE OF CALIFORNIA)
) ss.
COUNTY OF ORANGE)

On Dec. 10, 2014, before me, Michele E. Day, personally appeared Teresa E. Smith, who proved to me on the basis of satisfactory evidence) to be the person~~(s)~~ whose name~~(s)~~ is subscribed to the within instrument and acknowledged to me that ~~he~~/she/~~they~~ executed the same in ~~his~~/her/~~their~~ authorized capacity~~(ies)~~, and that by ~~his~~/her/~~their~~ signature on the instrument, the person~~(s)~~, or the entity upon behalf of which the person acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

MICHELE E. DAY
COMM. # 1936993
NOTARY PUBLIC - CALIFORNIA
ORANGE COUNTY
My Comm. Expires June 14, 2015

(SEAL)

Michele E. Day
Notary Public in and for said State

Back to Agenda

EXHIBIT "A"

LEGAL DESCRIPTION
605 BUILDING TWO

That certain real property located in the City of Orange, County of Orange, State of California, described as follows:

PARCEL A:

PARCEL 2 OF THE LOT LINE ADJUSTMENT NO. LL94-1, IN THE CITY OF ORANGE, COUNTY OF ORANGE, STATE OF CALIFORNIA, RECORDED APRIL 12, 1996 AS INSTRUMENT NO. 96-180461, OFFICIAL RECORDS.

EXCEPT FROM THAT PORTION THEREOF INCLUDED WITHIN THE NORTHWEST QUARTER OF THE SOUTHEAST QUARTER OF FRACTIONAL SECTION 35, TOWNSHIP 4 SOUTH, RANGE 10 WEST, IN THE RANCHO LAS BOLSAS, IN THE CITY OF ORANGE, COUNTY OF ORANGE, STATE OF CALIFORNIA, AS PER MAP RECORDED IN BOOK 51, PAGE 10 OF MISCELLANEOUS MAPS, IN THE OFFICE OF THE COUNTY RECORDER OF SAID COUNTY, ALL OIL AND OTHER MINERAL RIGHTS IN OR UNDER SAID LAND, LYING BELOW A DEPTH OF 500 FEET FROM THE SURFACE THEREOF, BUT WITHOUT THE RIGHT OF ENTRY, AS RESERVED IN THE DEED FROM CHESTER M. BARNES AND OTHERS, RECORDED OCTOBER 2, 1999 IN BOOK 4911, PAGE 214, OFFICIAL RECORDS.

ALSO EXCEPT THEREFROM ALL SUBSURFACE WATER AND SUBSURFACE WATER RIGHTS IN AND UNDER SAID LAND.

PARCEL B:

A NONEXCLUSIVE EASEMENT FOR UTILITY FACILITIES FOR THE BENEFIT OF PARCEL A, IN, ON, OVER, TO, UNDER, THROUGH, UPON AND ACROSS THE REAL PROPERTY DESCRIBED IN THAT CERTAIN DECLARATION OF UTILITY LINE EASEMENT, DATED JULY 11, 1996, AND RECORDED JULY 11, 1996 AS INSTRUMENT NO. 19960354693 OF OFFICIAL RECORDS, AS SET FORTH IN SAID DECLARATION.

Back to Agenda

EXHIBIT "B"

COPY OF RESOLUTION NO. 9843

OF THE CITY COUNCIL OF THE CITY OF ORANGE

Back to Agenda

RESOLUTION NO. 9843

A RESOLUTION OF THE CITY COUNCIL OF THE CITY OF ORANGE AMENDING CONDITIONAL USE PERMIT 2378-01, 2379-01 AND 2380-01; MAJOR SITE PLAN REVIEW NOS. 106-99, 107-99 AND 108-99.

WHEREAS, on October 10, 2001, the City Council adopted resolutions approving the following conditional use permits, major site plan reviews:

1. The Chapman Site consisting of 132,000 square feet of office space and a 137-room hotel (Resolution No. 9519);
2. City Tower Two Site consisting of 465,000 square feet of office space and eight-level parking structure (Resolution No. 9520);
3. 605 Building Site consisting of 200,000 square feet of office space and a five-level parking structure (Resolution No. 9521);
4. City Plaza Two Site consisting of 136,000 square feet of office building and a six-level parking structure (Resolution No. 9522); and

WHEREAS, the foregoing four projects are hereafter referred to as the EOP Projects; and

WHEREAS, the City Council considered and approved Final Environmental Impact Report No. 1612-01 (hereafter, the FEIR) which analyzed the environmental impacts of the EOP Projects; and

WHEREAS, the City commissioned the West Orange Circulation Study (hereafter, WOC Study) to analyze the traffic impacts of the EOP Projects, expansion of The Block at Orange and expansion of UCI Medical Center; and

WHEREAS, the WOC Study identified approximately $3.5 million in traffic improvements and assigned fair share costs of such improvements to the following projects: (1) UCI Medical Center expansion, 32%; (2) EOP Projects 38% (identified in the WOC Study as Spieker Office Properties); and (3) The Block at Orange expansion, 30%; and

WHEREAS, as a result of the WOC Study the FEIR, as well as Resolution Nos. 9519-9522 require the EOP Projects as a mitigation measure to pay 38% of the cost of the traffic improvements identified in the WOC Study as its fair share contribution (hereafter WOC Traffic Improvements); and

WHEREAS, Resolutions Nos. 9519-9522 also require the EOP Projects to fully fund three improvements identified in conditions nos. 32, 34 and 35 of such resolutions and pursuant to condition no. 33, to pay a fair share of the cost of a bridge

Back to Agenda

widening on Orangewood Avenue near its intersection with State Route 57 (hereafter conditions 32-35 are referred to as, Traffic Improvement Conditions); and

WHEREAS, on January 19, 2004, the Planning Commission adopted Resolution No. PC 04-04 approving a new development on the Chapman Site which includes, but is not limited to, 58,260 square feet of commercial space and a fast food restaurant (hereafter, Best Buy Project) which would replace the Chapman Site component (City Council Resolution 9519) of the EOP Projects; and

WHEREAS, CA-The City (Chapman) Limited Partnership is in escrow to sell the Chapman Site to City Town Center, L.P., for development of the Best Buy Project; and

WHEREAS, EOP-The City, L.L.C., has requested that the City proportionally reduce the fair share cost of the WOC Traffic Improvements and Traffic Improvement Conditions to reflect the fact that the Chapman Site is no longer a component of the EOP Projects; and

WHEREAS, City staff has determined that such a reduction is appropriate and will fairly reflect the traffic impacts caused by the EOP Projects, exclusive of the Chapman Site (hereafter, the Remaining EOP Projects).

NOW, THEREFORE, BE IT RESOLVED THAT THE CITY COUNCIL OF THE CITY OF ORANGE FINDS AND DETERMINES as follows:

1. The Remaining EOP Projects shall not bear the costs of the Chapman Site's fair share of the WOC Traffic Improvements, as originally identified in the FEIR and the WOC Study. The fair shares of the EOP Projects for the WOC Traffic Improvements, as identified in the FEIR and WOC Study are reflected in the attached **ExhibitA.**

2. The Remaining EOP Projects shall not bear the costs of the Chapman Site's fair share of the Traffic Improvement Conditions as identified in the FEIR. The fair shares of the EOP Projects for the Traffic Improvement Conditions, as identified in the FEIR are reflected in the attached Exhibit A.

3. This Resolution shall only become effective upon City Town Center, L.P., becoming the owner of the Chapman Site.

ADOPTED this 9th day of March, 2004.

ORIGINAL SIGNED BY
MARK A. MURPHY

Mark A. Murphy, Mayor, City of Orange

ATTEST:

ORIGINAL SIGNED BY
MARY E. MURPHY

Mary E. Murphy, City Clerk, City of Orange

I, MARY E. MURPHY, City Clerk of the City of Orange, California, do hereby certify that the foregoing Resolution was duly and regularly adopted by the City Council of the City of Orange at a regular meeting thereof held on the 9th day of March, 2004, by the following vote:

AYES:	COUNCILMEMBERS:	Ambriz, Alvarez, Murphy, Coontz
NOES:	COUNCILMEMBERS:	None
ABSENT:	COUNCILMEMBERS:	Cavecche
ABSTAIN:	COUNCILMEMBERS:	None

ORIGINAL SIGNED BY
MARY E. MURPHY

Mary E. Murphy, City Clerk, City of Orange

EXHIBIT "A"

	Intersection Identified in the WOC Study[1]	Chapman Site[2]	City Tower Two	City Plaza 2 Share	605 Bldg. Share	EOP Total
1	State College & Katella	0%	1%	1%	0%	2%
3	SR-57 NB Ramps & Katella	0%	1%	1%	0%	2%
4	State College & Gene Autry Way	0%	0%	0%	0%	0%
5	State College & Orangewood	0%	2%	1%	1%	4%
6	SR-57 SB Ramps & Orangewood	1%	3%	2%	1%	7%
→ 10	Haster & Chapman	6%	10%	8%	5%	29%
→ 11	Lewis & Chapman	15%	22%	24%	14%	75%
→ 13	The City & Chapman	8%	19%	4%	2%	33%
14	I-5 SB Ramp on-Ramp & Chapman	5%	16%	2%	1%	
→ 19	The City Dr. & The City Way	2%	10%	2%	1%	15%
→ 23	Haster & Lampson	4%	7%	14%	8%	33%
27	The City Dr. & SR-22 EB Ramps	1%	9%	4%	2%	
→ 29	Haster & Garden Grove Blvd.	1%	2%	2%	1%	6%
→ 30	Fairview & Garden Grove Blvd.	1%	3%	6%	3%	13%
→ 31	Lewis & Garden Grove Blvd.	1%	3%	15%	9%	28%
→ 32	The City Dr. & Garden Grove Blvd.	1%	7%	5%	3%	16%
34	Howell & Katella	2%	0%	0%	0%	2%

Traffic Improvement Conditions[3]	Intersection	Chapman Site	City Tower	City Plaza	605	EOP Total
32	The City Drive/Garden Grove	10%	90%			100%
33	SR-57/Orangewood Ave.(Bridge Widening)	14%	47%	25%	14%	100%
34	Haster St/Chapman Ave.	21%	36%	27%	16%	100%
35	Lewis St/Garden Grove Blvd.	5%	13%	52%	30%	100%

→ = [1] The shaded intersections are identified in the FEIR and WOC Study and are the only intersections requiring traffic improvements and a fair share contribution.

[2] Referred to as the "North Parcel" in the FEIR tables.

[3] Conditions are those referenced in City Council Resolutions 9519-9522.

EXHIBIT "C"

LEGAL DESCRIPTION
CITY TOWER TWO SITE

Parcel 2 of Parcel Map No. 81-769 recorded in Book 172, Pages 40-42 of Parcel Maps, in the Office of the County Recorder of Orange County, California.

EXHIBIT "D"

PUBLIC BENEFIT FEES

In the event that Developer elects, in accordance with the terms and upon the conditions set forth in Section "**12. Term of Agreement**" of this Agreement, to extend the term of this Agreement, then Developer shall pay the following Public Benefit Fees in the amounts and at the times hereinafter described:

1. Within forty-five (45) days of the mutual execution of this Agreement by Developer and the City, Developer shall pay to the City the sum of $50,000 (such amount being the "**First Public Benefit Fee**").

2. If Developer elects, in its sole and absolute discretion, to extend the term of this Agreement beyond the Initial Term, then Developer shall pay to the City the sum of $50,000 (such amount being the "**Second Public Benefit Fee**") no later than fifteen (15) days prior to the expiration of the Initial Term.

3. If Developer elects, in its sole and absolute discretion, to extend the term of this Agreement beyond the First Automatic Renewal Term, then Developer shall pay to the City the sum of $100,000 (such amount being the "**Third Public Benefit Fee**") no later than fifteen (15) days prior to the expiration of the First Automatic Renewal Term.

For the avoidance of doubt, Developer's election to extend the term of this Agreement shall be in Developer's sole and absolute discretion, and the City's sole remedy for Developer's failure to pay any portion of the Public Benefit Fee within the term periods set forth above shall be to terminate this Agreement.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

10. Authorize Vendor Contract(s) and/or Contract Amendment(s) for Services Related to CalOptima's Development Rights at the 505 City Parkway Site and Funding to Develop a Site Plan

Contact

Chet Uma, Chief Financial Officer, (714) 246-8400

Recommended Actions

1. Authorize the amendment of CalOptima's contract with real estate consultant Newport Real Estate Services to include site plan development; and
2. Appropriate expenditures from existing reserves of up to $7,000 to provide funding for this contract amendment.

Background

At its January 2011 meeting, the CalOptima Board of Directors authorized the purchase of land and an office building located at 505 City Parkway West, Orange, California, and the assumption of development rights associated with the parcel pursuant to a 2004 Development Agreement with the City of Orange. The development rights include the possible construction of an office tower of up to ten stories and 200,000 square feet of office space, and a parking structure of up to five-levels and 1,528 spaces. The potential second office tower and parking structure are referred to as the 605 Building Site. At the time of CalOptima's purchase of the land and building, the expiration date for the Development Agreement was October 28, 2014.

At its October 2, 2014 meeting, the CalOptima Board of Directors authorized the CEO to enter into an Amended and Restated development agreement with the City of Orange to extend CalOptima's development rights for up to six years. The extension was approved by the City of Orange Planning Commission on September 15, 2014, and the Orange City Council on November 25, 2014. Assuming CalOptima makes required public benefit fee payments to the City of Orange, the expiration date for the current development agreement is October 28, 2020.

At the August 4, 2016 meeting, the Board authorized a contract with a real estate consultant to assist in evaluating options related to CalOptima's development rights, and approved a budget allocation of $22,602 from existing reserves to fund the contract through June 30, 2017.

Discussion

Site Plan Development

Pursuant to the Board action on August, 4, 2016, CalOptima contracted with real estate consultant, Newport Real Estate Services, to provide market research, evaluate development feasibility and financial feasibility, and recommend options based on CalOptima's development rights. To move forward in exploring options related to the development rights, the consultant has recommended the

Back to Agenda

development of a site plan to further inform the Board of potential opportunities. The projected cost to develop a site plan is $7,000.

Update from the Finance and Audit Committee (FAC)
At the November 17, 2016, meeting, the FAC received presentations from Management and real estate consultant, Newport Real Estate Services. Committee members requested Staff return to the FAC with additional information on the development rights at the next FAC meeting on February 16, 2017. Tentatively, Staff anticipates the FAC's recommendation will be put forward for the full Board's consideration at the March 2, 2017, meeting.

Fiscal Impact
The recommended action to fund the contract with a real estate consultant to develop a site plan is an unbudgeted item. An allocation of $7,000 from existing reserves will fund this action.

Rationale for Recommendation
Management anticipates that CalOptima's space needs will continue to grow in the near term. To accommodate this growth, management recommends that the Board authorize the CEO to fully explore options available with the existing development rights and to ensure that CalOptima's space needs are adequately met in the future.

Concurrence
Gary Crockett, Chief Counsel

Attachment
CalOptima Board Action dated August 4, 2016, Consider Authorizing Contract with a Real Estate Consultant to Assist in the Evaluation of Options Related to CalOptima's Development Rights and Approve Budget Allocation

/s/ Michael Schrader — *11/22/2016*
Authorized Signature — **Date**

Back to Agenda

LONG-RANGE STRATEGIC REAL ESTATE PLAN – EXCESS REAL ESTATE: DEVELOPMENT OR DISPOSITION - UPDATE

- FINANCE AND AUDIT COMMITTEE MEETING
- FEBRUARY 16, 2017
- GLEN ALLEN, PRESIDENT
- NEWPORT REAL ESTATE SERVICES, INC.

NEWPORT Real Estate Services, Inc.®

Back to Agenda

Purpose of Presentation

- CalOptima Staffing Needs
- Review Site Plan
- Review Development Rights Options: Pros/Cons
- Review Development Rights Timeline
- CalOptima Development vs. 3rd Party Disposition

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Back to Agenda

Summary of Discussion

Needs Assessment

- Assumptions
- Conclusions

Real Estate Alternatives

- Develop CalOptima Property
- 3rd Party/Disposition Alternatives – With Rights to Occupy

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Back to Agenda

Needs Assessment - Assumptions

- Optimized Telecommuting
- Assumes Projected Programs
  - Cal-MediConnect
  - Medi-Cal
  - OneCare
  - PCC Program
  - ACA Related and Demographic-Trend Member Growth
- Recapture of all 505 Space
- 1 person/181 s.f. space allocation

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Back to Agenda

Current Space Projection

505 Building Available Seats	
On Site	749
Filled Seats	46
Sub-Total	**795**
Teleworker/Community	318
Total	**1,114**
Total Space Available	**1,025**
Filled Seats and Temp Help	(795)
Total Vacant Spaces	**257**
Pending Requests to Fill	(142)
Expected Employee Count for New Programs	(26)
Net Space Surplus (Shortfall)	**89**
10th Floor Space	85
Total Surplus (Shortfall)	**174**

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Back to Agenda

Space Alternatives

- Offsite Lease or Purchase
- Extensive Telecommuting
- Multiple Shifts
- Relocate to a Larger Building
- Develop Adjacent CalOptima Property

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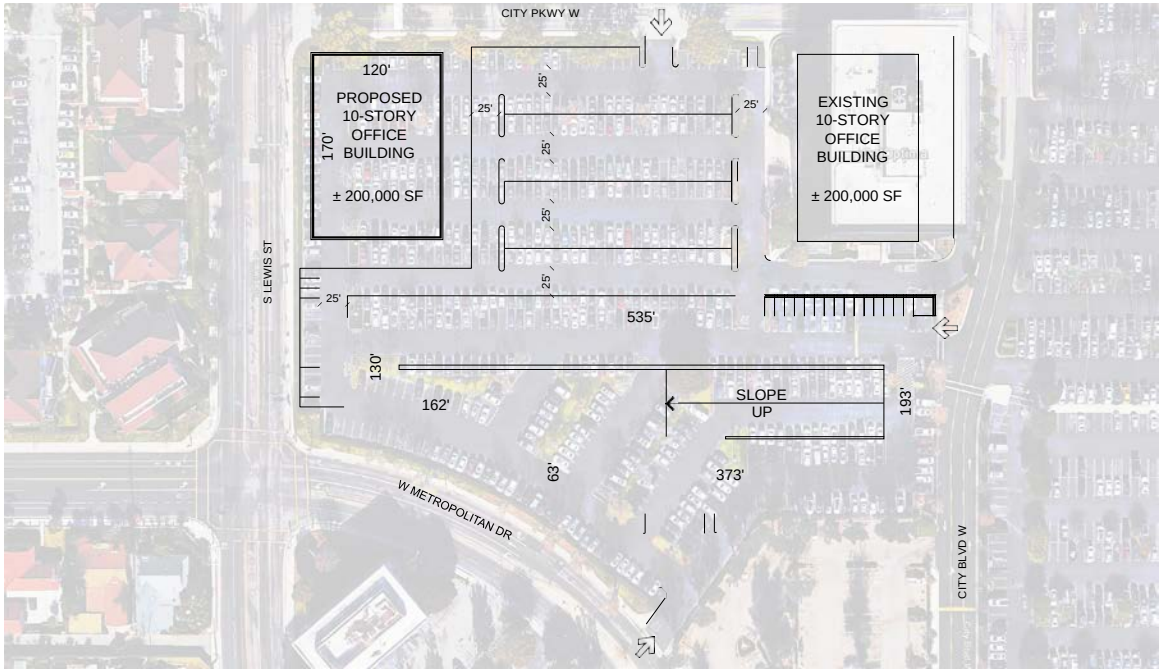
Back to Agenda

Site Plan



SITE PLAN

PROJECT DATA:

ZONING: UMU - URBAN MIXED USE

SITE AREA: ± 272J757 SF (±6.361 AC)

EXISTING BUILDING: 200,000 SF

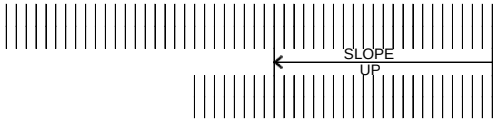
PROPOSED BUILDING: 200,000 SF

TOTAL BUILDING: 400,000 SF

F.A.R.: 1.46

PARKING REQUIRED: 2,000 STALLS
(400,000 SF @ 5/1000)

PARKING PROVIDED: ±2J032 STALLS
- SURFACE: 192 STALLS
- 1ST FLOOR STRUCTURE: 240 STALLS
- 2-6TH FLOOR STRUCTURE: 1,450 STALLS
  (290/STORY, TYP.)
- 7TH FLOOR: ±150 STALLS



TYPICAL PARKING LEVEL

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Back to Agenda

Development/Disposition Alternatives

RFI (To be Prepared)
- Direct Sale
- Ground Lease
- Joint Venture
- Trade of Nearby Property
  (Options to Occupy)

CalOptima Development/Construction
- Design/Bid/Build
- Design/Build
- Balance Sheet/Capital Implications
- Vacant Area Risk Assessment

Extend Development Agreement
- City Approval Required
- Fee Payment Likely Required

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Back to Agenda

Development Alternative Options

		Pros	Cons	Fiscal
Direct Sale:	**CalOptima could directly sell the development rights and secure space for CalOptima's use.**	**1. Large one time capital infusion 2. Reserved right for additional space 3. No development risk**	**1. Loss of future control 2. Restricted expansion rights 3. Lease payments required on additional space**	**1. Large, one-time capital event 2. No on-going income 3. Lease payments for additional space**
Ground Lease:	**CalOptima could lease the property to a developer.**	**1. Long-term income stream 2. Reserved right for additional space 3. No development risk**	**1. Loss of future control 2. Restricted expansive rights 3. Lease payments required on additional space**	**1. Long-term income stream with periodic adjustments 2. Lease payments for additional space**
Direct Development:	**CalOptima could assign the development rights to a developer, who would provide space back to CalOptima in return.**	**1. Property is already owned by CalOptima 2. Current Entitlement already in place 3. Multiple delivery/financing options 4. Total flexibility with building design 5. Future expansion space 6. Inclusion of PACE 7. Incorporation of formal board space 8. Eliminate need for offsite leased space**	**1. Time to delivery: 22-30 months 2. Splits staff to 2 buildings 3. Capital requirement**	**1. Large capital expenditures for development required 2. No future rent payments 3. No lease payment for additional space 4. Lease income from expansion space tenants**
Joint Venture:	**CalOptima could develop the property jointly with a developer.**	**1. Participation in development Upside 2. Reserved right for additional space 3. Reduced development risk**	**1. Participation in development Downside 2. Some cash flow and development risks 3. No cash flow during development and lease-up period 4. Consistency with CalOptima core mission 5. Market Risk**	**1. Variable on-going income from project cash flow 2. No large capital contribution required**
Exchange for Nearby Property:	**CalOptima could exchange the development rights for a developed property**	**1. Ability to obtain pre-built expansion space 2. Likely "built-in" phased space availability 3. On-going cash flow**	**1. Market Risk 2. Building operations obligations 3. Value of suitable trade property**	**1. No large capital outlay 2. On-going income stream**

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Back to Agenda

Conceptual Development Timeline

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Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item
17. Consider Ratification and Approval of Expenditures Related to Emergency Repairs for CalOptima Facilities

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

Recommended Actions
1. Ratify and approve identified expenditures of up to $68,648.75 from existing reserves for emergency repairs at CalOptima facilities located at 505 City Parkway West in Orange and 13300 Garden Grove Boulevard in Garden Grove; and
2. Ratify contracts with vendors Muir - Chase Plumbing Co, Inc., Bennett's Plumbing Inc., and Stellrecht Building Group to provide repair services.

Background
CalOptima owns a 10-story commercial office building located at 505 City Parkway West, Orange, CA 92868. Floors 1 through 10 are CalOptima occupied, with one remaining tenant in partial space on the 10th floor. CalOptima also leases a one story tilt up concrete building located at 13300 Garden Grove Boulevard which is the location for the PACE adult day health care facility. It is the responsibility of CalOptima to ensure that both facilities are clean and in full operational order to accommodate the needs of employees, members, and other visitors.

Discussion
Staff recommends the Board ratify and approve expenditures for the following emergency repairs:

1. In December 2016, the vendors adjusted numerous water valves to ensure compliance with hot and cold water temperature requirements throughout the facility. An emergency purchase of $13,398.74 was used to make repairs to the PACE water softener system which allowed PACE to continue to operate within the federal and state parameters that are required for water services at the facility.

2. In January 2017, the vendors impregnated the entire drain system through all ten floors of the building with a waterproof resin. In addition, the vendor made minor drywall repairs at drain access points throughout the building. An emergency purchase of $55,250 was used to make repairs to 505 City Parkway West to prevent additional leaks and property damage, and kept the facility fully operational and open for business.

These emergency purchases were undertaken in accordance with section II.P. (Emergency Purchases) of CalOptima's Board-approved Purchasing Policy (GA.5002).

Back to Agenda

Fiscal Impact
The recommended action to authorize expenditures for emergency repairs at 505 City Parkway West and 13300 Garden Grove Boulevard is an unbudgeted item. An allocation of up to $68,648.74 from existing reserves is proposed to fund the recommended actions.

Rationale for Recommendation
Staff recommends approval of the recommended actions to protect the properties and assets of CalOptima and to keep them fully functional and operational in accordance with State and Federal guidelines. This will allow CalOptima to provide a professional work environment for their employees and a safe and sanitary environment for our members.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

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

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item
18. Consider Election of Chair of the CalOptima Board of Directors for the Remainder of Fiscal Year 2016-17

Contact
Mark Refowitz, CalOptima Board Chair, (714) 246-8400

Recommended Action
Elect Chair of the CalOptima Board of Directors for term effective March 31, 2017 through June 30, 2017.

Background/Discussion
In accordance with Article VIII, Section 8.1 of CalOptima's Bylaws, the Board shall elect one of its Directors as Chair at an organizational meeting. The Chair shall be the principal officer of the Board and shall preside at all meetings of the Board, shall appoint all members of the Ad Hoc Committees, as well as the chairs of the Ad Hoc Committees and all Committees other than the Member and Provider Advisory Committees. The Chair shall perform all duties incident to the office and such other duties as may be prescribed by the Board from time to time. In the event of a vacancy in the office of Chair, the Board may elect a new Chair. The term of the current Chair is July 1, 2016 through June 30, 2017.

At the February 2, 2017 Board of Directors meeting, Chair Refowitz announced his retirement as Director of the Orange County Health Care Agency, and the completion of his service on the CalOptima Board of Directors effective March 31, 2017. At the February 2017 meeting, the Chair directed staff to place an item on the March 2, 2017 Board meeting agenda to elect a new Chair effective March 31, 2017 through June 30, 2017, and formed a Nominations Ad Hoc Committee to provide information on the duties, responsibilities and the number of extra hours the Chair position typically requires above and beyond serving as a member of the Board. The ad hoc will present nominations, along with any from the floor, at the March 2, 2017 meeting.

Fiscal Impact
None

Rationale for Recommendation
The recommended actions are in accordance with Article VIII, Section 8.1 of the CalOptima Bylaws.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

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

Back to Agenda

Board of Directors Meeting
March 2, 2017

Provider Advisory Committee (PAC) Update

February 9, 2017 PAC Meeting

Eleven (11) PAC members were in attendance at the February PAC meeting.

PAC members received an update from Chief Operating Officer Ladan Khamseh on the ongoing Department of Healthcare Services (DHCS) and Department of Managed Healthcare (DMHC) audits. Ms. Khamseh also gave a brief CEO report on behalf of Michael Schrader.

The PAC also received an informative presentation from Caryn Ireland, Executive Director of Quality Analytics, on the Pay for Value program (P4V) results for 2016. Based on these results, PAC members expressed a willingness to work with CalOptima staff and the health networks to educate providers to improve overall scores. The 2017 proposed program scoring and payment methodology is intended to reward providers for performance and improvement. Ms. Ireland noted that CalOptima staff will present the proposed changes to the P4V to the Board of Directors' Quality Assurance Committee for review prior to submitting to the Board for consideration.

Dr. Richard Bock, Deputy Chief Medical Officer, presented an update on the opioid epidemic and how it is changing. Additional information will be presented at a future PAC meeting.

Dr. Donald Sharps, Director of Behavioral Health Services, presented on the Magellan transition and noted that 274 contracts had been completed or received by Magellan, which represents 83 percent of the 327 providers initially recruited for contracts. These providers represent approximately 95 percent of CalOptima's members. PAC members were interested in learning how Magellan's providers are sharing medical records with the clinics and providers. Dr. Sharps encouraged the networks to make sure that they invite Magellan to the Interdisciplinary Care Team meeting for the members who have behavioral health needs. It was noted that the State is working on the Medi-Cal drug program.

Recruitment for four PAC seats will begin on March 1, 2017 and end on March 31, 2017. The open seats are for Community Health Centers, Hospital, Physician and Traditional/Safety Net Representatives as well as the PAC Chair and Vice-Chair. The duration of the term for each representative seat is three years and will expire on June 30, 2020.

Once again, the PAC appreciates and thanks the CalOptima Board for the opportunity to present input and updates on the PAC's activities.

Back to Agenda

Board of Directors Meeting
March 2, 2017

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

A quorum was not reached at the January 26, 2017 OneCare Connect Member Advisory Committee (OCC MAC) meeting. OCC MAC will provide a report at the next Board of Directors meeting.

Recruitment has begun to fill the OCC MAC seats whose terms expire on June 30, 2017. Candidates interested in applying for one of the two-year seats can find application forms on CalOptima's website. The following seats are available: Home and Community-Based Services (HCBS) representative serving members with disabilities; HCBS representative serving members from an ethnic or cultural community; In Home Supportive Services (IHSS) or Union Provider representative; and OneCare Connect (OCC) member or family member of an OCC member (2 seats available). The deadline to apply is March 31, 2017.

The OCC MAC appreciates the opportunity to provide the CalOptima Board with input and updates on OCC MAC activities.

Back to Agenda

Board of Directors Meeting
March 2, 2017

Member Advisory Committee Update

The Member Advisory Committee (MAC) did not have a meeting scheduled in February, as the committee meets bi-monthly. The next scheduled MAC meeting is March 9, 2017 and MAC will provide an update at the April 6, 2017 Board of Directors meeting.

Recruitment has begun to fill the MAC seats whose terms expire on June 30, 2017. Candidates interested in applying for one of the two-year seats can find application information on CalOptima's website. The available seats include the following: Adult Beneficiaries, Family Support, Medi-Cal Beneficiaries, Persons with Disabilities, Recipients of CalWORKs and Seniors. The deadline to apply is March 31, 2017.

The MAC appreciates the opportunity to provide the CalOptima Board with input and updates on the MAC's activities.

Back to Agenda

PACE

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PACE: Operational Analysis and Business Plan – Follow-Up

Board of Directors Meeting

March 2, 2017

Richard Helmer, M.D.

Chief Medical Officer

Back to Agenda

Objectives – Agenda

- Program of All-Inclusive Care for the Elderly (PACE) Overview
- CalOptima PACE Background
- Summary of Findings From Finance and Audit Committee (FAC) Meetings
- Next Steps

Back to Agenda

PACE Overview

Regulatory Agencies	• Regulated by CMS and DHCS
Eligibility	• Members must: ➢ Be age 55+ ➢ Have chronic illness and functional impairments ➢ Qualify for nursing home care but wish to continue living in their own homes
Benefits/Services	• Comprehensive approach to provide all necessary medical, restorative and social services • Additional services available, including nursing facility, personal care, nutrition counseling and recreational therapy
Regulatory Climate	• New regulatory changes allow for-profit entities to operate PACE organizations • New proposed PACE regulation may allow community-based PCP service without waiver requirements

Back to Agenda

CalOptima PACE Background

- In Orange County (a COHS county), CalOptima is the ONLY entity authorized to operate PACE
- Initial Board Action: October 2010
- Program Launch: October 2013
- CalOptima PACE is a public-private partnership
  - Primary Care
  - Transportation
  - Home Care
  - Meals

Back to Agenda

CalOptima PACE Background (Cont.)

- February 4, 2016, COBAR authorized the following:
  - "…Submit a PACE Service Area Expansion (SAE) application to the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS);
  - …Initiate a Request for Proposal (RFP) process for Alternative Care Settings (ACS) model for PACE expansion satellite locations;
  - …For staff to perform financial analysis of the Community-Based Adult Services (CBAS) business model and present to the Board of Directors' Finance and Audit Committee (FAC) for review;
  - …When the Garden Grove PACE Center reaches 80% capacity, return to Board to consider one or more additional PACE centers."

Back to Agenda

Alternative Care Settings (ACS) Model

- Can be any physical location in the PACE organization's CMS-approved existing service area
- May provide up to 6 out of 7 required PACE services, but not all 7
- Must be in compliance with all applicable local, state and federal laws
- Is subject to the CMS PACE Audit Methodology

Back to Agenda

ACS Model (Cont.)

- Provides greater geographic coverage to increase access
- Lowers investment and capital outlay
- Allows for scalable model, which is responsive to demand
- Leverages and strengthens existing capabilities by partnering with CBAS centers and other community providers
- Allows for greater flexibility to partner with community providers, as per proposed federal PACE regulations

Back to Agenda

Items Reviewed at FAC Meetings

- September 15, 2016
  - Reviewed metrics and business plan
  - Three requests for follow-up:
    - Cost of Like Populations
    - Options to Current Model
    - Risks of ACS Model

- February 16, 2017
  - Follow-up on performance and business plan
  - Follow-up on requests
  - Next steps: Initiate a Request for Information (RFI) for the ACS model and regular updates to FAC

Back to Agenda

Summary of Findings: Financial

		All FY16	Q1–FY17	Q2–FY17
Membership	Average Members	134	176	182
	Ending Members	167	177	183
MLR	As stated	102.5%	88.7%	73.8%
ALR		12.7%	9.8%	7.3%
MLR	Retroactive payment distributed by month	102.5%	82.0%	88.0%
ALR		12.7%	9.1%	8.7%

Back to Agenda

Summary of Findings: Enrollment

Item	Q1	Q2	YTD
Member Months	532	547	1,079
Average Membership	177	182	180
Additions (New enrollments)	31	16	47
Loss (Disenrollment, all cause)	21	12	33
Controllable drops	15	7	22
Rate / K / Y	338	154	245
Non-controllable drops	6	5	11

Back to Agenda

Summary of Findings: Business Plan

- Plan is in place to continue to improve performance
- Some items are completed but many are ongoing
- Two areas of intense focus
  - Increase enrollment
    - Boost outreach
    - Increase satisfaction and decrease controllable disenrollment
  - Improve inpatient utilization

Back to Agenda

Summary of Findings: Cost of Like Populations and Risk of ACS

- PACE is a cost-effective program for LTC-eligible beneficiaries

- ACS model risks are:
  - Less than alternative models
  - Manageable based on CalOptima's business model and increased oversight capabilities

Back to Agenda

Summary of Findings: Options to Current Model

- The following criteria support the Board's decision to pursue the ACS model:
  - Reach the largest number of eligible beneficiaries for all of Orange County
  - Limit exposure in delegation and use existing CalOptima oversight capabilities
  - Align with current CalOptima benefit and care management programs
  - Leverage the capabilities in the Orange County provider community for a private-public partnership
  - Minimize financial risk and provide the best opportunity to recover investment

Back to Agenda

Next Steps

- Issue Request for Information (RFI) in preparation for ACS Request for Proposal (RFP) to:
  - Increase awareness and identify potential respondents to RFP
  - Solicit feedback on proposed model
  - Create opportunities to propose alternative framework of participant

- Return to FAC to:
  - Inform committee on RFI results
  - Provide update on business plan and next steps

Back to Agenda

Opioid Reduction Program

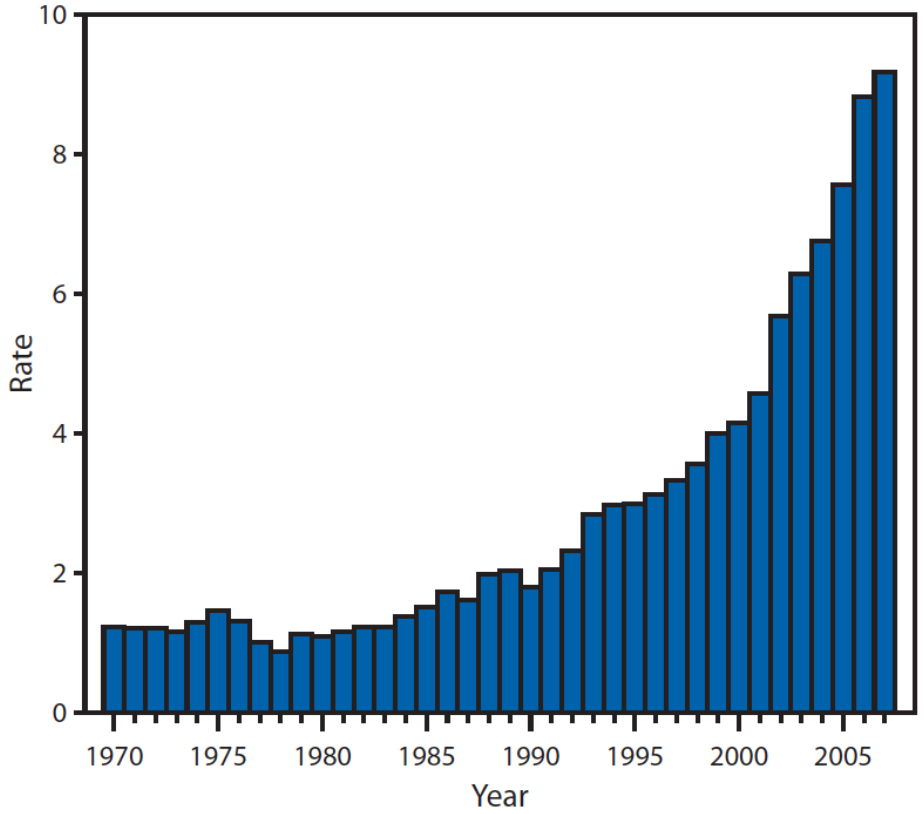
Board of Directors Meeting
March 2, 2017

Richard Bock, M.D., Deputy Chief Medical Officer
Scott Huffman, M.D., Assoc. Medical Director, OCHCA

Back to Agenda

U.S. Drug Overdose Deaths

FIGURE 1. Rate* of unintentional drug overdose deaths — United States, 1970–2007



Source: National Vital Statistics System. Available at http://www.cdc.gov/nchs/nvss.htm.
* Per 100,000 population.

Back to Agenda

On an Average Day in the U.S.

- More than **650,000 opioid prescriptions** dispensed
- **3,900 people** initiate nonmedical use of prescription opioids
- **580 people** initiate heroin use
- **78 people** die from an opioid-related overdose
- More people die of overdose than car accidents

Back to Agenda

How the Epidemic Began

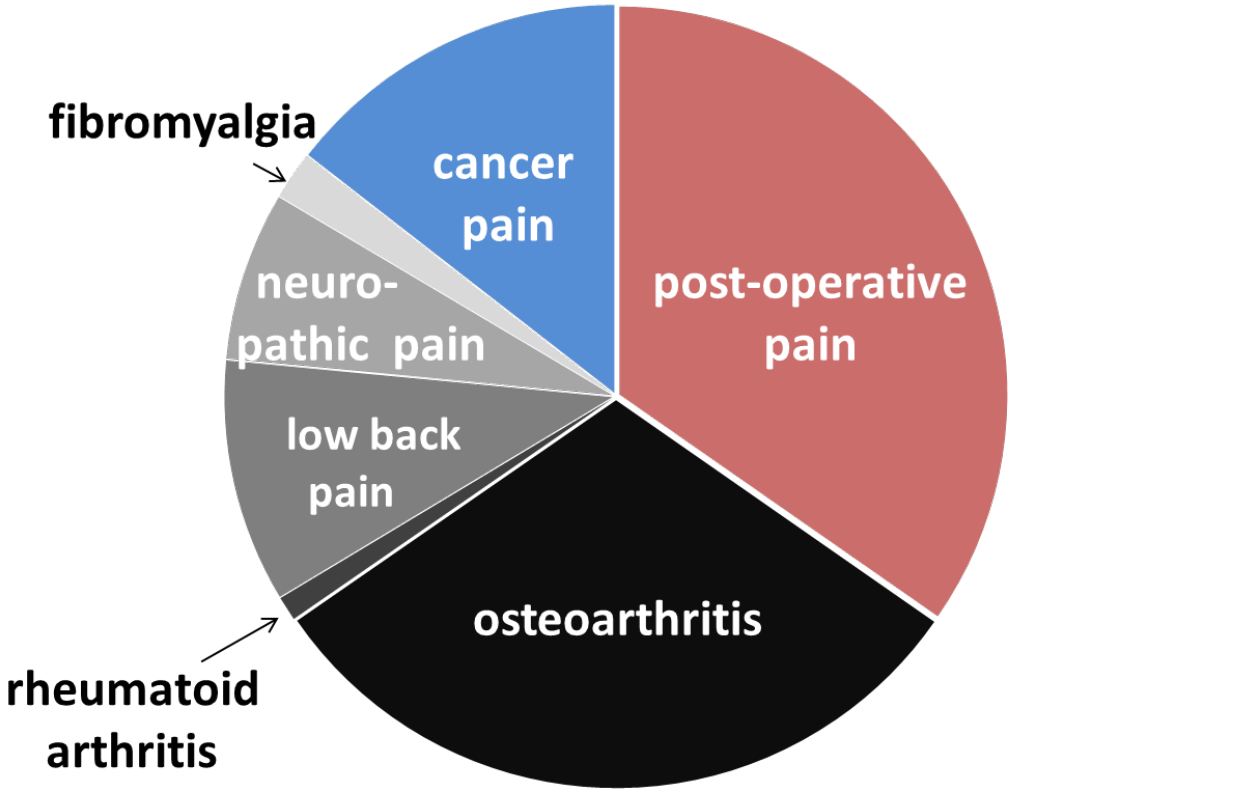
- Late 1990s — marketing of longer acting opioids
- States passed new laws and regulations moving from near prohibition of opioids to use without dosing guidance
- Laws were based on weak science, good experience with cancer pain and aggressive “pain control” lobby
- Thus, no ceiling on dose and axiom to use more opioid if tolerance develops

Back to Agenda

U.S. Opioids Market Revenues

U.S. opioids market revenues for 7 leading indications, 2010

Source: GBI Research. Opioids Market to 2017. June 2011



Back to Agenda

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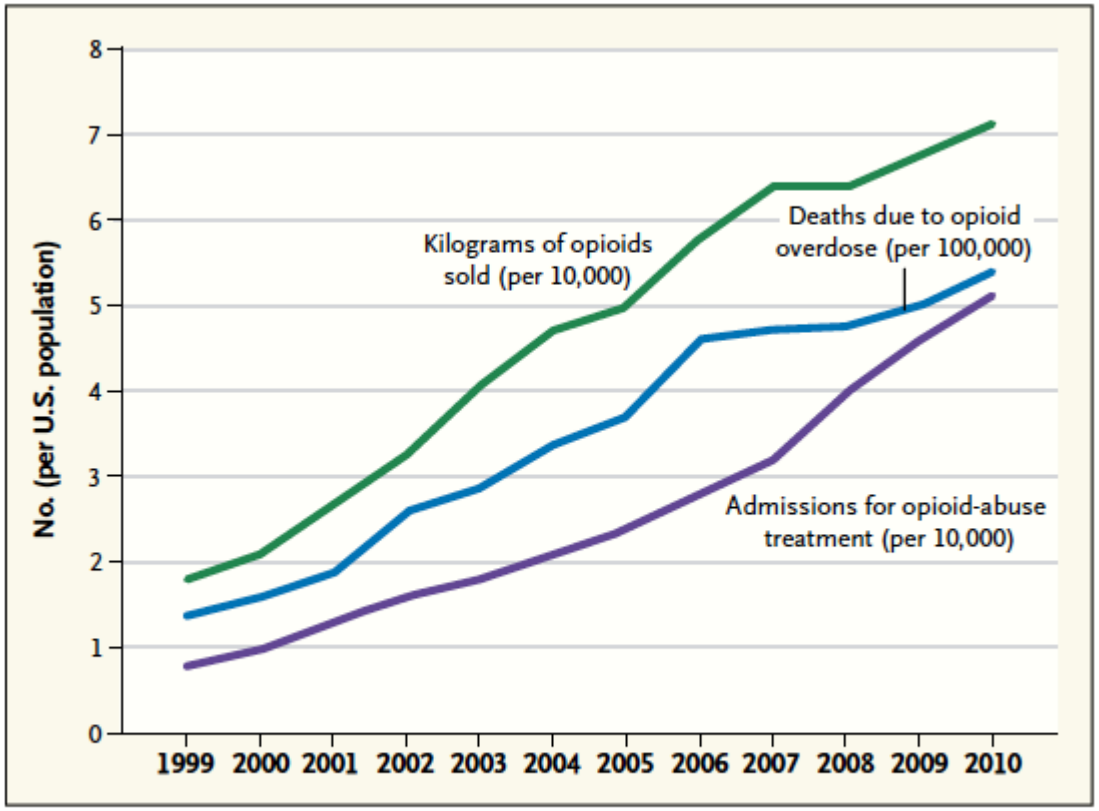
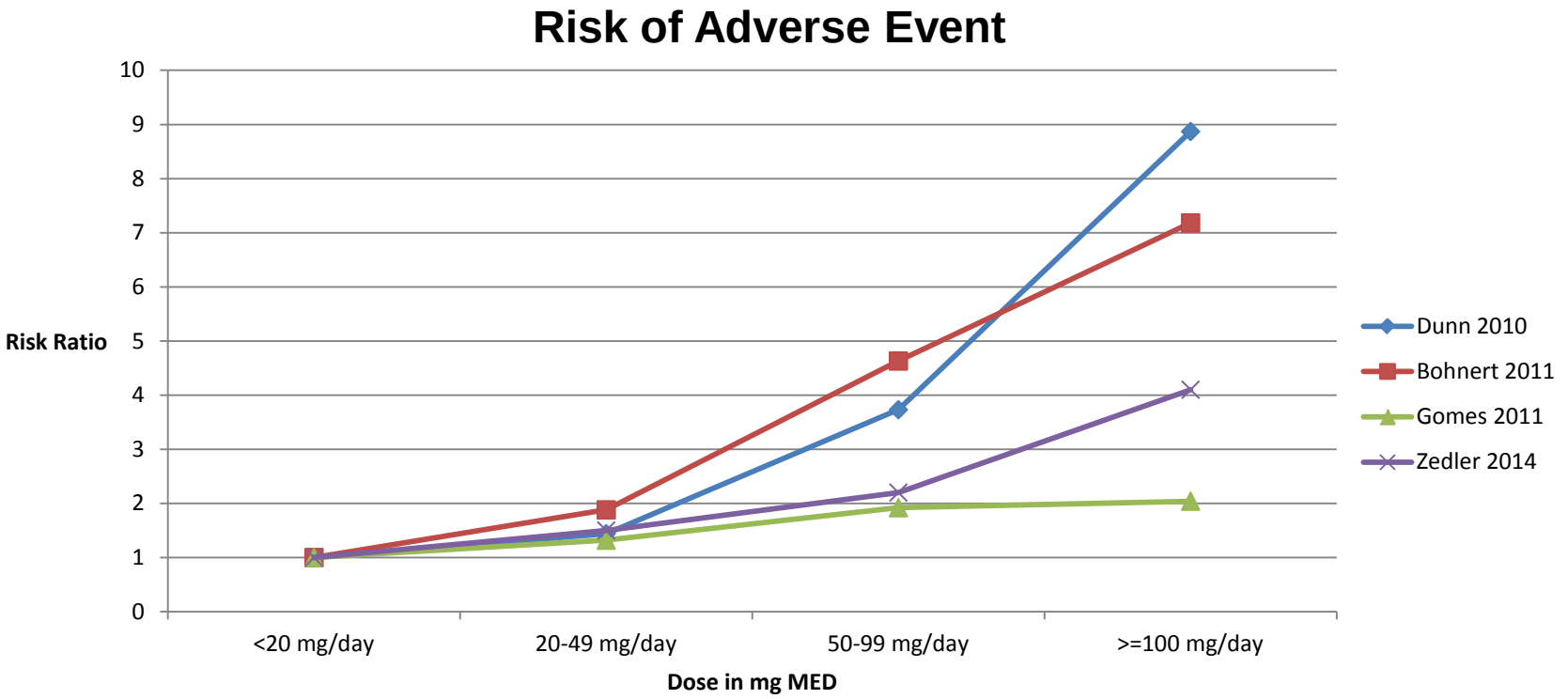
Opioid Deaths Rose With Increased Sales



Opioid Sales, Admissions for Opioid-Abuse Treatment, and Deaths Due to Opioid Overdose in the United States, 1999–2010.

Back to Agenda

Dose-Related Risk



Two thirds of those using opioid medications for 90 days continue to use them long term (more than 2 years)

Back to Agenda

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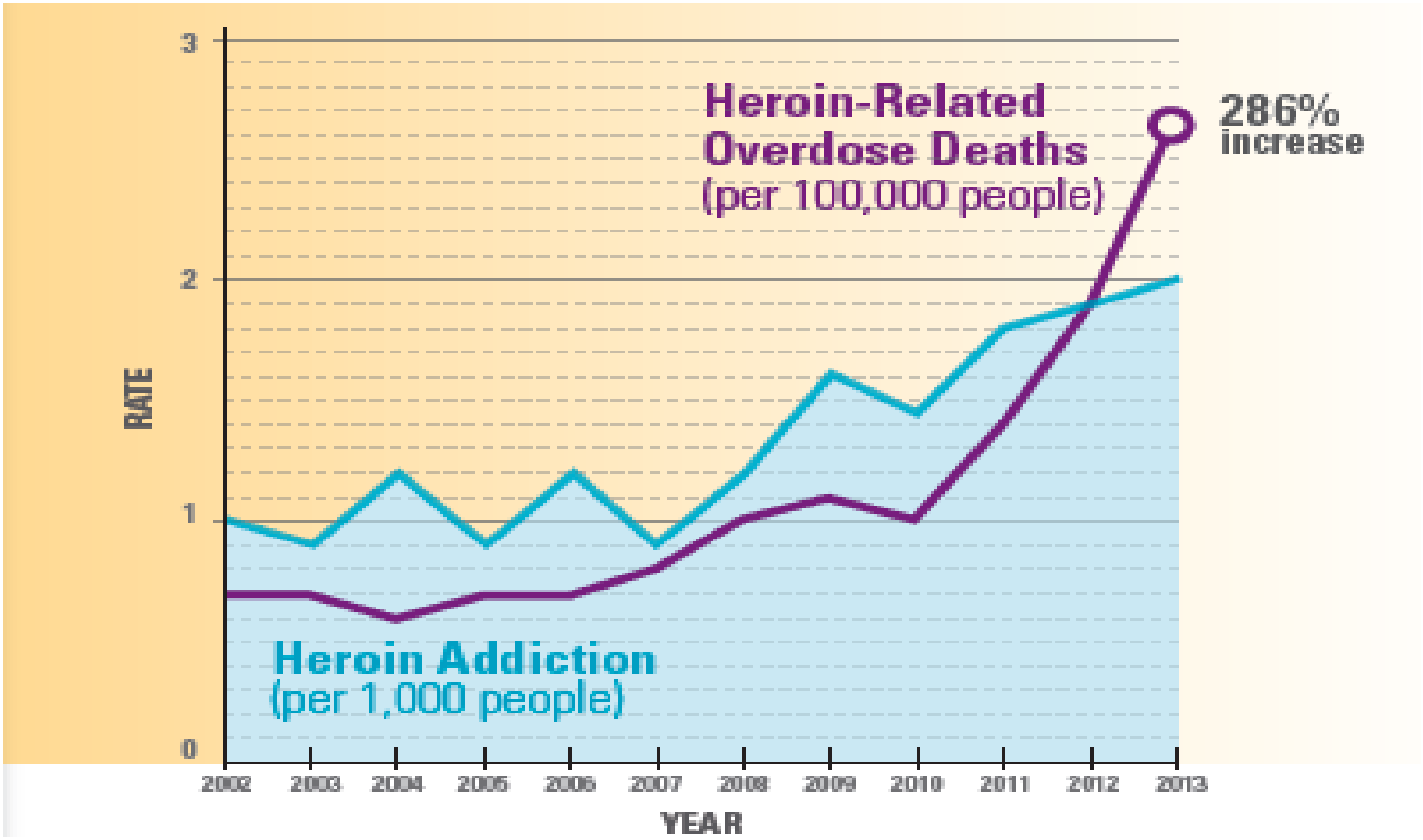
Heroin Addiction and Overdose



Source: National Survey on Drug Use and Health, 2002–13
National Vital Statistics System, 2001–13

Back to Agenda

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Impact on Medi-Cal

- >45% of fatal prescription drug overdoses were Medicaid enrollees
- Medicaid beneficiaries
  - 2x the prevalence of opioid Rx
  - 6x the risk of overdose death
- Prescription drug misuse elevated in poverty, rural communities, co-occurring mental illness, and a history of substance abuse
- Between 2000 and 2009, the rate of newborns diagnosed with Neonatal Abstinence Syndrome (NAS) nearly tripled
- Abusers of opioids have been found to have total health care costs 8 times that of non-abusers

Back to Agenda

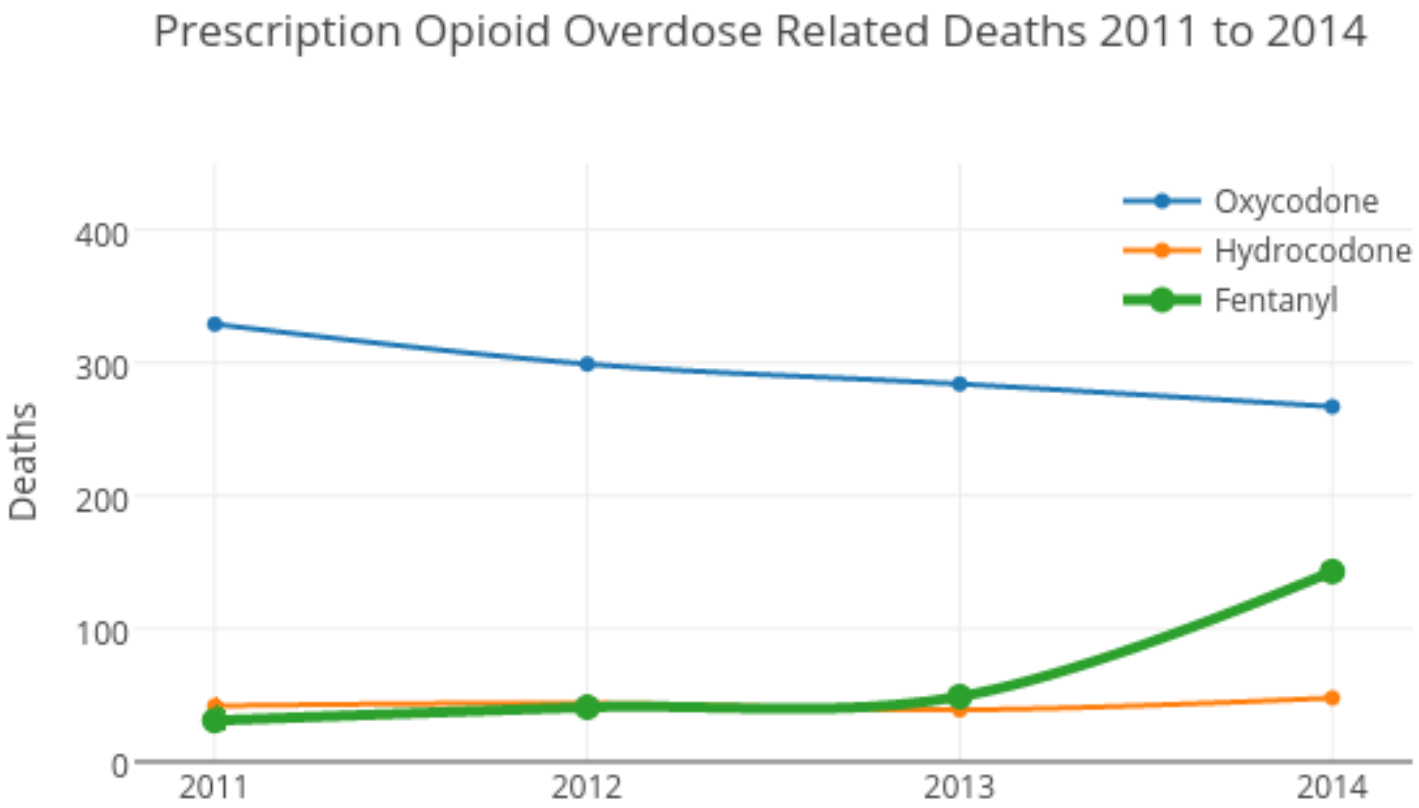
Effect on Orange County

- Drug overdose deaths in Orange County have soared to the highest levels in at least a decade
- Fatal drug overdoses climbed to at least 400 in 2016, a 63 percent jump compared with 2005 when the number stood at 246
- In the past five years, drug overdoses have killed 1,769 people in the county, topping the state
- More than two-thirds of last year's cases – 286 – involved opioids, including heroin and prescription painkillers such as Percocet, OxyContin and Vicodin

Orange County	3-Year Change
Opioid Prescriptions (excluding Buprenorphine)	2.1%
Residents on Opioids/Benzos	6.6%
Residents on >100MME Daily	-19.0%
Buprenorphine Prescriptions	36.4%
Residents w/ 6+ Prescribers or Pharmacies	6.6%

Back to Agenda

Changing Face of Opioid Epidemic



Back to Agenda

The Changing Face of the Opioid Epidemic

- Prescriptions for OxyContin have fallen nearly 40% since 2010, meaning billions in lost revenue for its Connecticut manufacturer, Purdue Pharmaceuticals.

- Taking a page from Big Tobacco: **OxyContin goes global — "We're only just getting started"**

- A network of international companies owned by the family is moving rapidly into Latin America, Asia, the Middle East, Africa and other regions, and pushing for broad use of painkillers

Changing Face of Opioid Epidemic

- Fentanyl-Related Overdoses Prompt CDC alert
- **Trial Reveals Deep Ties Between Pair of Doctors and Fentanyl Maker. Prosecutors allege two doctors made $40 million in illicit profit**
- DEA Issues Nationwide Warning on Carfentanil

  animal opioid sedative, 10,000 times that of morphine
- fentanyl and carfentanil have been mixed with powder heroin; and substituted for pill ingredients
- Combined Benzodiazepine use was associated with 30.1% of opioid overdose deaths

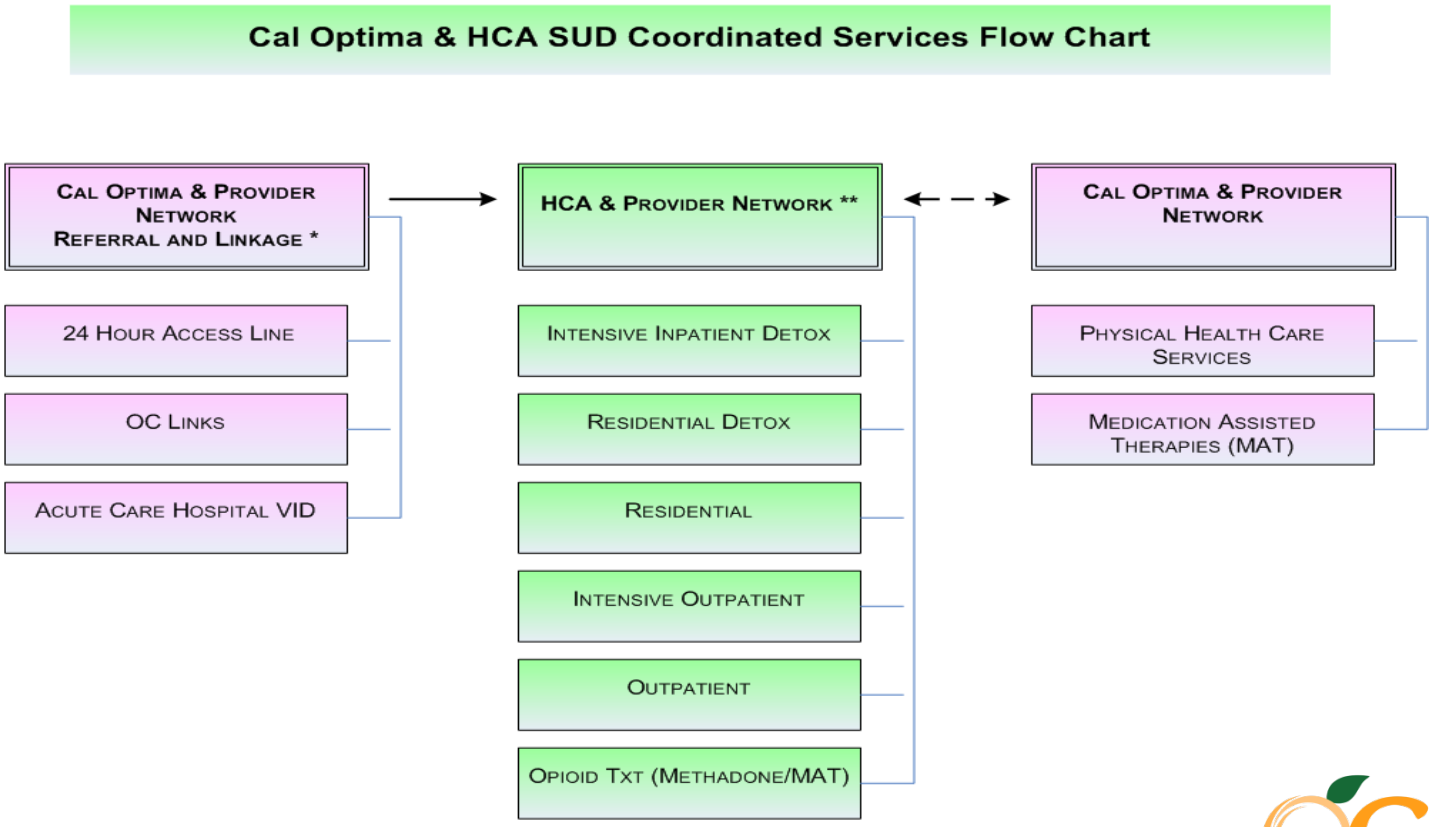
  opioid use was associated with 77.2% of benzodiazepine overdose deaths.

Opioid Use Disorder Treatment

- Medication-assisted treatment, e.g., Buprenorphine (Suboxone)
  - Stabilizes neurochemical imbalances
  - Relieves symptoms of abstinence syndromes
  - Prevents intoxication and overdose
  - Reduces benzodiazepines
- Overdose rescue – Naloxone
- No wrong door for starting treatment of opioid agonist
- Wellness model with treatment for stable patients located at medical home
- Behavioral restructuring
- Integrated care for needle-related chronic illness such as HIV and Hepatitis C

Back to Agenda

CalOptima and HCA SUD Coordinated Services



** Based Upon Screening, Brief Interventions, Referral to Tx (SBIRT)*

**Case Management, Physician Consultation and Recovery Support Services are available in all program*

OC health CARE AGENCY

Back to Agenda

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HCA BHS Substance Use Disorder Tx

- Orange County Health Care Agency (HCA) Behavioral Health Services (BHS) provides mental health and substance use disorder (SUD) services to eligible youth and adults

- California received a waiver from the federal government to develop a 5-year pilot project to better serve people with SUD and who are eligible for Drug Medi-Cal (DMC)

Back to Agenda

HCA BHS Substance Use Disorder Tx (Cont.)

- BHS currently provides the majority of the waiver required services, using other funding. The additional DMC revenue will enable service expansion and enhancement
  - HCA served more than 7,000 youth and adults with SUD this past Fiscal Year
    - More than 68 percent were Medi-Cal eligible
- DHCS approved Orange County DMC plan in December 2016 and services are anticipated to begin as early as July 2017
- Federal Financial Participation (FFP) will cover up to 95 percent of allowable costs of SUD treatment

Back to Agenda

CalOptima–HCA Coordination

- A longstanding MOU delineates the responsibilities of CalOptima and HCA to ensure members receive the appropriate level of care to address mental health issues

- An addendum to the MOU is in development to ensure the coordination of SUD screening and the provision of member services between CalOptima and HCA

- The MOU is currently under review by Orange County and CalOptima and will be submitted to DHCS upon approval

Back to Agenda

HCA SUD Service Benefits to CalOptima Members

- Supports the use of Medication-Assisted Treatment (MAT) for opioid and alcohol disorders
- Changes SUD services from a social model to a medical model
- Supports integrated services with both mental health and physical health
- Supports coordinated care and services with other systems

Back to Agenda

HCA SUD Continuum of Care for CalOptima Members

- Withdrawal Management Services
  - Social Model Residential and inpatient detox programs (up to 10 days)
- Residential Treatment with BHS authorization
  - Up to 90 days for adults and 30 days for youth
- Intensive Outpatient Treatment
  - 9–19 hours per week for adults and 6–13 hours for youth
  - Individual and group sessions
- Outpatient Drug Free
  - Up to 9 hours per week for adults and 6 hours per week for youth
  - Individual and group sessions

Back to Agenda

HCA SUD Continuum of Care for CalOptima Members (Cont.)

- Opioid Treatment
  - Methadone Maintenance and other Medication-Assisted Treatment (MAT)
- All Treatment Programs Include
  - Linkage to MAT services
  - Case management services
    - To ensure appropriate treatment levels, transitions and services
- Physician Consultation
  - MD to MD related to MAT and treatment
- Recovery Support Services
  - Counseling, ancillary services, linkage and peer support

CalOptima Interventions – I

- **Formulary restrictions January 1, 2017**
  - Cumulative Morphine equivalent dose (MED) pharmacy edits (Part D)
  - Restrictions for drugs with the highest risk of overdose
    - Methadone
    - Extended-release opioids
    - Concurrent use of opioids and buprenorphine pharmacy edits

Back to Agenda

CalOptima Interventions – II

- **Member restriction programs**
  - Pharmacy Home Program Policy (1,022 members enrolled)
  - Prescriber Restriction Program Policy (364 eligible Medi-Cal members, 40 enrolled)
  - Part D opioid overutilization monitoring and case management (60 member interventions)
  - Fraud and abuse referrals to Compliance (176 members)

Back to Agenda

CalOptima Interventions – III

- **Prescriber outreach programs**
  - Opioid-containing cough medicines
    - 177 resident reviews
    - 101 discontinued
  - Highest MED prescribers
    - 15 prescribers, 177 high-dose Rx
    - 237 concomitant benzodiazepines
  - High volume/high MED prescribers
    - Top 5 percent sent scorecards (December 2016)

Back to Agenda

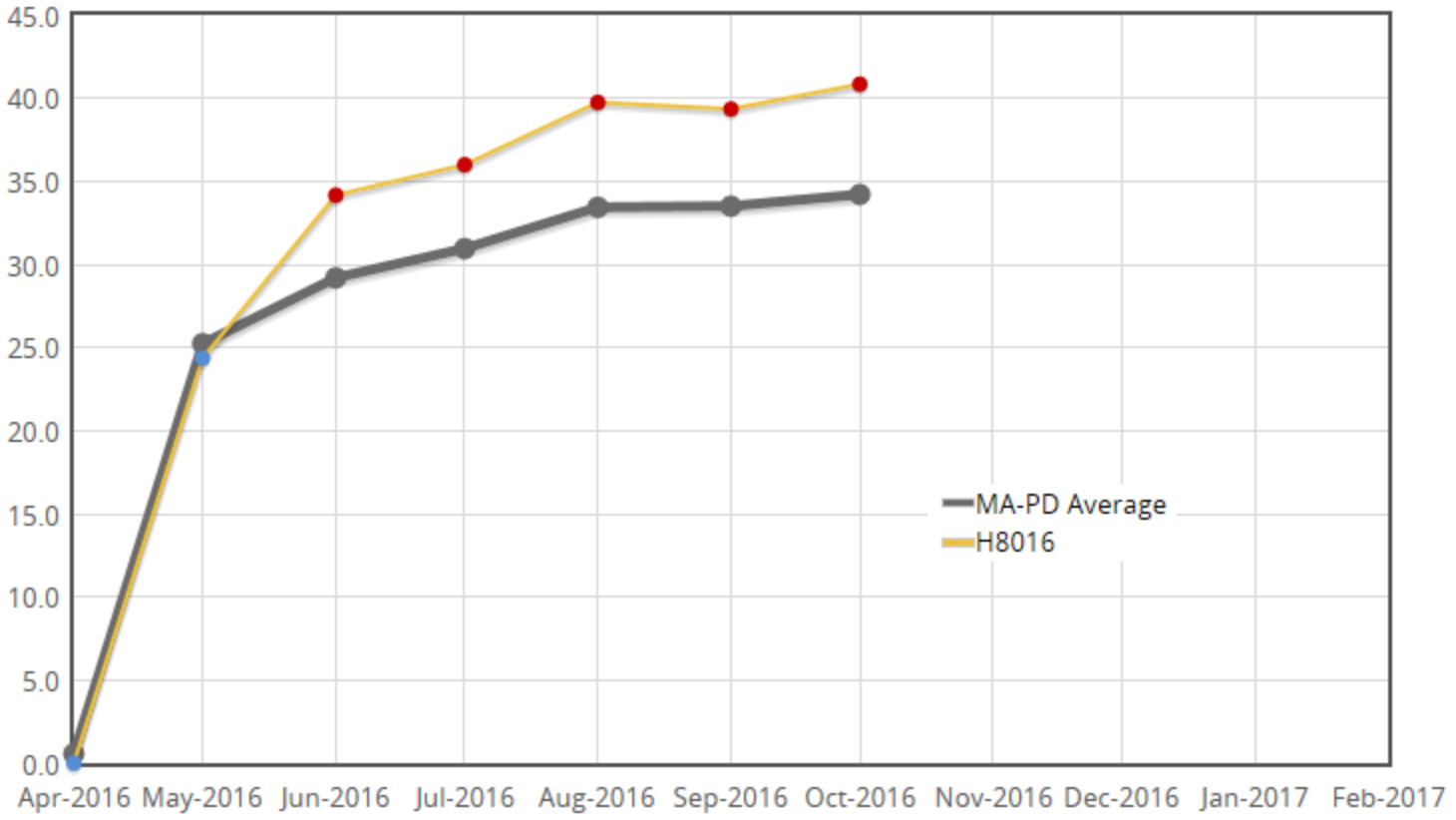
CalOptima Interventions – IV

- **Quality measures**
  - Retrospective review of opioid overutilization by medical director
    - 120 members referred to Compliance and/or Case Management
  - ACAP plan opioid utilization benchmarking study (on legal hold)
  - Pharmacy Quality Alliance (PQA) Part D Star display measures
    - High dosage
    - Multiple providers

Back to Agenda

OneCare Connect Part D Report Card – Display

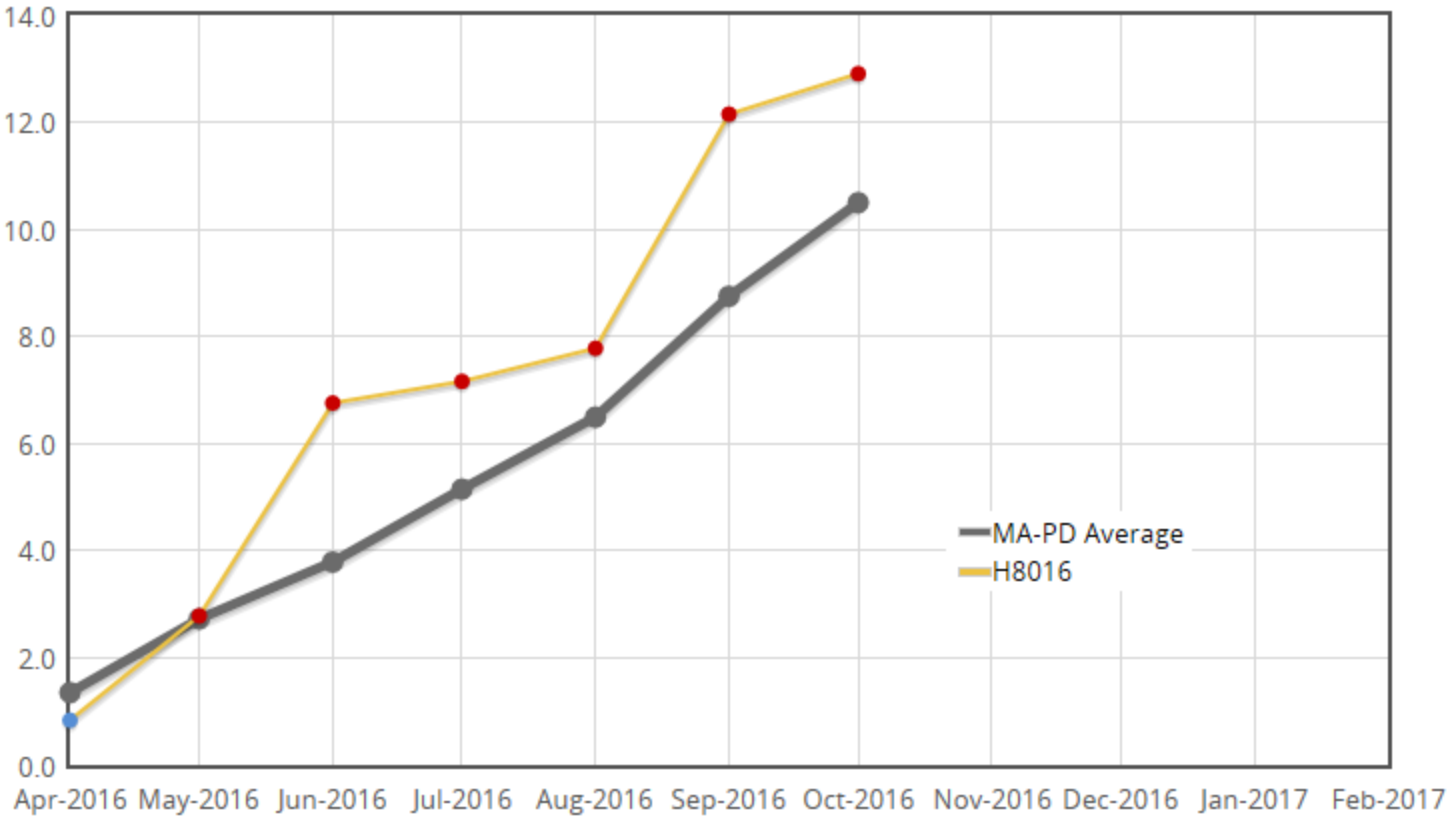
Opioid – High Dosage Measure Performance



Back to Agenda

OneCare Connect Part D Report Card – Display

Opioid – Multiple Providers Measure Performance



Back to Agenda

CalOptima Interventions – V

- **Ongoing CME series for physicians**
  - January 27, 2016

    The State of Opioid Prescribing in Orange County: Practical Strategies and Update on CURES 2.0

    Total attendees: 63
  - July 28, 2016

    The State of Opioid Prescribing in Orange County: Critical Issues in Over-the-Counter (OTC) Analgesia

    Total attendees: 72
  - March 30, 2017 (tentative)

    The State of Opioid Prescribing in Orange County: PCP Treatment Options and Access to Behavioral Health Services

CalOptima Interventions – VI

- **Coalition participation**
  - ACAP
    - Opioid Intervention (2015) – CalOptima cited as one of 13 Best Practice Plans for Pharmacy Lock-in Program
  - Safe Rx OC
    - Since 2015, CalOptima participating with public health agencies, hospitals, prescribers, community clinics, emergency rooms, medical associations and law enforcement to curb abuse and save lives
  - DHCS Health Homes Program (2018)
    - Care management for those with SUD and eligible chronic conditions

❖Community Informational Series: Friday, March 3, 2017

- Panel: Drs. Khatibi, Bock, Chakravarthy , Sandra Fair

Back to Agenda

Affiliations and Resources

- NIH: National Institute on Drug Abuse
- Drugabuse.gov
- SAMHSA: Substance Abuse and Mental Health Services Administration
- ACAP: SUD Collaborative
- Cures 2.0
- CHCF: Opioid Safety Coalition Network
- Smart Care California (DHCS, CalPERS, Covered CA)
- California Department of Public Health
  - Prescription Opioid Misuse and Overdose Prevention Workgroup
  - Prescription Drug Overdose Prevention Initiative
  - California Opioid Overdose Surveillance Dashboard

Back to Agenda

Financial Summary

January 2017

Board of Directors Meeting

March 2, 2017

Nancy Huang

Interim Chief Financial Officer

Back to Agenda

FY 2016-17: Consolidated Enrollment

- January 2017 MTD:
  - Overall enrollment was 795,352 member months
    - Actual lower than budget by 9,556 or 1.2%
      - Medi-Cal: unfavorable variance of 4,253 members
        - Decrease in Child and TANF members
      - OneCare Connect: unfavorable variance of 5,417 members
    - 0.6% or 4,649 decrease from prior month
      - Medi-Cal: decrease of 4,215 from December
      - OneCare: increase of 29 from December
      - PACE: increase of 1 from December
      - OneCare Connect: decrease of 464 from December

FY 2016-17: Consolidated Enrollment

- January 2017 YTD:
  - Overall enrollment was 5,587,581 member months
    - Actual lower than budget by 25,693 or 0.5%
      - Medi-Cal: favorable variance of 5,893 members
        - Medi-Cal Expansion (MCE) growth higher than budget
        - SPD enrollment higher than budget due to less than anticipated dual eligible members transferring to OneCare Connect
        - Offset by lower than budget TANF enrollment
      - OneCare Connect: unfavorable variance of 31,638 members or 20.5%
      - OneCare: favorable variance of 47 members or 0.6%
      - PACE: favorable variance of 5 members or 0.4%

Back to Agenda

FY 2016-17: Consolidated Revenues

- January 2017 MTD:
  - ➢ Actual lower than budget by $14.3 million or 5.1%
    - Medi-Cal: favorable to budget by $9.4 million
      - $9.4 million of LTC revenue for non-LTC members
    - OneCare Connect: unfavorable variance of $23.9 million or 54.6%
      - Unfavorable price variance of $13.0 million
        - ➢ CMC Medicare Part A and B rate decreases due to base rate and RAF score changes
        - ➢ CMC Medi-Cal adjustments related to prior year updates
        - ➢ CMC Medi-Cal member mix true-up for February 2016 through current period
      - Unfavorable volume variance of $10.9 million
    - OneCare: favorable to budget by $0.2 million

Back to Agenda

FY 2016-17: Consolidated Revenues (cont.)

- January 2017 YTD:
  - ➢ Actual lower than budget by $24.9 million or 1.3%
    - ▪ Medi-Cal: favorable to budget by $76.4 million
    - ▪ OneCare Connect: unfavorable variance of $101.8 million
      - • Medi-Cal revenue unfavorable $35.3 million
      - • Medicare revenue unfavorable $66.6 million

FY 2016-17: Consolidated Medical Expenses

- January 2017 MTD:
  - ➢ Actual lower than budget by $13.3 million or 4.9%
    - Medi-Cal: unfavorable variance of $4.7 million
      - MLTSS unfavorable variance $7.1 million
        - ➢ LTC unfavorable variance $5.5 million
          - $3.5 million higher LTC Claim expense due to less than anticipated members enrolling in OneCare Connect
          - $2.0 million variance from FY17 mandated rate increase
        - ➢ IHSS related unfavorable variance approximately $1.4 million
      - Professional Claims favorable variance of $4.5 million related to the transition of mental health services to capitation
    - OneCare Connect: favorable variance of $18.0 million
      - Favorable price variance of $7.6 million
        - ➢ Lower than budget in LTC and prescription drug categories
      - Favorable volume variance of $10.4 million

Back to Agenda

FY 2016-17: Consolidated Medical Expenses (cont.)

- January 2017 YTD:
  - Actual lower than budget by $4.1 million or 0.2%
    - Medi-Cal: unfavorable variance of $88.8 million
      - Unfavorable price variance of $87.1 million
        - IHSS estimated expense $37.3 million higher than budget
        - Long Term Care expense $31.9 million higher than budget
        - Facilities expense $17.5 million higher than budget
      - Unfavorable volume variance of $1.7 million
    - OneCare Connect: favorable variance of $91.6 million
      - Favorable volume variance of $61.1 million
      - Favorable price variance of $30.5 million

- Medical Loss Ratio (MLR):
  - January 2017 MTD: Actual: 97.0% Budget: 96.8%
  - January 2017 YTD: Actual: 96.8% Budget: 95.8%

Back to Agenda

FY 2016-17: Consolidated Administrative Expenses

- January 2017 MTD:
  - Actual lower than budget by $1.6 million or 13.3%
    - Salaries and Benefits: favorable variance of $1.1 million
    - Other categories: favorable variance of $0.5 million

- January 2017 YTD:
  - Actual lower than budget by $16.8 million or 20.7%
    - Salaries and Benefits: favorable variance of $11.5 million driven by lower than budgeted FTE
    - Other categories: favorable variance of $5.3 million

- Administrative Loss Ratio (ALR):
  - January 2017 MTD: Actual: 3.8% Budget: 4.2%
  - January 2017 YTD: Actual: 3.3% Budget: 4.1%

Back to Agenda

FY 2016-17: Change in Net Assets

- January 2017 MTD:
  - $0.4 million surplus
  - $2.9 million favorable to budget
    - Lower than budgeted revenue of $14.3 million
    - Lower than budgeted medical expenses of $13.3 million
    - Lower than budgeted administrative expenses of $1.6 million
    - Higher than budgeted investment income of $2.2 million

- January 2017 YTD:
  - $3.4 million surplus
  - $0.3 million favorable to budget
    - Lower than budgeted revenue of $24.9 million
    - Lower than budgeted medical expenses of $4.1 million
    - Lower than budgeted administrative expenses of $16.8 million
    - Higher than budgeted investment income of $3.9 million

Back to Agenda

Enrollment Summary: January 2017

Month-to-Date					Year-to-Date			
Actual	Budget	Variance	%	Enrollment (By Aid Category)	Actual	Budget	Variance	%
59,480	55,713	3,767	6.8%	Aged	408,415	386,649	21,766	5.6%
613	678	(65)	(9.6%)	BCCTP	4,357	4,736	(379)	(8.0%)
48,701	47,356	1,345	2.8%	*Disabled*	339,785	332,129	7,656	2.3%
330,849	342,494	(11,645)	(3.4%)	TANF Child	2,339,362	2,381,385	(42,023)	(1.8%)
99,852	109,062	(9,210)	(8.4%)	TANF Adult	715,861	766,532	(50,671)	(6.6%)
3,276	2,718	558	20.5%	LTC	22,844	18,855	3,989	21.2%
234,747	223,750	10,997	4.9%	MCE	1,624,689	1,559,137	65,552	4.2%
777,518	**781,771**	**(4,253)**	**(0.5%)**	**Medi-Cal**	**5,455,313**	**5,449,420**	**5,893**	**0.1%**
16,346	**21,763**	**(5,417)**	**(24.9%)**	**OneCare Connect**	**122,449**	**154,087**	**(31,638)**	**(20.5%)**
184	**195**	**(11)**	**(5.6%)**	**PACE**	**1,265**	**1,260**	**5**	**0.4%**
1,304	**1,179**	**125**	**10.6%**	**OneCare**	**8,554**	**8,507**	**47**	**0.6%**
795,352	**804,908**	**(9,556)**	**(1.2%)**	**CalOptima Total**	**5,587,581**	**5,613,274**	**(25,693)**	**(0.5%)**

Back to Agenda

CalOptima A Public Agency Better. Together.

Financial Highlights: January 2017

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
795,352	804,908	(9,556)	(1.2%)	Member Months	5,587,581	5,613,274	(25,693)	(0.5%)
267,340,029	281,612,948	(14,272,919)	(5.1%)	Revenues	1,947,527,539	1,972,468,212	(24,940,673)	(1.3%)
259,238,500	272,572,197	13,333,697	4.9%	Medical Expenses	1,884,936,793	1,889,058,571	4,121,778	0.2%
10,148,296	11,706,304	1,558,008	13.3%	Administrative Expenses	64,478,319	81,319,321	16,841,003	20.7%
(2,046,768)	**(2,665,553)**	**618,785**	**(23.2%)**	**Operating Margin**	**(1,887,572)**	**2,090,319**	**(3,977,892)**	**(190.3%)**
2,408,040	132,617	2,275,423	1715.8%	Non Operating Income (Loss)	5,314,453	992,117	4,322,336	435.7%
361,272	**(2,532,936)**	**2,894,208**	**114.3%**	**Change in Net Assets**	**3,426,881**	**3,082,436**	**344,444**	**11.2%**
97.0%	96.8%	(0.2%)		Medical Loss Ratio	96.8%	95.8%	(1.0%)	
3.8%	4.2%	0.4%		Administrative Loss Ratio	3.3%	4.1%	0.8%	
(0.8%)	(0.9%)	0.2%		Operating Margin Ratio	(0.1%)	0.1%	(0.2%)	
100.0%	100.0%			Total Operating	100.0%	100.0%		

Back to Agenda

UNAUDITED FINANCIAL STATEMENTS

January 2017

Back to Agenda

Table of Contents

Back to Agenda

CalOptima - Consolidated
Financial Highlights
For the Seven Months Ended January 31, 2017

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
795,352	804,908	(9,556)	(1.2%)	Member Months	5,587,581	5,613,274	(25,693)	(0.5%)
267,340,029	281,612,948	(14,272,919)	(5.1%)	Revenues	1,947,527,539	1,972,468,212	(24,940,673)	(1.3%)
259,238,500	272,572,197	13,333,697	4.9%	Medical Expenses	1,884,936,793	1,889,058,571	4,121,778	0.2%
10,148,296	11,706,304	1,558,008	13.3%	Administrative Expenses	64,478,319	81,319,321	16,841,003	20.7%
(2,046,768)	**(2,665,553)**	**618,785**	**(23.2%)**	**Operating Margin**	**(1,887,572)**	**2,090,319**	**(3,977,892)**	**(190.3%)**
2,408,040	132,617	2,275,423	1715.8%	Non Operating Income (Loss)	5,314,453	992,117	4,322,336	435.7%
361,272	**(2,532,936)**	**2,894,208**	**114.3%**	**Change in Net Assets**	**3,426,881**	**3,082,436**	**344,444**	**11.2%**
97.0%	96.8%	(0.2%)		Medical Loss Ratio	96.8%	95.8%	(1.0%)	
3.8%	4.2%	0.4%		Administrative Loss Ratio	3.3%	4.1%	0.8%	
(0.8%)	(0.9%)	0.2%		Operating Margin Ratio	(0.1%)	0.1%	(0.2%)	
100.0%	100.0%			Total Operating	100.0%	100.0%		

Back to Agenda

CalOptima
Financial Dashboard
For the Seven Months Ended January 31, 2017

MONTH

Enrollment

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	777,518	781,771	(4,253)	(0.5%)
OneCare	1,304	1,179	125	10.6%
OneCare Connect	16,346	21,763	(5,417)	(24.9%)
PACE	184	195	(11)	(5.6%)
Total	795,352	804,908	(9,556)	(1.2%)

Change in Net Assets ($000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 3,752	$ (1,874)	$ 5,626	300.1%
OneCare	228	7	221	3120.2%
OneCare Connect	(5,866)	(577)	(5,289)	(917.2%)
PACE	(181)	(221)	40	18.2%
505 Bldg.	4	(76)	80	105.1%
Investment Income & Other	2,425	208	2,217	1064.2%
Total	$ 361	$ (2,533)	$ 2,894	114.3%

MLR

	Actual	Budget	% Point Var
Medi-Cal	95.1%	96.9%	1.8
OneCare	79.8%	90.6%	10.8
OneCare Connect	120.8%	96.0%	(24.8)

Administrative Cost ($000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 8,172	$ 9,136	$ 964	10.6%
OneCare	101	122	22	17.7%
OneCare Connect	1,742	2,325	583	25.1%
PACE	134	123	(10)	(8.5%)
Total	$ 10,148	$ 11,706	$ 1,558	13.3%

Total FTE's Month

	Actual	Budget	Fav / (Unfav)
Medi-Cal	836	886	50
OneCare	4	3	(1)
OneCare Connect	225	239	14
PACE	43	59	15
Total	1,108	1,186	78

MM per FTE

	Actual	Budget	Fav / (Unfav)
Medi-Cal	930	882	47
OneCare	364	393	(29)
OneCare Connect	73	91	(19)
PACE	4	3	1
Total	1,371	1,370	1

YEAR - TO - DATE

Year To Date Enrollment

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	5,455,313	5,449,420	5,893	0.1%
OneCare	8,554	8,507	47	0.6%
OneCare Connect	122,449	154,087	(31,638)	(20.5%)
PACE	1,265	1,260	5	0.4%
Total	5,587,581	5,613,274	(25,693)	(0.5%)

Change in Net Assets ($000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 1,101	$ 1,147	$ (46)	(4.0%)
OneCare	(214)	179	(392)	(219.4%)
OneCare Connect	(3,518)	2,405	(5,923)	(246.3%)
PACE	703	(1,640)	2,343	142.8%
505 Bldg.	34	(466)	500	107.2%
Investment Income & Other	5,322	1,458	3,863	264.9%
Total	$ 3,428	$ 3,082	$ 345	11.2%

MLR

	Actual	Budget	% Point Var
Medi-Cal	97.0%	96.1%	(0.9)
OneCare	95.6%	91.0%	(4.6)
OneCare Connect	96.0%	94.0%	(1.9)

Administrative Cost ($000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 50,913	$ 63,329	$ 12,416	19.6%
OneCare	623	704	82	11.6%
OneCare Connect	12,171	16,458	4,287	26.0%
PACE	771	828	57	6.9%
Total	$ 64,478	$ 81,319	$ 16,841	20.7%

Total FTE's YTD

	Actual	Budget	Fav / (Unfav)
Medi-Cal	5,887	6,201	314
OneCare	25	21	(4)
OneCare Connect	1,575	1,670	95
PACE	281	398	116
Total	7,770	8,290	520

MM per FTE

	Actual	Budget	Fav / (Unfav)
Medi-Cal	927	879	48
OneCare	337	405	(68)
OneCare Connect	78	92	(15)
PACE	4	3	1
Total	1,346	1,379	(33)

Back to Agenda

CalOptima - Consolidated
Statement of Revenue and Expenses
For the One Month Ended January 31, 2017

	Month					
	Actual		Budget		Variance	
	$	PMPM*	$	PMPM*	$	PMPM
Member Months**	795,352		804,908		(9,556)	
Revenues						
Medi-Cal	$ 244,676,859	$ 314.69	$ 235,298,996	$ 300.98	$ 9,377,863	$ 13.71
OneCare	1,623,489	1,245.01	1,374,453	1,165.78	249,036	79.23
OneCare Connect	19,825,206	1,212.85	43,714,072	2,008.64	(23,888,866)	(795.79)
PACE	1,214,476	6,600.41	1,225,427	6,284.24	(10,951)	316.17
Total Operating Revenue	267,340,029	336.13	281,612,948	349.87	(14,272,919)	(13.74)
Medical Expenses						
Medi-Cal	232,731,658	299.33	228,037,361	291.69	(4,694,297)	(7.63)
OneCare	1,295,373	993.38	1,245,189	1,056.14	(50,185)	62.76
OneCare Connect	23,949,593	1,465.17	41,966,160	1,928.33	18,016,567	463.16
PACE	1,261,876	6,858.02	1,323,487	6,787.11	61,611	(70.91)
Total Medical Expenses	259,238,500	325.94	272,572,197	338.64	13,333,697	12.70
Gross Margin	8,101,529	10.19	9,040,751	11.23	(939,223)	(1.05)
Administrative Expenses						
Salaries and benefits	6,756,746	8.50	7,816,533	9.71	1,059,787	1.22
Professional fees	181,542	0.23	445,418	0.55	263,876	0.33
Purchased services	818,473	1.03	1,051,653	1.31	233,180	0.28
Printing and Postage	212,381	0.27	475,344	0.59	262,963	0.32
Depreciation and amortization	353,854	0.44	385,117	0.48	31,263	0.03
Other	1,432,193	1.80	1,104,934	1.37	(327,258)	(0.43)
Indirect Cost Allocation, Occupancy Expense	393,108	0.49	427,305	0.53	34,197	0.04
Total Administrative Expenses	10,148,296	12.76	11,706,304	14.54	1,558,008	1.78
Income (Loss) From Operations	(2,046,768)	(2.57)	(2,665,553)	(3.31)	618,785	0.74
Investment income						
Interest income	1,815,571	2.28	208,333	0.26	1,607,237	2.02
Realized gain/(loss) on investments	2,096	0.00	-	-	2,096	0.00
Unrealized gain/(loss) on investments	607,628	0.76	-	-	607,628	0.76
Total Investment Income	2,425,294	3.05	208,333	0.26	2,216,961	2.79
Net Rental Income	3,880	0.00	(75,717)	(0.09)	79,596	0.10
Total Net Operating Tax	-	-	-	-	-	-
Total Net Grant Income	(21,239)	(0.03)	-	-	(21,239)	(0)
QAF/IGT	-	-	-	-	-	-
Other Income	105	0.00	-	-	105	0.00
Change In Net Assets	**361,272**	**0.45**	**(2,532,936)**	**(3.15)**	**2,894,208**	**3.60**
Medical Loss Ratio	**97.0%**		**96.8%**		**(0.2%)**	
Administrative Loss Ratio	**3.8%**		**4.2%**		**0.4%**	

* PMPMs for Revenues and Medical Expenses are calculated using line of business enrollment
** Includes MSSP

Back to Agenda

CalOptima - Consolidated - Year to Date
Statement of Revenue and Expenses
For the Seven Months Ended January 31, 2017

	Year to Date					
	Actual		Budget		Variance	
	$	PMPM*	$	PMPM*	$	PMPM
Member Months**	5,587,581		5,613,274		(25,693)	
Revenues						
Medi-Cal	$ 1,714,661,288	$ 314.31	$ 1,638,234,984	$ 300.63	$ 76,426,304	$ 13.68
OneCare	9,320,184	1,089.57	9,777,146	1,149.31	(456,962)	(59.74)
OneCare Connect	214,685,712	1,753.27	316,497,051	2,054.02	(101,811,339)	(300.75)
PACE	8,860,356	7,004.23	7,959,031	6,316.69	901,325	687.54
Total Operating Revenue	1,947,527,539	348.55	1,972,468,212	351.39	(24,940,673)	(2.85)
Medical Expenses						
Medi-Cal	1,662,607,332	304.77	1,573,759,309	288.79	(88,848,023)	(15.97)
OneCare	8,910,736	1,041.70	8,893,798	1,045.47	(16,938)	3.76
OneCare Connect	206,032,099	1,682.60	297,633,639	1,931.59	91,601,540	249.00
PACE	7,386,626	5,839.23	8,771,825	6,961.77	1,385,199	1,122.54
Total Medical Expenses	1,884,936,793	337.34	1,889,058,571	336.53	4,121,778	(0.81)
Gross Margin	62,590,746	11.20	83,409,641	14.86	(20,818,894)	(3.66)
Administrative Expenses						
Salaries and benefits	43,119,190	7.72	54,647,580	9.74	11,528,390	2.02
Professional fees	1,276,641	0.23	2,853,432	0.51	1,576,791	0.28
Purchased services	5,864,203	1.05	6,603,471	1.18	739,268	0.13
Printing and Postage	1,960,459	0.35	3,246,195	0.58	1,285,736	0.23
Depreciation and amortization	2,200,579	0.39	2,695,821	0.48	495,242	0.09
Other	7,505,131	1.34	8,276,840	1.47	771,709	0.13
Indirect cost allocation, Occupancy Expense	2,552,116	0.46	2,995,983	0.53	443,867	0.08
Total Administrative Expenses	64,478,319	11.54	81,319,321	14.49	16,841,003	2.95
Income (Loss) From Operations	(1,887,572)	(0.34)	2,090,319	0.37	(3,977,892)	(0.71)
Investment income						
Interest income	9,774,859	1.75	1,458,334	0.26	8,316,525	1.49
Realized gain/(loss) on investments	225,455	0.04	-	-	225,455	0.04
Unrealized gain/(loss) on investments	(4,679,346)	(0.84)	-	-	(4,679,346)	(0.84)
Total Investment Income	5,320,968	0.95	1,458,334	0.26	3,862,634	0.69
Net Rental Income	33,656	0.01	(466,217)	(0.08)	499,872	0.09
Total Net Operating Tax	0	0	-	-	0	0
Total Net Grant Income	(40,898)	(0)	-	-	(40,898)	(0)
QAF/IGT	-	-	-	-	-	-
Other Income	728	0.00	-	-	728	0.00
Change In Net Assets	**3,426,881**	**0.61**	**3,082,436**	**0.55**	**344,444**	**0.06**
Medical Loss Ratio	**96.8%**		**95.8%**		**(1.0%)**	
Administrative Loss Ratio	**3.3%**		**4.1%**		**0.8%**	

* PMPMs for Revenues and Medical Expenses are calculated using line of business enrollment

** Includes MSSP

Back to Agenda

CalOptima - Consolidated - Month to Date
Statement of Revenues and Expenses by LOB
For the One Month Ended January 31, 2017

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare	OneCare Connect	PACE	Consolidated
Member Months	542,771	234,747	777,518	1,304	16,346	184	795,352
REVENUES							
Capitation Revenue	$ 134,511,567	$ 110,165,292	$ 244,676,859	$ 1,623,489	$ 19,825,206	$ 1,214,476	$ 267,340,029
Other Income	-	-	-	-	-	-	-
Total Operating Revenues	134,511,567	110,165,292	244,676,859	1,623,489	19,825,206	1,214,476	267,340,029
MEDICAL EXPENSES							
Provider Capitation	33,358,909	42,769,148	76,128,058	480,751	6,108,923	-	82,717,732
Facilities	27,610,371	30,634,643	58,245,014	298,313	6,969,066	380,523	65,892,916
Ancillary	-	-	-	59,631	697,313	-	756,944
Skilled Nursing	-	-	-	27,020	-	-	27,020
Professional Claims	4,816,665	8,660,863	13,477,529	-	-	239,904	13,717,432
Prescription Drugs	18,628,594	17,962,419	36,591,013	361,427	4,305,554	71,953	41,329,948
Long-term Care Facility Payments	42,640,015	2,084,458	44,724,472	-	4,848,306	12,542	49,585,320
Medical Management	3,005,920	-	3,005,920	62,855	940,033	393,867	4,402,676
Reinsurance & Other	(611,731)	1,171,383	559,651	5,376	80,398	163,086	808,512
Total Medical Expenses	129,448,743	103,282,914	232,731,658	1,295,373	23,949,593	1,261,876	259,238,500
Medical Loss Ratio	**96.2%**	**93.8%**	**95.1%**	**79.8%**	**120.8%**	**103.9%**	**97.0%**
GROSS MARGIN	**5,062,823**	**6,882,378**	**11,945,201**	**328,115**	**(4,124,388)**	**(47,401)**	**8,101,529**
ADMINISTRATIVE EXPENSES							
Salaries, Wages & Employee Benefits			5,723,326	22,988	912,218	98,213	6,756,746
Professional Fees			141,436	22,288	8,263	9,555	181,542
Purchased Services			657,393	30,171	123,973	6,935	818,473
Printing and Postage			212,249	1,849	(1,914)	196	212,381
Depreciation and Amortization			351,789	-	-	2,065	353,854
Other Expenses			1,372,638	379	44,656	14,519	1,432,193
Indirect Cost Allocation, Occupancy Expense			(286,561)	22,850	654,511	2,308	393,108
Total Administrative Expenses			8,172,271	100,525	1,741,708	133,793	10,148,296
Admin Loss Ratio			**3.3%**	**6.2%**	**8.8%**	**11.0%**	**3.8%**
INCOME (LOSS) FROM OPERATIONS			3,772,930	227,590	(5,866,095)	(181,193)	(2,046,768)
INVESTMENT INCOME			-	-	-	-	2,425,294
NET RENTAL INCOME			-	-	-	-	3,880
NET GRANT INCOME			(21,239)	-	-	-	(21,239)
OTHER INCOME			105	-	-	-	105
CHANGE IN NET ASSETS			**$ 3,751,796**	**$ 227,590**	**$ (5,866,095)**	**$ (181,193)**	**$ 361,272**
BUDGETED CHANGE IN ASSETS			(1,874,498)	7,068	(576,696)	(221,426)	(2,532,936)
VARIANCE TO BUDGET - FAV (UNFAV)			5,626,294	220,523	(5,289,399)	40,233	2,894,208

Back to Agenda

CalOptima - Consolidated - Year to Date
Statement of Revenues and Expenses by LOB
For the Seven Months Ended January 31, 2017

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare	OneCare Connect	PACE	Consolidated
Member Months	3,830,624	1,624,689	5,455,313	8,554	122,449	1,265	5,587,581
REVENUES							
Capitation Revenue	$ 966,488,093	$ 748,173,194	$ 1,714,661,288	$ 9,320,184	$ 214,685,712	$ 8,860,356	$ 1,947,527,539
Other Income	-	-	-	-	0	-	-
Total Operating Revenues	966,488,093	748,173,194	1,714,661,288	9,320,184	214,685,712	8,860,356	1,947,527,539
MEDICAL EXPENSES							
Provider Capitation	226,115,031	295,372,740	521,487,771	2,843,443	50,398,780	-	574,729,994
Facilities	197,454,715	216,038,285	413,493,000	2,262,914	64,170,913	1,812,070	481,738,897
Ancillary	-	-	-	321,261	5,214,781	-	5,536,042
Skilled Nursing	-	-	-	331,121	-	-	331,121
Professional Claims	67,097,290	61,318,172	128,415,462	-	-	1,457,584	129,873,046
Prescription Drugs	126,907,399	116,607,829	243,515,227	2,999,862	37,633,804	585,416	284,734,310
Long-term Care Facility Payments	317,328,273	13,815,012	331,143,285	-	40,961,645	36,053	372,140,982
Medical Management	20,561,058	-	20,561,058	119,863	7,007,442	2,751,007	30,439,371
Reinsurance & Other	(3,046,850)	7,038,379	3,991,529	32,271	644,734	744,496	5,413,030
Total Medical Expenses	952,416,915	710,190,417	1,662,607,332	8,910,736	206,032,099	7,386,626	1,884,936,793
Medical Loss Ratio	**98.5%**	**94.9%**	**97.0%**	**95.6%**	**96.0%**	**83.4%**	**96.8%**
GROSS MARGIN	**14,071,178**	**37,982,777**	**52,053,955**	**409,448**	**8,653,612**	**1,473,730**	**62,590,746**
ADMINISTRATIVE EXPENSES							
Salaries, Wages & Employee Benefits			36,814,963	111,954	5,547,600	644,673	43,119,190
Professional Fees			825,176	120,357	316,552	14,555	1,276,641
Purchased Services			4,741,487	165,576	928,687	28,454	5,864,203
Printing and Postage			1,434,504	60,117	463,642	2,196	1,960,459
Depreciation and Amortization			2,186,266			14,312	2,200,579
Other Expenses			7,203,176	2,071	249,374	50,510	7,505,131
Indirect Cost Allocation, Occupancy Expense			(2,292,573)	162,880	4,665,610	16,199	2,552,116
Total Administrative Expenses			50,912,999	622,955	12,171,465	770,900	64,478,319
Admin Loss Ratio			**3.0%**	**6.7%**	**5.7%**	**8.7%**	**3.3%**
INCOME (LOSS) FROM OPERATIONS			1,140,956	(213,507)	(3,517,852)	702,831	(1,887,572)
INVESTMENT INCOME			-	-	-	-	5,320,968
NET RENTAL INCOME			-	-	-	-	33,656
NET GRANT INCOME			(40,898)	-	-	-	(40,898)
OTHER INCOME			728	-	-	-	728
CHANGE IN NET ASSETS			**$ 1,100,786**	**$ (213,507)**	**$ (3,517,852)**	**$ 702,831**	**$ 3,426,881**
BUDGETED CHANGE IN ASSETS			1,146,595	178,875	2,405,253	(1,640,404)	3,082,436
VARIANCE TO BUDGET - FAV (UNFAV)			(45,809)	(392,382)	(5,923,106)	2,343,235	344,444

Back to Agenda

SUMMARY

MONTHLY RESULTS:

- Change in Net Assets is $0.4 million, $2.9 million favorable to budget
- Operating deficit is $2.1 million with a surplus in non-operating of $2.4 million

YEARLY RESULTS:

- Change in Net Assets is $3.4 million, $0.3 million favorable to budget
- Operating deficit is $1.9 million with a surplus in non-operating of $5.4 million

Change in Net Assets by LOB ($millions)

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
3.8	(1.9)	5.6	Medi-Cal	1.1	1.1	0.0
0.2	0.0	0.2	OneCare	(0.2)	0.2	(0.4)
(5.9)	(0.6)	(5.3)	OCC	(3.5)	2.4	(5.9)
(0.2)	(0.2)	0.0	PACE	0.7	(1.6)	2.3
(2.1)	**(2.7)**	**0.6**	**Operating**	**(1.9)**	**2.1**	**(4.0)**
2.4	0.1	2.3	Inv./Rental Inc, MCO tax	5.4	1.0	4.4
2.4	**0.1**	**2.3**	**Non-Operating**	**5.4**	**1.0**	**4.4**
0.4	**(2.5)**	**2.9**	**TOTAL**	**3.4**	**3.1**	**0.3**

Back to Agenda

CalOptima

Enrollment Summary

For the Seven Months Ended January 31, 2017

Month-to-Date					Year-to-Date			
Actual	**Budget**	**Variance**	**%**	**Enrollment (By Aid Category)**	**Actual**	**Budget**	**Variance**	**%**
59,480	55,713	3,767	6.8%	Aged	408,415	386,649	21,766	5.6%
613	678	(65)	(9.6%)	BCCTP	4,357	4,736	(379)	(8.0%)
48,701	47,356	1,345	2.8%	*Disabled*	339,785	332,129	7,656	2.3%
330,849	342,494	(11,645)	(3.4%)	TANF Child	2,339,362	2,381,385	(42,023)	(1.8%)
99,852	109,062	(9,210)	(8.4%)	TANF Adult	715,861	766,532	(50,671)	(6.6%)
3,276	2,718	558	20.5%	LTC	22,844	18,855	3,989	21.2%
234,747	223,750	10,997	4.9%	MCE	1,624,689	1,559,137	65,552	4.2%
777,518	**781,771**	**(4,253)**	**(0.5%)**	**Medi-Cal**	**5,455,313**	**5,449,420**	**5,893**	**0.1%**
16,346	**21,763**	**(5,417)**	**(24.9%)**	**OneCare Connect**	**122,449**	**154,087**	**(31,638)**	**(20.5%)**
184	**195**	**(11)**	**(5.6%)**	**PACE**	**1,265**	**1,260**	**5**	**0.4%**
1,304	**1,179**	**125**	**10.6%**	**OneCare**	**8,554**	**8,507**	**47**	**0.6%**
795,352	**804,908**	**(9,556)**	**(1.2%)**	**CalOptima Total**	**5,587,581**	**5,613,274**	**(25,693)**	**(0.5%)**

Enrollment (By Network)

49,254	48,921	333	0.7%	HMO	340,088	334,443	5,645	1.7%
225,988	235,738	(9,750)	(4.1%)	PHC	1,611,193	1,642,458	(31,265)	(1.9%)
333,777	339,879	(6,102)	(1.8%)	Shared Risk Group	2,383,618	2,384,775	(1,157)	(0.0%)
168,499	157,233	11,266	7.2%	Fee for Service	1,120,414	1,087,752	32,662	3.0%
777,518	**781,771**	**(4,253)**	**(0.5%)**	**Medi-Cal**	**5,455,313**	**5,449,420**	**5,893**	**0.1%**
16,346	**21,763**	**(5,417)**	**(24.9%)**	**OneCare Connect**	**122,449**	**154,087**	**(31,638)**	**(20.5%)**
184	**195**	**(11)**	**(5.6%)**	**PACE**	**1,265**	**1,260**	**5**	**0.4%**
1,304	**1,179**	**125**	**10.6%**	**OneCare**	**8,554**	**8,507**	**47**	**0.6%**
795,352	**804,908**	**(9,556)**	**(1.2%)**	**CalOptima Total**	**5,587,581**	**5,613,274**	**(25,693)**	**(0.5%)**

Back to Agenda

CalOptima
Enrollment Trend by Network Type
Fiscal Year 2017

Network Type	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	MMs
HMO													
Aged	351	350	355	368	363	381	379	-	-	-	-	-	2,547
BCCTP	1	1	1	(8)	2	1	1	-	-	-	-	-	(1)
Disabled	1,799	1,797	1,813	1,866	1,853	1,858	1,875	-	-	-	-	-	12,861
TANF Child	24,211	24,455	24,733	24,928	24,987	25,083	24,928	-	-	-	-	-	173,325
TANF Adult	7,929	7,872	7,914	7,850	8,029	7,967	7,871	-	-	-	-	-	55,432
LTC	-	-	-	-	-	-	-	-	-	-	-	-	-
MCE	12,989	13,224	13,464	14,034	13,897	14,116	14,200	-	-	-	-	-	95,924
	47,280	47,699	48,280	49,038	49,131	49,406	49,254	-	-	-	-	-	340,088
PHC													
Aged	1,495	1,464	1,488	1,458	1,427	1,419	1,408	-	-	-	-	-	10,159
BCCTP	-	-	-	1	-	-	-	-	-	-	-	-	1
Disabled	7,903	7,872	7,862	7,865	7,804	7,779	7,783	-	-	-	-	-	54,868
TANF Child	169,358	168,529	169,733	169,714	168,615	168,294	165,979	-	-	-	-	-	1,180,222
TANF Adult	15,260	14,945	14,649	14,593	14,161	13,880	13,457	-	-	-	-	-	100,945
LTC	-	-	-	4	-	-	-	-	-	-	-	-	4
MCE	38,002	38,200	37,601	38,070	37,874	37,886	37,361	-	-	-	-	-	264,994
	232,018	231,010	231,333	231,705	229,881	229,258	225,988	-	-	-	-	-	1,611,193
Shared Risk Group													
Aged	7,658	7,627	7,635	7,726	7,528	7,546	7,501	-	-	-	-	-	53,221
BCCTP	-	-	-	8	1	-	-	-	-	-	-	-	9
Disabled	14,428	14,307	14,189	14,253	14,073	14,084	14,005	-	-	-	-	-	99,339
TANF Child	118,748	118,149	118,421	117,922	116,971	116,744	114,746	-	-	-	-	-	821,701
TANF Adult	63,849	62,814	62,579	62,266	61,355	60,893	59,355	-	-	-	-	-	433,111
LTC	-	-	-	3	3	3	5	-	-	-	-	-	14
MCE	140,640	140,811	137,172	139,776	139,565	140,094	138,165	-	-	-	-	-	976,223
	345,323	343,708	339,996	341,954	339,496	339,364	333,777	-	-	-	-	-	2,383,618
Fee for Service (Dual)													
Aged	43,684	45,173	45,173	45,522	46,007	46,233	46,592	-	-	-	-	-	318,384
BCCTP	27	26	24	23	23	23	25	-	-	-	-	-	171
Disabled	19,790	20,086	20,071	20,264	20,375	20,497	20,471	-	-	-	-	-	141,554
TANF Child	3	2	2	3	4	3	3	-	-	-	-	-	20
TANF Adult	1,179	1,162	1,184	1,197	1,181	1,216	1,220	-	-	-	-	-	8,339
LTC	2,868	2,910	2,941	2,906	2,940	2,914	2,914	-	-	-	-	-	20,393
MCE	2,960	2,975	2,721	2,750	2,822	2,893	2,818	-	-	-	-	-	19,939
	70,511	72,334	72,116	72,665	73,352	73,779	74,043	-	-	-	-	-	508,800
Fee for Service (Non-Dual)													
Aged	3,746	2,850	3,183	3,608	3,450	3,667	3,600	-	-	-	-	-	24,104
BCCTP	606	608	598	589	594	595	587	-	-	-	-	-	4,177
Disabled	4,533	4,269	4,390	4,368	4,488	4,548	4,567	-	-	-	-	-	31,163
TANF Child	22,710	23,011	22,504	23,069	23,658	23,949	25,193	-	-	-	-	-	164,094
TANF Adult	15,792	16,253	16,501	17,109	17,090	17,340	17,949	-	-	-	-	-	118,034
LTC	368	370	362	314	334	328	357	-	-	-	-	-	2,433
MCE	35,946	36,543	37,812	36,999	38,607	39,499	42,203	-	-	-	-	-	267,609
	83,701	83,904	85,350	86,056	88,221	89,926	94,456	-	-	-	-	-	611,614
MEDI-CAL TOTAL													
Aged	56,934	57,464	57,834	58,682	58,775	59,246	59,480	-	-	-	-	-	408,415
BCCTP	634	635	623	613	620	619	613	-	-	-	-	-	4,357
Disabled	48,453	48,331	48,325	48,616	48,593	48,766	48,701	-	-	-	-	-	339,785
TANF Child	335,030	334,146	335,393	335,636	334,235	334,073	330,849	-	-	-	-	-	2,339,362
TANF Adult	104,009	103,046	102,827	103,015	101,816	101,296	99,852	-	-	-	-	-	715,861
LTC	3,236	3,280	3,303	3,227	3,277	3,245	3,276	-	-	-	-	-	22,844
MCE	230,537	231,753	228,770	231,629	232,765	234,488	234,747	-	-	-	-	-	1,624,689
	778,833	778,655	777,075	781,418	780,081	781,733	777,518	-	-	-	-	-	5,455,313
PACE	177	179	179	180	183	183	184	-	-	-	-	-	1,265
OneCare	1,171	1,164	1,192	1,220	1,228	1,275	1,304	-	-	-	-	-	8,554
OneCare Connect	18,902	18,245	17,727	17,352	17,067	16,810	16,346	-	-	-	-	-	122,449
TOTAL	799,083	798,243	796,173	800,170	798,559	800,001	795,352	-	-	-	-	-	5,587,581

Back to Agenda

ENROLLMENT:

Overall MTD enrollment was 795,352
- Unfavorable to budget by 9,556
- Decreased 4,649 or 0.6% from prior month
- Increased 16,651 or 2.1% from prior year (January 2016)

Medi-Cal enrollment was 777,518
- Unfavorable to budget by 4,253
    - Expansion favorable by 10,997
    - SPD favorable by 5,047
    - LTC favorable by 558
    - TANF unfavorable by 20,855
- Decreased 4,215 from prior month

OneCare Connect enrollment was 16,346
- Unfavorable to budget by 5,417
- Decreased 464 from prior month

OneCare enrollment was 1,304
- Favorable to budget by 125
- Increased 29 from prior month

PACE enrollment at 184
- Unfavorable to budget by 11
- Increased 1 from prior month

CalOptima - MediCal Total
Statement of Revenues and Expenses
For the Seven Months Ended January 31, 2017

Month					Year - To - Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
777,518	781,771	(4,253)	(0.5%)	Member Months	5,455,313	5,449,420	5,893	0.1%
				Revenues				
244,676,859	235,298,996	9,377,863	4.0%	Capitation revenue	1,714,661,288	1,638,234,984	76,426,304	4.7%
244,676,859	235,298,996	9,377,863	4.0%	Total Operating Revenues	1,714,661,288	1,638,234,984	76,426,304	4.7%
				Medical Expenses				
76,128,058	75,284,645	(843,413)	(1.1%)	Provider capitation	521,487,771	525,227,701	3,739,930	0.7%
58,245,014	57,440,841	(804,173)	(1.4%)	Facilities	413,493,000	395,961,878	(17,531,122)	(4.4%)
13,477,529	17,996,155	4,518,626	25.1%	Professional Claims	128,415,462	120,124,201	(8,291,261)	(6.9%)
36,591,013	35,075,550	(1,515,464)	(4.3%)	Prescription drugs	243,515,227	240,949,594	(2,565,634)	(1.1%)
44,724,472	37,607,488	(7,116,984)	(18.9%)	MLTSS	331,143,285	260,316,303	(70,826,982)	(27.2%)
3,005,920	4,616,016	1,610,096	34.9%	Medical Management	20,561,058	31,062,966	10,501,908	33.8%
559,651	16,667	(542,985)	(3,257.9%)	Reinsurance & other	3,991,529	116,667	(3,874,862)	(3,321.3%)
232,731,658	228,037,361	(4,694,297)	(2.1%)	Total Medical Expenses	1,662,607,332	1,573,759,309	(88,848,023)	(5.6%)
11,945,201	7,261,635	4,683,566	64.5%	Gross Margin	52,053,955	64,475,675	(12,421,719)	(19.3%)
				Administrative Expenses				
5,723,326	6,732,505	1,009,179	15.0%	Salaries, wages & employee benefits	36,814,963	47,205,575	10,390,611	22.0%
141,436	329,611	188,175	57.1%	Professional fees	825,176	2,168,819	1,343,643	62.0%
657,393	829,632	172,238	20.8%	Purchased services	4,741,487	5,187,212	445,726	8.6%
212,249	311,516	99,266	31.9%	Printing and postage	1,434,504	2,188,961	754,457	34.5%
351,789	383,061	31,272	8.2%	Depreciation & amortization	2,186,266	2,681,428	495,161	18.5%
1,372,638	1,090,510	(282,128)	(25.9%)	Other operating expenses	7,203,176	7,677,151	473,975	6.2%
(286,561)	(540,702)	(254,141)	(47.0%)	Indirect cost allocation	(2,292,573)	(3,780,066)	(1,487,493)	(39.4%)
8,172,271	9,136,133	963,862	10.6%	Total Administrative Expenses	50,912,999	63,329,080	12,416,081	19.6%
				Operating Tax				
10,106,435	8,856,941	(1,249,494)	(14.1%)	Tax Revenue	83,663,342	61,785,238	(21,878,104)	(35.4%)
10,225,313	0	(10,225,313)	0.0%	Premium tax expense	71,577,192	0	(71,577,192)	0.0%
(118,878)	8,856,941	8,975,819	101.3%	Sales tax expense	12,086,150	61,785,238	49,699,088	80.4%
0	0	0	0.0%	Total Net Operating Tax	0	0	0	0.0%
				Grant Income				
0	287,500	(287,500)	(100.0%)	Grant Revenue	607,500	2,012,500	(1,405,000)	(69.8%)
0	250,000	250,000	100.0%	Grant expense - Service Partner	516,375	1,750,000	1,233,625	70.5%
21,239	37,500	16,261	43.4%	Grant expense - Administrative	132,023	262,500	130,477	49.7%
(21,239)	0	(21,239)	0.0%	Total Net Grant Income	(40,898)	0	(40,898)	0.0%
105	0	105	0.0%	Other income	728	0	728	0.0%
3,751,796	(1,874,498)	5,626,294	300.1%	Change in Net Assets	1,100,786	1,146,595	(45,809)	(4.0%)
95.1%	96.9%	1.8%	1.9%	Medical Loss Ratio	97.0%	96.1%	(0.9%)	(0.9%)
3.3%	3.9%	0.5%	14.0%	Admin Loss Ratio	3.0%	3.9%	0.9%	23.2%

Back to Agenda

MEDI-CAL INCOME STATEMENT – JANUARY MONTH:

REVENUES of $244.7 million are favorable to budget by $9.4 million, driven by:

- Price related favorable variance of $10.7 million due:
  - $9.4 million of LTC revenue for non-LTC members
- Volume related unfavorable variance of: $1.3 million

MEDICAL EXPENSES: Overall $232.7 million, unfavorable to budget by $4.7 million due to:

- **Long term care claim payments (MLTSS)** are unfavorable to budget $7.1 million due to:
  - LTC unfavorable variance of $5.5 million driven by:
    - $3.5 million higher LTC claim expense due to less than anticipated members enrolling in OneCare Connect
    - $2.0 million variance from FY17 mandated rate increase
  - IHSS related unfavorable variance of approximately $1.4 million
- **Professional claims** are favorable to budget $4.5 million due to:
  - Price related favorable variance of: $4.4 million related to the transition of mental health services to capitation.

ADMINISTRATIVE EXPENSES are $8.2 million, favorable to budget $1.0 million, driven by:

- Salary & Benefits: $1.0 million favorable to budget
- Non-Salary: $45 thousand unfavorable to budget

CHANGE IN NET ASSETS is $3.8 million for the month, favorable to budget by $5.6 million

CalOptima - OneCare Connect
Statement of Revenues and Expenses
For the Seven Months Ended January 31, 2017

Month					Year - To - Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
16,346	21,763	(5,417)	(24.9%)	Member Months	122,449	154,087	(31,638)	(20.5%)
				Revenues				
696,271	11,536,830	(10,840,559)	(94.0%)	Medi-Cal Capitation revenue	48,650,456	83,907,030	(35,256,574)	(42.0%)
19,128,935	32,177,242	(13,048,307)	(40.6%)	Medicare Capitation revenue	166,035,256	232,590,021	(66,554,765)	(28.6%)
19,825,206	43,714,072	(23,888,866)	(54.6%)	Total Operating Revenue	214,685,712	316,497,051	(101,811,339)	(32.2%)
				Medical Expenses				
6,108,923	9,627,208	3,518,285	36.5%	Provider capitation	50,398,780	69,692,961	19,294,181	27.7%
6,969,066	11,286,544	4,317,478	38.3%	Facilities	64,170,913	80,368,270	16,197,357	20.2%
697,313	680,952	(16,361)	(2.4%)	Ancillary	5,214,781	4,821,338	(393,444)	(8.2%)
4,848,306	10,279,705	5,431,399	52.8%	Long Term Care	40,961,645	72,783,172	31,821,527	43.7%
4,305,554	8,183,227	3,877,673	47.4%	Prescription drugs	37,633,804	56,869,484	19,235,680	33.8%
940,033	1,281,780	341,747	26.7%	Medical management	7,007,442	8,660,891	1,653,448	19.1%
80,398	626,744	546,346	87.2%	Other medical expenses	644,734	4,437,524	3,792,790	85.5%
23,949,593	41,966,160	18,016,567	42.9%	Total Medical Expenses	206,032,099	297,633,639	91,601,540	30.8%
(4,124,388)	1,747,912	(5,872,299)	(336.0%)	Gross Margin	8,653,612	18,863,412	(10,209,800)	(54.1%)
				Administrative Expenses				
912,218	967,612	55,394	5.7%	Salaries, wages & employee benefits	5,547,600	6,641,738	1,094,139	16.5%
8,263	86,521	78,259	90.5%	Professional fees	316,552	526,041	209,489	39.8%
123,973	181,660	57,687	31.8%	Purchased services	928,687	1,253,482	324,795	25.9%
(1,914)	148,414	150,327	101.3%	Printing and postage	463,642	955,372	491,730	51.5%
44,656	2,910	(41,746)	(1,434.6%)	Other operating expenses	249,374	519,091	269,716	52.0%
654,511	937,491	282,980	30.2%	Indirect cost allocation, Occupancy Expense	4,665,610	6,562,435	1,896,824	28.9%
1,741,708	2,324,608	582,900	25.1%	Total Administrative Expenses	12,171,465	16,458,159	4,286,694	26.0%
				Operating Tax				
(256,948)	0	(256,948)	0.0%	Tax Revenue	(485,833)	0	(485,833)	0.0%
(256,948)	0	256,948	0.0%	Sales tax expense	(485,833)	0	485,833	0.0%
0	0	0	0.0%	Total Net Operating Tax	0	0	0	0.0%
(5,866,095)	(576,696)	(5,289,399)	(917.2%)	Change in Net Assets	(3,517,852)	2,405,253	(5,923,106)	(246.3%)
120.8%	96.0%	(24.8%)	(25.8%)	Medical Loss Ratio	96.0%	94.0%	(1.9%)	(2.1%)
8.8%	5.3%	(3.5%)	(65.2%)	Admin Loss Ratio	5.7%	5.2%	(0.5%)	(9.0%)

Back to Agenda

ONECARE CONNECT INCOME STATEMENT – JANUARY MONTH:

REVENUES of $19.8 million are unfavorable to budget by $23.9 million driven by:

- Price related unfavorable variance of $13.0 million due to:
    - CMC Medicare Part A and B rate decreases due to base rate and RAF score changes
    - CMC Medi-Cal adjustments related to prior year rate updates
    - CMC Medi-Cal member mix true-up for February 2016 through current
- Volume related unfavorable variance of $10.9 million due to lower enrollment

MEDICAL EXPENSES are favorable to budget $18.0 million due to:

- Price related variance of $7.6 million due to lower than budget in LTC and prescription drugs categories
- Volume related variance of $10.4 million

ADMINISTRATIVE EXPENSES are favorable to budget by $0.6 million

CHANGE IN NET ASSETS is ($5.9) million, $5.3 million unfavorable to budget

CalOptima - OneCare
Statement of Revenues and Expenses
For the Seven Months Ended January 31, 2017

Month					Year - To - Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
1,304	1,179	125	10.6%	Member Months	8,554	8,507	47	0.6%
				Revenues				
1,623,489	1,374,453	249,036	18.1%	Capitation revenue	9,320,184	9,777,146	(456,962)	(4.7%)
1,623,489	1,374,453	249,036	18.1%	Total Operating Revenue	9,320,184	9,777,146	(456,962)	(4.7%)
				Medical Expenses				
480,751	375,668	(105,083)	(28.0%)	Provider capitation	2,843,443	2,656,613	(186,830)	(7.0%)
298,313	307,418	9,105	3.0%	Inpatient	2,262,914	2,179,780	(83,134)	(3.8%)
59,631	47,110	(12,521)	(26.6%)	Ancillary	321,261	337,111	15,850	4.7%
27,020	22,424	(4,596)	(20.5%)	Skilled nursing facilities	331,121	160,311	(170,810)	(106.5%)
361,427	450,471	89,044	19.8%	Prescription drugs	2,999,862	3,250,478	250,616	7.7%
62,855	50,848	(12,007)	(23.6%)	Medical management	119,863	210,004	90,141	42.9%
5,376	(8,750)	(14,126)	(161.4%)	Other medical expenses	32,271	99,501	67,230	67.6%
1,295,373	1,245,189	(50,185)	(4.0%)	Total Medical Expenses	8,910,736	8,893,798	(16,938)	(0.2%)
328,115	129,264	198,851	153.8%	Gross Margin	409,448	883,348	(473,900)	(53.6%)
				Administrative Expenses				
22,988	21,913	(1,076)	(4.9%)	Salaries, wages & employee benefits	111,954	150,117	38,163	25.4%
22,288	17,619	(4,668)	(26.5%)	Professional fees	120,357	101,905	(18,453)	(18.1%)
30,171	39,373	9,202	23.4%	Purchased services	165,576	155,716	(9,860)	(6.3%)
1,849	13,710	11,861	86.5%	Printing and postage	60,117	89,660	29,542	32.9%
379	89	(290)	(327.9%)	Other operating expenses	2,071	620	(1,451)	(233.9%)
22,850	29,494	6,644	22.5%	Indirect cost allocation, Occupancy Expense	162,880	206,455	43,575	21.1%
100,525	122,197	21,672	17.7%	Total Administrative Expenses	622,955	704,473	81,517	11.6%
227,590	7,068	220,523	3,120.2%	Change in Net Assets	(213,507)	178,875	(392,382)	(219.4%)
79.8%	90.6%	10.8%	11.9%	Medical Loss Ratio	95.6%	91.0%	(4.6%)	(5.1%)
6.2%	8.9%	2.7%	30.4%	Admin Loss Ratio	6.7%	7.2%	0.5%	7.2%

Back to Agenda

CalOptima - PACE
Statement of Revenues and Expenses
For the Seven Months Ended January 31, 2017

Month					Year - To - Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
184	195	(11)	(5.6%)	Member Months	1,265	1,260	5	0.4%
				Revenues				
915,346	873,041	42,305	4.8%	Medi-Cal capitation revenue	6,669,221	5,638,139	1,031,082	18.3%
299,130	352,386	(53,256)	(15.1%)	Medicare capitation revenue	2,191,135	2,320,892	(129,757)	(5.6%)
1,214,476	1,225,427	(10,951)	(0.9%)	Total Operating Revenues	8,860,356	7,959,031	901,325	11.3%
				Medical Expenses				
288,614	412,904	124,291	30.1%	Clinical salaries & benefits	2,022,313	2,791,571	769,258	27.6%
0	0	0	0.0%	Pace Center Support salaries & benefits	0	0	0	0.0%
380,523	253,863	(126,661)	(49.9%)	Claims payments to hospitals	1,812,070	1,625,227	(186,844)	(11.5%)
239,904	270,934	31,030	11.5%	Professional Claims	1,457,584	1,721,197	263,613	15.3%
71,953	131,053	59,100	45.1%	Prescription drugs	585,416	914,698	329,282	36.0%
12,542	26,000	13,458	51.8%	Long-term care facility payments	36,053	166,452	130,399	78.3%
135,285	80,708	(54,577)	(67.6%)	Patient Transportation	539,193	516,691	(22,503)	(4.4%)
49,564	49,349	(215)	(0.4%)	Depreciation & amortization	343,498	345,443	1,945	0.6%
38,805	37,214	(1,591)	(4.3%)	Occupancy expenses	264,734	260,498	(4,236)	(1.6%)
16,735	13,833	(2,902)	(21.0%)	Utilities & Facilities Expense	119,422	96,831	(22,591)	(23.3%)
150	296	146	49.3%	Purchased Services	1,039	1,893	854	45.1%
16,587	24,547	7,960	32.4%	Indirect Allocation	124,055	171,829	47,774	27.8%
11,215	22,785	11,570	50.8%	Other Expenses	81,248	159,496	78,248	49.1%
1,261,876	1,323,487	61,611	4.7%	Total Medical Expenses	7,386,626	8,771,825	1,385,199	15.8%
(47,401)	(98,060)	50,659	51.7%	Gross Margin	1,473,730	(812,794)	2,286,524	281.3%
				Administrative Expenses				
98,213	94,503	(3,710)	(3.9%)	Salaries, wages & employee benefits	644,673	650,150	5,476	0.8%
9,555	11,667	2,111	18.1%	Professional fees	14,555	56,667	42,111	74.3%
6,935	988	(5,947)	(602.0%)	Purchased services	28,454	7,060	(21,394)	(303.0%)
196	1,704	1,508	88.5%	Printing and postage	2,196	12,203	10,007	82.0%
2,065	2,056	(9)	(0.4%)	Depreciation & amortization	14,312	14,393	81	0.6%
14,519	11,426	(3,094)	(27.1%)	Other operating expenses	50,510	79,979	29,468	36.8%
2,308	1,023	(1,285)	(125.7%)	Indirect cost allocation, Occupancy Expense	16,199	7,159	(9,039)	(126.3%)
133,793	123,366	(10,426)	(8.5%)	Total Administrative Expenses	770,900	827,610	56,711	6.9%
(181,193)	(221,426)	40,233	18.2%	Change in Net Assets	702,831	(1,640,404)	2,343,235	142.8%
103.9%	108.0%	4.1%	3.8%	Medical Loss Ratio	83.4%	110.2%	26.8%	24.4%
11.0%	10.1%	(0.9%)	(9.4%)	Admin Loss Ratio	8.7%	10.4%	1.7%	16.3%

Back to Agenda

CalOptima - Building 505 City Parkway
Statement of Revenues and Expenses
For the Seven Months Ended January 31, 2017

Month					Year - To - Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
				Revenues				
24,056	21,285	2,772	13.0%	Rental income	168,395	148,994	19,401	13.0%
24,056	21,285	2,772	13.0%	Total Operating Revenue	168,395	148,994	19,401	13.0%
				Administrative Expenses				
1,525	2,085	560	26.8%	Professional fees	10,096	14,595	4,499	30.8%
29,467	22,405	(7,063)	(31.5%)	Purchase services	209,021	156,833	(52,188)	(33.3%)
158,794	210,141	51,347	24.4%	Depreciation & amortization	1,096,990	1,470,985	373,995	25.4%
16,000	14,300	(1,700)	(11.9%)	Insurance expense	112,003	100,102	(11,902)	(11.9%)
127,205	200,171	72,966	36.5%	Repair and maintenance	712,654	1,337,395	624,741	46.7%
34,436	0	(34,436)	0.0%	Other Operating Expense	312,908	0	(312,908)	0.0%
(347,252)	(352,100)	(4,848)	(1.4%)	Indirect allocation, Occupancy Expense	(2,318,933)	(2,464,699)	(145,766)	(5.9%)
20,177	97,002	76,825	79.2%	Total Administrative Expenses	134,739	615,211	480,472	78.1%
3,880	(75,717)	79,596	105.1%	Change in Net Assets	33,656	(466,217)	499,872	107.2%

Back to Agenda

OTHER STATEMENTS – JANUARY MONTH:

ONECARE INCOME STATEMENT

REVENUES of $1.6 million are favorable to budget by $0.2 million

CHANGE IN NET ASSETS is $0.2 million, $0.2 million favorable to budget

PACE INCOME STATEMENT

CHANGE IN NET ASSETS for the month is ($181.2) thousand; $40.2 thousand favorable to budget

505 CITY PARKWAY BUILDING INCOME STATEMENT

CHANGE IN NET ASSETS for the month is $3.9 thousand; $79.6 thousand favorable to budget

CalOptima
BALANCE SHEET
January 31, 2017

ASSETS				**LIABILITIES & FUND BALANCES**	
Current Assets				Current Liabilities	
	Operating Cash	$382,502,374		Accounts payable	$19,569,865
	Catastrophic Reserves	11,638,936		Medical claims liability	633,933,858
	Investments	1,536,290,587		Accrued payroll liabilities	9,418,653
	Capitation receivable	351,246,570		Deferred revenue	1,017,884,972
	Receivables - Other	27,077,042		Deferred lease obligations	267,070
	Prepaid Expenses	12,620,378		Capitation and withholds	526,955,408
				Total Current Liabilities	**2,208,029,825**
	Total Current Assets	**2,321,375,887**			
Capital Assets	Furniture and equipment	33,303,693			
	Leasehold improvements	8,088,013			
	505 City Parkway West	49,269,863		Other employment benefits liability	29,212,495
		90,661,568			
	Less: accumulated depreciation	(35,444,574)		Net Pension Liabilities	11,180,136
	Capital assets, net	**55,216,995**		Long Term Liabilities	100,000
				TOTAL LIABILITIES	**2,248,522,456**
Other Assets	Restricted deposit & Other	300,000			
				Deferred inflows of Resources - Excess Earnings	502,900
	Board-designated assets			Deferred inflows of Resources - changes in Assumptions	1,651,640
	Cash and cash equivalents	5,042,719			
	Long term investments	526,732,438		Tangible net equity (TNE)	95,842,752
	Total Board-designated Assets	531,775,157		Funds in excess of TNE	567,151,307
	Total Other Assets	**532,075,157**			
				Net Assets	**662,994,059**
	Deferred outflows of Resources - Pension Contributions	3,787,544			
	Deferred outflows of Resources - Difference in Experience	1,215,473			
TOTAL ASSETS & OUTFLOWS		**2,913,671,056**		**TOTAL LIABILITIES, INFLOWS & FUND BALANCES**	**2,913,671,056**

Back to Agenda

CalOptima
Board Designated Reserve and TNE Analysis
as of January 31, 2017

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
Board-designated Reserve	Tier 1 - Payden & Rygel	145,397,302				
	Tier 1 - Logan Circle	145,123,167				
	Tier 1 - Wells Capital	145,167,161				
		435,687,630	290,138,261	455,558,695	145,549,369	(19,871,065)
TNE Requirement	Tier 2 - Logan Circle	96,087,527	95,842,752	95,842,752	244,775	244,775
	Consolidated:	**531,775,157**	**385,981,013**	**551,401,447**	**145,794,144**	**(19,626,290)**
	Current reserve level	*1.93*	*1.40*	*2.00*		

Back to Agenda

CalOptima
Statement of Cash Flows
January 31, 2017

	Month Ended	Year-To-Date
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets	361,272	3,426,881
Adjustments to reconcile change in net assets to net cash provided by operating activities		
Depreciation and amortization	353,854	2,200,579
Changes in assets and liabilities:		
Prepaid expenses and other	(1,531,411)	(5,836,131)
Catastrophic reserves		
Capitation receivable	(30,351,845)	108,427,395
Medical claims liability	(83,747,565)	35,239,000
Deferred revenue	55,566,471	427,182,331
Payable to providers	21,411,220	125,129,107
Accounts payable	(20,863,553)	11,741,448
Other accrued liabilities	922,700	6,067,065
Net cash provided by/(used in) operating activities	(57,878,856)	713,577,672
GASB 68 CalPERS Adjustments	-	-
CASH FLOWS FROM INVESTING ACTIVITIES		
Purchase of Investments	(244,827,230)	(517,025,955)
Purchase of property and equipment	(94,003)	(2,422,009)
Change in Board designated reserves	(940,060)	(55,939,792)
Net cash provided by/(used in) investing activities	(245,861,294)	(575,387,755)
NET INCREASE/(DECREASE) IN CASH & CASH EQUIVALENTS	(303,740,149)	138,189,916
CASH AND CASH EQUIVALENTS, beginning of period	$697,881,459	255,951,393
CASH AND CASH EQUIVALENTS, end of period	**$ 394,141,309**	**$ 394,141,309**

Back to Agenda

BALANCE SHEET:

ASSETS decreased $26.3 million from December

- **Cash and Cash Equivalents** decreased by $303.7 million due to the timing of state checks received, month-end cut-off and cash funding requirements
- **Net Capitation Receivables** increased $28.1 million based upon payment receipt timing and receivables
- **Investments** increased $244.8 million due to payment receipt timing and cash funding requirements

LIABILITIES decreased $26.7 million from December

- **Medical Claims Liability** decreased by $83.7 million from December due to tax and IGT payments
- **Deferred Revenue** increased $55.6 million driven by state payment activity
- **Total Capitation Payable** increased $21.4 million based upon timing of pool estimates, recalculations and payouts
- **Accrued Expenses** decreased **$**21.6 million due to Quarterly sales tax payment

NET ASSETS are $663.0 million

CalOptima Foundation
Statement of Revenues and Expenses
For the Seven Months Ended January 31, 2017
Consolidated

Month					Year - To - Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
0	2,264	(2,264)	(100.0%)	Income - Grant	27,164	15,851	11,313	71.4%
2,083	0	2,083	100.0%	In Kind Revenue - HITEC Grant	68,246	0	68,246	100.0%
2,083	2,264	(181)	(8.0%)	Total Operating Revenue	95,410	15,851	79,559	501.9%
				Operating Expenditures				
0	6,184	6,184	100.0%	Personnel	27,195	43,289	16,095	37.2%
0	2,985	2,985	100.0%	Taxes and Benefits	26,240	20,894	(5,346)	(25.6%)
0	0	0	0.0%	Travel	(3)	0	3	100.0%
0	0	0	0.0%	Supplies	7,009	10,000	2,991	29.9%
0	0	0	0.0%	Contractual	20,388	17,174	(3,214)	(18.7%)
3,789	232,065	228,276	98.4%	Other	16,287	1,624,456	1,608,169	99.0%
3,789	241,234	237,445	98.4%	Total Operating Expenditures	97,117	1,715,813	1,618,697	94.3%
0	0	0	0.0%	Investment Income	0	0	0	0.0%
(1,706)	(238,970)	(237,264)	(99.3%)	Program Income	(1,706)	(1,699,963)	(1,698,256)	(99.9%)

Back to Agenda

CalOptima Foundation
Balance Sheet
January 31, 2017

ASSETS		LIABILITIES & NET ASSETS	
Operating cash	2,893,139	Accounts payable-Current	0
Grants receivable	0	Deferred Revenue	0
Prepaid expenses	0	Payable to CalOptima	0
Total Current Assets	**2,893,139**	Grants-Foundation	0
		Total Current Liabilities	0
		Total Liabilities	0
		Net Assets	2,893,139
TOTAL ASSETS	**2,893,139**	**TOTAL LIABILITIES & NET ASSETS**	**2,893,139**

Back to Agenda

CALOPTIMA FOUNDATION – JANUARY MONTH

INCOME STATEMENT:

Revenues

- Revenues from Health Information Technology for Economic and Clinical Health Act (HITECH) and in-kind contributions from CalOptima
- The Foundation recognized $95,410 FY17 YTD in total operating revenues
    - HITECH Grant revenue totaled $27,164 YTD which leaves $0 remaining in HITECH Grant funding as of January 2017
    - CalOptima in-kind contribution totaled $68,246 YTD
- Revenue budget variances attributed to:
    - YTD CalOptima grant budget is $0, as the ONC grant funding was to have ended in the previous fiscal year. The grant was extended through September 26, 2016
    - CalOptima in-kind revenue was not included in FY17 budget

Expenses

- $97,117 for grant related activities incurred YTD FY17
- Expense categories include staff services, travel and miscellaneous supplies
    - $1.6 million favorable variance YTD
    - FY17 budget was based on remaining fund balance in Foundation total assets
    - Actual expenses were much lower than anticipated for CalOptima support activities

BALANCE SHEET:

Assets

- Cash of $2.9 million remains from the FY14 transfer of $3.0 million from CalOptima for grants and programs in support of providers and the community

Liabilities

- $0

Budget Allocation Changes
Reporting changes for January 2017

Transfer Month	Line of Business	From	To	Amount	Expense Description
July	OneCare Connect	Office of Compliance - Professional Fees (Consultant for Annual CPE Audit & CMS Mock Audit)	Office of Compliance - Professional Fees - Consultant for DMHC Mock Audit	$69,000	Re-purpose $53,631 from Professional Fees (Consultant for Annual CPE Audit) and $15,369 from Professional Fees (Consultant for CMS Mock Audit) to pay for consultant for DMHC Mock Audit
July	COREC	REC - Other	REC - Comp Supply/Minor Equip	$10,000	Re-allocate funds to cover costs for computer equipment upgrade which is approved ONC grant managers
July	Medi-Cal	IS-Application Development - Software Maintenance - Corporate Software Maintenance	IS-Application Development - Software Maintenance - Human Resources Corporate Application Software Maintenance	$63,810	Re-purpose funds within Software Maintenance (from Corporate Software Maintenance to Human Resources Corporate Application Software Maintenance) to pay for FY17 Ceridian Software Maintenance
July	Medi-Cal	IS-Application Development - Software Maintenance - Corporate Software Maintenance	IS-Application Development - Software Maintenance - Human Resources Corporate Application Software Maintenance	$15,010	Re-purpose funds within Software Maintenance (from Corporate Software Maintenance to Human Resources Corporate Application Software Maintenance) to pay for FY17 Talentova Learning Management System
July	Medi-Cal	IS-Application Development - Software Maintenance - Corporate Software Maintenance	IS-Application Development - Software Maintenance - Human Resources Corporate Application Software Maintenance	$23,900	Re-purpose funds within Software Maintenance (from Corporate Software Maintenance to Human Resources Corporate Application Software Maintenance) to pay for Silk Road
July	Medi-Cal	Claims Administration - Purchased Services - Integration of Claim Editing Software	Claims Administration - Purchased Services - LTC Rate Adjustments	$98,000	Re-purpose funds from within Purchased Services (Integration of Claim Editing Software) to pay for LTC Adjustments (TriZetto Robot Process)
July	Medi-Cal	Human Resources - Advertising, Travel, Comp Supply/Minor Equip, Subscriptions, Courier/Delivery	Human Resources - Professional Fees (Salary & Compensation Research), Public Activities, Office Supplies, Food Service Supplies, Professional Dues, Training & Seminars, Cert./Cont. Education	$84,491	Re-allocate HR FY17 Budget based on HR dept's past spending trends to better meet department's need
July	Medi-Cal	IS-Infrastructure - Telephone - General Telecommunication and Network Connectivity	IS-Infrastructure - Purchased Services - Disaster Recovery Services	$35,575	Re-allocate funds from Telephone (General Telecommunication and Network Connectivity) to Purchased Services to pay for Disaster Recovery Services
August	Medi-Cal	Other Pay	Quality Analytics - Purchased Services	$67,000	Re-allocate funds to Quality Analytics Purchased Services for additional funds that is needed for CG-CAHPS survey
August	Medi-Cal	Other Pay	Community Relations - Professional Fees & Printing	$43,640	Re-allocate funds to Community Relations Professional Fees and Printing budgets for contracts with Tony Lam and Communications Lab and printing costs of Community Option Fair
August	Medi-Cal	IS-Application Management - Purchased Services - Healthcare Productivity Automation	IS-Application Management - Purchased Services - Direct Hire Fees	$10,957	Re-purpose funds from Purchased Services (Healthcare Productivity Automation) to pay for Direct Hire fees
August	Medi-Cal	Other Pay	IS-Application Development - Comp Supplies/Minor Equipments	$20,400	Re-allocate funds to cover costs of DocuSign, Box, and Primal Script 2016
August	Medi-Cal	Claims Administration - Purchased Services	Claims Administration - Office Supplies, Training & Seminars, Printing	$15,000	Re-allocate funds from Purchased Services (Integration of Claim Editing Software & Inventory Management Forecasting) to Office Supplies, Training & Seminars, and Printing to better meet department's needs
September	Medi-Cal	Health Education & Disease Management - Professional Fees	Health Education & Disease Management - Other Operating Expenses	$30,000	Re-allocate funds from Professional Fees (Childhood Obesity Program Design & Evaluation) to Member & Provider Incentives to support incentives for the Group Needs Assessment (GNA) and other Health Education / Disease Management activities.
October	Capital	Facilities - Relocate Trash Enclosure	Facilities - 505 Sound Recording System	$50,555	Re-allocate from Relocate Trash Enclosure project for additional funds that are needed for the 505 Sound Recording System project.
October	Medi-Cal	IS-Infrastructure - Professional Fees - Enterprise Identity Access Management	IS-Infrastructure - HW/SW Maintenance - Information Security Data Loss Prevention Solution	$21,041	Re-allocate from Professional Services for an Enterprise Identity Access Management to HW/SW Maintenance for Information Security Data Loss Prevention Solution Annual Maintenance on additional funds that are needed.
October	Medi-Cal	Facilities - Computer Supply/Minor Equipment - Office Furniture & Equipment	Facilities - Computer Supply/Minor Equipment - Other Articles of Minor Equipment	$27,000	Repurpose funds in Comp supply/minor equipment for re-upholstering chairs in the member service lobby and other minor equipment expenses to better meet the Department's need.
December	Medi-Cal	Human Resources - Professional Fees - Executive Coaching	Human Resources - Professional Fees - Consultant Fees	$20,000	Repurpose from Executive Coaching for interim director of HR consultant fees
December	Medi-Cal	Health Education & Disease Management - Medical Management Activities	Health Education & Disease Management - Medical Management Activities	$75,000	Repurpose funds for the department printing and postage needs
January	Capital	IS-Application Development - Finance Reporting Tool to Great Plains	IS-Application Development - Great Plains Software Upgrade	$20,000	Re-allocate funds from Finance Reporting Software for Great Plains budget to Great Plains Software Upgrade budget for additional funds are needed to complete the project.

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.

Back to Agenda

Board of Directors' Meeting
March 2, 2017

Monthly Compliance Report

The purpose of this report is to provide compliance updates to CalOptima's Board of Directors, including but may not be limited to, updates on internal and health network audits conducted by CalOptima's Audit & Oversight department, regulatory audits, privacy updates, fraud, waste, and abuse (FWA) updates, and any notices of non-compliance or enforcement action issued by regulators.

A. Updates on Regulatory Audits

1. OneCare Connect

- DMHC Audit: The Department of Managed Health Care (DMHC) audited the provision of Medicaid-based services in OneCare Connect from February 6-10, 2017. The DMHC conducted this audit on behalf of the Department of Health Care Services (DHCS) as part of an inter-agency agreement. The DMHC audit consisted of an evaluation of CalOptima's compliance with its contract and regulations in the areas of utilization management, continuity of care, availability and accessibility of services, member rights, and quality management. The DMHC has indicated that it can take between three (3) to six (6) months to issue out a preliminary report to the DHCS.

- CMS Mock Audit of Medication Therapy Management (MTM) Program:
  In preparation for a CMS MTM program pilot audit, CalOptima has engaged a consultant to conduct a mock audit on its MTM program using the 2017 MTM regulatory audit protocols. The scope of the audit includes all OneCare Connect members who were enrolled in the MTM program during the look-back period of January 1, 2016 through December 31, 2017. The mock audit will take place from April through July 2017.

2. OneCare

- CMS Timeliness Monitoring of Organization Determinations, Appeals & Grievances (ODAG) and Part D Coverage Determinations, Appeals and Grievances (CDAG):

  As of January 2017, CMS began to collect various ODAG and CDAG audit universes from each plan sponsor to assess timeliness and compliance in processing Part C and D requests and with forwarding cases to the Independent Review Entity (IRE). The request will be retrospective capturing data from February 2016 through April 2016. CalOptima is currently waiting for the engagement notice from CMS, but has already collected the required audit universes and is in the process of validating the data in anticipation of the audit.

Back to Agenda

3. Medi-Cal

- 2017 Medi-Cal Audit: The DHCS conducted an onsite audit of CalOptima's Medi-Cal program from February 6-17, 2017. The DHCS Medi-Cal audit consisted of an evaluation of CalOptima's compliance with its contract and regulations in the areas of utilization management, case management and care coordination, access and availability, member rights and responsibilities, quality improvement system, organization and administration of CalOptima, facility site reviews, and medical records review. The DHCS expects to issue the draft report in April followed by an Exit Conference. CalOptima will have fifteen (15) days to respond to the draft report. The final report will be finalized thirty (30) days after CalOptima's response to the draft report.

- DMHC 1115 Waiver Seniors and Persons with Disabilities (SPDs) Audit: The DMHC conducted an audit of Medi-Cal SPDs from February 6-10, 2017. The DMHC conducted this audit on behalf of the DHCS as part of an inter-agency agreement. The DMHC audit consisted of an evaluation of CalOptima's compliance with its contract and regulations in the areas of utilization management, continuity of care, availability and accessibility of services, member rights, and quality management. The DMHC has indicated that it can take between three (3) to six (6) months to issue out a preliminary report to the DHCS.

B. Regulatory Compliance Notices

1. CalOptima did not receive any compliance notices from its regulators for the months of January and February 2017.

C. Updates on Internal and Health Network Audits

1. Internal Audits: Medi-Cal

- Medi-Cal Utilization Management (UM): Prior Authorization (PA) Requests

Month	Timeliness for Denials	Clinical Decision Making (CDM) for Denials	Letter Score for Denials	Timeliness for Modified	CDM for Modified	Letter Score for Modified	Timeliness for Deferrals	CDM or Deferral	Letter Score for Deferrals
September 2016	70%	70%	84%	80%	75%	100%	0%	72%	100%
October 2016	70%	67%	97%	83%	67%	85%	17%	89%	95%
November 2016	90%	87%	98%	100%	73%	99%	50%	58%	95%

- The lower scores for timeliness were due to the following:
  - Failure to meet provider written notification timeframe (2 business days)
  - Failure to meet timeframe for provider notification for delayed decision (14 calendar days)

- The lower scores for clinical decision making were due to the following:
  - Failure to obtain adequate clinical information
  - Failure to use criteria for decision

- The lower letter scores were due to the following:
  - Failure to provide information on how to file a grievance
  - Failure to describe why request did not meet criteria in lay language
  - Failure to provide description of services in lay language
  - Failure to provide referral back to Primary Care Provider (PCP) on denial letter
  - Failure to use language assistance program (LAP) insert with approved threshold languages

- Medi-Cal Claims: Professional and Hospital Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
September 2016	100%	100%	100%	100%
October 2016	100%	100%	100%	100%
November 2016	100%	100%	100%	100%

- The compliance rate for paid and denied claims timeliness and accuracy has remained at 100% from September 2016 through November 2016.

- Medi-Cal Claims: Provider Dispute Resolutions (PDRs)

Month	Letter Accuracy	Determination Timeliness	Acknowledgement Timeliness
September 2016	100%	73%	100%
October 2016	100%	100%	100%
November 2016	100%	100%	100%

- The compliance rate for letter accuracy and acknowledgement timeliness has remained at 100% from September 2016 through November 2016.

- The compliance rate for determination timeliness has remained at 100% from October 2016 through November 2016.

- Medi-Cal Customer Service: Call center activity is reviewed for appropriate classification, routing, and privacy handling.

Month	Medi-Cal Call Center	Member Liaison Call Center
September 2016	98%	98%
October 2016	99%	100%
November 2016	99%	99%

- The compliance rate for the Medi-Cal and Member Liaison Call Centers has remained at or above 98% from September 2016 through November 2016.

2. Internal Audits: OneCare

- OneCare Pharmacy: Formulary Rejected Claims Review

Month	% Claims Rejected in Error (Member Impact)
September 2016	0%
October 2016	0%
November 2016	0%

- No claims were rejected in error due to formulary restrictions from September 2016 through November 2016.

- OneCare Pharmacy: Coverage determination timeliness is reviewed on a daily basis to ensure that they are processed in the appropriate timeframe.

Month	% Compliant with Timeliness
September 2016	100%
October 2016	100%
November 2016	100%

- The compliance rate for coverage determination timeliness remained at 100% from September 2016 through November 2016.

- OneCare Pharmacy: Coverage determinations for protected classes of drugs are reviewed weekly to ensure that they are processed in accordance with regulatory requirements.

Month	Protected Drug Cases Reviewed	Protected Drug Cases Failed	Overall Compliance
September 2016	2	0	100%
October 2016	2	0	100%
November 2016	4	0	100%

- The compliance rate for coverage determinations for protected drug cases has remained at 100% from September 2016 through November 2016.

- OneCare Pharmacy: Coverage determinations for unprotected classes of drugs are reviewed weekly to ensure that they are processed in accordance with regulatory requirements.

Month	Unprotected Drug Cases Reviewed	Unprotected Drug Cases Failed	Overall Compliance
September 2016	9	0	100%
October 2016	12	0	100%
November 2016	23	0	100%

- The compliance rate for coverage determinations for unprotected drug cases remained at 100% from September 2016 through November 2016.

- OneCare Utilization Management

Month	Timeliness for Expedited Initial Organization Determination (EIOD)	Clinical Decision Making for EIOD	Letter Score for EIOD	Timeliness for Standard Organization Determination (SOD)	Letter Score for SOD	Timeliness for Denials	Clinical Decision Making for Denials	Letter Score for Denials
September 2016	Nothing to Report	Nothing to Report	Nothing to Report	0%	33%	Nothing to Report	Nothing to Report	Nothing to Report
October 2016	Nothing to Report	Nothing to Report	Nothing to Report	0%	100%	Nothing to Report	Nothing to Report	Nothing to Report
November 2016	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report

- Due to decreased membership under the OneCare product line, there were no utilization management activities reported for the month of November 2016.

- OneCare Claims: Professional and Hospital Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
September 2016	100%	100%	100%	93%
October 2016	100%	100%	100%	100%
November 2016	100%	100%	100%	97%

  - The compliance rate for paid claims timeliness, paid claims accuracy, and denied claims timeliness remained at 100% from September 2016 through November 2016.

  - The compliance rate for denied claims accuracy decreased to 97% in November 2016 due to incomplete denial letters to members.

- OneCare Claims: Provider Dispute Resolutions (PDRs)

Month	Determination Timeliness	Payment Accuracy	Letter Accuracy	Check Lag
September 2016	100%	100%	100%	100%
October 2016	100%	100%	100%	100%
November 2016	75%	100%	100%	100%

  - The compliance rate for payment accuracy, letter accuracy, and check lag has remained at 100% from September 2016 to November 2016.

  - The compliance rate for determination timeliness has decreased to 75% in November 2016 due to failure to meet PDR processing timeframe (30 calendar days).

- OneCare Customer Service: Call center activity is reviewed for appropriate classification, routing, and privacy handling.

Month	OneCare Call Center
September 2016	100%
October 2016	100%
November 2016	100%

  - The compliance rate for the OneCare Call Center has remained at 100% from September 2016 through November 2016.

3. Internal Audits: OneCare Connect

- OneCare Connect Pharmacy: Formulary Rejected Claims Review

Month	% Claims Rejected in Error (Member Impact)
September 2016	0%
October 2016	0%
November 2016	0%

  - ➢ No claims were rejected in error due to formulary restrictions from September 2016 through November 2016.

- OneCare Connect Pharmacy: Coverage determination timeliness is reviewed on a daily basis to ensure that they are processed in the appropriate timeframe.

Month	% Compliant with Timeliness
September 2016	99%
October 2016	100%
November 2016	99%

  - ➢ The compliance rate for coverage determination timeliness remains at or above 99% from September 2016 through November 2016.

- OneCare Connect Pharmacy: Coverage determinations for protected classes of drugs are reviewed weekly to ensure that they are processed in accordance with regulatory requirements.

Month	Protected Drug Cases Reviewed	Protected Drug Cases Failed	Overall Compliance
September 2016	32	1	97%
October 2016	25	0	100%
November 2016	20	0	100%

  - ➢ The compliance rate for coverage determinations for protected drug cases remained at 100% from October 2016 through November 2016.

- OneCare Connect Pharmacy: Coverage determinations for unprotected classes of drugs are reviewed weekly to ensure that they are processed in accordance with regulatory requirements.

Month	Unprotected Drug Cases Reviewed	Unprotected Drug Cases Failed	Overall Compliance
September 2016	88	0	100%
October 2016	125	1	99%
November 2016	100	1	99%

  - The compliance rate for coverage determinations for unprotected classes of drugs remained at or above 99% from September 2016 through November 2016.

- OneCare Connect Utilization Management: Prior Authorization (PA) Requests

Month	Timeliness for Denials	Clinical Decision Making for Denials	Letter Score for Denials	Timeliness for Modified	Clinical Decision Making for Modified	Letter Score for Modified	Timeliness for Deferrals	Clinical Decision Making for Deferrals	Letter Score for Deferrals
September 2016	100%	67%	63%	N/A	N/A	N/A	N/A	N/A	N/A
October 2016	N/A	N/A	N/A	83%	67%	85%	17%	89%	95%
November 2016	100%	100%	89%	NA	NA	NA	NA	NA	NA

  - The lower scores for timeliness were due to the following:
    - Failure to meet timeframe for written notification (2 business days)

  - The lower scores for letter review were due to the following:
    - Failure to provide letter with description of services in lay language
    - Failure to provide the reason why request did not meet the criteria in lay language

- OneCare Connect Claims: Professional and Hospital Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
September 2016	100%	100%	100%	100%
October 2016	100%	100%	100%	100%
November 2016	70%	93%	100%	100%

- The compliance rate for paid claims timeliness decreased to 70% in November 2016 due to untimely processing of clean claims (30 calendar days).

- The compliance rate for paid claims accuracy decreased to 93% in November 2016 due to incorrect application of interest.

- The compliance rate for denied claims timeliness and denied claims accuracy has remained at 100% from September 2016 through November 2016.

- OneCare Connect Claims: Provider Dispute Resolutions (PDRs)

Month	Determination Timeliness	Payment Accuracy	Letter Accuracy	Check Lag
September 2016	100%	100%	100%	67%
October 2016	100%	88%	94%	100%
November 2016	93%	87%	100%	100%

- The compliance rate for determination timeliness decreased from to 93% in November 2016 due to untimely processing of PDR claims (30 calendar days).

- The compliance rate for payment accuracy slightly decreased to 87% in November 2016 due to incorrect application of interest.

- The compliance rate for letter accuracy increased to 100% in November 2016.

- The compliance rate for check lag has remained at 100% from October 2016 to November 2016.

- OneCare Connect Customer Service: Call center activity is reviewed for appropriate classification, routing, and privacy handling.

Month	OneCare Connect Call Center
September 2016	99%
October 2016	99%
November 2016	98%

- The compliance rate for the OneCare Connect Call Center remained at or above 98% from September 2016 through November 2016.

4. Internal Audits: PACE

- PACE Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
September 2016	100%	100%	100%	100%
October 2016	100%	100%	100%	100%
November 2016	100%	100%	100%	100%

➢ The compliance rate for paid claims timeliness, paid claims accuracy, denied claims timeliness, and denied claims accuracy has remained at 100% from September 2016 through November 2016.

- PACE Claims: Provider Dispute Resolutions (PDRs)

Month	Determination Accuracy	Letter Accuracy	Acknowledgement Timeliness	Check LAG
September 2016	82%	100%	100%	NA
October 2016	83%	100%	100%	100%
November 2016	100%	100%	100%	100%

➢ The compliance rate for determination accuracy has increased from 83% in October 2016 to 100% in November 2016.

➢ The compliance rate for letter accuracy and acknowledgement timeliness remained at 100% from September 2016 through November 2016.

➢ The compliance rate for check lag has remained at 100% from October 2016 through November 2016.

5. Health Network Audits: Medi-Cal

- Medi-Cal Utilization Management (UM): Prior Authorization (PA) Requests

Month	Timeliness for Denials	Clinical Decision Making for Denials	Letter Score for Denials	Timeliness for Modifieds	Clinical Decision Making for Modifieds	Letter Score for Modifieds	Timeliness for Deferrals	Clinical Decision Making for Deferrals	Letter Score for Deferrals
September 2016	60%	91%	86%	60%	87%	88%	100%	Nothing to Report	100%
October 2016	53%	89%	90%	47%	87%	88%	50%	83%	75%
November 2016	65%	88%	87%	58%	94%	91%	83%	100%	63%

- The lower scores for timeliness were due to the following:
  - Failure to meet timeframe for provider initial notification (24 hours)
  - Failure to provide proof of successful initial notification to requesting provider (24 hours)

- The lower scores for clinical decision making were due to the following**:**
  - Failure to cite the criteria utilized to make the decision
  - No indication of adequate clinical information obtained to make the decision to deny
  - No indication that the medical reviewer was involved in the denial determination

- The lower letter scores were due to the following:
  - Language assistance program (LAP) insert was not provided to member and typographical errors were identified throughout the document
  - Failure to provide letter with description of services in lay language
  - Failure to provide letter in member's primary language
  - Failure to include name and contact information for health care professional responsible for decision to deny in the initial notification
  - Failure to provide information on how to file a grievance
  - Failure to outline reason for not meeting the criteria in lay language
  - Failure to provide referral back to Primary Care Provider (PCP) on denial letter
  - Failure to notify provider of delayed decision and anticipated decision date

- Medi-Cal Claims: Misclassified Claims

Month	Misclassified Paid Claims	Misclassified Denied Claims
September 2016	98%	98%
October 2016	98%	100%
November 2016	99%	99%

  - The compliance rate for misclassified paid and denied claims remained at or above 98% from September 2016 through November 2016.

- Medi-Cal Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
September 2016	96%	93%	97%	92%
October 2016	99%	94%	100%	95%
November 2016	99%	99%	100%	83%

  - The compliance rate for paid claims timeliness remained at 99% from October 2016 to November 2016.
  - The compliance rate for paid claims accuracy increased from 94% in October 2016 to 99% in November 2016.
  - The compliance rate for denied claims timeliness remained at 100% from October 2016 to November 2016
  - The compliance rate for denied claims accuracy decreased to 83% from October 2016 to November 2016 due to the following reasons:
    - Incorrect denial reason
    - Claim paid not using the Medi-Cal fee schedule
    - Payment of unauthorized services

- Medi-Cal Claims: Misclassified Hospital Claims

Month	Misclassified Paid Claims	Misclassified Denied Claims
September 2016	100%	100%
October 2016	100%	100%
November 2016	100%	100%

  - The compliance rate for misclassified paid and denied hospital claims remained at 100% from September 2016 through November 2016.

- Medi-Cal Claims: Hospital Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
September 2016	100%	100%	100%	100%
October 2016	100%	100%	100%	100%
November 2016	93%	97%	100%	97%

  - The compliance rate for paid claims timeliness decreased to 93% from October 2016 to November 2016 due to misdirected claims being incorrectly processed.

  - The compliance rate for paid claims accuracy decreased to 97% from October 2016 to November 2016 due to payment amount incorrectly processed.

  - The compliance rate for denied claims timeliness remained at 100% from September 2016 through November 2016.

  - The compliance rate for denied claims accuracy decreased to 97% from October 2016 to November 2016 due to use of an incorrect denial reason for a covered benefit.

6. Health Network Audits: OneCare

- OneCare Utilization Management (UM): Prior Authorization (PA) Requests

Month	Timeliness for Expedited Initial Organization Determination (EIOD)	Clinical Decision Making for EIOD	Letter Score for EIOD	Timeliness for Standard Organization Determination (SOD)	Letter Score for SOD	Timelines for Denials	Clinical Decision Making for Denials	Letter Score for Denials
September 2016	50%	Nothing to Report	93%	90%	90%	100%	65%	92%
October 2016	40%	0%	83%	90%	82%	100%	73%	94%
November 2016	77%	Nothing to Report	84%	97%	79%	100%	78%	95%

- The lower scores for timeliness were due to the following:
  - Failure to meet timeframe for member oral notification (Expedited – 72 hours)
  - Failure to meet timeframe for favorable member written notification (Expedited – 72 hours)
  - Failure to meet timeframe for provider notification (Expedited – 24 hours)

- The lower scores for clinical decision making were due to the following:
  - Failure to cite the criteria utilized to make the decision
  - No indication of adequate clinical information obtained to make the decision to deny
  - Failure to have evidence of appropriate professional making decision

- The lower letter scores were due to the following:
  - Failure to use approved CMS letter template
  - Failure to provide letter with description of services in lay language
  - Failure to use the CalOptima logo on letter template

- OneCare Claims: Misclassified Claims

Month	Misclassified Paid Claims	Misclassified Denied Claims
September 2016	100%	100%
October 2016	99%	100%
November 2016	99%	100%

  - The compliance rate for misclassified paid and denied claims remained at or above 99% from September 2016 through November 2016.

- OneCare Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
September 2016	98%	56%	100%	52%
October 2016	98%	58%	100%	54%
November 2016	88%	88%	100%	93%

  - The compliance rate for paid claims timeliness decreased in November 2016 to 88% due to untimely processing of claims (30 calendar days).

  - The compliance rate for paid claims accuracy increased to 88% from October 2016 to November 2016.

  - The compliance rate for denied claims timeliness remained at 100% from September 2016 through November 2016.

  - The compliance rate for denied claims accuracy increased to 93% from October 2016 to November 2016.

7. Health Network Audits: OneCare Connect

- OneCare Connect Utilization Management (UM): Prior Authorization (PA) Requests

Month	imelines for Urgents	Clinical Decision Making for Urgents	Letter Score for Irgent	imelines For Routine	Letter Score for Routin	imelines for Denials	Clinical Decisio Making for Denials	Letter Score for Denial	imelines for Modifieds	Clinical Decision Making for Modifieds	Letter Score for lodified	imelines for Deferrals	Clinical Decision Making for Deferrals	Letter Score for Deferrals
September 2016	50%	100%	69%	58%	75%	42%	66%	66%	0%	67%	100%	Nothing to Report	Nothing to Report	Nothing to Report
October 2016	48%	100%	72%	65%	73%	48%	82%	73%	52%	92%	99%	Nothing to Report	Nothing to Report	Nothing to Report
November 2016	58%	84%	68%	77%	69%	90%	83%	82%	44%	89%	99%	Nothing to Report	Nothing to Report	Nothing to Report

- The lower scores for timeliness were due to the following:
  - Failure to meet timeframe for member notification (Routine - 2 business days)
  - Failure to provide proof of successful initial written notification to requesting provider (24 hours)

- The lower scores for clinical decision making were due to the following:
  - Failure to cite the criteria utilized to make the decision
  - No indication of adequate clinical information obtained to make the decision to deny
  - No indication that the medical reviewer was involved in the denial determination

- The lower letter scores were due to the following:
  - Failure to provide letter in member's primary language
  - Failure to provide letter with description of services in lay language

- OneCare Connect Claims: Misclassified Claims

Month	Misclassified Paid Claims	Misclassified Denied Claims
September 2016	99%	100%
October 2016	99%	100%
November 2016	99%	99%

- The compliance rate for misclassified paid claims remained at 99% from September 2016 through November 2016.

- The compliance rate for misclassified denied claims decreased slightly to 99% in November 2016 due to inappropriate application of 2% sequestration rate.

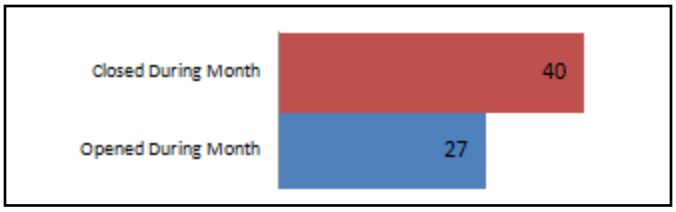
- OneCare Connect Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
September 2016	94%	41%	100%	69%
October 2016	94%	49%	99%	78%
November 2016	95%	95%	98%	90%

  - The compliance rate for paid claims timeliness increased to 95% from October 2016 to November 2016.
  - The compliance rate for paid claims accuracy increased to 95% from October 2016 to November 2016.
  - The compliance rate for denied claims timeliness slightly decreased to 98% in November 2016 due to untimely processing of unclean claims (60 calendar days).
  - The compliance rate for denied claims accuracy increased to 90% from October 2016 to November 2016.

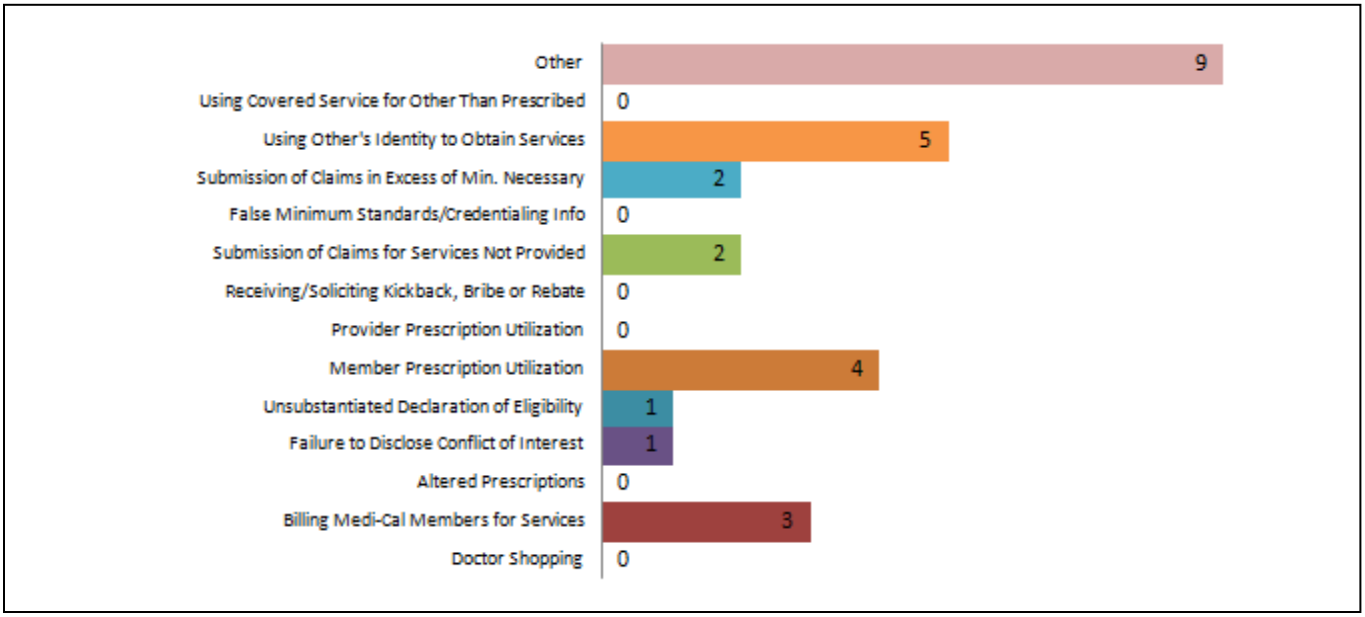
D. Special Investigations Unit (SIU) / Fraud, Waste & Abuse (FWA) Investigations (January 2017)

Case Status
Case status at the end of January 2017

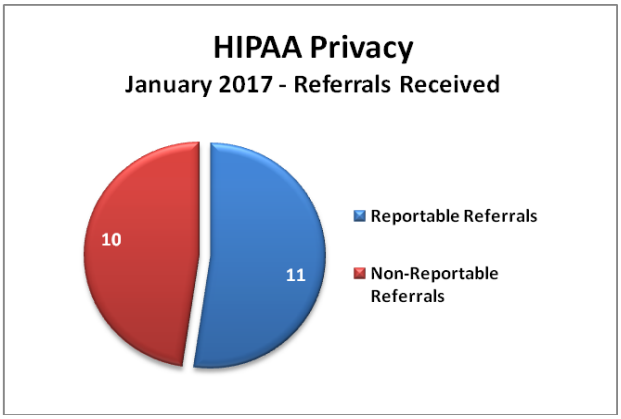


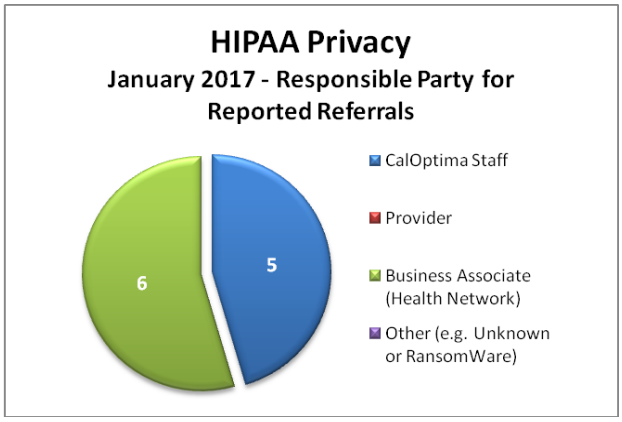
Note: Cases that are referred to DHCS or the MEDIC are not "closed" until CalOptima receives notification of case closure from the applicable government agency.

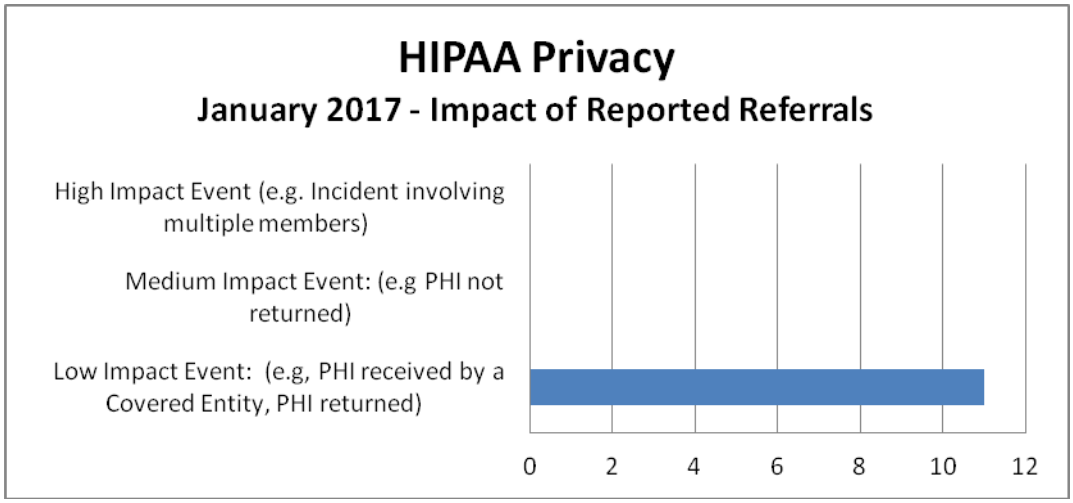
Types of FWA Cases: (Received in January 2017)



E. Privacy Update (January 2017)







PRIVACY STATISTICS

Total Number of Referrals Reported to DHCS (State)	11
Total Number of Referrals Reported to DHCS and Office for Civil Rights (OCR)	0
Total Number of Referrals Reported	**11**

CalOptima
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Federal & State Legislative Advocate Reports

Board of Directors Meeting
March 2, 2017

James McConnell / Edelstein Gilbert Robson & Smith

Back to Agenda

JAMES F. MCCONNELL
ATTORNEY-AT-LAW
1130 CONNECTICUT AVENUE, N.W.
SUITE 300
WASHINGTON, D.C. 20036
Mobile: 917-434-3603
E-mail: jmcconnell@tfgnet.com

CalOptima
Washington Report
February 16, 2017

CEO Michael Schrader was on the East Coast in February, for meetings in Washington of the Association of Community-Affiliated Plans (ACAP) as well as with the Orange County Congressional Delegation and California's Senators; and in Baltimore with officials of the Centers for Medicare and Medicaid Services (CMS). It was the first visit by CalOptima to Washington since the inauguration of President Donald Trump.

Meanwhile, the 115th Congress has now been in session for six weeks. Despite talk that the Affordable Care Act (ACA) would be repealed and replaced as the first order of business in the new Congress, there has yet to be an agreed upon plan for the replacement of Obamacare. There has, however, been more than a little discussion among Members of the House and Senate as to how the congressional majority may wish to proceed in this regard.

After the November election, there was talk that the Senate would take the lead on legislation to repeal and place the ACA given a wider difference of opinion among House Republicans on what the replacement should look like than there was among Republican Senators. However, the Senate majority began talking about "repair" rather than outright repeal of the act. And, as January has turned to February, House Speaker Paul Ryan (R-WI) has taken the lead, promising to unveil replacement legislation on February 16 to the fractious House Republican Caucus.

Meanwhile, political tensions heightened further in early February as many House Members faced angry constituents at town hall meetings over questions about what the replacement legislation would look like, especially as regards the most popular provisions of Obamacare: children remaining on parents' insurance until age 26, no discrimination by insurers on the basis of pre-existing conditions, the ban on lifetime caps, and insurance portability between jobs. This increased pressure on the congressional majority to have replacement legislation ready at the same time as repeal.

The new Administration's Secretary of Health and Human Services, former Representative Tom Price, was only confirmed and sworn into office the second week of the month. Thus, the President has not weighed in with Congress on what a replacement bill should look like.

Back to Agenda

CEO Schrader's meeting with the County delegation, however, went very smoothly. Congresswoman Mimi Walters has moved this Congress to the Energy and Commerce (E&C) Committee. Together with the Ways and Means Committee, E&C will have jurisdiction over the preparation of whatever replacement bill ultimately emerges from the House. She was eager to have CalOptima's input on what programs and procedures of the ACA were of greatest benefit to her constituents and to the County. While she is not on the Health Subcommittee, she will be involved legislatively when the bill moves from subcommittee to full committee.

Representative Alan Lowenthal, whose wife is a physician, is very familiar with many aspects of health care delivery, and is eager to see Obamacare improved while not discarding the positive features of the law. Similarly, the County's new Member, Lou Correa, a former state legislator, as well as a former County supervisor, understands the importance of the delivery of affordable, and cost-conscious, medical services by public agencies such as CalOptima.

Congressman Dana Rohrabacher was also solicitous of CalOptima's advice on how the repeal (or repair) and replacement should move forward. While he has been straightforward in his opposition to the provision of government-funded health care services to undocumented persons, he recognizes that such services have been prohibited under the ACA from its inception.

Other meetings were held with staff to Representatives Ed Royce and Darrell Issa. They also expressed interest in CalOptima's views on what a workable replacement bill would consist of.

On the Senate side of the Capitol, CEO Schrader held a joint meeting with staff for Senator Dianne Feinstein as well as newly–elected Senator Kamala Harris. The state's new Senator has not finalized her staffing yet, but her deputy chief of staff, Rohini Kosoglu, joined the meeting. She previously served as senior health care advisor to Senator Michael Bennet (D-CO) and is, therefore, familiar with all of the issues surrounding the ACA.

While nearly everything surrounding the future of ACA and its replacement remains to be decided, CalOptima got off on a good footing this month with regard to the Orange County Delegation and our Senators in 2017.

EDELSTEIN GILBERT ROBSON & SMITH LLC

Donald B. Gilbert Michael R. Robson Trent E. Smith Alan L. Edelstein OF COUNSEL

CalOptima Legislative Report
February 15, 2017
By Don Gilbert and Trent Smith

Democrats in the State Legislature continue to be consumed with defending California against the actions of the Trump Administration and the Republican controlled Congress. So far, most of the resolutions and floor speeches have focused on immigration policies. The potential repeal of the Affordable Care Act (ACA) is receiving far less attention, although it is not being totally ignored. Health Committee consultants are busy gathering information and crunching numbers to determine the potential impact if California loses its federal ACA money. Some estimate the loss could reach $16 billion – a sum the state could not easily backfill.

CalOptima CEO Michael Schrader and other staff visited Sacramento on February 14 as part of the Local Health Plans of California (LHPC) legislative day. They were joined by other County Organized Health Systems (COHS) and Local Initiative Health Plans in providing key legislative staff an overview of the services that public, non-profit health plans provide. Plans provided data on the growth each experienced as a result of the ACA and Medi-Cal expansion. Health plans, including CalOptima, also met with several key legislators to provide similar updates. It was a very successful day. Legislators and staff were impressed with the services CalOptima, and similar plans, provide their constituents. The ACA enrollment data was also appreciated.

The deadline to introduce new bills is February 17. We expect that nearly a thousand bills will be introduced in the last few days before the deadline. Once we have had the opportunity to review them all, we will provide a report on those measures that are of interest to CalOptima.

The Assembly Budget Subcommittee 2, which covers health and human services, will meet on March 2. The agenda includes a discussion of the Governor's Coordinated Care Initiative (CCI) proposal. As reported last month, the Governor wants to remove In Home Support Services (IHSS) from the program, thereby reestablishing the Cal Medi-Connect program. CalOptima and most of the other CCI plans are supportive of the Governor's proposal, but the counties are opposed as the cost to provide IHSS service will now fall on county governments. From what we have been able to gather, the Governor seems unwilling to compromise on his proposal. In fact, technically he does not need Legislative approval for his proposal. However, the counties are pushing the Legislature to develop a compromise for consideration in budget deliberations.

On February 22 both the Senate and Assembly Health Committees will meet together for an informational hearing to learn more about the Centers for Medicare and Medicaid Services (CMS) Mega Regulations. These regulations are over one thousand pages, hence the Mega Regulations title. The regulations cover a broad range of issues including: managed care rate development and Medical Loss Ratio (MLR) standards; managed care enrollment and disenrollment; continuity of care upon managed care enrollment; network adequacy; stakeholder engagement in managed long term care programs; enrollee rights; grievances and appeals; continuation of services pending appeal and fair hearing; a new Medicaid managed care quality rating system; and program integrity.

1127 11TH Street SUITE 1030 Sacramento, CA 95814 (916) 443-6400 FAX (916) 443-6445
www.edelsteingilbert.com

States, health plans, and providers must now realign their traditional operations to comply with the new regulations. Many technical changes will be required. The health committees would like to hear from the Department of Health Care Services and others on what progress is being made and any potential hurdles that may make it difficult to comply with the new regulations.

Back to Agenda

IMPACT Medi-Cal Growth in Orange County

Nearly a Quarter Million Residents May Lose Access to Care

CalOptima is a community-based health plan that serves Orange County's low-income Medi-Cal members. In 2014, when the Affordable Care Act expanded eligibility for Medi-Cal, CalOptima welcomed a new group of Orange County residents as members. The uninsured rate in Orange County went down to 8.7 percent in 2015, compared with 16.2 percent in 2013. Today, the Medi-Cal Expansion population is 234,000, and CalOptima's Medi-Cal Expansion revenue is $1.1 billion, which goes to pay local private-sector health care providers. This fact sheet explains the impact of Medi-Cal growth in terms of access to care and local economic benefits.

Medi-Cal growth has resulted in tremendous gains, which may be at risk with any changes to the program.

Expansion Members & Dollars

234,000

30% of CalOptima membership

$1.1 Billion

30% of CalOptima revenue

Source: CalOptima membership and finance data

Community Health Centers

INCREASE in number of centers:

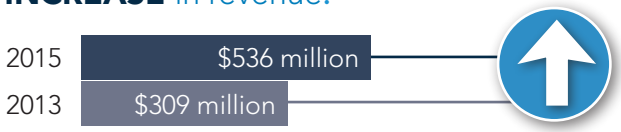
Up 13 Centers

72 community health centers in Orange County today, compared with 59 community health centers in 2013

Source: Coalition of Orange County Community Health Centers

Hospitals

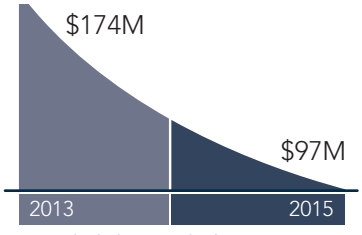
INCREASE in revenue:



Payments to hospitals in 2015, compared with 2013

Up $227M

DECREASE in bad debt & charity care:



Bad debt and charity care

$77M

less bad debt & charity care

Source: Office of Statewide Health Planning and Development

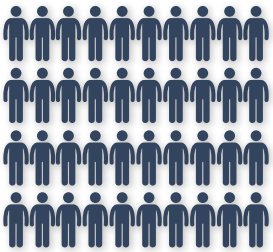
Health Networks

INCREASE in revenue:

Payments to doctors and health networks in 2015, compared with 2013

Up $565M

WORKFORCE



400

jobs created

Estimated jobs created at contracted health networks since 2013

Source: CalOptima contracted health networks

Back to Agenda

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Medi-Cal Growth in Orange County

The Patient Protection and Affordable Care Act (ACA) was signed into law on March 23, 2010, and most of its provisions went into effect on January 1, 2014. President Trump has made the repeal and replacement of the ACA a central part of his domestic policy agenda. Key Republican leaders, including Speaker of the House Paul Ryan and Secretary of Health and Human Services Tom Price have shared policy priorities to repeal and replace substantial portions of the law, including the optional expansion of Medicaid. This is likely to have a significant impact on California, given the sizeable growth in the state's Medicaid population under the ACA. This brief highlights the major implications of a potential rollback of Medicaid expansion and the impact it would have on Orange County.

What is Medicaid?

Medicaid is a joint federal and state health care program for the poor, created by the 1965 amendments to the Social Security Act. Today, more than 70 million people nationwide — mostly children, seniors and people with disabilities[1] — have access to health care through Medicaid. Access to the program is an entitlement. In other words, if a person is eligible, then he or she is guaranteed access. Individuals and families at or below the Federal Poverty Level, approximately $12,000 per year for an individual or $24,000 per year for a family of four, are eligible for Medicaid coverage.

Each state administers its own Medicaid program — California's is known as Medi-Cal — under federal rules. The program is jointly funded by states and the federal government. The current Medicaid financing system is a per-member federal match, known as the Federal Medical Assistance Percentage, or FMAP. The FMAP is customized to each state depending on the state's per capita income, compared with the national average. Each quarter, states report their Medicaid costs to the federal government, and those costs are matched at the state's FMAP. California's match is 50/50. Generally, for each Medi-Cal dollar, 50 cents is from the state and 50 cents is from the federal government.

How Did The ACA Affect Medicaid?

The ACA has had a broad impact on the health care industry, especially the Medicaid program. In its original form, the law mandated that states expand their Medicaid programs. However, the Supreme Court's 2012 ruling in National Federation of Independent Business v. Sebelius made expansion an optional part of the ACA. In states that chose to implement the expansion, eligibility was expanded to include individuals with income up to 138 percent of the Federal Poverty Level, approximately $16,000 for an individual and $33,000 for a family of four. Importantly, coverage for the Medicaid expansion population was 100 percent funded by the federal government for the first three years of the program. Beginning in calendar year 2017, states are responsible for a share of this cost, starting at 5 percent and increasing to 10 percent by 2020. In California's proposed state budget, Gov. Brown estimates that spending related to Medi-Cal expansion will be $18.9 billion in Fiscal Year (FY) 2017–18, and he has allocated $1.6 billion from the General Fund to cover the state's share of this cost.[2]

How was California Impacted?

California is one of 32 states that chose to expand Medicaid, authorizing the change with the passage of Senate Bill (SB) X1-1 (2013) and Assembly Bill (AB) X1-1 (2013). Since 2014, approximately 3.7 million Californians have gained health care coverage through Medi-Cal expansion (MCE).[3] MCE has helped reduce the number of uninsured Californians by half, from 17.2 percent in 2013 to 8.6 percent in 2015.[4] MCE enrollees gain access to Medi-Cal's core set of health benefits, including doctor visits, hospital care, immunizations, pregnancy-related services and nursing home care. Further, under the ACA, Medi-Cal health plans must offer their members a comprehensive array of services, including mental health and substance use disorder services, and preventive and wellness services, among others.

MCE has had a broadly positive affect on the state's health care infrastructure. For example, MCE has contributed to a 70 percent increase in hospital Medi-Cal revenue from 2011 to 2015.[5] In turn, this has helped California hospitals reduce bad debt (defined as payment for services anticipated, but not received) by 38 percent, from $5.1 billion in 2011 to $3.1 billion 2015.[6]

Repeal of the ACA will have a significant impact on California because many of the state's laws implementing the federal legislation have tie-back language that sunsets state provisions if the ACA is repealed or amended. SB X1-1 in particular includes language that would end Medi-Cal expansion within 12 months if the federal match falls below 70 percent before January 1, 2018.

Back to Agenda

How Was Orange County Impacted?

Any changes related to the MCE population would be keenly felt in Orange County, as CalOptima has more than 230,000 MCE members and receives more than $1.1 billion in funding related to this population. Expansion has provided these members with access to high-quality and cost-effective care. In September 2016, the National Committee for Quality Assurance awarded CalOptima a quality score of 4 out of 5 — the highest rating in California and in the top 10 percent nationwide. The score measures preventive care, treatment and customer satisfaction. Orange County's MCE dollars have also been efficiently managed. CalOptima maintains one of the lowest overhead rates — approximately 4 percent — among both public and private health plans in California.

At the heart of CalOptima's system of care is the plan's robust public-private partnership with local physicians, hospitals, health networks, pharmacies and other ancillary providers. This ensures access and offers choice to members. CalOptima contracts with 13 commercial health networks, which offer CalOptima members access to nearly 2,000 primary care providers and 6,000 specialists. The table below provides membership data for CalOptima's contracted health network partners.

Contracted Private-Sector Health Networks

Network	Medi-Cal Classic Members	Medi-Cal Expansion Members
AltaMed Health Services	23,336	18,427
AMVI Care Health Network	11,675	11,116
Arta Western Health Network	50,174	25,993
CHOC Health Alliance	150,070	4,347
Family Choice Health Network	27,093	21,379
Heritage	1,764	2,127
Kaiser Permanente	33,338	12,128
Monarch Family HealthCare	53,707	34,936
Noble Mid-Orange County	17,896	15,879
OC Advantage	335	644
Prospect Medical Group, Inc	17,672	17,428
Talbert Medical Group	14,212	10,819
United Care Medical Group	19,438	15,905

CalOptima also partners with 39 hospitals across the region, including CHOC Children's in Orange, Hoag Memorial Hospital Presbyterian in Newport Beach and St. Jude Medical Center in Fullerton.

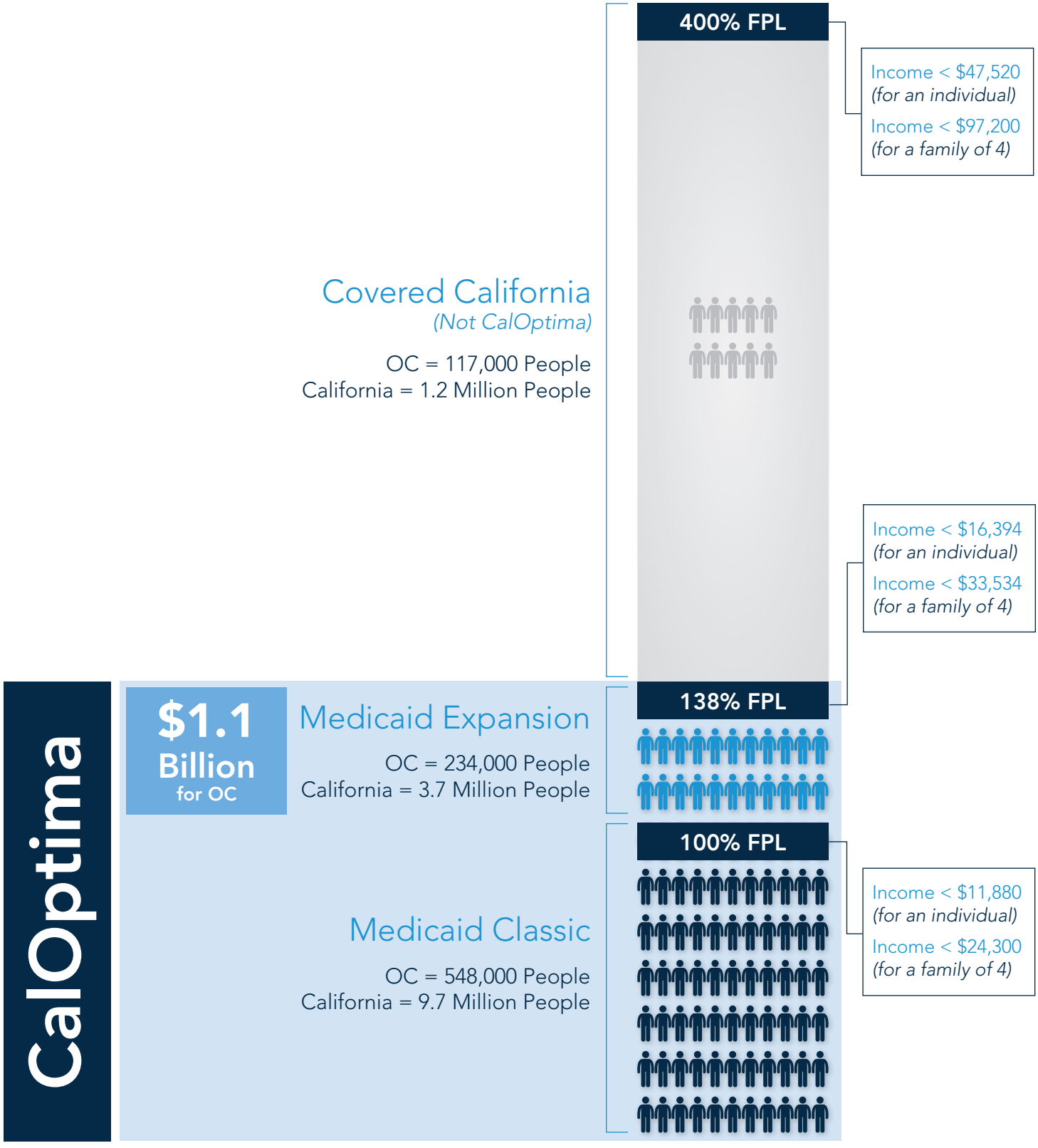
If MCE was rolled back as part of repealing the ACA, there would be major impacts to Orange County providers, health networks and hospitals. Due to growth in the Medi-Cal program, CalOptima has increased payments to contracted health networks by $565 million ($928 million in 2015, compared with $363 million in 2013) and increased payments to contracted hospitals by $227 million ($536 million in 2015, compared with $309 million in 2013). In part, this has contributed to Orange County's hospitals experiencing a 44 percent decrease in bad debt and charity care ($97 million in 2015, compared with $174 million in 2013). Overall, the Orange County uninsured population has decreased by 45 percent, going from 505,000 in 2013 to 276,000 in 2015.[7]

A rollback of MCE could also have a significant impact on Orange County's local economy due to the potentially drastic reduction in federal spending. An estimated 400 jobs have been created at CalOptima's contracted health networks related to MCE. Overall, ACA repeal could lead to Orange County losing 15,000 jobs in health care and other industries.[8]

Conclusion

While CalOptima recognizes the health care industry's continuous evolution, the new federal landscape has the potential to fundamentally change Medi-Cal in Orange County. In this environment, Orange County can benefit by amplifying our longstanding strength — the public-private partnership between CalOptima and private-sector hospitals, health networks and ancillary providers to ensure that low-income residents have guaranteed access to care. CalOptima intends to participate in Medicaid reform discussions to highlight our unique partnership and our commitment to delivering access to high-quality, cost-effective care.

Appendix: Medicaid Eligibility



FPL = Federal Poverty Level

Back to Agenda

About CalOptima

CalOptima is a county organized health system that administers health insurance programs for low-income children, adults, seniors and people with disabilities in Orange County. Our mission is to provide members with access to quality health care services delivered in a cost-effective and compassionate manner. As one of Orange County's largest health insurers, we provide coverage through four major programs: Medi-Cal, OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan), OneCare (HMO SNP) (a Medicare Advantage Special Needs Plan), and Program of All-Inclusive Care for the Elderly (PACE).

If you have any questions regarding the above information, please contact:

Phil Tsunoda
Executive Director, Public Policy and Public Affairs
(714) 246-8632; ptsunoda@caloptima.org

Arif Shaikh
Director, Public Policy and Government Affairs
(714) 246-8418; ashaikh@caloptima.org

Shamiq Hussain
Senior Policy Analyst, Government Affairs
(714) 347-3208; shussain@caloptima.org

Sean McReynolds
Senior Policy Analyst, Government Affairs
(657) 900-1296; smcreynolds@caloptima.org

Endnotes

[1] "Medicaid: An Overview," Congressional Research Service, January 2014.
[2] 2017–18 Governor's Budget Summary, p. 53, www.ebudget.ca.gov/2017-18/pdf/BudgetSummary/FullBudgetSummary.pdf, accessed January 31, 2017.
[3] "California's Projected Economic Losses Under ACA Repeal," UC Berkeley Center for Labor Research and Education, December 2016.
[4] U.S. Census Bureau, American Community Survey, 2013–15, Table A1: Population Without Health Insurance.
[5] Office of Statewide Health Planning and Development, 2011–15 Summary Trends – Hospital Quarterly Financial and Utilization Data.
[6] Ibid.
[7] "ACA Repeal in California: Who Stands to Lose?" UCLA Center for Health Policy and Research and UC Berkeley Center for Labor Research and Education, December 2016.
[8] "Fact Sheet: What does Orange County Stand to Lose under ACA Repeal?" UCLA Center for Health Policy and Research and UC Berkeley Center for Labor Research and Education, January 2017.

2017–18 State Legislative Matrix

Bill Number Author	Bill Summary	Bill Status	CalOptima Position
AB 15 (Maienschein)	This bill would require DHCS to increase the Denti-Cal provider reimbursement rates to the regional commercial rates for the 15 most common dental services. While the bill does not specify a dollar amount for the increase, it does note Denti-Cal's low utilization and funding levels, citing the need for increased reimbursement rates to attract additional providers. CalOptima members who receive Denti-Cal benefits outside of CalOptima may be affected by this proposed increase in funding. This bill would take effect on January 1, 2018.	**01/19/2017** Referred to Assembly Committee on Health	Watch
SB 171 (Hernandez)	This bill would lengthen the amount of time that Medi-Cal members have to request a state fair hearing. Under current law, if a Medi-Cal member who is enrolled in a county organized health system (COHS) plan is unhappy with their health plan, health network, or provider, the member can file a complaint or appeal with their health plan or the State Department of Social Services (DSS). The complaint or appeal must be submitted within 90 days of receiving a notice from the health plan or health network. This bill would allow members to file a complaint or appeal with DSS within 120 days of receiving the notice.	**02/02/2017** Referred to Senate Committees on Health and Appropriations	Watch
State Budget Trailer Bill (Cal MediConnect)	This trailer bill language (TBL) would establish statutory authority for the continuation of Cal MediConnect (CMC), which includes CalOptima's OneCare Connect. CMC is currently part of the Coordinated Care Initiative (CCI), which operates in seven counties and consists of both CMC, and the integration of Medi-Cal long-term services and supports, including In-Home Supportive Services (IHSS), into managed care. Gov. Brown's FY 2017–18 state budget proposed the continuation of CMC until December 31, 2019, even as the broader CCI is discontinued as of January 1, 2018. CCI's discontinuation means that IHSS administration will be transferred back to counties from managed care plans and that new state legislation will be required to authorize the CMC program past January 1, 2018.	**02/01/2017** Preliminary trailer bill language published by the Department of Finance	Watch

The CalOptima Legislative Tracking Matrix includes information regarding legislation that directly impacts CalOptima and our members. These bills are closely tracked and analyzed by CalOptima's Government Affairs Department throughout the legislative session. All official "Support" and "Oppose" positions are approved by the CalOptima Board of Directors. Bills with a "Watch" position are monitored by staff to determine the level of impact.

Back to Agenda

2017 State Legislative Deadlines

January 4	Legislature reconvenes
February 17	Last day for legislation to be introduced
April 28	Last day for policy committees to hear and report bills to fiscal committees
May 12	Last day for policy committees to hear and report non-fiscal bills to the floor
May 26	Last day for fiscal committees to report fiscal bills to the floor
May 30–June2	Floor session only
June 2	Last day to pass bills out of their house of origin
June 15	Budget bill must be passed by midnight
July 21–August 21	Summer recess
September 1	Last day for fiscal committees to report bills to the floor
September 5–15	Floor session only
September 15	Last day for bills to be passed. Interim recess begins
October 15	Last day for Governor to sign or veto bills passed by the Legislature

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Phil Tsunoda
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(714) 246-8632; ptsunoda@caloptima.org

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(714) 246-8418; ashaikh@caloptima.org

Shamiq Hussain
Senior Policy Analyst, Government Affairs
(714) 347-3208; shussain@caloptima.org

Sean McReynolds
Senior Policy Analyst, Government Affairs
(657) 900-1296; smcreynolds@caloptima.org

Board of Directors Meeting
March 2, 2017

CalOptima Community Outreach Summary — February 2017

Background

CalOptima is committed to serving our community by sharing information with current and potential members and strengthening relationships with our community partners. One of the ways CalOptima accomplishes this is through our participation in public events. CalOptima participates in public activities that meet at least one of the following criteria:

- Member interaction/enrollment: The event/activity attracts a significant number of CalOptima members and/or potential members who could enroll in any of CalOptima's programs.
- Branding: The event/activity promotes awareness of CalOptima in the community.
- Partnerships: The event/activity has the potential to create positive visibility for CalOptima and create a long-term collaborative partnership between CalOptima and the requesting entity.

Requests for sponsorship are considered based on several factors including: the number of people the activity/event will reach; the marketing benefits for CalOptima; the strength of the partnership or level of involvement with the requesting entity; past participation; staff availability; and budget availability.

In addition to participating in community events, CalOptima staff actively participates in a number of community meetings including coalitions/collaboratives, committees and advisory groups focused on community health issues. CalOptima strives to address issues related to improving access to health care, reducing health disparities, strengthening the safety net system and promoting a healthier Orange County.

CalOptima Community Events Update

According to the lunar calendar and the Chinese zodiac, this year's Lunar New Year begins on Saturday, January 28, and is the Year of the Fire Rooster. To welcome the Year of the Fire Rooster, Community Relations collaborated with various internal departments to host a resource table at two festivals and a concert in the park. The first festival was held in Costa Mesa on Saturday, January 28, and Sunday, January 29, and the second festival was held in Garden Grove on Saturday, February 4, and Sunday February 5. The concert in the park was held at Mile Square Park in Fountain Valley on Saturday January 28. Staff handed out fliers and brochures about CalOptima's programs and services to thousands of attendees at both festivals and the concert. At the festivals, attendees patiently waited in line to test their luck by spinning a prize wheel to win various giveaways.

Community Relations also hosted a resource table at the Black History Cultural Faire on Saturday, February 4, in downtown Anaheim in observance of Black History Month. This annual event, hosted by the Orange County Heritage Council, was preceded by the Black History Parade celebrating and showcasing the positive attributes and strength of African American heritage, culture and history. Staff provided information on CalOptima's programs and services and community resources to hundreds of attendees.

For additional information or questions, please contact Tiffany Kaaiakamanu, manager of Community Relations at 657-235-6872 or via email at tkaaiakamanu@caloptima.org.

Back to Agenda

Summary of Public Activities

CalOptima participated in 26 community events and coalition and committee meetings:

Date	Events/Meetings	Audience Reached
2/01/17	• Anaheim Human Service Network Meeting	Health and Human Service Providers
2/02/17	• Homeless Provider Forum	Health and Human Service Providers
2/03/17	• Resource Fair hosted by Garden Grove Unified School District	Members/Potential Members
2/04/17	• Tet Festival hosted by A Plus Education (*Registration Fee: $450 included one table and two chairs for outreach, and 20 admission tickets for staff for Saturday and Sunday)*	Members/Potential Members
	• 2017 Orange County Black History Cultural Faire hosted by Orange County Heritage Council (*Registration Fee: $150 included one table and two chairs for outreach, recognition on website, company's name and contact information listed in program)*	Members/Potential Members
2/05/17	• Health Fair hosted by Community Action Partnership Orange County and Our Lady of Guadalupe Church	Members/Potential Members
2/06/17	• Orange County Health Care Agency Mental Health Services Act Steering Committee Meeting	Health and Human Service Providers
2/07/17	• Collaborative to Assist Motel Families Meeting	Health and Human Service Providers
2/08/17	• Buena Park Collaborative Meeting	Health and Human Service Providers
	• Anaheim Homeless Collaborative Meeting	Health and Human Service Providers
2/10/17	• Senior Citizen Advisory Committee Meeting	Health and Human Service Providers
	• San Clemente Youth Wellness and Prevention Coalition Meeting	Health and Human Service Providers
2/11/17	• 23rd Annual Health and Wellness Fair hosted by Magnolia School District and University of Southern California Dental Clinic	Members/Potential Members
2/13/17	• Orange County Veterans and Military Families Collaborative Meeting	Health and Human Service Providers
	• Fullerton Collaborative Meeting	Health and Human Service Providers

Back to Agenda

2/14/17	• Buena Clinton Neighborhood Coalition Meeting	Health and Human Service Providers
2/15/17	• Minnie Street Family Resource Center Professional Roundtable	Health and Human Service Providers
2/17/17	• County Community Service Center education seminar — Topic: Who is CalOptima: Selecting Your Health Network and Doctor (*Spanish*) • Orange County Promotoras	Member/Potential Member Providers Health and Human Service Providers
2/16/17	• Orange County Children's Partnership Committee Meeting	Health and Human Service Providers
2/21/17	• OneCare Connect Forum hosted for Episcopal Senior Communities — Topic: OneCare Connect • Surf City Senior Providers Network Luncheon	Member/Potential Member Providers Health and Human Service Providers
2/22/17	• Community-based organization presentation for Westminster Family Resource Center — Topic: CalOptima Overview	Health and Human Service Providers
2/17/17	• Commission to End Homelessness • The Condition of Children Forum hosted by the Office of Supervisor Michelle Steel and Orange County Children's Partnership	Health and Human Service Providers Members/Potential Members
2/23/17	• County Community Service Center Presentation — Topic: CalOptima New Member Orientation	Member/Potential Member Providers
2/21/17	• Placentia Collaborative Meeting	Health and Human Service Providers
2/24/17	• County Community Service Center education seminar — Topic: Who is CalOptima: Selecting a Health Network and Doctor (*Vietnamese*)	Member/Potential Member Providers
2/27/17	• Stanton Collaborative Meeting • 2017 Annual Health Summit and Legislative Advocacy Day hosted by Family Voices of California (*Sponsorship Fee: $2,500 included admission for two families to attend the summit)*	Health and Human Service Providers Members/Potential Members
2/28/17	• Orange County Senior Roundtable	Health and Human Service Providers

CalOptima organized or convened the following 10 community stakeholder events, meetings and presentations:

Date	Event/Meeting	Audience Reached
02/03/17	• Health education seminar for Community Garden Tower — Topic: Healthy Heart (*Korean*)	Member/Potential Member Providers
	• Community-based organization presentation for California Elementary School — Topic: CalOptima Overview	Member/Potential Member Providers
2/06/17	• Community-based organization presentation for South Orange County Wellness Center — Topic: CalOptima Overview	Member/Potential Member Providers
2/10/17	• County Community Service Center education seminar — Topic: Who is CalOptima: Selecting Your Health Network and Doctor (*English*)	Member/Potential Member Providers
2/14/17	• Community-based organization presentation for the Cambodian Family Community Center — Topic: CalOptima Overview	Health and Human Service Providers

Back to Agenda

CalOptima endorsed the following four events during this reporting period (e.g., letters of support, program/public activity event with support, or use of name/logo):

1. Tet Festival hosted by A Plus Education (Listed in Public Activities)
2. 2017 Orange County Black History Cultural Faire hosted by Orange County Heritage Council (Listed in Public Activities)
3. 2017 Annual Health Summit and Legislative Advocacy Day hosted by Family Voices of California (Listed in Public Activities)
4. Letter of support for Illumination Foundation's grant application for Orange County Health Care Agency's Adult Full Services Partnership RFP.

Back to Agenda

CalOptima Board of Directors
Community Activities

For more information on the listed items, contact Tiffany Kaaiakamanu, Manager of Community Relations, at 657-235-6872 or by email at tkaaiakamanu@caloptima.org.

Day/Date/Time	Name of Activity/Event	Type of Activity/Event	Location
March			
Thursday, 3/2 9-11am	++Homeless Provider Forum	**Steering Committee Meeting: Open to Collaborative Members**	1855 Orange Olive Rd. Orange
Thursday, 3/2 9-10:30am	++Refugee Forum of Orange County	**Steering Committee Meeting: Open to Collaborative Members**	631 S. Brookhurst St. Anaheim
Saturday, 3/4 10am-3pm	+UC Irvine Jumpstart for Young Children 2017 Spring Literacy and Resource Fair	**Health/Resource Fair Open to the Public**	3101 W. Harvard St. Santa Ana
Sunday, 3/5 10am-3pm	+Vietnamese Community Health at UCLA	**Health/Resource Fair Open to the Public**	8200 Westminster Blvd. Westminster
Monday, 3/6 1-4pm	++OCHCA Mental Health Services Act Steering Committee	**Steering Committee Meeting: Open to Collaborative Members**	505 E. Central Ave. Santa Ana
Tuesday, 3/7 9:30-11am	++Collaborative to Assist Motel Families	**Steering Committee Meeting: Open to Collaborative Members**	250 E. Center St. Anaheim
Wednesday, 3/8 9-11am	*CalOptima Community Alliances Forum	**Networking Session and Presentation: Open to the CBO's, Health Advocates and Services Providers** ***Registration recommended***	Delhi Community Center 505 E. Central Ave. Santa Ana

* *CalOptima Hosted*

\+ *Exhibitor/Attendee*
++ *Meeting Attendee*

Back to Agenda

Day/Date/Time	Name of Activity/Event	Type of Activity/Event	Location
Wednesday, 3/8 12-1:30pm	++Anaheim Homeless Collaborative	**Steering Committee Meeting: Open to Collaborative Members**	500 W. Broadway Anaheim
Friday, 3/10 10am-3pm	+Office of Senator Bates and Assemblyman Brough's South OC Senior Day 2017	**Health/Resource Fair Open to the Public**	24932 Veterans Way Mission Viejo
Friday, 3/10 4-5:30pm	++San Clemente Youth Wellness & Prevention Coalition	**Steering Committee Meeting: Open to Collaborative Members**	700 Avenida Pico San Clemente
Monday, 3/13 1-2:30pm	++OC Veterans and Military Families Collaborative Meeting	**Steering Committee Meeting: Open to Collaborative Members**	525 N. Cabrillo Park Dr. Santa Ana
Monday, 3/13 2:30-3:30pm	++Fullerton Collaborative	**Steering Committee Meeting: Open to Collaborative Members**	353 W. Commonwealth Ave. Fullerton
Tuesday, 3/14 11:30am-12:30pm	++Buena Clinton Neighborhood Coalition	**Steering Committee Meeting: Open to Collaborative Members**	12661 Sunswept Ave. Garden Grove
Tuesday, 3/14 2-4pm	++Susan G. Komen Orange County- Unidos Contra el Cancer del Seno Coalition	**Steering Committee Meeting: Open to Collaborative Members**	3191-A Airport Loop Dr. Costa Mesa
Wednesday, 3/15 7:30am-3:15pm	+Hoag, St. Joseph Health and Alzheimer's Family Services Center's Spirituality Conference	**Conference: Open to the CBO's, Health Advocates and Services Providers** ***Registration recommended***	4545 MacArthur Blvd. Newport Beach
Wednesday, 3/15 11am-1pm	++Minnie Street Family Resource Center Professional Roundtable	**Steering Committee Meeting: Open to Collaborative Members**	1300 McFadden Ave. Santa Ana
Wednesday, 3/15 1-4pm	++Orange County Promotoras	**Steering Committee Meeting: Open to Collaborative Members**	Location Varies
Thursday, 3/16 8:30-10am	++Orange County Children's Partnership Committee	**Steering Committee Meeting: Open to Collaborative Members**	10 Civic Center Plaza Santa Ana

Day/Date/Time	Name of Activity/Event	Type of Activity/Event	Location
Tuesday, 3/21 10-11:30am	++Placentia Community Collaborative	**Steering Committee Meeting: Open to Collaborative Members**	849 Bradford Ave. Placentia
Tuesday, 3/21 2-3pm	++Vision Y Compromiso OC Committee Meeting	**Steering Committee Meeting: Open to Collaborative Members**	2 Executive Circle Irvine
Saturday, 3/25 12-4pm	+Active Learning USA 4th Annual Health Fair	**Health/Resource Fair Open to the Public**	1202 Flower St. Santa Ana
Monday, 3/27 12:30-1:30pm	++Stanton Collaborative	**Steering Committee Meeting: Open to Collaborative Members**	7800 Katella Ave. Stanton
Tuesday, 3/28 7:30-9am	++OC Senior Roundtable	**Steering Committee Meeting: Open to Collaborative Members**	170 S. Olive Orange
Tuesday, 3/28 3:30-4:30pm	++Santa Ana Building Healthy Communities	**Steering Committee Meeting: Open to Collaborative Members**	1902 W. Chestnut Ave. Santa Ana
April			
Monday, 4/3 1-4pm	++OCHCA Mental Health Services Act Steering Committee	**Steering Committee Meeting: Open to Collaborative Members**	505 E. Central Ave. Santa Ana
Tuesday, 4/2 9:30-11am	++Collaborative to Assist Motel Families	**Steering Committee Meeting: Open to Collaborative Members**	250 E. Center St. Anaheim
Wednesday, 4/5	++Anaheim Human Services Network	**Steering Committee Meeting: Open to Collaborative Members**	150 W. Vermont Anaheim
Thursday, 4/6 9-11am	++Homeless Provider Forum	**Steering Committee Meeting: Open to Collaborative Members**	1855 Orange Olive Rd. Orange

Day/Date/Time	Name of Activity/Event	Type of Activity/Event	Location
Saturday, 4/8	+City of Westminster Spring Festival	**Health/Resource Fair Open to the Public**	8200 Westminster Blvd. Westminster