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

AUGUST 3, 2023
2:00 P.M.

505 CITY PARKWAY WEST, SUITE 108
ORANGE, CALIFORNIA 92868

BOARD OF DIRECTORS

Clayton Corwin, Chair	Blair Contratto, Vice Chair
Debra Baetz	Isabel Becerra
Supervisor Doug Chaffee	Norma Garcia Guillen
José Mayorga, M.D.	Supervisor Vicente Sarmiento
Nancy Shivers, R.N.	Trieu Tran, M.D.

Supervisor Donald Wagner, Alternate

CHIEF EXECUTIVE OFFICER	OUTSIDE GENERAL COUNSEL	CLERK OF THE BOARD
Michael Hunn	Troy R. Szabo Kennaday Leavitt	Sharon Dwiers

This agenda contains a brief description of each item to be considered. Except as provided by law, no action shall be taken on any item not appearing on the agenda. To speak on an item, complete a Public Comment Request Form identifying the item 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 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 materials are available for review at CalOptima Health, 505 City Parkway West, Orange, CA 92868, Monday-Friday, 8:00 a.m. – 5:00 p.m. These materials are also available online at www.caloptima.org. Board meeting audio is streamed live on the CalOptima Health website at www.caloptima.org.

Members of the public may attend the meeting in person. Members of the public also have the option of participating in the meeting via Zoom Webinar (see below).
Participate via Zoom Webinar at:
https://us06web.zoom.us/webinar/register/WN_kZsxh9AlSzCTAB4HT7OoiA and Join the Meeting.

Webinar ID: **836 1277 3054**
Passcode: **339611** -- Webinar instructions are provided below.

CALL TO ORDER
Pledge of Allegiance
Establish Quorum

PRESENTATIONS/INTRODUCTIONS

MANAGEMENT REPORTS
1. Chief Executive Officer Report

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 June 1, 2023 Regular Meeting of the CalOptima Health Board of Directors and the Minutes of the June 29, 2023 Special Meeting of the CalOptima Health Board of Directors
   b. Receive and File Minutes of the March 15, 2023 Special Meeting of the CalOptima Health Board of Directors' Quality Assurance Committee

3. Approve New CalOptima Health Policy GG.1661: External Quality Review Requirements

4. Approve the 2022 CalOptima Health Utilization Management Program Evaluation and the 2023 CalOptima Health Integrated Utilization Management/Case Management Program Description

5. Ratify a Contract Amendment Related to Local Advocacy Services

6. Appointments to the CalOptima Health Whole-Child Model Family Advisory Committee

7. Appointments to the CalOptima Health Board of Directors' Member Advisory Committee

8. Appointments to the CalOptima Health Board of Directors' Provider Advisory Committee

9. Receive and File:
   a. May and June 2023 Financial Summaries
   b. Compliance Report
   c. Federal and State Legislative Advocates Reports
   d. CalOptima Health Community Outreach and Program Summary

REPORTS/DISCUSSION ITEMS
10. Extend the Terms of the Current Chair and Vice Chair of the Board of Directors until the September 2023 Board Meeting

11. Authorize Naloxone Distribution Event for CalOptima Health Members

12. Approve Actions Related to the Housing and Homelessness Incentive Program for the Nonprofit Healthcare Academy

13. Ratify the Temporary, Short-Term Supplemental Medi-Cal Payment Increase for Contracted Fee-for-Service Physicians, Except Physicians Employed by UCI Health or the University of California, Irvine, to Support Expenses for Services Provided to Members during the Transition out of the Public Health Emergency

14. Ratify a Temporary, Short-Term Supplemental Medi-Cal Payment Increase for Contracted Fee-for-Service Physicians Employed by UCI Health or the University of California, Irvine to Support Expenses for Services Provided to Members during the Transition out of the Public Health Emergency

15. Authorize Contract with a Non-Medical Transportation and a Non-Emergency Medical Transportation Vendor Effective January 1, 2024

16. Authorize an Amendment to the Contract with Pharmacy Benefit Manager, MedImpact Healthcare Systems, Inc. to Extend the Contract

ADVISORY COMMITTEE UPDATES

17. Regular Joint Meeting of the Member Advisory Committee and Provider Advisory Committee Update

CLOSED SESSION

CS-1. CONFERENCE WITH REAL PROPERTY NEGOTIATORS Pursuant to Government Code Section 54956.8
Under Negotiation: Price and terms of payments
Property: 7900 Garden Grove Avenue, Garden Grove, CA 92841
Agency Negotiators: David Kluth, and Mai Hu, Newmark Knight Frank
Negotiating Parties: Lvt, Inc.

CS-2. PUBLIC EMPLOYEE PERFORMANCE EVALUATION Pursuant to Government Code Section 54957(b)(1) Title: [Chief Executive Officer]

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

ADJOURNMENT

TO REGISTER AND JOIN THE MEETING

Please register for the Regular Meeting of the CalOptima Health Board of Directors on August 3, 2023 at 2:00 p.m. (PST)

To **Register** in advance for this webinar:
https://us06web.zoom.us/webinar/register/WN_kZsxh9AlSzCTAB4HT7OoiA

To **Join** from a PC, Mac, iPad, iPhone or Android device:
Please click this URL to join.
https://us06web.zoom.us/s/83612773054?pwd=TGpCK0IrTHlsQjdCUVJlUytSa2UwZz09

Passcode: 500426

Or One tap mobile:
+16694449171,,83612773054#,,,,*500426# US
+12532158782,,83612773054#,,,,*500426# US (Tacoma)

Or join by phone:
Dial(for higher quality, dial a number based on your current location):
US: +1 669 444 9171 or +1 253 215 8782 or +1 346 248 7799 or +1 719 359 4580 or +1 720 707 2699 or +1 253 205 0468 or +1 312 626 6799 or +1 360 209 5623 or +1 386 347 5053 or +1 507 473 4847 or +1 564 217 2000 or +1 646 558 8656 or +1 646 931 3860 or +1 689 278 1000 or +1 301 715 8592 or +1 305 224 1968 or +1 309 205 3325

Webinar ID: 836 1277 3054
Passcode: 500426

International numbers available: **https://us06web.zoom.us/u/ks6aWZRTm**

MEMORANDUM

DATE: July 27, 2023

TO: CalOptima Health Board of Directors

FROM: Michael Hunn, Chief Executive Officer

SUBJECT: CEO Report — August 3, 2023, Board of Directors Meeting

COPY: Sharon Dwiers, Clerk of the Board; Member Advisory Committee; Provider Advisory Committee; and Whole-Child Model Family Advisory Committee

A. Importance of Medi-Cal Renewal Drives Multiple Outreach Strategies

Media Coverage

- CalOptima Health was featured in a July 17 New York Times article on the potential loss of members due to Medi-Cal renewal. This piece represents a new milestone of high-profile national coverage for our agency.
- The Orange County Register ran an article on June 30, highlighting fears that Medi-Cal members will lose coverage due to not returning renewal forms. I was quoted about what our agency is doing to inform members about the importance of completing the renewal process.

Events

- More than 3,000 community members attended CalOptima Health's Medi-Cal Renewal and CalFresh Enrollment Event on June 10 at St. Anthony Claret Catholic Church in Anaheim. The large turnout underscored how important it is to offer community resource fairs and opportunities to assist with Medi-Cal renewal and Medi-Cal and CalFresh enrollment. Fox Channel 11 ran a segment from the event during the 10 p.m. news.
- CalOptima Health is co-hosting a Medi-Cal Renewal Event on June 29, at Ponderosa Park in Anaheim with Board Member and County Supervisor Vicente Sarmiento. The County of Orange Social Services Agency (SSA) will be on-site to assist attendees.
- CalOptima Health is hosting a Back-to-School Event to help with Medi-Cal renewal as children and families get ready for the new school year. The event will be held on August 26 t t nt on r t t o i r in n i fro p and will include:
  - Medi-Cal renewal and Medi-Cal, CalFresh and CalWORKS enrollment
  - Free vision exams, sports physicals and haircuts by appointment
  - Community resources for basic needs, mental health, early childhood education, and services for older adults and people with disabilities
  - Distribution of food, diapers, bike helmets and backpacks while supplies last

Texting Campaign

- In July, CalOptima Health launched additional outreach via texting campaigns to reach members in support of the renewal process. More than 99,500 text messages (in threshold languages) have been sent to members with renewal months from June to October. There are two types of messages: one urges them to update their contact information and the other is a

reminder to return their renewal packet. Updated information may be available to share at the Board meeting.

City Council Visits

- Over the past few months, I have visited four city councils to share information about Medi-Cal renewal along with SSA Director An Tran. Speaking to the leaders of the cities of Stanton, Irvine, Buena Park and Anaheim, we have encouraged them to join our renewal campaign by hosting events, adopting a proclamation and using our toolkit materials to communicate with residents. Several cities have already shared messages on their website.

B. CSA Audit Follow-Up Report Addressed

On June 29, at our Special Board of Directors meeting, John Tanner, Chief Compliance Officer, provided the Board with a verbal update on the 90-Day California State Auditor (CSA) Audit follow-up on the implementation of the seven recommendations. CalOptima Health has fully implemented three of the recommendations, closed one of the recommendations, and will close out the implementation of one recommendation in October. CalOptima Health will continue to work with the California State Auditor and the Board to address the remaining two. Please see attached recommendations and responses.

C. CalOptima Health's Street Medicine Program Reports Early Success

Our street medicine program has made significant strides in providing health care and social services to the unhoused population of Garden Grove during the first 100 days of operation. Since the beginning of April, Healthcare in Action has interacted with 172 individuals and now has 85 participants in the program. Other milestones include:

- 529 patient visits completed
- 81 unique individuals enrolled in CalOptima Health Connect
- 54 unique individuals evaluated/treated for substance use disorder
- 11 unique individuals evaluated/treated for opiate use disorder (including fentanyl)
- 40 individuals evaluated/treated for mental illness

D. Governor Signs Fiscal Year (FY) 2023–24 Enacted State Budget

On June 27, Gov. Gavin Newsom and the State Legislature reached a final agreement on the FY 2023–24 state budget package totaling $310.8 billion, including $226 billion in General Fund spending. Effective July 1, 2023, it is the second largest budget in California history and closes the gap on a $32 billion deficit while still safeguarding $37.8 billion in reserves. A series of shifts to funding sources, recovery of unused funds and delayed commitments in certain sectors helped achieve a balanced budget. In addition, the package includes several trailer bills that enact health-related policy changes, including to Medi-Cal. Notably, the budget re-enacts the Managed Care Organization (MCO) Provider Tax, retroactively to April 1, 2023, through December 31, 2026, and allocates its revenues toward Medi-Cal provider rate increases and workforce development totaling $11.1 billion over the next few years. These new investments resulted from recent advocacy efforts by a broad health care coalition, including CalOptima Health's trade associations. Please reference the full FY 2023-24 Enacted State Budget Analysis for additional details and potential impacts to CalOptima Health. A few highlights of the enacted budget are found below:

- Transitional Rent as a new Community Support option for up to six months of rent or temporary housing for eligible individuals experiencing or at risk of homelessness and transitioning out of certain facilities or the foster care system

- $480 million per year for a five-year BH-CONNECT Demonstration to support behavioral health workforce development
- $237 million in Medi-Cal rate increases for primary, maternity and non-specialty mental health services to at least 87.5% of Medicare rates, effective January 1, 2024
- $150 million for the Distressed Hospital Loan Program to provide interest-free loans to hospitals at risk of closure
- $10 million to develop state infrastructure for school-based mental health providers billing via a new statewide fee schedule
- $10 million for additional health enrollment navigators through community clinics

E. President Signs Debt Ceiling Legislation

On June 3, Pres. Joe Biden signed into law H.R. 3746: Fiscal Responsibility Act (FRA), which previously passed the U.S. Senate and U.S. House of Representatives on bipartisan votes. The FRA represents the negotiated agreement between Pres. Biden and House Speaker Kevin McCarthy to address the debt ceiling crisis ahead of the June 5 deadline imposed by the U.S. Department of the Treasury. Key highlights of the legislation include but are not limited to the following:

- Sets discretionary spending caps in the FY 2024 and 2025 federal budgets, and sets appropriations targets for the FY 2026–29 federal budgets
- Rescinds $27 billion in unspent COVID-19 relief funding previously allocated by the American Rescue Plan Act and the Coronavirus Aid, Relief and Economic Security Act
- Raises the age of Supplemental Nutrition Assistance Program (SNAP) recipients subject to work requirements from 49 to 55 years old, but only until October 1, 2030
- Creates new exemptions that waive SNAP work requirements for young adults ages 18 to 24 aging out of foster care, veterans and individuals experiencing homelessness, but only until October 1, 2030
- Places new restrictions on how often states can waive work requirements for SNAP recipients, and requires the U.S. Department of Agriculture to publish a report of which state waivers it approves and rejects
- Terminates the current pause on student loan repayments and interest accrual, effective August 29, 2023

F. Branding Campaign Video Debuts

As part of CalOptima Health's brand awareness campaign, we are producing four inspirational member videos through our marketing partner Maricich Health. The videos will be used in community presentations and other outreach to increase awareness and understanding of our agency. The first one features Hai Hoang who survived osteosarcoma as a child. As a former CalOptima Health member and current member of our Member Advisory Committee, he shares that he is eternally grateful for how CalOptima Health treated him. Please view Hai's story here.

G. Elected Officials to Present $2 Million Traffic Control Check

On August 15, U.S. Reps. Young Kim and Lou Correa will jointly present a $2 million check to CalOptima Health to help fund the buildout of the Care Traffic Control command center on the third floor of the new 500 building. This federal earmark was included in the Consolidated Appropriations Act of 2023 and signed into law on December 29, 2022. The formal grant documents have been submitted to the U.S. Department of Health & Human Services, which is expected to officially award and transfer the funds in September or October.

H. U.S. Rep. Katie Porter Commends CalOptima Health

U.S. Rep. Katie Porter gave a speech on the floor of the U.S. House of Representatives to commend CalOptima Health's $25.5 million investment in Orange County's 29 school districts as part of the Student Behavioral Health Incentive Program. She notably declared that "mental health care is health care." We look forward to working with Rep. Porter to improve behavioral health policies.

I. Transitions of Care Roundtable Has Robust Attendance

CalOptima Health hosted the Transitions of Care Roundtable on July 18 with a strong turnout of 55 leaders from hospitals, long-term acute care hospitals, skilled nursing facilities and recuperative care centers. The goal was to discuss ways to better coordinate care for our members.

J. CalOptima Health Gains Media Coverage

CalOptima Health continues to receive substantial positive and valuable TV, radio, print and online media coverage. In the month of June, we were featured in 88 media clips, with a publicity value of $314,110, reaching an audience of 22.5 million people.

- CalOptima Health conducted media outreach about the proposed Community Living Center in Tustin, and several responded, including the following major outlets. On June 17, the Orange County Register published a story online and in the June 18 Sunday print version. On June 20, KCBS/KCAL interviewed Kelly Bruno-Nelson, Executive Director of Medi-Cal/CalAIM and others for a piece that aired on the 4 p.m. news.
- OC World published a two-part news program featuring an interview with Board Chair Clay Corwin, Kelly Bruno-Nelson and me. During the interview, we discussed CalOptima Health's role in caring for Orange County's vulnerable community members, insights into our priority programs, and the outcomes of our recent audit and more.
- On June 27, Stephen Faessel, chairman of the Orange County Housing Finance Trust and an Anaheim City Council Member, published an opinion piece in the OC Register that stated housing is key to solving the homelessness crisis in Orange County. He mentions CalOptima Health as one of the primary collaborators in the community providing permanent housing along with programs and services that the most vulnerable need to improve their lives.
- On June 28, newsantaana.com published CalOptima Health's press release on the provider rate increase.
- On July 11, Javier Sanchez, Executive Director of Medicare Programs, was featured in a U.S. News article "Will My Disability Benefits Change When I Turn 65?"

CalOptima Health

Fast Facts
August 2023

Mission: To serve member health with excellence and dignity, respecting the value and needs of each person.

Membership Data* (as of June 30, 2023)

Total CalOptima Health Membership

988,716

Program	Members
Medi-Cal	970,590
OneCare (HMO D-SNP)	17,687
Program of All-Inclusive Care for the Elderly (PACE)	439

*Based on unaudited financial report and includes prior period adjustment

Operating Budget (for 12 months ended June 30, 2023)

	YTD Actual	YTD Budget	Difference
Revenues	$4,246,920,626	$4,002,166,211	$244,754,415
Medical Expenses	$3,857,653,291	$3,763,117,812	($94,535,479)
Administrative Expenses	$192,886,333	$220,226,217	$27,339,884
Operating Margin	$196,381,001	$18,822,182	$177,558,819
Medical Loss Ratio (MLR)	90.8%	94.0%	(3.2%)
Administrative Loss Ratio (ALR)	4.5%	5.5%	1.0%

Reserve Summary (as of June 30, 2023)

	Amount (in millions)
Board Designated Reserves	$576.6*
Capital Assets (Net of depreciation)	$84.2
Resources Committed by the Board	$654.4
Resources Unallocated/Unassigned	$364.2*
Total Net Assets	$1,679.4

**Total of Board designated reserves and unallocated resources can support approximately 91 days of CalOptima Health's current operations.*

Total Annual Budgeted Revenue **$4 Billion**

NOTE: CalOptima Health receives its funding from state and federal revenues only. CalOptima Health does not receive any of its funding from the County of Orange.

CalOptima Health Fast Facts

August 2023

Personnel Summary (as of July 1, 2023, pay period)

	Filled	Open	Vacancy %
Staff	1,312.1	84.3	6.04%
Supervisor	79.0	5.0	5.95%
Manager	109.0	6.0	5.22%
Director	59.0	11.0	15.71%
Executive	21.0	1.0	4.55%
Total FTE Count	1,580.1	107.3	6.36%

FTE count based on position control reconciliation and includes both medical and administrative positions.

Provider Network Data (as of June 30, 2023)

	Number of Providers
Primary Care Providers	1,288
Specialists	8,374
Pharmacies	563
Acute and Rehab Hospitals	43
Community Health Centers	34
Long-Term Care Facilities	103

Treatment Authorizations (as of May 31, 2023)

	Mandated	Average Time to Decision
Inpatient Concurrent Urgent	72 hours	9.81 hours
Prior Authorization – Urgent	72 hours	13.28 hours
Prior Authorization – Routine	5 days	1.76 days

Average turnaround time for routine and urgent authorization requests for CalOptima Health Community Network.

Member Demographics (as of June 30, 2023)

Member Age	
0 to 5	8%
6 to 18	25%
19 to 44	35%
45 to 64	20%
65 +	12%

Language Preference	
English	58%
Spanish	27%
Vietnamese	9%
Other	2%
Korean	2%
Farsi	1%
Chinese	<1%
Arabic	<1%

Medi-Cal Aid Category	
Temporary Assistance for Needy Families	39%
Expansion	38%
Optional Targeted Low-Income Children	8%
Seniors	9%
People With Disabilities	5%
Long-Term Care	<1%
Other	<1%

CalOptima Health, A Public Agency

Back to Agenda

CSA Audit Status Update As of 6/28/23

Rec #	Recommendation	Status	CSA Narrative Response (250 words or less)	CSA Due Date	Status
1	To ensure that it uses its existing surplus funds for the benefit of its members and to comply with county ordinance, ***by June 2024 CalOptima should create and implement a detailed plan to spend*** its surplus funds for expanding access, improving benefits, or augmenting provider reimbursement, or for a combination of these purposes. This plan should be reviewed by its board and approved in a public board meeting.	Not Fully Implemented	CalOptima Health senior leadership will continue to report to the Finance and Audit Committee and the Board of Directors on the status of reserves and expenditures, including a written report in the publicly available Board materials. The Board will review levels of total assets and Board-designated reserve funds on an annual basis, at minimum, during the development of the strategic plan and the annual operating budget. ***During this review, the Board will assess resources to be used for the purposes of expanding access, improving benefits, and/or augmenting provider reimbursement. The Board will determine when a spending plan(s) for various initiatives are appropriate.*** CalOptima Health has been drastically accelerating our efforts to improve access and quality of health care for the most vulnerable residents in Orange County. These efforts continued with the Board's approval to allocate $182 million in reserves at the June 1, 2023, CalOptima Health Board of Directors Meeting. The Board of Directors has and will continue to take separate actions to allocate available funds, and to do so wisely in a manner that best serves our members. As communicated previously, CalOptima Health must ensure tactical use of government funds to support our members and providers. It would not be fiscally prudent to spend all unallocated funds above the minimum reserve requirement within a defined period.	June 2024	Open
2	To comply with county ordinance and to ensure that in the future it does not accumulate surplus funds in excess of its reserve policy, ***by June 2023 CalOptima should adopt a surplus funds policy or amend its policy for board-designated reserves to provide that if surplus funds accrue, CalOptima will use those funds to expand access, improve member benefits, or augment provider reimbursement, or for a combination of these purposes.*** The policy should require that the board review the amount of surplus funds each year when it receives CalOptima's audited financial statements and direct staff to create an annual spending plan subject to the board's approval to use those funds within the next 12 months.	Not Fully Implemented	***The CalOptima Health Board of Directors reviewed the current reserve policy at the June 1, 2023, Board of Directors meeting.*** In addition to the current reserve policy, the Board reviewed CalOptima Health's reserve position in comparison to other Medi-Cal managed care plans, reviewed scenarios for different minimum reserve levels and discussed pending DHCS financial performance guidance in the upcoming 2024 Medi-Cal contract. ***The Board directed staff to return with additional information on the status of the enacted State Budget and the federal debt ceiling negotiations, and DHCS's financial performance requirement.*** In light of this additional information, ***the Board will review and direct staff to formalize the current reserve process into policy at the September Board of Directors meeting.*** Given sufficient reserves are needed to provide stability in healthcare delivery, the minimum threshold, pending Board of Directors' adoption, does not mandate that reserves be drawn down to this level. The Board shall have discretion on the appropriate reserve level, above the minimum threshold, taking into account current and future economic conditions. The Board reviews levels of total assets and Board-designated reserve funds on an annual basis, at minimum, during the annual operating budget. During this review, the Board will assess resources to be used for the purposes of expanding access, improving benefits, and/or augmenting provider reimbursement. CalOptima Health must ensure tactical use of government funds to support our members and providers. It would not be fiscally prudent to spend all unallocated funds above the minimum reserve requirement within a defined period.	June 2023	Open
3	To ensure that it can determine whether funds allocated to initiatives intended to improve the health of CalOptima members experiencing homelessness are accomplishing their intended purpose, ***by June 2023 CalOptima should develop a policy*** that requires it to do the following when spending those funds or allocating funds for that purpose in the future: - ***Establish one or more goals for the use of the fund*** s. - Establish one or more metrics signifying the successful accomplishment of its goals. - ***Measure progress toward the established metric and provide the board with periodic updates*** on the effectiveness of its use of funds based on those measurements.	Fully Implemented	***CalOptima Health developed policy AA.1400: Grant Management (Attachment A1). This policy outlines the criteria and expectations to ensure consistency and accountability in managing discretionary Grant funding disbursed by CalOptima Health. CalOptima Health's Board of Directors approved the implementation of this policy on May 4, 2023.***	June 2023	Complete

Rec #	Recommendation	Status	CSA Narrative Response (250 words or less)	CSA Due Date	Status
4	To ensure that members of CalOptima's board do not violate state law by entering into employment contracts made by the board on which they serve, ***by June 2023 CalOptima should amend its bylaws*** to prohibit all CalOptima board members from being employed by CalOptima for a period of one year after their term on the board ends.	Will Not Implement	CalOptima's By Laws reference and restrict Board Members employment with the Agency pursuant to Section 14087.59 W&I and Section 1090 of the Government Code. ***Neither regulation includes a blanket restriction of employment with the agency for one year for all Board Members.***	June 2023	Closed
5	To better protect itself from criticism about the objectivity, appropriateness, and transparency of its hiring practices and to help ensure that CalOptima attracts and selects the most qualified candidates, ***by June 2023 CalOptima's board should adopt a policy that governs its hiring processes for all positions, including executive positions.*** Such a policy should incorporate best practices, including the minimum length of time that CalOptima will advertise job openings, the minimum number of qualified candidates CalOptima will interview for each position, and a requirement that it will use the same interview method for each candidate for a position. These steps should be documented for each recruitment.	Fully Implemented	***CalOptima Health developed policy GA.8060: Recruitment, Selection, and Hiring (Attachment A1).*** This policy incorporates best practices, including the minimum length of time that CalOptima Health will advertise job openings, the minimum number of qualified candidates CalOptima Health will interview for each position, and a requirement that it will use the same interview method for each candidate for a position. ***CalOptima Health's Board of Directors approved the implementation of this policy on May 4, 2023.***	June 2023	Complete
6	To reduce the risk that it does not appropriately evaluate allegations of fraud, waste, and abuse and report them to DHCS, ***by June 2023 the FWA unit should revise its written procedures*** to clearly specify the types of cases that should be addressed through investigations and the types that should be addressed through monitoring activities. In addition, it should establish written procedures for conducting monitoring activities.	Fully Implemented	***CalOptima Health updated policy HH.1107: Fraud, Waste, and Abuse Investigation and Reporting (Attachment A1)***. This policy has been updated to clearly specify that all allegations of suspected FWA shall be preliminarily researched, and all allegations received shall be documented in a FWA tracking log within one (1) business day. Allegations for which sufficient information is initially provided or garnered through preliminary investigation will undergo a full investigation. ***CalOptima Health's Board of Directors approved the implementation of this policy on June 1, 2023.***	June 2023	Complete
7	To help ensure the maintenance of an atmosphere free from fear of retaliation for reporting misconduct, ***by October 2023 and annually thereafter, CalOptima should conduct or contract for an anonymous survey of staff and contractors*** to determine whether they understand how to make such reports and feel comfortable doing so.	Not Fully Implemented	***CalOptima Health launched a 2023 Best Places to Work Survey in March, 2023.*** An announcement was sent on March 15, 2023 to "All Email Users" stating that we would be participating in the 2023 Best Places to Work Survey from March 31, 2023 - April 21, 2023 (Attachment A1). ***This survey included questions developed by CalOptima Health's Compliance and Human Resources departments regarding retaliation*** (Attachment A2). In the weekly "Week Ahead" emails starting March 27th CalOptima Health's Human Resources sent an email to "All Email Users" encouraging employees to participate in the survey (Attachment A3). As of April 21st, CalOptima Health had a completion rate of 66% (Attachment A4). CalOptima Health will not know the final completion rate of the survey until late July. CalOptima Health is in the process of updating CalOptima Health policy HH. 3012 Non-retaliation for Reporting Violations to include a requirement for conducting an annual survey for all staff. ***This policy remains on track for October 2023.***	October 2023	Open

MINUTES
REGULAR MEETING
OF THE
CALOPTIMA HEALTH BOARD OF DIRECTORS

June 1, 2023

A Regular Meeting of the CalOptima Health Board of Directors (Board) was held on June 1, 2023, at CalOptima Health, 505 City Parkway West, Orange, California. The meeting was held in person and via Zoom webinar as allowed for under Assembly Bill (AB) 2449, which took effect after Governor Newsom ended the COVID-19 state of emergency on February 28, 2023. Chair Corwin called the meeting to order at 2:03 p.m., welcomed Norma García Guillén as CalOptima Health's newest Board member, and asked Director García Guillén to lead the Board in the Pledge of Allegiance.

ROLL CALL

Members Present: Clayton Corwin, Chair; Blair Contratto, Vice Chair; Isabel Becerra; Supervisor Doug Chaffee; Supervisor Vicente Sarmiento; Trieu Tran, M.D.

(All Board Members in attendance participated in person except Director Becerra, who participated remotely under Just Cause, using her first use under Just Cause as permitted by AB 2449)

Members Absent: Clayton Chau, M.D. (non-voting); José Mayorga M.D.; Nancy Shivers

Others Present: Michael Hunn, Chief Executive Officer; Yunkyung Kim, Chief Operating Officer; James Novello, Outside General Counsel, Kennaday Leavitt; Nancy Huang, Chief Financial Officer; Richard Pitts, D.O., Ph.D., Chief Medical Officer; Sharon Dwiers, Clerk of the Board

PRESENTATIONS/INTRODUCTIONS

The Clerk administered the ceremonial Oath of Office for Director García Guillén.

MANAGEMENT REPORTS

1. Chief Executive Officer Report

Michael Hunn, Chief Executive Officer (CEO), started his report by welcoming Director García Guillén to the CalOptima Health Board and to the mission of CalOptima Health.

Mr. Hunn reviewed the Fast Facts data, noting that currently CalOptima Health serves 984,986 individuals with membership continuing to increase monthly. CalOptima Health spends 92.6% of every dollar on medical care, and 4.4% is the overhead cost to administer the program.

CalOptima Health's Board-designated reserves are $579.9 million; its capital assets are $67.1 million; its resources committed by the Board are $466.5 million; and its unallocated and unassigned resources are $463.7 million. Mr. Hunn noted that CalOptima Health's total net assets are currently $1.5 billion.

Mr. Hunn also reviewed the CalOptima Health personnel data and noted that there are about 1,500 employees with a vacancy/turnover rate of about 7.7% as of the May 6, 2023, pay period. CalOptima Health's vacancy/turnover target is to be at less than 12.5% to 15% at any given time.

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Mr. Hunn reviewed the provider data, noting that CalOptima Health has over 9,500 providers, 1,285 primary care providers, and 8,286 specialists; 563 pharmacies; 45 acute and rehab hospitals; 34 community health centers; and 101 long term care facilities.

Mr. Hunn reviewed CalOptima Health's treatment authorizations, noting that this data is as of March 31, 2023. For urgent inpatient treatment authorizations, the average approval is within 11.36 hours; the state-mandated response is 72 hours. For urgent prior authorizations, the average approval is within 13.09 hours; the state-mandated response is 72 hours. And for routine prior authorizations, the average approval is 1.48 days; the state-mandated response is 5 days. Mr. Hunn noted that the treatment authorization numbers above are for the approximately 225,000 members that are CalOptima Health's direct responsibility. He added that CalOptima Health is encouraging its delegated networks that manage the other 750,000 lives to aspire to these same types of turnaround times for treatment authorizations.

Mr. Hunn also provided an overview of the total dollars that CalOptima Health spends on all types of heath care, including total dollars to health networks, acute care, doctor office visits, and hospitals. For example, Children's Hospital in Orange County (CHOC), sees about 150,000 of CalOptima Health's children and on average CalOptima Health provides about $384 million in revenue; over a three-year period that is about $1.1 billion. For the University of California, Irvine (UCI), which is part of the UC Health System and not a public hospital, CalOptima Health pays between $200 million to $300 million depending on the year. In the last three years, CalOptima Health has paid about $744 million into the UC Health System. CalOptima Health is very fortunate to have UCI, which is considered a quaternary and tertiary hospital, providing very high-level care and specialty care. Mr. Hunn added that with all of the other hospitals listed, on an annual basis over a billion dollars go to CalOptima Health's acute care providers.

Mr. Hunn noted that he asked Dr. Michael Hochman to join today in the discussion of the Street Medicine Program that was approved by the Board. The Street Medicine Program launched in the City of Garden Grove on April 1, 2023, and it has been hugely successful. CalOptima Health's partner is Healthcare in Action led by Dr. Hochman. To date, Healthcare in Action has outreached to 119 individuals with 50 active individuals that have signed up for care management services. It is extraordinary to have almost 50% of these individuals agree to enroll in the program and is a testament to the Dr. Hochman and the Healthcare in Action team. Mr. Hunn asked Dr. Hochman to offer a few comments to the Board.

Michael Hochman, M.D., Chief Executive Officer, Healthcare in Action, noted what an honor it is to be at the Board meeting today. Dr. Hochman noted that he is a general internist, and that Healthcare in Action is a nonprofit medical group that serves exclusively unhoused populations. Healthcare in Action serves 11 different sites in California and 6 different counties. Dr. Hochman added that the Garden Grove site in many ways, is the most exciting and explained that of the 11 sites, at the Garden Grove site Healthcare in Action is working with a health plan, the City of Garden Grove, the county, the Sheriff's Department, and the Fire Department, which all came together and work collaboratively. Dr. Hochman also added that Mr. Hunn gives Healthcare in Action a lot of the credit, but it is really the vision of CalOptima Health and Mr. Hunn, along with Kelly Bruno-Nelson, Nicole Garcia, Danielle Camron, and many others who have made this Street Medicine Program happen. Dr. Hochman thanked the Board for supporting this work together and introduced Benjamin Kaska, who is the lead medical provider for the Healthcare in Action team.

Benjamin Kaska, Director, Clinical Operations, Healthcare in Action thanked the Board for this opportunity. He noted that he is a physician assistant by training, and he supervises the Garden Grove

team. Healthcare in Action has a physician assistant and a nurse who are in the field with the community health workers to provide excellent primary care to the homeless neighbors that Healthcare in Action has in the community. Healthcare in Action is offering full scope primary care services, as well as addiction services. to help people live a healthier and more fruitful life. Mr. Kaska mentioned that, as Mr. Hunn noted, Healthcare in Action has a very high sign-up rate, which really demonstrates a proof of concept that individuals on the street are willing to accept care if given as a rapport building approach. He thanked the Board, Mr. Hunn, and staff for the opportunity to pilot this program.

Mr. Hunn, on behalf of CalOptima Health and the Board, presented Healthcare in Action a framed version of what was published in the Orange County Register to say thank you and as a reminder that this reflects the work that is being done for the individuals CalOptima Health serves.

Mr. Hunn provided an update on Governor Newsom's Fiscal Year 2023-24 revised budget, referred to as the May Revise, and noted that despite a $31.5 billion deficit, the budget continues to reflect full funding of at least the current Medi-Cal investments and priorities. He added that CalOptima Health is happy that it is not anticipating reductions in revenues from the state to take care of Medi-Cal members. In addition, the May Revise proposes to reenact a managed care organization tax, referred to as MCO tax. The MCO tax will be retroactive to April 1, 2023, and then extend through December 31, 2026, which will generate about $19.4 billion dollars to be dedicated towards the following rates: $8.3 billion to the general fund and $11.1 billion in provider investments over an 8 to 10-year period, including Med-Cal rate increases for primary care, maternity care, and non-specialty mental services to at least 87.5% of Medicare rates, with an effective date starting in January of 2024. For specific programs the remaining $10.3 billion of provider investment funding will be developed later this year for inclusion in the fiscal year 2025 state budget. Mr. Hunn added that the state sets CalOptima Health's rates and revenues it receives for Medi-Cal. Staff will keep a very close eye on the medical loss ratio (MLR) and ensure CalOptima Health is financially viable given the uncertainty with discussions in Washington, D.C. over the debt ceiling. He added that 90% of CalOptima Health's revenue comes from the state.

Vice Chair Contratto asked for additional details on the proposed MCO tax, which CalOptima Health had for a while and now it is back. Mr. Hunn responded that the revenues come from CalOptima Health as the plan and Ms. Huang can provide the mechanics of the MCO tax itself.

Nancy Huang, Chief Financial Officer, explained that the MCO provider tax is an allowable funding mechanism whereby a tax is imposed by states on health care services where the burden of the tax falls mostly on providers, such as tax on managed care plans per members served. The MCO tax is used as a mechanism to generate new state funds that can be used to match with federal funds to bring additional federal Medicaid dollars. Ms. Huang added that CalOptima Health treats the MCO tax revenue as a pass through to providers so the net impact to CalOptima Health is zero. This is why it is part of the budget, but it does not impact CalOptima Health's operating revenue nor its operating expenses.

Director García Guillén noted that she mentioned to staff earlier this week related to the Street Medicine Program, which is very exciting and great work, that she is eager to see it adopted in neighboring cities and looks forward to a report on that as well.

Supervisor Chaffee also noted the great work being done in the City of Garden Grove and the creation of a navigation center. He noted that the City of Garden Grove is working with two other cities, Westminster, and Fountain Valley. Supervisor Chaffee said sometimes cities create a navigation center or

just a shelter, but they limit it to their city, which does not solve the problem. He added that when the outreach is regional it works better and noted that this came about because of the point in time count that the county conducted illustrated that there is a cluster of homeless people in that area that were not well served.

2. Reserve Policy Review

Ms. Huang provided an overview of CalOptima Health's total net assets, including funding balance, and how it compares to other Medi-Cal plans. She also reviewed the current Board-designated reserve policy. Ms. Huang started with the number Mr. Hunn shared during his CEO report, noting that when looking at the ultimate total net assets for CalOptima Health, which is $1.58 billion as of April 2023, that total net assets can be allocated into four different categories. The first category is Board-designated reserves, currently at $580 million, representing about 37% of CalOptima Health's total net assets. This includes $100 million of the minimum tangible net equity requirements imposed by the Department of Managed Health Care. These funds are designated reserves that stay in CalOptima Health's tier one accounts and are used to fulfill CalOptima Health's current reserve policy requirements, which requires that CalOptima Health have 1.4 to two times its monthly revenue in this account or funding bucket. In looking at the current balance of $579.9 million, those funds represent about 1.91 times of CalOptima Health's current monthly revenue. The second category is capital assets, currently at about $67 million, and is a fixed asset, representing about 4% of CalOptima Health's total net worth. The third category is resources committed by the Board, currently at $466.5 million. Ms. Huang reviewed the various initiatives that are included in the category, including spent and unspent dollars. The fourth category is unallocated resources, currently at $463.7 million. Ms. Huang added that as Mr. Hunn mentioned earlier, there are several actions before the Board today that will reduce the unallocated reserves to approximately $282 million if approved.

Ms. Huang also reviewed a comparison of CalOptima Health's reserves compared to other California Medicaid plans, noting that the total number of days in reserves ranges from 7 to 232 days. CalOptima Health has 155 days in reserves, including fixed assets. She added that staff checked with some of CalOptima Health's sister plans to find out what their policy requirements are related to board-designated reserves. As mentioned earlier, CalOptima Health's policy requires that it have between 1.4 to 2 months of revenue, converted to days is about 42 to 60 days, based on the current policy requirements. The sister plans' policies ranged from 60 days to 4 months revenue in board-designated reserves. Ms. Huang noted that all of the California Medicaid plans, including CalOptima Health, had excess reserves over their policy requirements as of December 31, 2022.

Ms. Huang responded to questions from Board members regarding reserves and provided additional details.

3. Transplants Update

Richard Lopez, M.D., Medical Director, presented an update on transplant activities at CalOptima Health after a brief introduction from Mr. Hunn. Dr. Lopez noted that he is a transplant surgeon. He spent the first two thirds of his career transplanting solid organs, mainly livers with some kidneys, and the last third operating on advanced cancers of the liver, the bile duct system, and the pancreas. Dr. Lopez added that when he was recruited to CalOptima Health, he was asked to focus on transplants and advanced cancer care. To do this, it was important to partner with transplant and cancer centers of excellence. Dr. Lopez noted that with partnerships, CalOptima Health's referrals get expedited, treatment is expedited, and ultimately, care is provided for members in a very prompt and efficient way. Another key component is

communication between the specialist at the transplant centers and the cancer centers and the community providers here in Orange County. Dr. Lopez noted that one of the first things he wanted to do is have a system where CalOptima Health could monitor and track its patients who undergo transplants. He added that CalOptima Health is in the process of putting that system in place and will report to the Board and the rest of the community how its transplant patients are doing and statistics going forward. Dr. Lopez reviewed the transplant centers of excellence that CalOptima Health currently is partnering with and the centers of excellence that CalOptima Health staff are currently in discussions with for future partnerships so that its members can receive the best care possible.

PUBLIC COMMENTS

There was one general public comment.

- Dr. Michael Weiss, CHOC Children's – Oral Re: CalOptima Health Policy EE.1106

There were nine public comments regarding Agenda Item 8: Approve New CalOptima Health Policy GG.1707: Doula Services.

- Shamiesha Ebbotemen, HERstory, Inc.
- Briantria Smocks, Arri Kenzo Foundation
- Arthur Smocks, Arri Kenzo Foundation
- Angela Brown, R.N., Hypno-Doula, DoulaLove's Creation and HERstory, Inc.
- Stephanie Arjona, HERstory, Inc.
- Hoda Shawky, HERstory, Inc.
- Janay Cook, JayCare Doula Services
- Jemilla White, HERstory, Inc.
- Arissa Palmer

There were four public comments regarding Agenda Item 21: Approve Actions Related to Wellness Prevention Foundation, dba Wellness & Prevention Center *allcove*™ South Orange County Mental Health Youth Center.

- Stephen Schueller, University of California, Irvine
- Cassandra Seidler, *allcove*™ and Wellness & Prevention Center
- Monika Robles, *allcove*™ and Wellness & Prevention Center
- Suhina Chand, *allcove*™, Irvine Youth Advisory Group, Beckman High School

There were six public comments regarding Agenda Item 33: Authorize Amendments to the Medi-Cal Mental Health Non-Applied Behavioral Analysis and Applied Behavioral Analysis Provider Contracts

- Andrew Patterson, Autism Behavior Services
- Eric Linder, Autism Behavior Services
- Briana Jaramillo, Autism Behavior Services
- Rob Haupt, Autism Spectrum Therapies
- Joseph Khang Nguyen, M.S., BCBA, Hearts of ABA
- Junie Lazo-Pearson, Ph.D., BCBA-D, Advanced Behavioral Health

CONSENT CALENDAR

4. Minutes

a. Approve Minutes of the May 4, 2023 Regular Meeting of the CalOptima Health Board of Directors

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b. Receive and File Minutes of the March 9, 2023 Special Meeting of the CalOptima Health Board of Directors' Finance and Audit Committee

5. Authorize and Direct Execution of Amendments to CalOptima Health's Primary Agreement with the California Department of Health Care Services Related to Rate Changes

6. Adopt Resolution No. 23-0601-01, Authorizing and Directing Execution of Contract MS-2324-41 with the California Department of Aging for the Multipurpose Senior Services Program for Fiscal Year 2023-24

7. Approve New CalOptima Health Policy GG.1667: CalAIM Population Health Management Program

8. Approve New CalOptima Health Policy GG.1707: Doula Services
This item was pulled from the Consent Calendar for discussion and public comment.

9. Approve New CalOptima Health Policy ITS.1308p: DHCS 834 Eligibility Process

10. Approve Updated CalOptima Health Office of Compliance Policy HH.1107
Supervisor Sarmiento thanked staff for the work being done regarding the fraud, waste, and abuse investigation and reporting, especially with the findings in the recent California State Audit of CalOptima Health.

11. Approve Actions Related to an Existing Contract for Zscaler to Include Zero Trust Network Architecture

12. Authorize Amendment to the Standard Grant Agreement to Reflect Updated Insurance Requirements

13. Authorize Extending Contract with the Infomedia Group Inc. dba Carenet Healthcare Services for one year

14. Approve Actions Related to State Advocacy Services

15. Adopt the Proposed CalOptima Health Board of Directors Meeting Schedule for Fiscal Year 2023-24

16. Receive and File:
a. April 2023 Financial Summary
b. Compliance Report
c. Federal and State Legislative Advocates Reports
d. CalOptima Community Outreach and Program Summary

Action: ***On motion of Supervisor Chaffee, seconded and carried, the Board of Directors approved the Consent Calendar Agenda Items 4 through 16,***

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minus Agenda Item 8 as presented. (Motion carried 6-0-1; Director García Guillén abstained; Directors Mayorga and Shivers absent)

8. Approve New CalOptima Health Policy GG.1707: Doula Services

The Board heard many public comments regarding the importance of doula services and need for these services in Orange County.

Supervisor Sarmiento thanked the speakers for their comments and asked about next steps with regard to doula services. Yunkyung Kim, Chief Operating Officer, responded that the action before the Board today is to approve the new CalOptima Health Policy GG.1707 Doula Services in accordance with regulatory requirement from the Department of Health Care Services. Ms. Kim added that once the policy is established for the doula services benefit, CalOptima Health will begin to contract for a network of providers to provide the services. The rates discussions are included as part of the contracting process and changes to the template used for contracting will come back to the Board for approval.

Vice Chair Contratto also thanked the speakers for the heartfelt comments and noted that as CalOptima Health looks at workforce development, it should also be looking at the opportunity to help train more doulas in its community.

Director García Guillén thanked all the public speakers and noted that this being her first meeting, this was a really great opportunity to hear the members that are here today and the community and the members that CalOptima Health impacts.

Action: ***On motion of Supervisor Chaffee, seconded and carried, the Board of Directors approved new CalOptima Health Policy GG.1707: Doula Services in accordance with regulatory requirements (Motion carried 7-0-0; Directors Mayorga and Shivers absent)***

REPORTS/DISCUSSION ITEMS

17. Election of Officers of the Board of Directors for Fiscal Year 2023-24

Vice Chair Contratto made a motion to elect Clayton Corwin to serve as Chair for Fiscal Year 2023-24.

No Action Taken: ***On motion of Vice Chair Contratto, the motion was seconded to elect Clayton Corwin to service as the Chair for Fiscal Year 2023-24 and a roll call vote was conducted. (Motion failed; 3-2-2; Chair Corwin, Vice Chair Contratto, and Director Tran voting yes; Supervisor Chaffee and Supervisor Sarmiento voting no; Director Becerra and Director García Guillén abstaining; Directors Mayorga and Shivers absent)***

After considerable discussion, Supervisor Sarmiento made a motion to defer the election of officers of the Board for Fiscal Year 2023-24 to the August Board meeting to allow all Board members to be in attendance.

Action: ***On motion of Supervisor Sarmiento, seconded and carried, the Board of Directors deferred the election of officers of the Board of Directors for Fiscal Year 2023-24 to the August Board Meeting. A roll call vote was***

conducted. (Motion carried; 6-1-0; Director Becerra, Supervisor Chaffee, Vice Chair Contratto, Director García Guillén, Supervisor Sarmiento, and Director Tran voting yes; Chair Corwin voting no; Directors Mayorga and Shivers absent)

In consultation with James Novello, Outside General Counsel, Kennaday Leavitt, the Board took the following action:

Action: ***On motion of Supervisor Sarmiento, seconded and carried, the Board of Directors approved the continuation of Clayton Corwin and Blair Contratto serving as Chair and Vice Chair until the August Board meeting at which the Election of Officers for Fiscal Year 2023-24 will take place. A roll call vote was conducted. (Motion carried; 7-0-0; Directors Mayorga and Shivers absent)***

18. Approval of the CalOptima Health Fiscal Year 2023-24 Operating Budget and Non-Operating Items

Director Isabel Becerra, who is also the Chair of the Finance and Audit Committee (FAC), provided opening comments regarding the Fiscal Year (FY) 2023-24 Operating Budget. FAC Chair Becerra congratulated Ms. Huang and the team for putting together a robust budget that fully took into account all of the needs of the members as well as those of the agency to ensure the best outcomes for the coming year. The FAC has thoroughly reviewed every budget detail of the proposed budget and supports the budget proposal that is before the Board today for approval.

Mr. Hunn thanked Ms. Huang and her entire finance team for the work that went into CalOptima Health's very complex budgets. He noted that with a $4 billion dollar budget there are many moving parts, and when he started at CalOptima Health about 14 months ago it had a budget deficit. Now, CalOptima Health has balanced budgets, and it is very careful with its overhead/administrative costs, which is currently about 4.4%. Mr. Hunn also pointed out that in the California State Audit report of CalOptima Health, from a fiscal management standpoint, there were no recommendations, so CalOptima Health is fiscally responsible with its dollars in order to provide members with the services they need in order to live healthy lives.

Ms. Huang reviewed the budget details starting with CalOptima Health's consolidated projected revenues for FY 2023-24, which is $4.01 billion. Combining CalOptima Health's medical and administrative expenses, which are projected to be $3.99 billion. Ms. Huang added that as Mr. Hunn mentioned, CalOptima Health is projecting a break-even budget, which puts its operating margin at $17 million. Ms. Huang reviewed in greater depth the details of the budget, including projected enrollment, revenue, medical costs, administrative expenses, MLR, and administrative loss ratio. She also reviewed enrollment projections across all lines of business, and explained the primary drivers for the projections, which included the effects of Medi-Cal eligibility redetermination activities, the addition of adult expansion members aged 26 to 49, and the Kaiser membership carved-out to state-wide Medi-Cal direct contract. Ms. Huang reviewed in detail the provider capitation, claims payments, case management and other medical costs for FY 2022-23 and FY 2023-24, and the comparison between the two fiscal years. In addition, Ms. Huang reviewed the costs for salaries, wages & benefits, non-salary expenses: operating, non-salary expenses: other, and total administrative expenses for FY 2022-23 and FY 2023-24 and the comparison between the two fiscal years. Ms. Huang also provided and update on the digital transformation strategy spending and projections for FY 2023-24.

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Ms. Huang responded to Board member questions and provided additional details and clarification.

Action: ***On motion of Director Becerra, seconded and carried, the Board of Directors: 1.) Approved the CalOptima Health Fiscal Year 2023-24 Budget, as reflected in Attachment A: Fiscal Year 2023-24 Operating Budget for All Lines of Business and Non-Operating Items; and 2.) Authorized the expenditures and appropriated the funds for the items listed in Attachment B: Administrative Budget Details and Attachment B1: Digital Transformation Administrative Budget Details, which shall be procured in accordance with CalOptima Health Policy GA.5002: Purchasing. (Motion carried; 7-0-0; Directors Mayorga and Shivers absent)***

19. Approval of the CalOptima Health Fiscal Year 2023-24 Routine Capital and Digital Transformation Year Two Capital Budgets

Ms. Huang introduced this item and reviewed the details of the FY 2023-24 routine capital and digital transformation year two capital budgets. For the routine capital budget, CalOptima Health is projecting $14.7 million, which includes information technology services (ITS), building improvements at the 500 building and the 505 building, as well as improvement at the PACE building. For the digital transformation strategy year two, CalOptima Health is projecting $21 million in spending for FY 2023-24. Ms. Huang responded to Board member questions by providing additional details and clarification as needed in addition to the in-depth information provided in the Board meeting materials.

Action: ***On motion of Supervisor Sarmiento, seconded and carried, the Board of Directors: 1.) Approved the CalOptima Health Fiscal Year 2023-24 Routine Capital and Digital Transformation Year Two Capital Budgets; and 2.) Authorized the expenditures and appropriated the funds for the following items, which shall be procured in accordance with CalOptima Health Board-approved policies: a.) Attachment A: Fiscal Year 2023-24 Routine Capital Budget by Project; and b.) Attachment A1: Fiscal Year 2023-24 Digital Transformation Year Two Capital Budget by Project. (Motion carried; 6-0-0; Supervisor Chaffee and Directors Mayorga and Shivers absent)***

20. Approve Actions Related to the Housing and Homelessness Incentive Program

Ms. Kim introduced the item and responded to Board member questions and provided additional details and best practices and lessons learned from the first round of Housing and Homelessness Incentive Program funding.

Action: ***On motion of Vice Chair Contratto, seconded and carried, the Board of Directors: 1.) Approved the new Housing and Homelessness Incentive Program (HHIP) priority area, Innovation and Implementation of Strategic Interventions, including system change projects; 2.) Authorized CalOptima Health staff to develop scopes of work to be used in requests for proposals, notices of funding opportunities, or direct contracts for defined programs that fall under one of the following initiatives within***

the priority areas: a.) Capital Projects; b.) Equity Grants Programs Serving Underrepresented Populations; or c.) System Change projects, including Nonprofit Healthcare Academy; 3.) Approved allocation of up to $22.3 million in HHIP funds earned through the Submission 1 report from the California Department of Health Care Services (DHCS) pursuant to Exhibit 1: HHIP Allocation and Awards; 4.) Allocated up to $22.3 million from existing reserves to match the DHCS funds and provide additional support for HHIP priorities pursuant to Exhibit 1: HHIP Allocation and Awards; and 5.) Made a finding that such expenditures are for a public purpose and in furtherance of CalOptima Health's mission and purpose. (Motion carried 7-0-0; Directors Mayorga and Shivers absent)

21. Approve Actions Related to Wellness Prevention Foundation, dba Wellness & Prevention Center *allcove*™ South Orange County Mental Health Youth Center

The Board heard several comments from members of the public on this item.

Ms. Kim introduced the item and noted that CalOptima Health's partners spoke most eloquently about the need and the background of the proposal. She noted that CalOptima Health is asking the Board to support the center with a grant of $2.47 million over four years. Ms. Kim noted that this is additional funding to the $2 million grant that the partners already received from the state that is intended to create a sustainable *allcove* model that CalOptima Health hopes will be replicable in other parts of Orange County.

Directors Becerra and García Guillén expressed that they would like to see this type of program in other cities in Orange County and not just focused on South County.

Action: ***On motion of Vice Chair Contratto, seconded and carried, the Board of Directors: 1.) Authorized CalOptima Health's Chief Executive Officer to develop and execute a grant agreement for a four-year term with the Wellness & Prevention Foundation, dba Wellness & Prevention Center (WPC), no earlier than July 1, 2023, to support the allcove™ South Orange County mental health youth center; 2.) Authorized unbudgeted expenditures in an amount up to $2.7 million from existing reserves to fund the grant agreement with WPC; and 3.) Made a finding that such expenditures are for a public purpose and in furtherance of CalOptima Health's mission and purpose. (Motion carried 7-0-0; Directors Mayorga and Shivers absent)***

22. Authorize Creation of a CalOptima Health Provider Workforce Development Reserve Fund

Mr. Hunn introduced the item, noting that this action is meant to start addressing the workforce shortages in healthcare all across the county. Recently, the California Hospital Association was in Sacramento providing information to the Senate Committee particularly on the ability to have nurses and caregivers tending to patients. Mr. Hunn thanked Supervisors Sarmiento and Chaffee for their support in the various workforce development initiatives.

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Supervisor Chaffee added that it was a pleasure to help create the Social Worker Program and especially how receptive CalOptima Health has been with regard to helping give students assistance and encouraging their education in social work.

Supervisor Sarmiento noted that it will be helpful for CalOptima Health to work with the county to ensure it is working together and to avoid duplicative efforts.

Action: ***On motion of Supervisor Chaffee, seconded and carried, the Board of Directors: 1.) Created a restricted CalOptima Health Provider Workforce Development Fund in the amount of $50 million from existing reserves to support the education, training, recruitment, and retention of safety net providers in Orange County; 2.) Directed the Chief Executive Officer to create a 5-year Provider Workforce Development Plan for the local safety net provider community; and 3.) Made a finding that such expenditures are for a public purpose and in furtherance of CalOptima Health's mission and purpose. (Motion carried 7-0-0; Directors Mayorga and Shivers absent)***

Chair Corwin noted for the record that Agenda Items 23 to 30 all deal with the same topic, which is authorization of temporary short-term supplemental payments to CalOptima Health providers. He noted that there are 8 different items due to the need to group different providers for purposes of dealing with Board member recusals and abstentions. Chair Corwin added that because of this the Board and public will hear the same or similar verbiage on the next 8 agenda items.

23. Authorize a Temporary, Short-Term Supplemental Medi-Cal Payment Increase for Certain Health Networks to Support Expenses for Services Provided to Members during the Transition out of the Public Health Emergency
Supervisor Sarmiento did not participate in this item due to campaign contributions under the Levine Act.

Ms. Kim introduced the item, noting that CalOptima Health anticipates that 200,000 may lose medical coverage in the next year due to redetermination also known as renewal. In addition, this will also affect CalOptima Health's providers as they see patients lose eligibility coming out of the public health emergency. In recognition of these challenges that CalOptima Health's providers will face, staff is recommending a temporary rate increase of 7.5% to all providers in the network. Ms. Kim noted that the total allocation across all of the 8 actions is approximately $107 million and will be funded from CalOptima Health's reserves.

Action: ***On motion of Vice Chair Contratto, seconded and carried, the Board of Directors: 1.) Authorized the Chief Executive Officer to implement temporary, short-term supplemental Medi-Cal rate increases of up to 7.5% for certain Medi-Cal health networks for the period of July 1, 2023, through August 31, 2024; 2.) Authorized the Chief Executive Officer to execute contract amendments and approve policies and procedures to implement these temporary, short-term public health emergency transition supplemental Medi-Cal rate increases; and 3.) Authorized unbudgeted expenditures from existing reserves in an amount up to $34.0 million to support the public health emergency transition supplemental payment program. (Motion carried 6-0-0;***

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Supervisor Sarmiento recused; Directors Mayorga and Shivers absent)

Chair Corwin noted for the record that he will be recusing himself on Agenda Item 24 due to his affiliation with Pomona Valley Hospital and will pass the gavel to Vice Chair Contratto.

The Clerk noted for the record that for Agenda Items 24 through 30, only the portions that change in each recommended action will be read into the record, and the full recommended actions for each Agenda Item will be reflected in the meeting minutes.

24. Authorize a Temporary, Short-Term Supplemental Medi-Cal Payment Increase for Contracted Hospitals Except Fountain Valley Regional Hospital & Medical Center, Los Alamitos Medical Center and Placentia Linda Hospital, to Support Expenses for Services Provided to Members During the Transition out of the Public Health Emergency
Chair Corwin did not participate in this item due to his affiliation with Pomona Valley Hospital.

Action: ***On motion of Supervisor Chaffee, seconded and carried, the Board of Directors: 1.) Authorized the Chief Executive Officer to implement temporary, short-term supplemental Medi-Cal rate increases of up to 7.5% for contracted fee-for-service hospitals except for Fountain Valley Regional Hospital & Medical Center, Los Alamitos Medical Center, and Placentia Linda Hospital, for the period of July 1, 2023, through August 31, 2024; 2.) Authorized the Chief Executive Officer to execute contract amendments and approve policies and procedures to implement these temporary, short-term public health emergency transition supplemental Medi-Cal rate increases; and 3.) Authorized unbudgeted expenditures from existing reserves in an amount up to $38.7 million to support the public health emergency transition supplemental payment program. (Motion carried 6-0-0; Chair Corwin recused; Directors Mayorga and Shivers absent)***

Vice Chair Contratto passed the gavel back to Chair Corwin.

25. Authorize a Temporary, Short-Term Supplemental Medi-Cal Payment Increase for Fee-for-Service Hospitals Fountain Valley Regional Hospital & Medical Center, Los Alamitos Medical Center and Placentia Linda Hospital, to Support Expenses for Services Provided to Members during the Transition out of the Public Health Emergency
Supervisor Sarmiento did not participate in this item due to campaign contributions under the Levine Act.

Action: ***On motion of Chair Corwin, seconded and carried, the Board of Directors: 1.) Authorized the Chief Executive Officer to implement temporary, short-term supplemental Medi-Cal rate increases of up to 7.5% for fee-for-service hospitals Fountain Valley Regional Hospital & Medical Center, Los Alamitos Medical Center, and Placentia Linda Hospital, for the period of July 1, 2023, through August 31, 2024; 2.) Authorized the Chief Executive Officer to execute contract amendments and approve policies and procedures to implement these temporary, short-term public health emergency transition supplemental Medi-Cal rate***

increases; and 3.) Authorized unbudgeted expenditures from existing reserves in an amount up to $4.4 million to support the public health transition emergency supplemental payment program. (Motion carried 6-0-0; Supervisor Sarmiento recused; Directors Mayorga and Shivers absent)

26. Authorize a Temporary, Short-Term Supplemental Medi-Cal Payment Increase for Contracted Community Clinics AltaMed Health Services Corporation, to Support Expenses for Services Provided to Members during the Transition out of the Public Health Emergency

Director Becerra did not participate in this item due to her role as Chief Executive Officer of the Coalition of Orange County Community Health Centers. Supervisor Sarmiento did not participate in this item due to campaign contributions under the Levine Act.

Action: ***On motion of Supervisor Chaffee, seconded and carried, the Board of Directors: 1.) Authorized the Chief Executive Officer to implement a temporary, short-term supplemental Medi-Cal rate increase of up to 7.5% for contracted Community Clinic AltaMed Health Services Corporation, for the period of July 1, 2023, through August 31, 2024; 2.) Authorized the Chief Executive Officer to execute contract amendments and approve policies and procedures to implement this temporary, short-term public health emergency transition supplemental Medi-Cal rate increase; and 3.) Authorized unbudgeted expenditures from existing reserves in an amount up to $0.16 million to support the public health transition emergency supplemental payment program. (Motion carried 5-0-0; Director Becerra and Supervisor Sarmiento recused; Directors Mayorga and Shivers absent)***

27. Authorize a Temporary, Short-Term Supplemental Medi-Cal Payment Increase for Contracted Community Clinics, except AltaMed Health Services Corporation, to Support Expenses for Services Provided to Members during the Transition out of the Public Health Emergency

Director Becerra did not participate in this item due to her role as Chief Executive Officer of the Coalition of Orange County Community Health Centers.

Action: ***On motion of Supervisor Sarmiento, seconded and carried, the Board of Directors: 1.) Authorized the Chief Executive Officer to implement a temporary, short-term supplemental Medi-Cal rate increase of up to 7.5% for contracted Community Clinics, except AltaMed Health Services Corporation, for the period of July 1, 2023, through August 31, 2024; 2.) Authorized the Chief Executive Officer to execute contract amendments and approve policies and procedures to implement this temporary, short-term public health emergency transition supplemental Medi-Cal rate increase; and 3.) Authorized unbudgeted expenditures from existing reserves in an amount up to $0.95 million to support the public health emergency transition supplemental payment program. (Motion carried 6-0-0; Director Becerra recused; Directors Mayorga and Shivers absent)***

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28. Authorize a Temporary, Short-Term Supplemental Medi-Cal Payment Increase for Contracted Fee-for-Service Physicians to Support Expenses for Services Provided to Members during the Transition out of the Public Health Emergency
This item was continued due to lack of a quorum.

29. Authorize a Temporary, Short-Term Supplemental Medi-Cal Payment Increase for Contracted Behavioral Health Providers to Support Expenses for Services Provided to Members during the Transition out of the Public Health Emergency
Supervisor Sarmiento did not participate in this item due to campaign contributions under the Levine Act.

Action: ***On motion of Supervisor Chaffee, seconded and carried, the Board of Directors: 1.) Authorized the Chief Executive Officer to implement temporary, short-term supplemental Medi-Cal rate increases of up to 7.5% for Contracted Behavioral Health Providers for the period of July 1, 2023, through August 31, 2024; 2.) Authorized the Chief Executive Officer to execute contract amendments and approve policies and procedures to implement these temporary, short-term public health emergency transition supplemental Medi-Cal rate increases; and 3.) Authorized unbudgeted expenditures from existing reserves in an amount up to $6.0 million to support the public health emergency transition supplemental payment program. (Motion carried 6-0-0; Supervisor Sarmiento recused; Directors Mayorga and Shivers absent)***

30. Authorize a Temporary, Short-Term Supplemental Medi-Cal Payment Increase for Contracted Ancillary Providers to Support Expenses for Services Provided to Members during the Transition out of the Public Health Emergency
Supervisor Sarmiento did not participate in this item due to campaign contributions under the Levine Act.

Action: ***On motion of Supervisor Chaffee, seconded and carried, the Board of Directors: 1.) Authorized the Chief Executive Officer to implement temporary, short-term supplemental Medi-Cal rate increases of up to 7.5% for contracted Ancillary Providers for the period of July 1, 2023, through August 31, 2024; 2.) Authorized the Chief Executive Officer to execute contract amendments and approve policies and procedures to implement these temporary, short-term public health emergency transition supplemental Medi-Cal rate increases; and 3.) Authorized unbudgeted expenditures from existing reserves in an amount up to $13.1 million to support the public health emergency transition supplemental payment program. (Motion carried 6-0-0; Supervisor Sarmiento recused; Directors Mayorga and Shivers absent)***

31. Authorize Amendments to the CalOptima Health Medi-Cal Health Network Services Contracts, Effective July 1, 2023
Supervisor Sarmiento did not participate in this item due to campaign contributions under the Levine Act.

Action: ***On motion of Chair Corwin, seconded and carried, the Board of Directors: 1.) Authorized amendments to the CalOptima Health Medi-Cal***

Health Network Contracts, except Kaiser Foundation Health Plan, effective July 1, 2023, to reflect: a.) Capitation base rate changes, including changes to Whole Child Model, maternity supplemental kick, and reinsurance provisions, as recommended by the recent Milliman rebasing analysis; b.) Updated rates for Enhanced Care Management services; and 2.) Authorized amendments to all CalOptima Health Medi-Cal Health Network Contracts to modify contract terms to align with program changes, including removal of provisions for funding for Health Homes Program and Whole Child Model Program start-up. (Motion carried 6-0-0; Supervisor Sarmiento recused; Directors Mayorga and Shivers absent)

32. Authorize Amendments to the CalOptima Health Ancillary Contracts with Community Supports Providers to Incorporate Enhanced Care Management Program Services in Accordance with Department of Health Care Services Requirements, Effective July 1, 2023

Director Becerra did not participate in this item due to her role as Chief Executive Officer of the Coalition of Orange County Community Health Centers.

Action: ***On motion of Supervisor Sarmiento, seconded and carried, the Board of Directors: Authorized staff to amend the CalOptima Health Ancillary Services Contracts with Community Supports providers as follows: 1.) Incorporate Enhanced Care Management (ECM) program services and modifications that align with updates in the Department of Health Care Services (DHCS) ECM Policy Guide, effective July 1, 2023; and 2.) Implement new ECM provider case rates. (Motion carried 6-0-0; Director Becerra recused; Directors Mayorga and Shivers absent)***

33. Approve Amendments to the Medi-Cal Mental Health Non-Applied Behavioral Analysis and Applied Behavioral Analysis Provider Contracts

The Board heard several comments from members of the public, after which they took the following action:

Action: ***On motion of Supervisor Sarmiento, seconded and carried, the Board of Directors: 1.) Authorized amendments to the Medi-Cal Professional Services Contract for Mental Health Non-Applied Behavioral Analysis services to reflect reimbursement rate increases effective July 1, 2023; and 2.) Authorized amendments to the Medi-Cal Professional Services Contract for Applied Behavioral Analysis services to reflect reimbursement rate increases effective July 1, 2023. (Motion carried 7-0-0; Directors Mayorga and Shivers absent)***

34. Approve Rate Increase for Contracted Medi-Cal Community-Based Adult Services Providers and Authorize Prospective Contract Amendments to Update Payment Rates

Action: ***On motion of Vice Chair Contratto, seconded and carried, the Board of Directors authorized amendments to the CalOptima Health Ancillary Services Contract with Medi-Cal Community-Based Adult Services***

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providers, effective July 1, 2023, to update payment rates for covered services. (Motion carried 7-0-0; Directors Mayorga and Shivers absent)

35. Authorize Assignment of the Restated Medi-Cal and Medicare Health Network Contracts with ARTA Western California Inc. dba Optum and Talbert Medical Group P.C. dba Optum to Monarch Health Plan, Inc.

Action: ***On motion of Supervisor Sarmiento, seconded and carried, the Board of Directors: Authorized assignment of ARTA Western California Inc. dba Optum (ARTA) and Talbert Medical Group P.C. dba Optum (Talbert) Medi-Cal health networks to Monarch Health Plan, Inc. (Monarch), and corresponding contract model changes, effective January 1, 2024, by way of the following actions: 1.) Authorized the Chief Executive Officer (CEO) to assign the ARTA and Talbert Shared Risk Group (SRG) contracts to Monarch via the "Consent to Assignment Agreement", which transfers enrollment and converts these entities from shared risk group (SRG) to a health maintenance organization (HMO), effective January 1, 2024; 2.) Authorized the CEO to enter into an amended and restated HMO Medi-Cal contract with Monarch on behalf of itself and ARTA and Talbert, effective January 1, 2024; and 3.) Authorized the CEO to enter into a restated HMO Medicare Advantage (OneCare) contract with Monarch, on behalf of itself and ARTA and Talbert, effective January 1, 2024. (Motion carried 7-0-0; Directors Mayorga and Shivers absent)***

CLOSED SESSION

CS-1. CONFERENCE WITH REAL PROPERTY NEGOTIATORS Pursuant to Government Code Section 54956.8, Under Negotiation: Price and terms of payments, Property: 7900 Garden Grove Avenue, Garden Grove, CA 92841, Agency Negotiators: David Kluth, and Mai Hu, Newmark Knight Frank, Negotiating Parties: Lvt, Inc.

This item was continued due to lack of a quorum.

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

Vice Chair Contratto thanked staff for the work that went into the Board packet and the incredible investment that CalOptima Health is making for its members. She added that she was deeply appreciative of everything the Board reviewed today and thanked Mr. Hunn for his leadership.

ADJOURNMENT

Hearing no further business, Chair Corwin adjourned the meeting at 6:05 p.m.

/s/ Sharon Dwiers
Sharon Dwiers
Clerk of the Board

Approved: August 3, 2023

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MINUTES
SPECIAL MEETING
OF THE
CALOPTIMA HEALTH BOARD OF DIRECTORS

June 29, 2023

A Special Meeting of the CalOptima Health Board of Directors (Board) was held on June 29, 2023, at CalOptima Health, 505 City Parkway West, Orange, California. The meeting was held in person and via Zoom webinar as allowed for under Assembly Bill (AB) 2449, which took effect after Governor Newsom ended the COVID-19 state of emergency on February 28, 2023. Chair Corwin called the meeting to order at 2:09 p.m., and Director Trieu Tran led the Board in the Pledge of Allegiance.

ROLL CALL

Members Present: Clayton Corwin, Chair; Blair Contratto, Vice Chair; Isabel Becerra; Jose Mayorga, M.D.; Supervisor Vicente Sarmiento; Nancy Shivers, R.N.; Trieu Tran, M.D.

(All Board Members in attendance participated in person except Director Mayorga, who participated remotely under Just Cause as permitted by AB 2449)

Members Absent: Supervisor Doug Chaffee; Norma García Guillén; Melinda Winterswyk

Others Present: Michael Hunn, Chief Executive Officer; Yunkyung Kim, Chief Operating Officer; James Novello, Outside General Counsel, Kennaday Leavitt; Nancy Huang, Chief Financial Officer; Richard Pitts, D.O., Ph.D., Chief Medical Officer; Sharon Dwiers, Clerk of the Board

PRESENTATIONS/INTRODUCTIONS

None.

MANAGEMENT REPORTS

1. California State Audit Update

John Tanner, Chief Compliance Officer, provided an update on CalOptima Health's California State Audit (CSA), noting that its 60-day update is tomorrow, June 30, 2023. CalOptima Health staff will submit status updates on various findings as a result of the CSA through the California State Auditor's portal. Mr. Tanner noted that there are seven recommendations for which CalOptima Health will provide responses, four responses are either complete or on track for timely completion, two are in progress pertaining to reserves and will be discussed in greater detail at a future Board meeting, and one is regarding the Bylaws.

Mr. Tanner responded to Board member questions and provided additional detail and clarification.

PUBLIC COMMENTS

There were no requests for public comment.

REPORTS/DISCUSSION ITEMS

2. Ratify Amendment to Contract with Newmark Knight Frank

Nancy Huang, Chief Financial Officer, introduced the item.

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Action: ***On motion of Vice Chair Contratto, seconded and carried, the Board of Directors: 1.) Ratified the amendment to contract with Newmark Knight Frank for real estate services to expand the scope of work; and 2.) Authorized unbudgeted expenditures in an amount not to exceed $35,000 from existing reserves for additional real estate-related services. (Motion carried; 7-0-0; Supervisor Chaffee and Director García Guillén absent)***

3. Approve Actions Related to the Garden Grove Street Medicine Support Center

Kelly Bruno-Nelson, Executive Director, Medi-Cal/CalAIM, introduced the item, noting that CalOptima Health is working in partnership with the City of Garden Grove to expand its Street Medicine Program. The proposed Street Medicine Support Center is a hotel that has 52 beds and 52 rooms, and it will be an extension of the Street Medicine Program. Members enrolled in the Street Medicine Program will be able to go there while enrolled and stabilized for roughly about 90 days and then move on to the next step and housing. Ms. Bruno-Nelson noted that if all goes well, escrow will close at the end of September and the property would undergo renovation, which would probably take about a year. She added that CalOptima Health is very excited about its partnership with the City of Garden Grove and the memorandum of understanding is a reflection of that partnership.

Ms. Bruno-Nelson responded to Board member questions, including whether walk-ins would be taken at the proposed Street Medicine Support Center and also regarding the non-refundable $150,000 deposit request. After considerable discussion, the Board took the following action:

Action: ***On motion of Supervisor Sarmiento, seconded and carried, the Board of Directors: 1.) Approved a Memorandum of Understanding (MOU) between the City of Garden Grove (City) and CalOptima Health pertaining to the establishment of a Street Medicine Support Center at 7900 Garden Grove Boulevard; and 2.) Authorized the release of the $150,000 deposit on July 25, 2023, to LVT Inc., as stated in the Purchase and Sale Agreement to enter into the escrow period for Street Medicine Support Center at 7900 Garden Grove Boulevard. (Motion carried 7-0-0; Supervisor Chaffee and Director García Guillén absent)***

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

There were no Board members comments.

ADJOURNMENT

Hearing no further business, Chair Corwin adjourned the meeting at 2:38 p.m.

/s/ Sharon Dwiers
Sharon Dwiers
Clerk of the Board

Approved: August 3, 2023

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MINUTES

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

CALOPTIMA
505 CITY PARKWAY WEST
ORANGE, CALIFORNIA

March 15, 2023

A Special Meeting of the CalOptima Health Board of Directors' Quality Assurance Committee was held on March 15, 2023, at CalOptima Health, 505 City Parkway West, Orange, California. The meeting was held in person and via Zoom webinar as allowed for under Assembly Bill (AB) 2449, which took effect after Governor Newsom ended the COVID-19 state of emergency on February 28, 2023.

Chair Trieu Tran, called the meeting to order at 3:00 p.m., and Director Mayorga led the Pledge of Allegiance.

CALL TO ORDER

Members Present: Trieu Tran, M.D., Chair; José Mayorga, M.D.; Nancy Shivers, R.N.
(All Committee Members participated in person, except Director Shivers, who participated remotely under "Just Cause" using her first of two uses for the Quality Assurance Committee)

Members Absent: None

Others Present: Michael Hunn, Chief Executive Officer; Yunkyung Kim, Chief Operating Officer; Richard Pitts, M.D., Chief Medical Officer; Troy R. Szabo, Outside General Counsel, Kennaday Leavitt; Linda Lee, Executive Director; Quality Improvement; Donna Frisch, M.D., Medical Director, PACE; Monica Macias, Director, PACE; Sharon Dwiers, Clerk of the Board

Chair Tran reordered the agenda to hear Management Reports ahead of the Information Items.

PUBLIC COMMENTS

There were no requests for public comment.

CONSENT CALENDAR

2. Approve the Minutes of the December 14, 2022, Regular Meeting of the CalOptima Board of Directors' Quality Assurance Committee

Action: ***On motion of Director Shivers, seconded and carried, the Committee approved the Consent Calendar as presented. (Motion carried 3-0-0)***

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REPORTS/DISCUSSION ITEMS

3. Receive and File 2022 CalOptima Health Program of All-Inclusive Care for the Elderly Quality Improvement Plan Evaluation and Recommend Board of Directors Approval of the 2023 Program of All-Inclusive Care for the Elderly Quality Improvement Plan

Donna Frisch, M.D., Medical Director, PACE Program, introduced the item, starting with major accomplishments from the 2022 PACE Quality Improvement Plan Evaluation. Some of the accomplishments included: swift response to updates regarding the COVID-19 pandemic; continued use of telehealth modalities; 95% of eligible PACE participants received at least one COVID-19 booster vaccine; 93% of participants received their annual influenza vaccine; 88% of participants received their Pneumococcal vaccine series; and 100% of participants had their medications reconciled within 15 days of hospital discharge.

Areas for improvement include transportation and medical care. Dr. Frisch noted there was a lot of turn-over of providers in medical care and transportation continues to be a challenge.

Dr. Frisch reviewed the proposed 2023 PACE Quality Improvement Plan, which included the following: reducing repeat falls and fall prevention, increasing the number of PACE participants that have completed an advanced health care directive with a goal of over 50%; increasing participant satisfaction with contracted dental services with a goal of less than one dental-related grievance per quarter; and increasing participant satisfaction with transportation services with a goal of less than three transportation-related grievances per quarter.

Action: ***On motion of Director Mayorga, seconded and carried, the Committee recommended that the Board of Directors: Receive and file the 2022 CalOptima Health Program of All-Inclusive Care for the Elderly (PACE) Quality Improvement (QI) Plan Evaluation, and Approve the 2023 PACE QI Plan. (Motion carried 3-0-0)***

4. Receive and File 2022 CalOptima Health Quality Improvement Program Evaluation and Recommend Board of Directors Approval of the 2023 CalOptima Health Quality Improvement Program and Work Plan

Linda Lee, Executive Director, Quality Improvement, introduced the item, starting with achievements in 2022. Some of the achievements/public recognition included: in September 2022 received 4 out of 5 in the National Committee for Quality Assurance (NCQA's) Medicaid Health Plan rating, and in October 2022 Chief Executive Officer Michael Hunn and Chief Medical Officer Richard Pitts, D.O., Ph.D., were recognized as 2022 Orange County Visionaries in a special publication of the LA Times OC. Some of CalOptima Health's accomplishments in 2022 include: establishing a health equity workgroup, which collected stakeholder feedback to determine what framework components should be included and what should be focused on. Ms. Lee noted that one of the first areas CalOptima Health focused on was cross functional training for internal and external stakeholders for social determinants of health data collection. Another goal was achievement of a high star rating for Medicaid. CalOptima Health also implemented two CalAIM programs, Enhanced Care Management and Community Supports, and initiated a Homeless Health program. Ms. Lee noted that CalOptima Health met 13 of the 15 Medi-Cal Accountability Set measures that the Department of Health Care Services (DHCS) measures on an annual basis.

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Ms. Lee also reviewed opportunities for improvement, which included falling below the minimum performance level of the 50th percentile for two measures, well-child visits from birth to 15 months and well-child visits from 15 to 30 months. She noted that CalOptima Health has implemented corrective action and is actively working on improving these measures. Ms. Lee also noted that low member satisfaction is the main driver of low performance indicated by CalOptima's OneCare stars rating. She noted that the areas identified as opportunities for improvement will be the focus of the 2023 Quality Improvement Work Plan. Ms. Lee added that CalOptima Health did not meet the goal of 80% in members to providers ratio and members getting appointments within established timeframes, so this is another focus area for 2023.

Ms. Lee reviewed the proposed 2023 Quality Improvement Work Plan, noting that it has been reorganized into four main categories: quality of care, safety, member experience, and quality of service. She added that CalOptima Health has established three overarching goals for 2023: to implement a comprehensive health equity framework; to improve quality of care and member experience to obtain NCQA 5-star rating and 4 stars for Medicare; and to implement pay for value programs that touch all CalOptima Health's provider partners.

Action: ***On motion of Director Tran, seconded and carried, the Committee recommended that the Board of Directors: Receive and File the 2022 CalOptima Health Quality Improvement Program Evaluation, and Recommended Board of Directors Approval of the 2023 CalOptima Health Quality Improvement Program and Work Plan. (Motion carried 3-0-0)***

5. Recommend Board of Directors Approval of Revision to the Measurement Set for the CalOptima Health's Measurement Year 2023 Medi-Cal Quality Pay for Value Program

Ms. Lee introduced the item, noting that this is a change from what was recommended at the December 2022 Board meeting. She added that since December 2022, DHCS has revised the proposed accountability set that it is holding health plans accountable to, which is what CalOptima Health's pay for value program is based on. Ms. Lee clarified that this item is being brought before the Committee so that CalOptima Health is in alignment with DHCS's measurement set.

Director Mayorga asked if certain measures are weighed more heavily. Yunkyung Kim, Chief Operating Officer, responded that yes there is a weighting, but it is not based on CalOptima Health's performance. It is based on the type of metric.

Action: ***On motion of Director Shivers, seconded and carried, the Committee recommended that the Board of Directors: Recommend Board of Directors Approval of Modification of the Measurement Set for the 2023 Health Network Medi-Cal Pay for Value Performance Program for the Measurement Period Effective January 1, 2023, through December 31, 2023. (Motion carried 3-0-0)***

6. Recommend Board of Directors Approval of New CalOptima Health Policy GG.1132: Medi-Cal Annual Wellness Visit Program

Ms. Lee introduced the item, noting that this is a new policy that CalOptima Health is implementing to ensure that Medi-Cal members ages 45 and older receive a comprehensive annual wellness visit

from their primary care physician and the program is inclusive of incentives to both members and providers. Members can receive $50 gift card for completion and providers receive $125 for providing the annual wellness visit and can receive an additional $100 if they fully document all of the components of a well care visit.

Director Mayorga did not participate in this item due to his role as Executive Director at UC Irvine Health.

Action: ***On motion of Director Shivers, seconded and carried, the Committee recommended that the Board of Directors: Recommend Board of Directors Approval of new CalOptima Health Policy GG.1132: Medi-Cal Annual Wellness Visit Program. (Motion carried 2-0-0; Director Mayorga recused)***

MANAGEMENT REPORTS

1. Chief Medical Officer Report

Richard Pitts, D.O., Ph.D., Chief Medical Officer, reviewed his Chief Medical Officer Report with the Committee. Regarding Ms. Lee's comment and his name being mentioned as an OC visionary, Dr. Pitts noted that he would say that the recognition includes all of the staff. Nothing gets done without CalOptima Health staff.

Dr. Pitts noted that his report is in the Quality Assurance Committee meeting materials, but he wanted to highlight the five-year comprehensive community cancer screening program. He noted that it is a very important initiative and will help all of the other efforts by the American Cancer Society, University of California, Irvine, and others to raise awareness and reduce late stage cancers and save lives.

INFORMATION ITEMS

7. Update on Assessment of Quality

Ms. Lee introduced the item, noting that this assessment of quality reflects her findings over the last few months of being the new Executive Director of Quality Improvement. She added that she launched a comprehensive review of CalOptima Health's quality infrastructure policies, processes, and programs and looked at current strengths, risks, and opportunities for improvement. Ms. Lee noted an area of strength that she identified is Healthcare Effectiveness Data and Information Set (HEDIS) report and audit processes. This process is very mature. Ms. Lee noted that CalOptima Health went through its HEDIS audit this week and finished in record time because the auditors had very little to ask and CalOptima Health was fully compliant with requirements.

Ms. Lee reviewed some areas of risk, which included decreased performance for OneCare star ratings. CalOptima Health's rating is trending down and is projected to continue to trend down. Last year CalOptima Health was at 4 stars, this year it is at 3 stars, and next year it is projected to be at 2.5 stars. As previously reported, CalOptima Health is below the state's minimum performance level for well care visits, which is a requirement by DHCS. CalOptima Health is also at risk in the area of access and availability. Ms. Lee reviewed several additional areas for improvement and noted that staff has put into place focused initiatives to improve upon risk areas and will be monitoring all areas closely and will report back regularly to this Committee and the full Board on the status of these interventions.

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8. Program of All-Inclusive Care for the Elderly Member Advisory Committee Update
Ms. Macias provided an update on the recent activities of the PACE Member Advisory Committee.

The following items were accepted as presented.

9. Quarterly Reports to the Quality Assurance Committee
   a. Quality Improvement Committee Report
   b. Program of All-Inclusive Care for the Elderly Report
   c. Member Trend Report

COMMITTEE MEMBER COMMENTS
The Committee members thanked staff for the work that went into preparing for the meeting. Chair Tran thanked Marsha Choo and Monica Macias for their reports.

ADJOURNMENT
Hearing no further business, Chair Tran adjourned the meeting at 4:15 p.m.

/s/ Sharon Dwiers
Sharon Dwiers
Clerk of the Board

Approved: June 14, 2023

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CalOptima Health Board Action Agenda Referral

Action To Be Taken August 3, 2023
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar
3. Approve New CalOptima Health Policy GG.1661: External Quality Review Requirements

Contacts
Yunkyung Kim, Chief Operating Officer, (714) 923-8834
Linda Lee, Executive Director, Quality Improvement, (657) 900-1069

Recommended Action
Approve new CalOptima Health Policy GG.1661: External Quality Review Requirements, in accordance with regulatory requirements.

Background/Discussion
CalOptima regularly reviews its policies and procedures to ensure they are up-to-date and aligned with federal and state health care program requirements, contractual obligations, and laws as well as CalOptima operations.

Policy GG.1661: External Quality Review (EQR) Requirements defines the guidelines for CalOptima Health's EQR requirements, as designated by the Department of Health Care Services (DHCS), in accordance with Title 42, Code of Federal Regulations, Section 438.310, *et seq*., DHCS All Plan Letter 19-017: Quality and Performance Improvement Requirements, and the Centers for Medicare and Medicaid Services EQR protocols.

Fiscal Impact
The recommended action is operational in nature and has no additional fiscal impact beyond what was incorporated in the Fiscal Year 2023-24 Operating Budget.

Rationale for Recommendation
To ensure CalOptima Health's continuing commitment to conducting its operations in compliance with all applicable state and federal laws and regulations, CalOptima Health staff recommends that the Board of Directors approve and adopt the presented policy and procedure.

Concurrence
Troy R. Szabo, Outside General Counsel, Kennaday Leavitt

Attachments
1. CalOptima Health Policy GG.1661: External Quality Review Requirements

/s/ Michael Hunn *07/27/2023*
Authorized Signature **Date**

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Policy:	GG.1661p
Title:	**External Quality Review (EQR) Requirements**
Department:	Medical Management
Section:	Quality Analytics
CEO Approval:	*/s/*
Effective Date:	TBD
Revised Date:	Not Applicable
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy defines the guidelines for CalOptima Health's External Quality Review (EQR) requirements, as designated by the Department of Health Care Services (DHCS), in accordance with Title 42, Code of Federal Regulations (CFR), Section 438.310, et seq., DHCS All Plan Letter (APL) 19-017: Quality and Performance Improvement Requirements, and the Centers for Medicare and Medicaid Services (CMS) External Quality Review (EQR) protocols.

II. POLICY

A. CalOptima Health shall participate in EQR activities at least annually or more frequently as directed by DHCS and the External Quality Review Organization (EQRO).

B. EQR requirements include:

1. Quality and Health Equity Performance Measures;
2. Performance Improvement Projects (PIP);
3. Consumer Satisfaction Survey;
4. Network Adequacy Validation;
5. Encounter Data Validation;
6. Focused Studies; and
7. Technical Assistance.

III. PROCEDURE

A. Quality Performance Measures

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1. On an annual basis, CalOptima Health shall track and report on a set of quality performance measures and Health Equity measures identified by DHCS, in accordance with all of the following requirements:

    a. CalOptima Health shall work with the EQRO to conduct an onsite assessment of the Quality Measure Compliance Audit and DHCS-required quality performance measures;

    b. CalOptima Health shall calculate, and report all required Quality Performance Measures and Health Equity measures at the reporting unit level directed by DHCS. CalOptima Health shall separately report to DHCS all required performance measure results at the reporting unit level for its fully delegated subcontractors and downstream fully delegated subcontractors;

        i. CalOptima Health shall calculate performance measure rates, to be verified by the EQRO; and

        ii. CalOptima Health shall report audited results on the required performance measures to DHCS no later than June 15 of each year, or on another date as established by DHCS.

2. CalOptima Health shall make every effort to exceed the DHCS-established Minimum Performance Level (MPL) for each required Quality Performance Measure and Health Equity measure selected by DHCS.

3. CalOptima Health shall ensure that its fully delegated subcontractors and downstream fully delegated subcontractors whose rates are separately reported to DHCS, also exceed the DHCS-established MPL for each required Quality Performance Measure and Health Equity measure selected by DHCS;

    a. CalOptima Health shall communicate to its fully delegated subcontractors and downstream fully delegated subcontractors the DHCS-required Quality Performance and Health Equity measures, the DHCS-established MPL for each required Quality Performance Measure and Health Equity measure selected by DHCS; and their performance measure results.

4. CalOptima Health shall make every effort to meet Health Disparity reduction targets for specific populations and measures as identified by DHCS;

5. CalOptima Health shall conduct or coordinate an improvement project for measures that do not meet the MPL as outlined in CalOptima Health Policy GG.1634: Quality and Performance Improvement Projects; and

6. CalOptima Health shall collect and report Quality Performance Measures, in accordance with CalOptima Health Policy GG.1205: HEDIS Data Collection and Reporting.

B. Performance Improvement Projects (PIPs)

1. CalOptima Health shall conduct or participate in PIPs, including any PIP required by CMS, in accordance with 42 CFR section 438.330. CalOptima Health shall conduct or participate in, at a minimum, two (2) PIPs per year, as directed by DHCS and any additional PIPs or DHCS required statewide collaborative PIP workgroups.

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2. CalOptima Health shall require and ensure that its fully delegated subcontractors and downstream fully delegated subcontractors also conduct and participate in PIPs and any collaborative PIP workgroups as directed by CMS or DHCS.

3. CalOptima Health shall comply with the PIP requirements outlined in DHCS APL 19-017: Quality and Performance Improvement Requirements and as specified in CalOptima Health Policy GG.1634: Quality and Performance Improvement Projects.

4. Each PIP shall include:

   a. Measurement of performance using objective quality indicators;

   b. Implementation of equity-focused interventions to achieve improvement in the access to and quality of care;

   c. Evaluation of the effectiveness of the interventions based on the performance measures; and

   d. Planning and initiation of activities for increasing or sustaining improvement.

5. CalOptima Health shall report the status of each PIP at least annually to DHCS.

C. Consumer Satisfaction Survey

1. On an annual basis CalOptima Health shall timely provide all data requested by the EQRO in a format designated by the EQRO in conducting a consumer satisfaction survey.

2. As an accredited health plan by the National Committee for Quality Assurance (NCQA), CalOptima Health shall publicly post the annual results of its, and its fully delegated subcontractor's and downstream fully delegated subcontractor's, Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey on the CalOptima Health website, including results of any supplemental questions as directed by DHCS.

3. CalOptima Health shall incorporate results from the CAHPS survey in the design of quality improvement and Health Equity activities.

4. CalOptima Health shall conduct the CAHPS survey and take quality improvement action, in accordance with CalOptima Health Policy GG.1637: Assessing Member Experience.

D. Network Adequacy Validation

1. CalOptima Health shall participate in the EQRO's validation of CalOptima Health's Network adequacy representations from the preceding twelve (12) months to comply with requirements set forth in 42 CFR sections 438.14(b), 438.68, and 438.358.

E. Encounter Data Validation

1. As directed by DHCS, CalOptima Health shall participate in EQRO's validation of Encounter Data from the preceding twelve (12) months to comply with requirements set forth in 42 CFR sections 438.242(d), and 438.818.

F. Focused Studies

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1. As directed by DHCS, CalOptima Health shall participate in an external review of focused clinical and/or non-clinical topic(s) as part of DHCS' review of quality outcomes and timeliness of, and access to, services provided by CalOptima Health.

G. Technical Assistance

1. In accordance with 42 CFR section 438.358(d) and at the direction of DHCS, CalOptima Health shall implement EQRO's technical guidance in conducting mandatory and optional activities described in 42 CFR section 438.358.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Health Policy GG.1205: HEDIS Data Collection and Reporting
C. CalOptima Health Policy GG.1634: Quality and Performance Improvement Projects
D. CalOptima Health Policy GG.1637: Assessing Member Experience
E. Department of Health Care Services (DHCS) All Plan Letter (APL) 19-017: Quality and Performance Improvement Requirements (Supersedes APL 17-014)
F. Title 42, Code of Federal Regulations (CFR), §§422.152, 438.310(c)(2), 438.330, 438.350, 438.358, and 438.364

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
04/27/2023	Department Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
TBD	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	TBD	GG.1661	External Quality Review Organization Requirements	Medi-Cal

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IX. GLOSSARY

Term	Definition
Centers for Medicare & Medicaid Services (CMS)	The federal agency under the United States Department of Health and Human Services responsible for administering the Medicare and Medicaid programs
Consumer Assessment of Healthcare Providers and Systems (CAHPS)	A multiyear initiative of the Agency for Healthcare Research and Quality to support and promote the assessment of consumers' experiences with health care by developing standardized patient questionnaires that can be used to compare results across sponsors and over time and generate tools and resources that sponsors can us to produce understandable and usable comparative information for both consumers and health care providers.
Department of Health Care Services (DHCS)	The single State Department responsible for administration of the Medi-Cal Program, California Children Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP), and other health related programs.
External Quality Review (EQR)	The analysis and review by the External Quality Review Organization (EQRO) of aggregated information on quality, timeliness, and access to the health care services that Contractor, its Subcontractor, its Downstream Subcontractor, or its Network Provider furnishes to Members.
External Quality Review Organization (EQRO)	An organization that meets the competence and independence requirements set forth in 42 CFR section 438.354 and performs EQR and other EQR–related activities as set forth in 42 CFR section 438.358 pursuant to its contract with DHCS.
Health Disparity	Differences in health, including mental health, and outcomes closely linked with social, economic, and environmental disadvantage, which are often driven by the social conditions in which individuals live, learn, work, and play. Characteristics such as race, ethnicity, age, disability, sexual orientation or gender identity, socio-economic status, geographic location, and other factors historically linked to exclusion or discrimination are known to influence the health of individuals, families, and communities.
Health Equity	The reduction or elimination of Health Disparities, Health Inequities, or other disparities in health that adversely affect vulnerable populations.
Minimum Performance Level (MPL)	CalOptima Health's minimum performance requirements for select Quality Performance Measures.
Quality and Performance Improvement Project	A component of a comprehensive quality improvement program that addresses the quality of clinical care as well as the quality of health services delivery. A Quality and Performance Improvement Project is an initiative by the organization to measure its own performance in major focus areas of clinical and non-clinical care. Also known as Quality Improvement Projects (QIPs) and Performance Improvement Projects (PIPs).
Quality Measure Compliance Audit	A thorough assessment of Contractor's information system capabilities and compliance with each HEDIS specification to ensure accurate, reliable, and publicly reportable data.
Quality Performance Measures	Tools that help measure healthcare processes, outcomes, patient perceptions, and organizational structure and/or systems that are associated with the ability to provide high-quality health care and/or that relate to one or more quality goals for health care.

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CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 3, 2023
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

4. Approve the 2022 CalOptima Health Utilization Management Program Evaluation and the 2023 CalOptima Health Integrated Utilization Management/Case Management Program Description

Contacts

Richard Pitts, D.O., Ph.D., Chief Medical Officer, Medical Management, (714) 246-8491
Kelly Giardina, MSG, CCM, Executive Director, Utilization Management, (657) 900-1013

Recommended Actions

- Approval of the 2022 CalOptima Health Utilization Management Program Evaluation, and
- Approval of the 2023 CalOptima Health Integrated Utilization Management and Case Management Program Description.

Background

CalOptima Health's Utilization Management (UM) Program describes how medically necessary and quality health care services are delivered to members in a coordinated, comprehensive, and culturally competent manner. The program ensures that medical decision making is not influenced by financial considerations, does not reward practitioners or other individuals for issuing denials of coverage, nor does it encourage decisions that result in underutilization.

CalOptima Health's UM Program is reviewed and evaluated annually and approved by the Board of Directors. The UM Program defines the structure within which utilization management activities are conducted and establishes processes for systematically coordinating, managing, and monitoring these processes to achieve positive member outcomes.

CalOptima Health's achievements in 2022 included:

- Resolved the Q4 2021-Q1 2022 treatment authorization backlog issue and ensured interventions and protocols are in place to mitigate further occurrences;
- Improved workflows to prioritize aging inventory to exceed regulatory turnaround time compliance;
- Expanded Medical Directors' responsibilities and capacities;
- Enhanced the behavioral health role in the development and oversight of the UM Program; and
- Implemented the 90 Day Emergency Department (ED) Pilot Program to determine if focused clinical support in real time within the ED setting would impact members accessing post ED care.

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In 2022, the CalOptima Health UM leadership worked with the analytics team to develop real time reporting capabilities and implemented internal structural changes to improve the timeliness and operational effectiveness of the UM Program. Additional improvements included the addition of Medical Director leaders, a dedicated clinical trainer, and filling several key roles that were vacant in 2021. Process improvements such as improved workflows, standardized templates and improved real time reporting all contributed to UM Program enhancements during 2022.

Discussion

CalOptima Health staff has newly developed the 2023 Integrated UM and Case Management (CM) Program Description to include quality, pharmacy, Population Health Management (PHM), and behavioral health initiatives and care delivery. This will ensure that all regulatory requirements and National Committee for Quality Assurance (NCQA) accreditation standards are met in a consistent manner across all lines of business and aligned with health network and strategic organizational changes.

The revisions are summarized as follows:

- Comprehensive Health Equity framework to further enhance and improve quality of care and member experience;
- Clinical Pharmacy updates;
- PHM Program framework;
- UM Program Goals;
- CalAIM Goals;
- CM Program Goals;
- Utilization Management Committee Updates;
- Behavioral Health highlights; and
- CBAS updates.

The purpose of the 2023 Integrated UM and CM Program Description is to define the oversight and delivery of CalOptima Health's structure, clinical processes, and programmatic approach. All health care services serve the culturally diverse needs of the CalOptima Health population and are delivered at the appropriate level of care, in an effective, and timely manner by delegated and non-delegated providers.

The changes to CalOptima Health's Integrated UM and CM Program Description are reflective of current clinical operations and are necessary to meet the requirements specified by the Centers of Medicare and Medicaid Services, California Department of Health Care Services, and NCQA accreditation standards.

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Fiscal Impact

The recommended action to approve the 2023 CalOptima Health Integrated UM and CM Program Description does not have a fiscal impact beyond what was incorporated in the Fiscal Year 2023-24 Operating Budget and separate Board actions.

Concurrence

Troy R. Szabo, Outside General Counsel, Kennaday Leavitt
Quality Assurance Committee

Attachments

1. 2022 UM Program Evaluation
2. 2023 UM/CM Integrated Program Description (Redline version)
3. 2023 UM/CM Integrated Program Description (Clean version)
4. Annual Review: 2022 UM Program Evaluation and 2023 UM/CM Integrated Program Description (PowerPoint)

/s/ Michael Hunn *07/27/2023*
Authorized Signature **Date**

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2022 CalOptima Health
Utilization Management
Program Evaluation

A. EXECUTIVE SUMMARY

The 2022 Utilization Management (UM) Program description defines and outlines CalOptima Health's activities to provide optimal utilization and quality health care services that are delivered compassionately at the right time and in the appropriate setting.

CalOptima Health evaluates the UM program structure, scope, processes, and information sources used to determine utilization trends, medical necessity, and benefit coverage determinations. This evaluation of UM activity is reviewed and approved annually by the UM Committee (UMC), the Quality Improvement Committee (QIC) and the Quality Assurance Committee (QAC). The look back period for the 2022 UM program evaluation is Q4'2021 through the end of Q3'2022.

Program Structure and Process

The UM program was enhanced throughout 2022 to ensure member needs were addressed, while maintaining compliance with regulatory and accreditation standards. Although the staffing model for the UM department working prior authorization requests and conducting inpatient reviews did not change during the 2022 reporting period, CalOptima implemented multiple process improvement throughout the year to address operational and clinical enhancements. These included but not limited to the following:

- Improved workflows to prioritize aging inventory to exceed regulatory turnaround time compliance
- UM clinical team standardized templates for medical director reviews
- Inpatient facility clinical rounds to conduct peer to peer and complex discharge planning and support
- Improved access to real time reporting and tools to address authorization requests
- Enhanced provider portal automation and capabilities
- Addition of a dedicated clinical trainer
- Temporary coverage for all vacant roles to minimize the impact of staffing fluctuations

Program Structure

During 2022, CalOptima added three additional medical directors to the UM Program to continue to address clinical complexities and the need for additional specialty programs and interventions.
The following specialties and medical directors with robust experience in key areas were

added to the full-time medical director team within the UM Program:

- Internal and Preventative Medicine with Case Management and Gender Affirming Care experience and expertise
- Family Practice with extensive experience with Population Health Management experience
- Surgery and Transplant with experience in performing complex cancer procedures

The Deputy Chief Medical Officer and the PACE Medical Director vacated in 2021 were filled during 2022. A dedicated clinical trainer role was added and a process to secure clinical and non-clinical temporary staffing coverage for any open positions was established. Information sources as well as staff assigned activities used to determine benefit coverage and medical necessity remained current and appropriate. Medical Necessity coverage tools and hierarchical protocols are reviewed and approved annually at the UMC.

Program Scope Impact

Effective January 1, 2022, DCHS mandated MediCal retail pharmacy and pharmacy grievances be carved out of managed care health plans and on January 1, 2022, Magellan Rx began managing the pharmacy benefit for CalOptima. CalOptima assisted in the transition by resolving access issues around outpatient pharmacy and educating the members on the variances with the formulary and access continuity of treatment. In addition,

B. PROJECTS, PROGRAMS AND INITIATIVES

A. Utilization Management

Oversight of prior authorization (PA) inventory continued to be part of the overall UM program to improve average time to decision aligned with CalOptima Health's strategic vision for same day treatment authorizations. Interventions put into place to address a backlog of cases identified during Q4 2021 continue to ensure regulatory and accreditation requirements remain compliant, and members receive timely decisions on requested services. The UM Medical Director(s) remained very engaged in the UM process and provided continuing clinical oversight for the administration of the UM Program. This oversight and support included but is not limited to reviewing outcomes in UMC to ensure compliance with regulatory, contractual and accreditation guidelines and clinical evidence-based criteria, and by evaluating the program's effectiveness against established goals.

UM Medical Directors

The UM Medical Directors (including Behavioral Health and Pharmacy) are responsible for overseeing provider and member satisfaction efforts through the activities of the Benefit Management Subcommittee (BMSC). The purpose of this committee is to evaluate new and modified benefits and determine the need for prior authorization. This committee is led by the chair Medical Director and includes input from peer Medical Directors, Deputy Chief Medical Officer, and Clinical Leaders within Utilization management. This activity continues to gain provider and member satisfaction by allowing the provider network to inform decisions on what requires prior authorization and allow for access and automation where appropriate.

The assigned UM Medical Director responsible for facilitating the bi-weekly Utilization

Management Work Group (UMWG) ensures collective CalOptima Clinical leadership, Medical Director leaders, including behavioral health, pharmacy and Deputy Chief Medical Officer all provide input to the development and processes of the UM Program to ensure that quality care is delivered to CalOptima Health members to meet their physical health, behavioral health and social drivers of health needs. The Medical Director team conducted semiweekly case rounds with the nursing team and ad hoc meetings with hospitals and health networks to provide guidance in managing complex cases in post-acute and ambulatory settings as appropriate. The Medical Director team also provided to the CalOptima clinical team and external provider education and consultation on specific topics including, but not limited to:

- Genetic testing
- Gender Affirming Care and Procedures
- Management of administrative days
- Appropriate Long-Term Acute Care vs. Chronic/Subacute Level of Care (LOC) criteria
- Letter of Agreement (LOA) process
- and Evaluation and Medical Director oversight of the appropriateness of one-day inpatient stays.

The assigned Behavioral Health Medical Director and the Behavioral Health Integration (BHI) clinical leadership team provided oversight and input on the UM program throughout the year to ensure that all BH activities are integrated and aligned with the medical program to ensure compliance with UM regulatory and accreditation requirements and to ensure parity in decision-making. The designated BH Medical Director and BH clinical leadership participated in biweekly UM work groups and quarterly, Utilization Management Committee (UMC) and Benefit Management Subcommittee (BMSC) meetings to ensure adequate representation of critical BH topics such as expansion of the autism benefit and development of strategies to address substance use disorder, eating disorders and coordination with the county to serve our shared members during this period.

During Q3 2022, a 90-day Emergency Department (ED) Diversion pilot was implemented to determine if focused clinical support of CalOptima in real time within the ED setting would impact members accessing post ED care. The primary measurements of success established for the pilot were:

- Increase CalAIM authorized community support.
- Increase PCP follow up visits within 30 days of the ED visit.
- Decrease unnecessary ED utilization by redirecting to a more appropriate setting.

The pilot included a CalOptima embedded LVN within the ED to provide real-time prior authorizations post stabilization to appropriate alternate levels of care and/or outpatient services including coordination and scheduling services and referrals to case management.

- Early outcomes analysis determined that 72% of the members initially identified as high utilizers of ED services were successfully connected with ambulatory care and CalAIm Enhanced Care Management (ECM) services after pilot interventions.
- A total of 190 members were seen as a part of the pilot program for the following

successful interventions in real time:

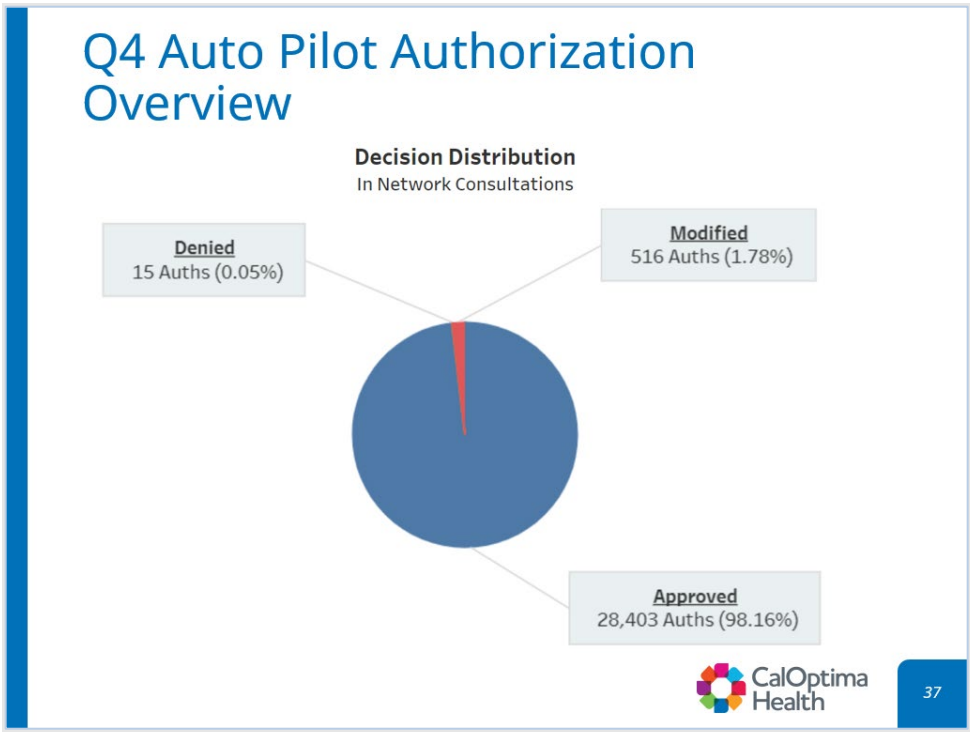
- PCP Appointments scheduled 16%
- Specialty Appointments scheduled 11%
- Other Case Management Referrals 4%
- Prior Auth Referrals completed 9%
    - Transportation issues resolved 3%
    - Medication Issues resolved 8%
    - Community Support Referrals 13%

Next Steps:

- Additional pilot analysis including claims review
- Consideration of automation for specific and targeted services based on analysis and MD review.
- Continue program through real time remote communication (Teams channel, telephonic secure email)
- Identify future opportunities programmatic and remote support to leverage economies of scale

Auto-Authorization Pilot

During Q2 2022 an auto-authorization pilot project was implemented for the CCN and COD to assess auto-authorization trends for in-network consultations. Each quarter UM leadership and Medical Directors reviewed utilization patterns during pilot automation. Below is the Q3 data for utilization oversight reported to UMC in Q4.



Q4'22 Auto-Authorization (pilot) – *Top Referring Specialty*

CCN/COD only

Quarter 4		
Auto Approved Referring Specality (pilot)	*Count*	*%*
Family Medicine	9873	30.6%
Internal Medicine	3871	12.0%
Nurse Practitioner	3110	9.6%
Clinic (mixed specialty)	1998	6.2%
Physician Assistant	1655	5.1%
Group (mixed specialty)	1084	3.4%
Ophthalmology	1075	3.3%
CalAIM Community Supports	1063	3.3%
General Practice	997	3.1%
Certified Family NP	893	2.8%
Hematology/Oncology	891	2.76%
Orthopaedic Surgery	606	1.88%
Endocrinology/DiabetesMellitus	589	1.83%
Grand Total: 32,229		

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Q4'22 Auto-Authorization (pilot) – *Top Refer-To Provider*

CCN/COD only

Quarter 4		
Auto Approved Refer-to-Provider (pilot)	*Count*	*%*
Acuity Eye Group	794	2.5%
Sun Terra Produce Traders Inc	626	1.9%
Ivy-Joan E Madu	563	1.7%
OC Gastrocare	543	1.7%
Island Dermatology	541	1.7%
George H Garcia	532	1.7%
Martin J Backman	522	1.6%
Philip L Bucur	436	1.4%
Quoc A Nguyen	419	1.3%
Pacific Cardiovascular Associates	382	1.2%
Haresh S Jhangiani	381	1.18%
Christopher C Ninh	379	1.18%
Essam R Quraishi	368	1.14%
Grand Total: 32,229		

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B. Behavioral Health Integration

CalOptima Health manages all the administrative functions of Medi-Cal, OneCare (OC) and OneCare Connect (OCC) mild to moderate mental health benefits and behavioral health treatment (BHT) services for CalOptima Health members. The BHI department continues to

be directly responsible for BH UM activities including but not limited to prior authorization of routine and urgent outpatient behavioral health services and concurrent review of inpatient psychiatric admission.

C. UM Data Management

The UM data reporting design is led by the director of UM and generated by CalOptima Health's Enterprise Analytics (EA) and Information Technology Services (ITS) department staff. Together with UM department subject matter experts, EA and ITS maintained a focused effort to improve the visibility and understanding of key data standards to ensure reliable tracking and trending of metrics for both CalOptima Health and the delegated health networks (HNs). Further refinement of daily inventory reports continued throughout 2022 to ensure continued timely processing of treatment authorization requests. Additional efforts are being planned to leverage availability of this information to UM, Quality Improvement and Audit and Oversight (A&O) by developing standard queries in the CalOptima Health data mart.

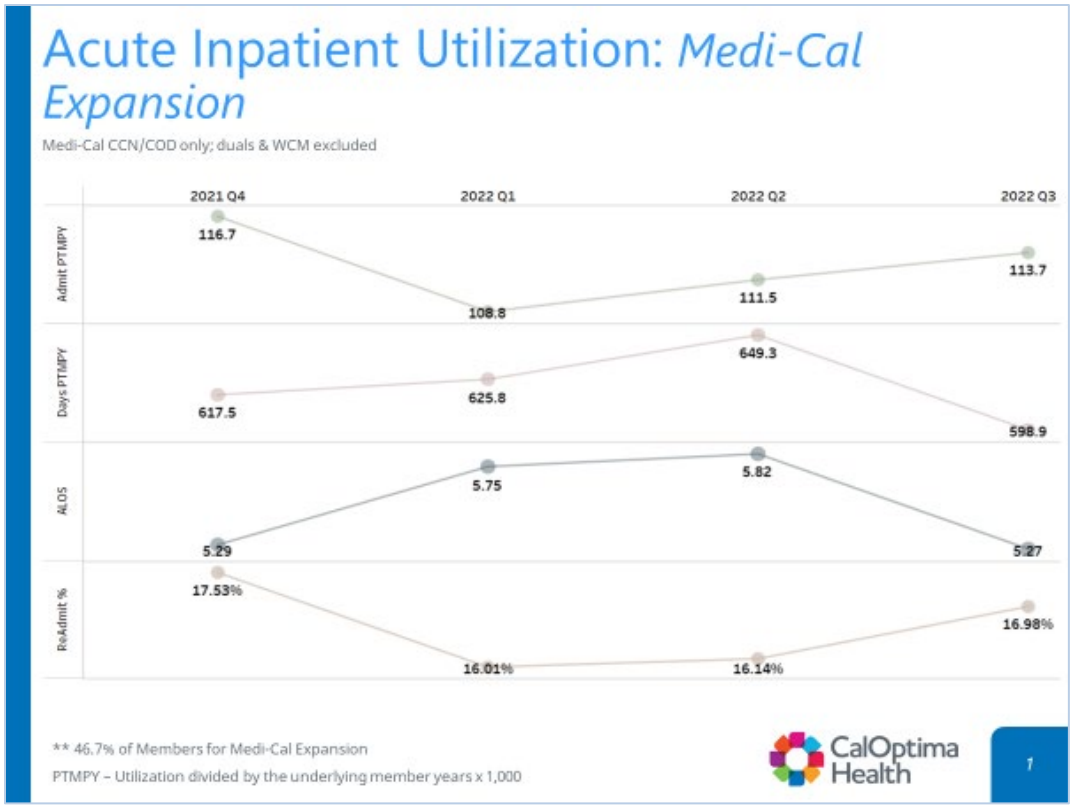
Inpatient and Emergency Department (ED) Utilization Performance

A. 2022 Performance Goals – MCD roll up (excludes WCM and HN data)

Metric	Goal	2021 Q4	2022 Q1	2022 Q2	2022 Q3
ALOS	4.3	5.09	5.30	5.31	4.82
Admit PTMPY	284	120.4	114.2	116.6	126.0
Days PTMPY	358	613.1	605.4	619.5	607.1
Readmit %	25%	16.73%	15.96%	15.26%	16.79%

The goals for 2022 were set for a rollup of all MediCal Aid categories. During a 2022 UMC the request was to split out and report on each MediCal Aid category therefore there is an expediated variance in the goal based on MediCal Aid category.

B. MediCal Expansion



Metric	Goal	2021 Q4	2022 Q1	2022 Q2	2022 Q3
ALOS	4.3	5.29 ↑	5.75 ↑	5.82 ↑	5.27 ↑
Admit PTMPY	284	116.7 ↓	108.8 ↓	111.5 ↓	113.7 ↓
Days PTMPY	358	617.5 ↑	625.8 ↑	649.3 ↑	598.8 ↑
ReAdmit %	25%	17.53% ↓	16.01% ↓	16.14% ↓	16.98% ↓

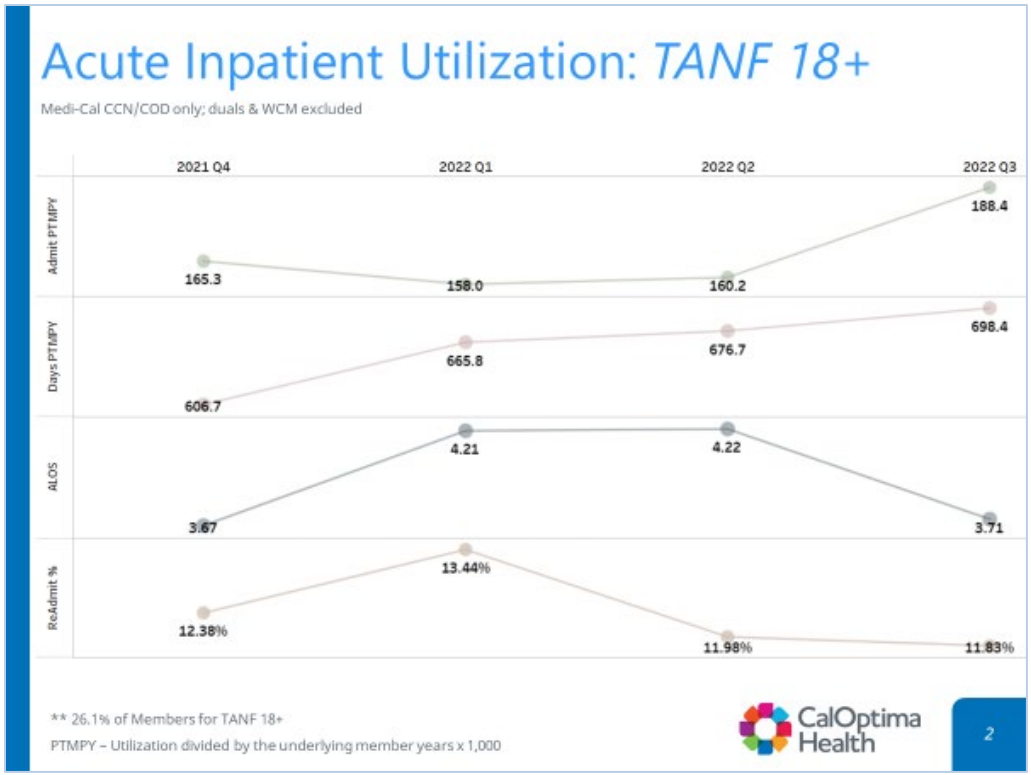
Average Length of Stay (ALOS): The ALOS for this population remained above the goal of 4.3 throughout the 2022 reporting period with an uptick during 2022 Q1 and Q2 and a slight decline during Q3.

Admits/1000 per Year (PTPMY): Admits/1000 fell below the goal of 284 throughout the 2022 reporting period with a drop during 2022 Q1 and an upward trend during Q2 and Q3.

Bed Days/Per Thousand Members Per Year (PTMPY): Bed Days/100 remained above the goal of 358 throughout the 2022 reporting period with an uptick during 2022 Q1 and Q2 and a downward trend during Q3.

Readmissions: Readmits remained below the goal of 25% throughout the 2022 reporting period declining in 2022 Q1 and Q2 with an upward trend in Q3.

TANF +18



Metric	Goal	2021 Q4	2022 Q1	2022 Q2	2022 Q3
ALOS	4.3	3.67 ↓	4.21 ↓	4.22 ↓	3.71 ↓
Admit PTMPY	284	165.3 ↓	158.0 ↓	160.2 ↓	188.4 ↓
Days PTMPY	358	606.7 ↑	665.8 ↑	676.7 ↑	698.4 ↑
ReAdmit %	25%	12.38% ↓	13.44% ↓	11.98% ↓	11.83% ↓

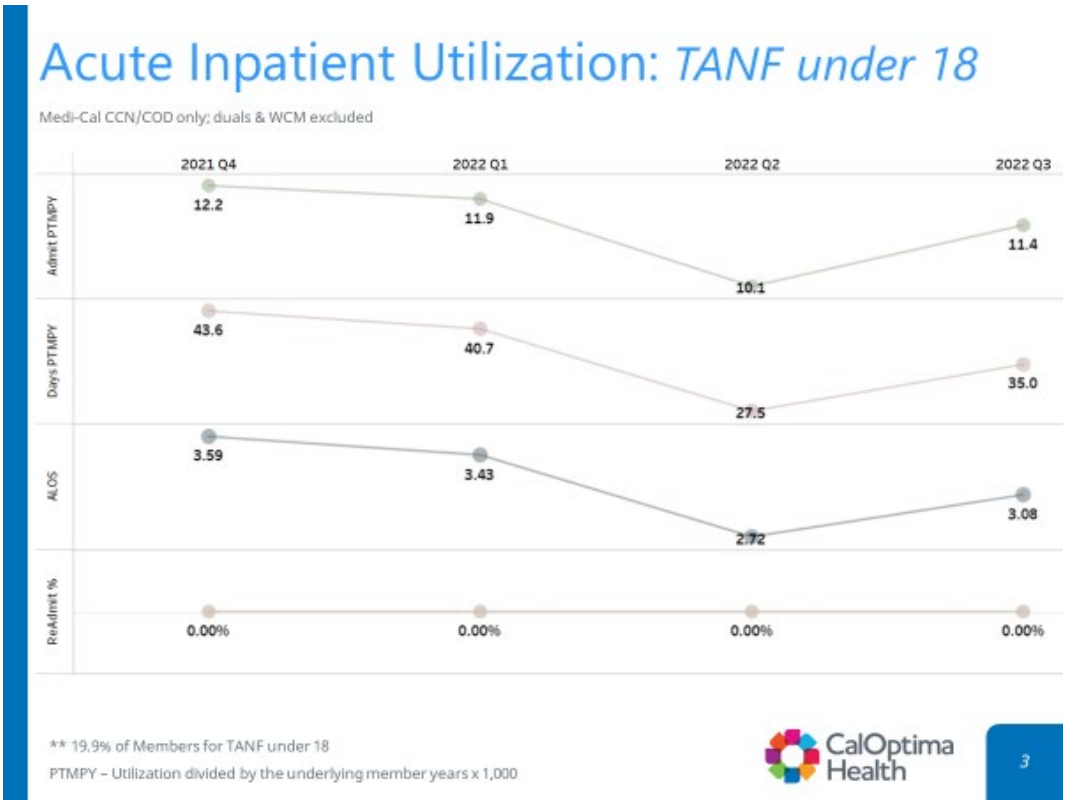
Average Length of Stay (ALOS): The ALOS for this population remained below the goal of 4.3 throughout the 2022 reporting period with an uptick during 2022 Q1 and Q2 and a slight decline during Q3.

Admits/1000 per Year (PTPMY): Admits/1000 fell below the goal of 284 throughout the 2022 reporting period with a drop during 2022 Q1 and Q2 an upward trend during Q3.

Bed Days/Per Thousand Members Per Year (PTMPY): Bed Days/100 remained above the goal of 358 throughout the 2022 reporting period with an upward trend throughout 2022 Q1 – Q3.

Readmissions: Readmits remained below the goal of 25% throughout the 2022 reporting period with a slight increase in 2022 Q1 and a downward trend during Q2 and Q3.

TANF <18



Metric	Goal	2021 Q4	2022 Q1	2022 Q2	2022 Q3
ALOS	4.3	3.59 ↓	3.43 ↓	2.72 ↓	3.08 ↓
Admit PTMPY	284	12.2 ↓	11.9 ↓	10.1 ↓	11.4 ↓
Days PTMPY	358	43.6 ↓	40.7 ↓	27.5 ↓	35.0 ↓
ReAdmit %	25%	0.00%	0.00%	0.00%	0.00%

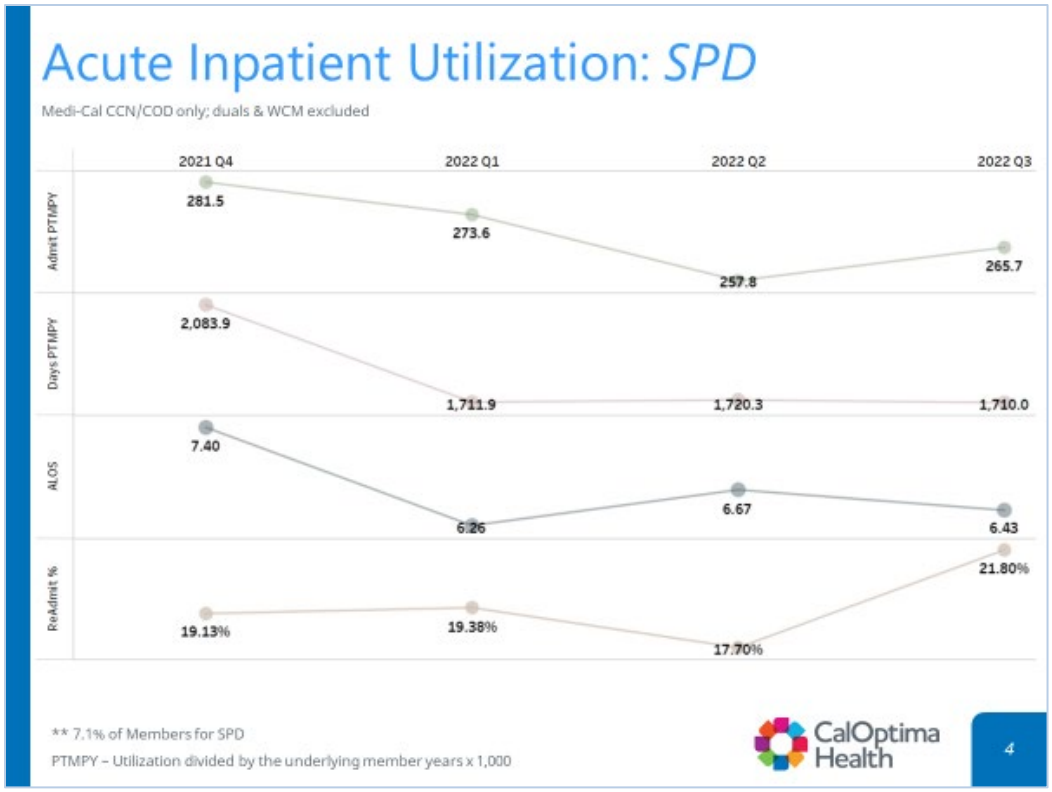
Average Length of Stay (ALOS): The ALOS remained below the goal throughout the 2022 reporting period.

Admits/1000 per Year (PTPMY): The Admits/1000 remained below the goal throughout the 2022 reporting period.

Bed Days/Per Thousand Members Per Year (PTMPY): Bed Days/1000 remained below the goal throughout the reporting period.

Readmissions: Data regarding readmits was unavailable for this population during the 2022 reporting period.

SPD



Metric	Goal	2021 Q4	2022 Q1	2022 Q2	2022 Q3
ALOS	4.3	7.40 ↑	6.26 ↑	6.67 ↑	6.43 ↑
Admit PTMPY	284	281.5 ↓	273.6 ↓	257.8 ↓	265.7 ↓
Days PTMPY	358	2,083.9 ↑	1,711.9 ↑	1,720.3 ↑	1,710.0 ↑
ReAdmit %	25%	19.13% ↓	19.38% ↓	17.70% ↓	21.80% ↓

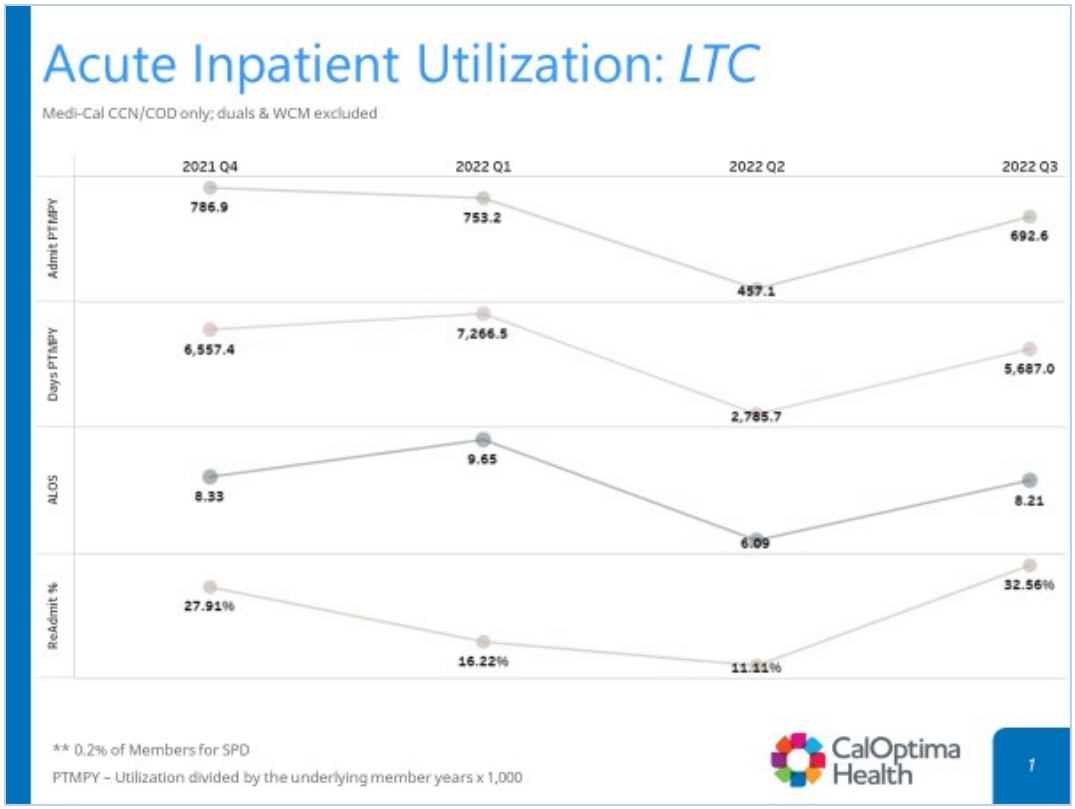
Average Length of Stay (ALOS): The ALOS for this population remained above the goal of 4.3 throughout the 2022 reporting period with an uptick during 2022 Q2 and a slight decline during Q3.

Admits/1000 per Year (PTPMY): Admits/1000 fell below the goal of 284 throughout the 2022 reporting period with a drop during 2022 Q1 and Q2 an upward trend during Q3.

Bed Days/Per Thousand Members Per Year (PTMPY): Bed Days/100 remained significantly above the goal of 358 throughout the 2022 reporting period, however, a downward trend was noted during 2022 Q1 – Q3.

Readmissions: Readmits remained below the goal of 25% throughout the 2022 reporting period with a decrease during 2022 Q2 and an uptick during Q3.

Long Term Care (LTC)



Metric	Goal	2021 Q4	2022 Q1	2022 Q2	2022 Q3
ALOS	4.3	8.33 ↑	9.65 ↑	6.09 ↑	8.21 ↑
Admit PTMPY	284	786.9 ↑	753.2 ↑	457.1 ↑	692.6 ↑
Days PTMPY	358	6,557.40 ↑	7,266.50 ↑	2,785.70 ↑	5,687.00 ↑
ReAdmit %	25%	27.91% ↑	16.22% ↓	11.11% ↓	32.56% ↑

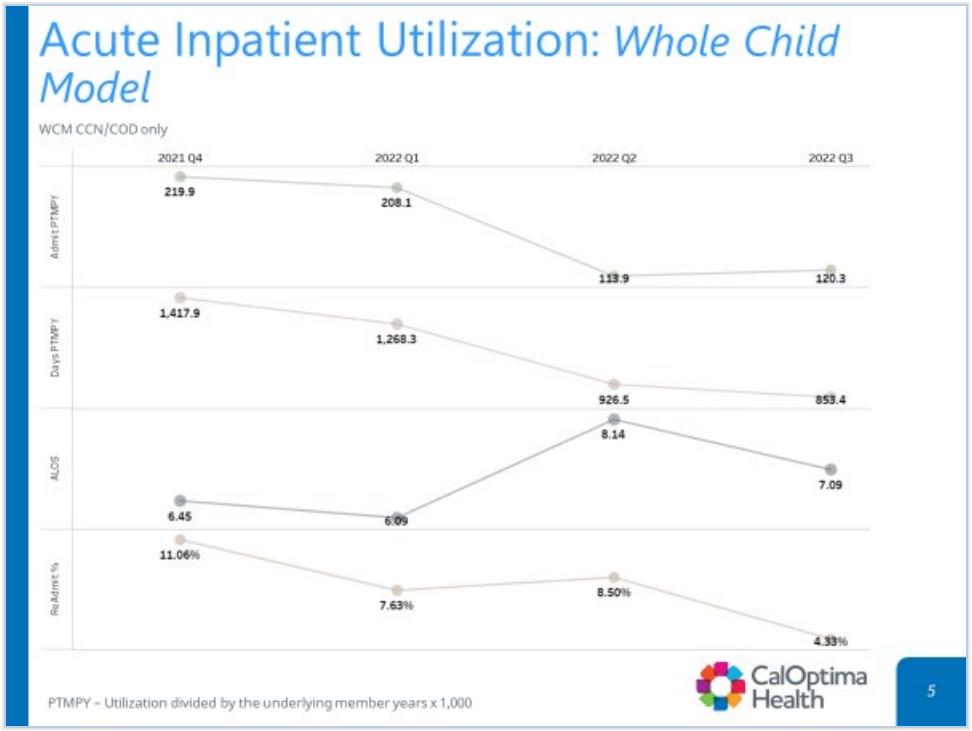
Average Length of Stay (ALOS): The ALOS remained above the goal throughout the 2022 reporting period.

Admits/1000 per Year (PTPMY): The Admits/1000 remained above the goal throughout the 2022 reporting period with a notable decrease in 2022 Q2.

Bed Days/Per Thousand Members Per Year (PTMPY): Bed Days/1000 remained above the goal throughout the 2022 reporting period with a notable decrease in 2022 Q2.

Readmissions: Readmits remained below goal during 2022 Q1 and Q2.

Whole Child Model



Metric	Goal	2021 Q4	2022 Q1	2022 Q2	2022 Q3
ALOS	4.3	6.45 ↑	6.09 ↑	8.14 ↑	7.09 ↑
Admit PTMPY	284	219.9 ↓	208.1 ↓	113.9 ↓	120.3 ↓
Days PTMPY	358	1,417.9 ↑	1,268.3 ↑	926.5 ↑	853.4 ↑
ReAdmit%	25%	11.06% ↓	7.63% ↓	8.50% ↓	4.33% ↓

Average Length of Stay (ALOS): The ALOS for this population remained above the goal of 4.3 throughout the 2022 reporting period with an uptick during 2022 Q2 and a slight decline during Q3.

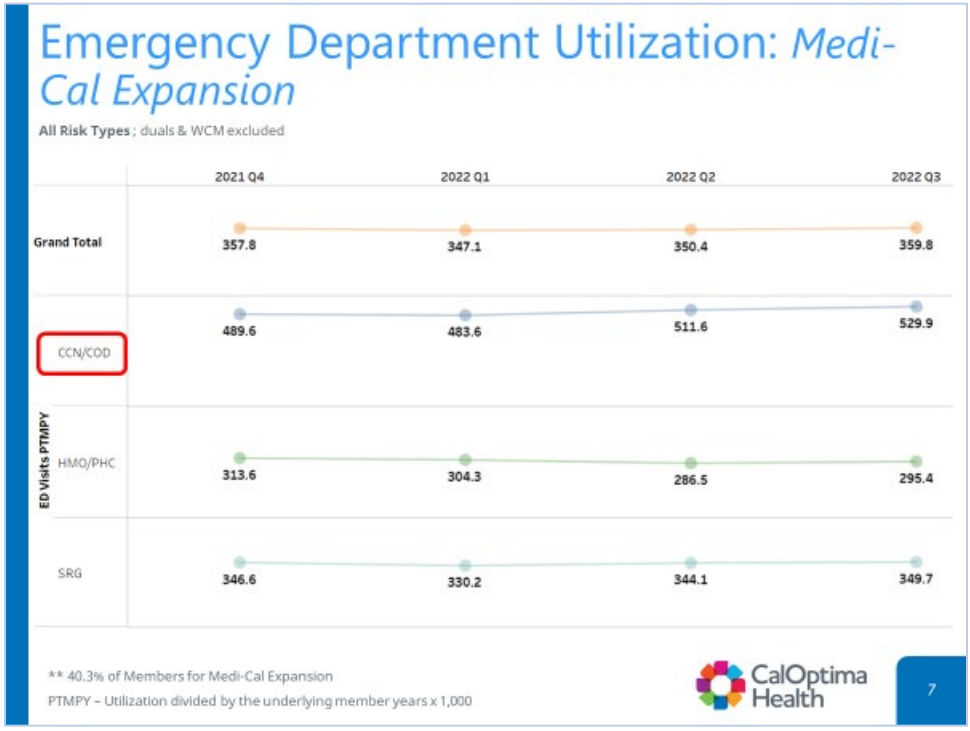
Admits/1000 per Year (PTPMY): Admits/1000 fell below the goal of 284 throughout the 2022 reporting period with a drop during 2022 Q1 and Q2 an upward trend during Q3.

Bed Days/Per Thousand Members Per Year (PTMPY): Bed Days/100 remained significantly above the goal of 358 throughout the 2022 reporting period, however, a downward trend was noted during 2022 Q2 – Q3.

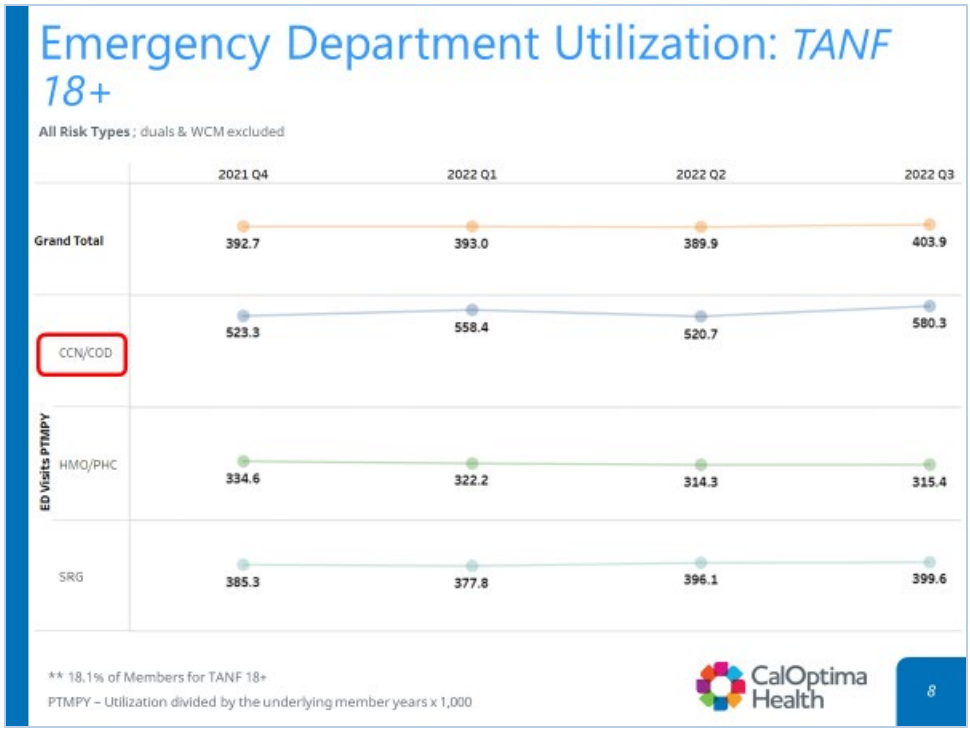
Readmissions: Readmits remained below the goal of 25% throughout the 2022 reporting period with a decrease during 2022 Q3

Emergency Department Utilization by Aid Code line of business

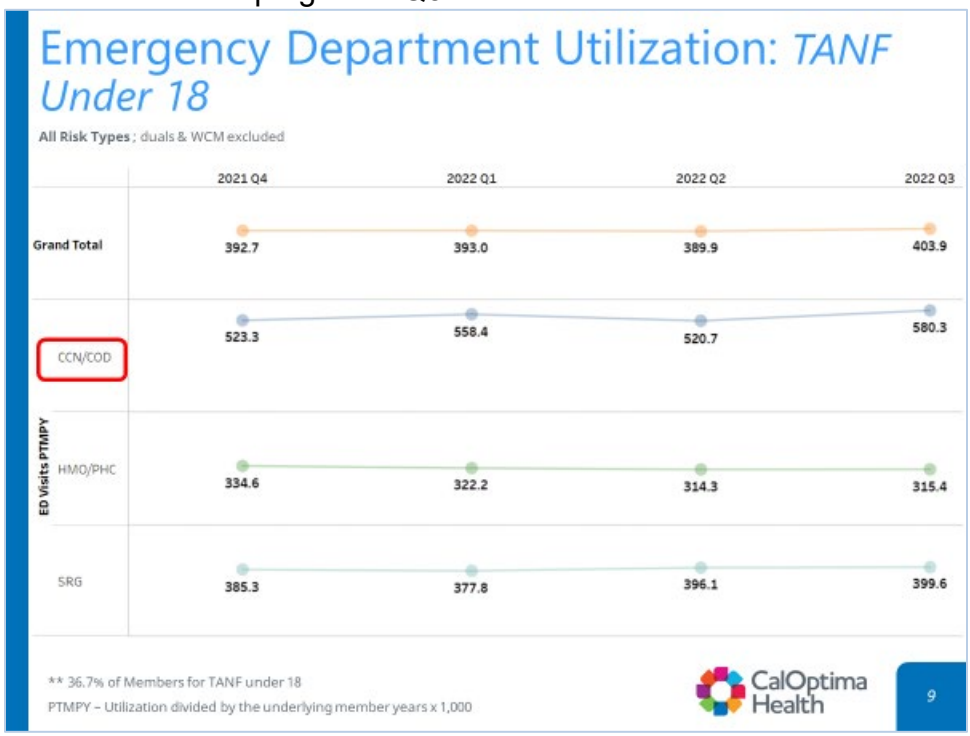
Line of Business	2021 Q4	2022 Q1	2022 Q2	2022 Q3
MediCal Expansion	489.6	483.6	511.6	529.9
TANF 18+	523.3	558.4	520.7	580.3
TANF <18	355.7	342.9	368.8	375.1.
SPD	772.6	700.1	688.0	748.3
LTC	480.9	487.4	385.7	386.2
WCM	519.7	491.2	278.1	293.2



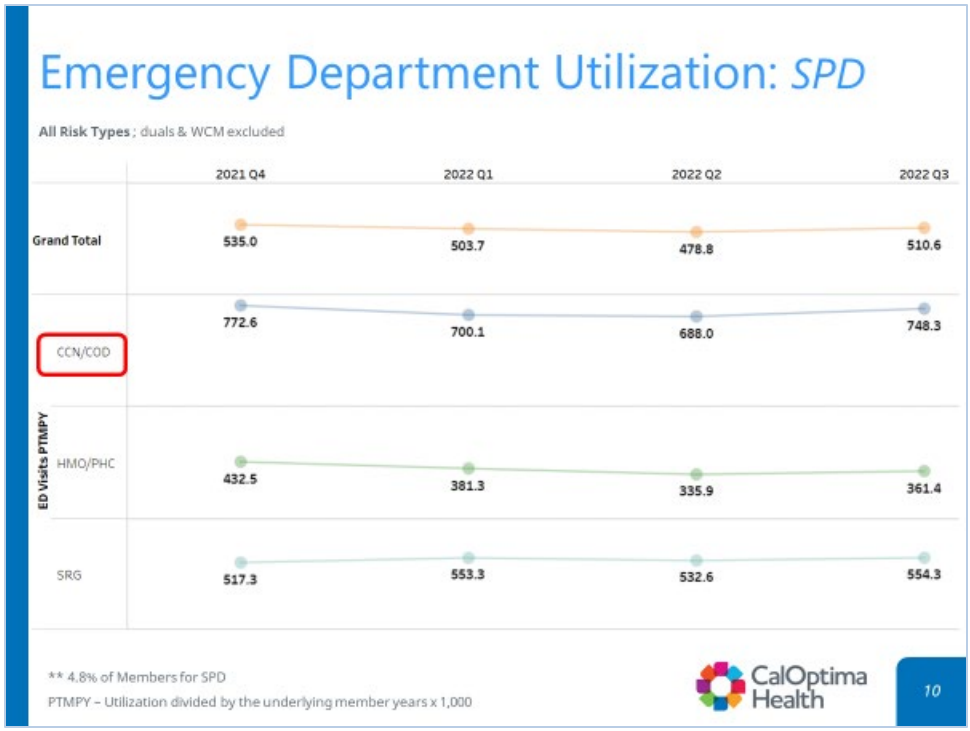
- **MediCal Expansion:** ED utilization declined in 2022 Q1 from 2021 Q4 and then trended upward 2022 Q2 and Q3.



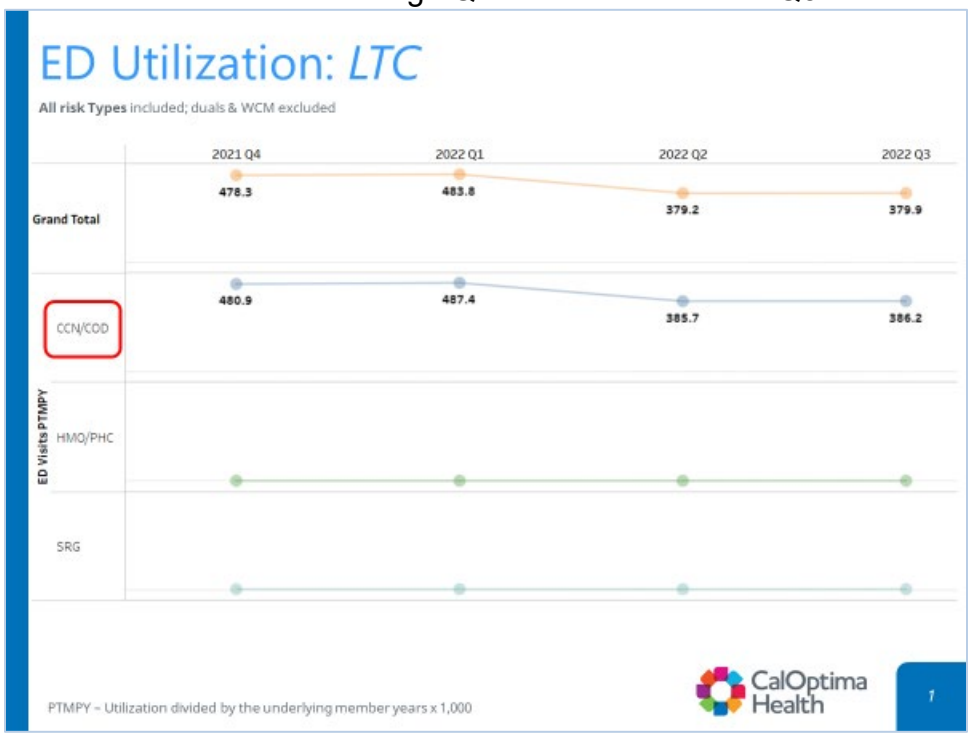
- **TANF 18+**: ED utilization increased during 2022 Q1 from 2021 Q4, trended down in Q2 and back up again in Q3.



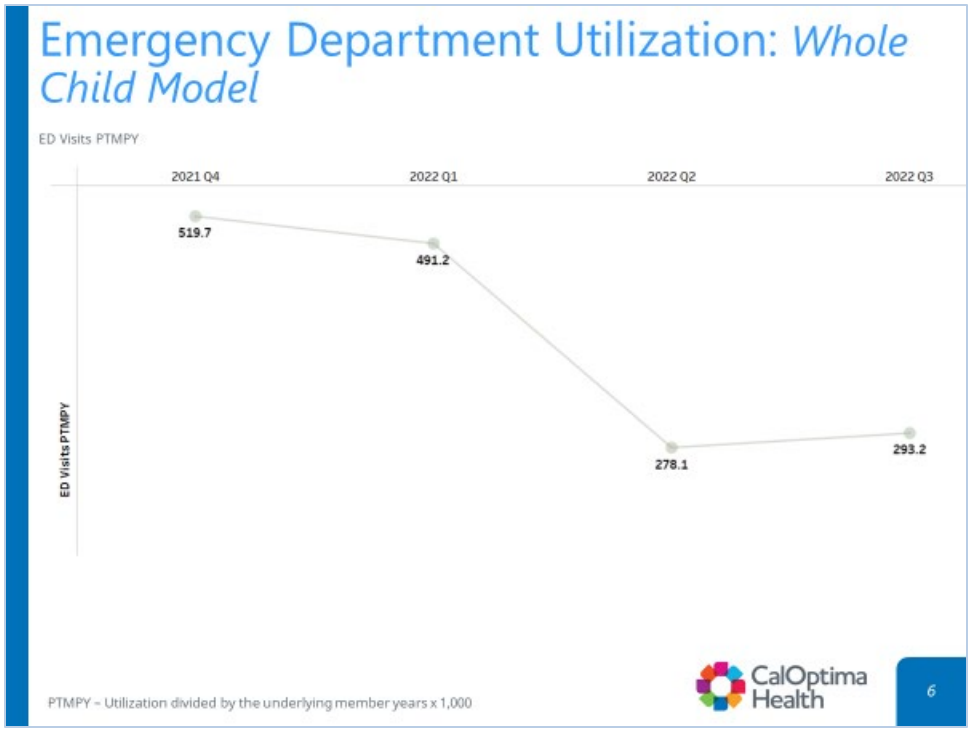
- **TANF <18**: ED utilization decreased during 2022 Q1 from 2021 Q4 then trended up during Q2 and Q3.



- **SPD**: ED utilization decreased during 2022 Q1 from 2021 Q4 and continued the downward trend through Q2 with an increase in Q3.



- **LTC**: ED utilization increased slightly during 2022 Q1 from 2021 Q4 then trended downward during Q2 and Q3.



WCM: ED utilization decreased during 2022 Q1 from 2021 Q4 and continued with a significant downward trend during Q2 and Q3.

Whole – Child Model (WCM)

Whole-Child Model (WCM) Membership

CalOptima Health

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WCM Member Counts

Health Network	Reporting Period	# of total WCM Eligible Members as of 1st day of Reporting Period	# of total newly eligible WCM members as of 1st day of Reporting Period	# of aged out WCM members
506-Cal Optima-Orange	**December 2022**	**11,524**	**185**	**1,492**
CalOptima Community Network	December 2022	1,047	65	207
Kaiser Permanente	December 2022	924	22	125
HPN - Regal	December 2022	24	1	4
Optum Care Network – Monarch	December 2022	863	18	108
Prospect Medical Group, Inc.	December 2022	169	2	39
Family Choice Health Network	December 2022	239	2	49
CHOC Health Alliance	December 2022	6,810	50	680
AMVI Care Health Network	December 2022	162	2	25
Noble Mid-Orange County	December 2022	166	4	25
Optum Care Network – Talbert	December 2022	116	2	33
Optum Care Network – Arta	December 2022	325	5	77
AltaMed Health Services	December 2022	364	4	78
United Care Medical Group	December 2022	315	8	42

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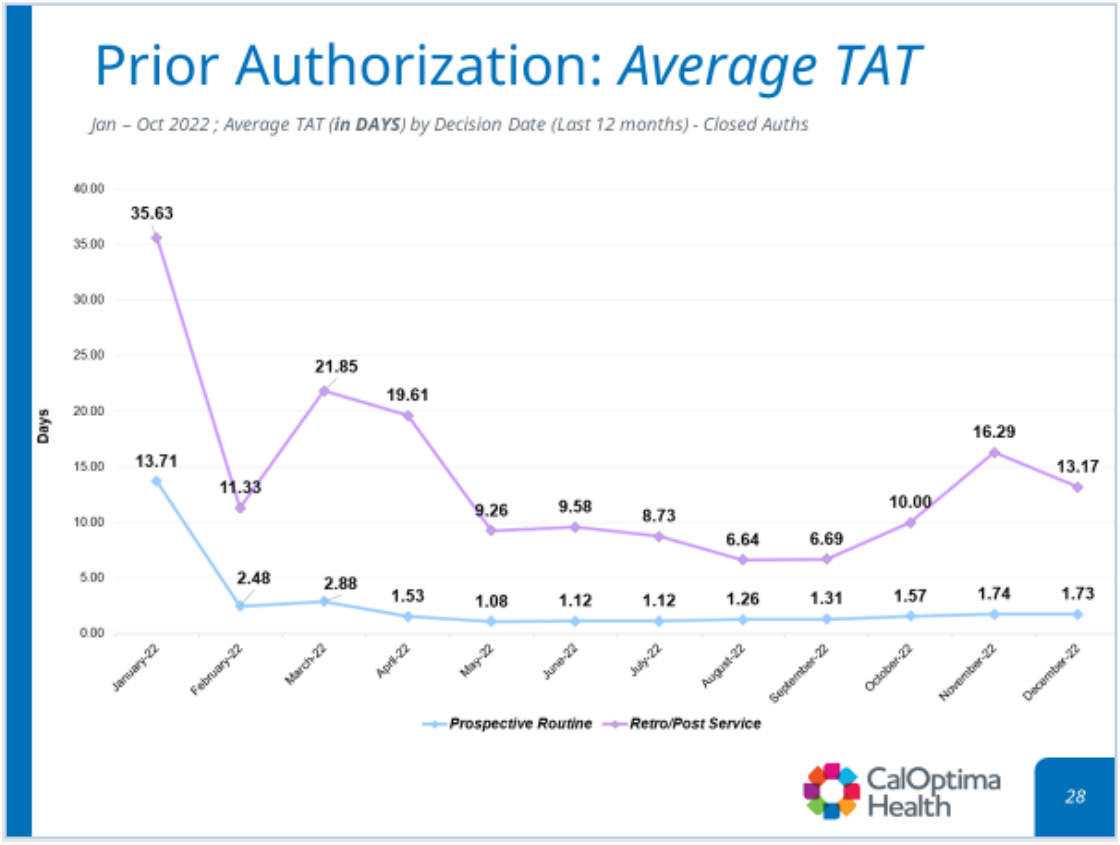
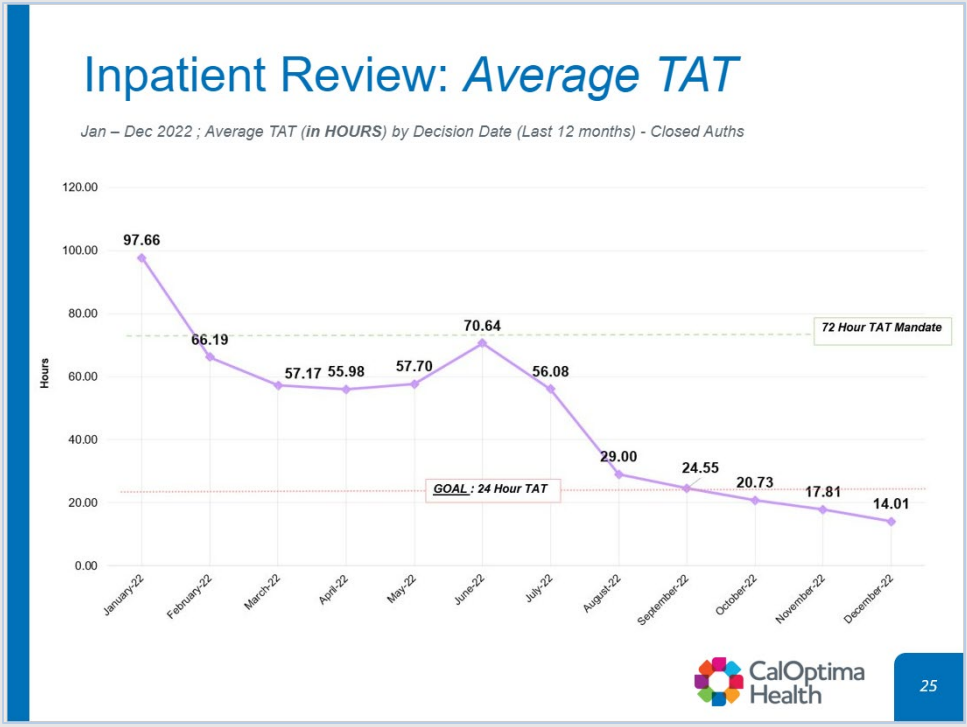


Prior Authorization Turnaround Time Compliance (TAT) Q4 2021 - Q3 2022					
Year	**Quarter**	**LOB**	**Prospective Routine**	**Prospective Urgent**	**Retro / Post Service**
2021	**Qtr4**	Medi-Cal	65.18%	87.31%	70.55%
		OneCare	60.00%	50.00%	100.00%
		OneCare Connect	94.41%	90.32%	86.36%
2022	**Qtr1**	Medi-Cal	90.15%	99.10%	63.60%
		OneCare	87.50%	100.00%	-
		OneCare Connect	99.43%	98.44%	90.65%
	Qtr2	Medi-Cal	99.96%	99.74%	100.00%
		OneCare	100.00%	100.00%	-
		OneCare Connect	99.94%	100.00%	99.24%
	Qtr3	Medi-Cal	99.99%	99.95%	100.00%
		OneCare	100.00%	100.00%	100.00%
		OneCare Connect	100.00%	100.00%	100.00%

Q4 2021 TAT compliance reflects the ongoing resolution of the backlog that was identified in Q3 2021.The backlog was resolved 01/27/2022. The results of these efforts are evident with compliance in all areas at the beginning of 2022 Q2.

Inpatient Review Authorization Average time to decision - January 2022 thru December 2022



Inpatient Turn Around Compliance

Inpatient Turn Around Compliance (TAT) Q4 2021 - Q3 2022				
Year	Quarter	LOB	Urgent Inpatient	Retrospective Inpatient
2021	Qtr4	Medi-Cal	62.35%	69.10%
2022	Qtr1	Medi-Cal	68.34%	77.38%
		OneCare	0.00%	100.00%
		OneCare Connect	66.47%	76.92%
	Qtr2	Medi-Cal	71.79%	73.49%
		OneCare	100.00%	100.00%
		OneCare Connect	78.42%	83.33%
	Qtr3	Medi-Cal	89.79%	78.07%
		OneCare	50.00%	-

		OneCare Connect	93.72%	80.00%

Referrals Processed Q4 2021 - Q3 2022					
Year	**Quarter**	**LOB**	**Prospective Routine**	**Prospective Urgent**	**Retro / Post Service**
2021	**Qtr4**	Medi-Cal	37,414	6,256	421
		OneCare	5	2	2
		OneCare Connect	1,878	341	154
2022	**Qtr1**	Medi-Cal	44,678	5,857	684
		OneCare	8	4	-
		OneCare Connect	1,936	320	107
	Qtr2	Medi-Cal	47,626	7,682	1,180
		OneCare	9	2	-
		OneCare Connect	1,543	304	131
	Qtr3	Medi-Cal	42,298	8,359	611
		OneCare	11	2	2
		OneCare Connect	2,146	346	121
Grand Total			179,552	29,475	3,413

Referrals Received Q4 2021 - Q3 2022	
Faxes	251,346
COLAS	198,728
• COLAS Auto Approved	75,136
Total	450,074

C. Over and Underutilization

During 2022 we continued to enhance the identification and process for monitoring over and underutilization as organization wide initiative to ensure appropriate monitoring of activities with CalOptima related to over and underutilization. Metrics are identified throughout the organization as good indicators of over and underutilization, as well as drilling down into the metrics to ensure proper identification of over and underutilization. Metrics from the following area are included and will be reviewed on an annual basis to ensure they are indicative of over and underutilization monitoring. The integrated utilization metrics include (physical/behavioral health and Rx) inpatient and prior authorization UM measure, appeal volumes and overturn rate, member grievances, adult and children's access to PCP services, measures indicative of appropriate utilization for pharmaceuticals, outlier reporting from the fraud, waste and abuse department within CalOptima, referral pattern analyses, member utilization, UM related member complaints, potential quality issues (PQI) monitoring, and measures related to behavioral health care. Over and underutilization was monitored, tracked, managed, and reported by UM during 2022 and reported to UMC, QIC and the Quality Assurance Committee (QAC).

D. Operational Performance

A. Authorization for Expedited / Urgent, Standard / Routine, Retrospective Requests — Medical

Summary of referral volume (Q4 2021 to Q3 2022)

Referrals Processed		Referrals Received		Turnaround Time Compliance (TAT)	
Routine	**177,262**	Faxed	**251,346**	Routine TAT	**90.87%**
+-Urgent	**27,931**	COLAS	**198,728**	Urgent TAT	**96.95%**
Retro	**2,734**	Auto Auth	**93,341**	Retro TAT	**89.94%**
Total	**207,927***	**Total**	**543,415**		

VI. Authorization for Expedited / Urgent / Routine / Retro Requests – Pharmacy

Annual summary of turnaround time compliance for CY22:

LOB	TAT Compliance
OC	99.89%
OCC	99.92%

Pharmacy Prior Authorization TAT processing time are above the goal of 98% for all plans.

Pharmacy metric targets were achieved for 2022.

VII. Authorization for Expedited / Urgent / Routine / Retro Requests — LTSS (CBAS, LTC)

- LTSS consistently met required turnaround times throughout the year. LTSS metric targets were achieved for Q4 2020–Q3 2021:
  - CBAS CEDT: 99.90%
  - CBAS Routine: 99.80%
  - CBAS Expedited: None received
    - Members participating in CBAS Q4 2020 & Q1–Q3 2021: Potentially program-eligible members.

Authorization for Expedited / Urgent / Routine / Retro Requests — LTSS (CBAS, LTC)					
Year	**Quarter**	**LOB**	**Members Participating in CBAS Q4 2019-Q3 2021 / Potentially Program-Eligible Members**	**% Participating**	**Change from Previous Qtr.**
2021	**Q4**	Medi-Cal	2,657/99,910	2.65	↑
		OCC	151/19,965	1.01	↓
2022	**Q1**	Medi-Cal	2,738/120,535	2.27%	↑
		OCC	151/14,591	1.03%	↑
	Q2	Medi-Cal	2780/122,953	2.26%	↓
		OCC	167/14,288	1.17%	↑
	Q3	Medi-Cal	2,871/126,808	2.26%	NC
		OCC	173/14,667	1.18%	↑

- 80% of authorized CBAS participation days will be utilized/delivered Q4 2021

CBAS Participation Days Used / Days Authorized				
Year	**Qtr.**	**CBAS Participation Days Used / Days Authorized**	**% Used**	**Change from Previous Qtr.**
2021	**Q4**	117,601/104,003	88.43%	↑
2022	**Q1**	171,621/131,161	76.42%	↓
	Q2	166,668/154,217	92.5%	↑

	Q3	182,267/140,056	76.84%	↓

* Change in tableau reporting will true-up in future data

- LTC routine turnaround time goal is >95%. Goal met.
  - Q4 2021: 98.19%
  - Q1 2022: 97.45%
  - Q2 2022: 95.69%
  - Q3: 2022: 98.65%
  - Q4: 2022: 96.76%
- LTC Urgent: None received

MSSP Discharges will not exceed New Admissions by more than 2 members during the quarter.

MSSP Admissions / Discharges			
Year	**Qtr.**	**Admissions/ Discharges**	**Change from Previous Qtr.**
2021	**Q4**	18/ 21	Admissions ↓
2022	**Q1**	29/ 21	Admissions ↑
	Q2	32/ 25	Admissions ↑
	Q3	41/ 39	Admissions **NC**

MSSP Goal not met in Q4 2021 due to the PHE. Continue with this goal.

E. Utilization Performance / Outcomes

A. LTC and CBAS Transition

Analysis of inpatient and ED data in 2021 identified positive performance against goals in Bed Days/PTMPY, however, the emergency department utilization was variable, and overall, higher than anticipated.

Review of 2021 ED Data will be conducted, and additional interventions may be applied as needed.
LTC Nursing facility members transitioned to the Community:

LTC Nursing Facility Members Transition to the Community					
Year	Qtr.	LOB	LTC Nursing Facility Members Transitioned	% Transitioned	Change from Previous Qtr.

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			otherCommunity		
	C 4	M edi - C al	126/4,751	2.65%	↓
		C C C	7/175	2.65%	↓
	C 1	M edi - C al	141/4,628	3.05%	↑
		C C C	5/165	3.03%	↑

Q2	Medi-Cal	194/4,869	3.98%	↑
	OCC	7/164	3.98%	↑
Q3	Medi-Cal	200/4,868	4.11%	↑
	OCC	4/161	7.14%	↑

CBAS: Track CBAS participants who transition to LTC.

CBAS participants who transition to LTC					
Year	**Qtr.**	**LOB**	**CBAS participants who transition to LTC**	**% Transitioned**	**Change from Previous Qtr.**
2021	Q4	Medi-Cal	4/2,657	0.15%	↓
		OCC	0/1	0.00%	↓
2022	Q1	Medi-Cal	8/2,738	0.29%	↓
		OCC	1/151	0.66%	↑
	Q2	Medi-Cal	8/2,780	0.29%	↑
		OCC	0/167	0.00%	←
	Q3	Medi-Cal	9/2,780	0.31%	↑
		OCC	1/173	0.58%	←

LTC: Members residing in LTC: Potentially nursing home eligible members.

Members Residing in LTC/ Potentially Nursing Home Eligible Members					
Year	Qtr	LOB	Members Residing in LTC/ Potentially Nursing H	% Residing in LTC	Change from Prev. Qtr.

			oneEligibleMembers		
2021	**Q4**	Medi-Cal	4,751/99,910	4.76%	↑
		COC	175/14,965	1.17%	↓
2022	**Q1**	Medi-Ca	4,628/1	3.84%	↓

		I	20,535		
		CCC	165/14,591	1.13%	↓
	Q2	Medi-Cal	4,869/122,593	3.96%	↓
		CCC	164/14,288	1.15%	↑
	Q3	Medi-Ca	4,468/	3.84%	↓

		I	126,808		
		CCC	182/14,667	1.24%	↑

B. Pharmacy Utilization

- Retail Pharmacy: $PMPM costs for CY22 are below expected spend for OneCare and above expected spend for OneCare Connect. OneCare Connect drug cost increases are primarily driven by increased utilization of brand diabetes and chemotherapy medications.
- Goals were met for two of the three adherence measures. Interventions include provider faxes, member educational materials, medication therapy management-eligible member education, and individual member refill reminders phone calls.

Pharmacy Utilization			
Measure	**Medication Adherence for Diabetes Medications**	**Medication Adherence for Hypertension (RAS antagonists)**	**Medication Adherence for Cholesterol (Statins)**
Rate	87%	89%	88%
Goal	88%	89%	88%

F. **Inter-Rater Reliability (Physicians, Nurses, Pharmacy) pertains to agency quality review of UM, CBAS, MSSP, LTC by annual assessment of appropriate guideline application.**

The IRR was administered in compliance with the UM Program. IRR metric targets were achieved for 2022. All staff who apply medical necessity guidelines successfully exceeded the annual goal of 90%.

Department	IRR Score
UM Clinical Staff: Prior Authorization	96%
UM Clinical Staff: Concurrent Review	96%
Physicians	99%
Pharmacy	94%
LTSS: LTC	97%
LTSS: CBAS	97%
LTSS: MSSP	97%
Behavioral Health	98%

C. Member and Provider Satisfaction

Satisfaction with the UM Program is evaluated based upon analysis of Grievances and Appeals, Member and Provider Experience Surveys, including the CAHPS survey, related to the UM Program. Complaints about the UM Program demonstrated some trends in the following categories:

- Member feedback obtained through Grievances and Appeals:
  - Access to providers, specifically providers no longer contracted with CalOptima health.
  - Provider not seeing new patients.
  - Provider was unable to see the member due to the type of care the member required or the members age was not in the scope of their specialty practice.
  - Limitation of members ability to see certain providers, as there are some providers who only see members already affiliated with their organization.

- Member Feedback from 2022 CAHPS survey:
  - Only 71.3% of adult members and 73.0% of child members usually or always got an

appointment with a specialist as soon as needed, with a decrease from 81.4% from the previous survey for adult members.
    - Only 80.8% of child members felt it was usually or always easy to get the care, tests, or treatment child needed, with a decrease from 85.6% from the previous survey.

- Provider feedback from CalOptima Provider Satisfaction survey 2022:
    - 55% of providers reported being satisfied or very satisfied with the UM Program experience, with further examples citing
        - Rapid response to questions
        - Access to direct referrals
        - Timely processing of treatment requests
    - 10% of providers reported being somewhat dissatisfied or very dissatisfied with the UM Program Experience, with examples citing.
        - Challenges with the Authorization Dept processing retro-authorization requests for Private Duty Nursing
        - Denial policy is not in guide with standards of care

Potential Quality Issues (PQIs) are reviewed by the CalOptima Health Medical Directors and trend data related to authorization issues is reported quarterly at the Utilization Management Committee. In 2022, there were a total of 27 PQIs related to related to the UM Program:

Potential Quality Issues (PQIs)					
	Q1	**Q2**	**Q3**	**Q4**	**TOTAL**
Authorization Denied or Delayed	0	5	9	13	27

CalOptima is continually looking at improving response times to treatment authorizations including proactive peer to peer consultations and communication to expediate health plans decisions.

G. SUMMARY

In January 2022, UM resolved the backlog of UM of treatment authorization requests that were identified in Q4 2021. The resolution was reflected in the Q2 2022 turnaround time data. The CalOptima UM leadership team worked with the analytics team to develop real-time reporting capabilities and implemented internal structural changes to improve the timeliness and operational effectiveness of the UM program.
Additional improvements included the addition of medical director leaders, dedicated clinical trainer, and filling several key roles that were vacant in 2021. Process improvements such as improved workflows, standardized templates and improved real time reporting all contributed to UM Program enhancements during 2022. CalOptima enhanced monitoring protocols internally to align and oversee direct network and delegated Health Networks. Major initiatives included improvements to CalOptima's operational process and improvements to leadership oversight to address treatment authorizations fluctuating inventory and staffing needs. Continuous improvement took place during 2022 based on monitoring, auditing and outcomes.

The UMC and the UM Medical Director and Behavioral Health Medical Director continue to

guide and support CalOptima UM programs, both medical and behavioral. The UMC, QIC and Medical Director team including behavioral health leadership continued to guide and support process improvement, review and address utilization trends and continues to enhance the CalOptima program through committee and workgroup efforts.

~~2022~~

2023
INTEGRATED UTILIZATION MANAGEMENT AND CASE MANAGEMENT PROGRAM DESCRIPTION

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CalOptima Health

2023

~~Utilization Management Program~~ ~~Description~~

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~~2021~~ UTILIZATON MANAGEMENT PROGRAM SIGNATURE PAGE

Utilization Management Committee Chair:

~~Himmet Dajee~~
Dabbah, Zeinab, M.D. *Date*
Deputy Chief Medical ~~Director~~Officer

Board of Directors' Quality Assurance Committee Chairperson:

Trieu Tran, M.D. *Date*

Board of Directors Chair:

~~Supervisor Andrew Do~~Clayton M. Corwin **Date:**

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~~WE ARE CALOPTIMA~~

CASE MANAGEMENT PROCESS

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WE ARE CALOPTIMA HEALTH

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

Our Mission

To serve member health with excellence and dignity, respecting the value and needs of each person.

~~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

By 2027, remove barriers to health care access for our members, implement same day treatment authorizations and real-time claims payments for our providers, and annually assess members' social determinants of health.

~~**Our Values — CalOptima CARES**~~

~~**Collaboration**~~

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

~~**Accountability**~~

~~We were created by the community, for the community, and are accountable to the community. Meetings open to the public are: Board of Directors, Board Finance and Audit Committee, Board Quality Assurance Committee, Investment Advisory Committee, Member Advisory Committee, OneCare Connect Member Advisory Committee, Provider Advisory Committee, and Whole Child Model Family Advisory Committee.~~

~~**Respect**~~

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

- ~~We treat members with dignity in our words and actions.~~
- ~~We respect the privacy rights of our members.~~
- ~~We speak to our members in their languages.~~
- ~~We respect the cultural traditions of our members.~~
- ~~We respect and care about our partners.~~
- ~~We develop supportive working relationships with providers, community health centers and community stakeholders.~~

~~**Excellence**~~

~~We base our decisions and actions on evidence, data analysis and industry recognized standards so our providers and community stakeholders deliver quality programs and services that meet our members' health needs. We embrace innovation and welcome differences of opinion and individual initiative. We~~

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~~take risks and seek new and practical solutions to meet health needs or solve challenges for our members.~~

~~Stewardship~~

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

We are "Better. Together."

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

Our Strategic Plan

In ~~2019, CalOptima's~~2022, CalOptima Health's Board and executive team worked together to develop the ~~2020–2022~~2023 Strategic Plan. After engaging a wide variety of stakeholders and collecting feedback, the strategic plan was approved ~~in December 2019. Members are the essential focus of the 2020–2022 Strategic Plan,~~by the CalOptima Health Board of Directors in June 2022. The core strategy of the Strategic Plan is an inter-agency co-creation of services and programs, together with our delegated networks, providers, and community partners, to support the mission and vision and our Priorities and Objectives are designed to enhance the programs and services provided to members by CalOptima~~.~~ Health.

The five Strategic Priorities and Objectives are:

- ~~Innovate and Be Proactive~~
- ~~Expand CalOptima's Member-Centric Focus~~
- ~~Strengthen Community Partnerships~~
- ~~Increase Value and Improve Care Delivery~~
- ~~Enhance Operational Excellence and Efficiency~~

~~What Is CalOptima?~~

- Organizational and Leadership Development
- Overcoming Health Disparities
- Finance and Resource Allocation
- Accountabilities and Results Tracking
- Future Growth

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WHAT IS CALOPTIMA HEALTH?

Our Unique Dual Role

CalOptima ~~is~~Health operates as both a public agency and a community health plan.

~~As both~~In this dual role, CalOptima Health must:

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

WHAT WE OFFER

Medi-Cal

In California, Medicaid is known as Medi-Cal. Medi-Cal covers low-income adults, families with children, seniors, people with disabilities, Affordable Care Act (ACA) expansion members, children in foster care (as well as former foster youth up to age 26), pregnant women, and low-income people with specific diseases, such as tuberculosis, breast cancer or HIV/AIDS. A Medi-Cal member must reside in Orange County to be enrolled in CalOptima Health Medi-Cal.

Scope of Services

~~**Scope of Services**~~

CalOptima Health provides a comprehensive scope of acute and preventive care services for Orange County's Medi-Cal and dual eligible population, including eligible conditions under California Children's Services (CCS) managed by CalOptima Health through the Whole-Child Model (WCM) Program that began in 2019.

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

- Specialty mental health and substance use disorder services are administered by the Orange County Health Care Agency (HCA).
- ~~Substance use disorder services are administered by HCA.~~
- Dental services are provided through the Medi-Cal Dental Program.

Members with Special Health Care Needs

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

Additionally, CalOptima Health works with community programs to ensure that members with special health care needs (or with high risk or complex medical and developmental conditions) receive additional services that enhance their Medi-Cal benefits. These partnerships are established as special services through a specific Memoranda of

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Understanding (MOU) with certain community agencies, including HCA and the Regional Center of Orange County (RCOC).

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

These integrated LTSS benefits include three programs:

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

OneCare (HMO D-SNP)

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

OC provides a comprehensive scope of services for dual eligible members enrolled in Medi-Cal and Medicare Parts A and B. To be a member of OC, a person must live and reside in Orange County and not be eligible for OCC. Enrollment in OC is by member choice and voluntary. OC has an innovative Model of Care, which is the structure for supporting consistent provision of quality of care. Each member has a Case Management single point of contact, a case manager or 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 workcase management team works with our members and their doctors to create an individualized health care plan that fits each member's needs. Addressing individual needs results in a better, more efficient, and higher quality health care experience for the member.

Scope of Services

OneCare ConnectIn addition to the comprehensive scope of acute care, preventive care and behavioral health services covered under Medi-Cal and

The OneCare Connect Cal MediConnect Plan (Medicare, CalOptima OC members are eligible Medicaid Plan) was launched in 2015 for enhanced services such as transportation to medical services and gym memberships.

OneCare Connect

1) The OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) was launched in

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2015 for people who qualify for both Medicare and Medi-Cal. people who qualify for both Medicare and Medi-Cal. The OneCare Connect (OCC) isprogram, as 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. The demonstration program will end on December , was discontinued 12/31, /2022, and members in OCC will transition to OC and .

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

At no extra cost, OCC adds benefits such as vision care, gym benefits, and worldwide urgent/emergency care 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 members and their doctors to create an individualized health care plan that fits each member's needs. Addressing individual needs results in a better, more efficient and higher quality health care experience for the member.

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

Scope of Services

OCC simplifies and improves health care for low-income seniors and people with disabilities, while ensuring timely access to the comprehensive scope of acute, preventive care and behavioral health services covered under Medi-Cal and Medicare benefits. At no extra cost, OCC adds enhanced benefits such as vision care, gym benefits, over the counter medication benefits and transportation. OCC also includes personalized services through the PCCs to ensure each member receives the services they need when they need themcontinuity of care for their existing services.

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

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

To be a CalOptima Health PACE participant, members must be at least 55 years old, live in Orange County, and be determined to be eligible:

- Eligible for nursing facility services by the State of California, and be able.
- Able to live safely at home or in a community setting with proper support.

Scope of Services

- PACE provides all the acute and long-term care services covered by Medicare and Medi-Cal

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~~through an Interdisciplinary Team (IDT). The IDT is made up of physicians, nurses, social workers, dietitians, physical therapists, occupational therapists, home care staff, activity staff and transportation staff who are committed to planning, coordinating and delivering the most fitting and personalized health care to our participants.~~Able to receive all non-emergent services within the CalOptima Health network.

Scope of Services

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

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

CalOptima Health's Utilization Management team is the designated lead for administrative and nursing clinical review functions for PACE program inpatient admissions and works directly with the IDT for clinical determinations and transition coordination.

Quality PROGRAM INITIATIVES

CalOptima Health's QI Goals and Objectives are aligned with CalOptima Health's 2022–25 Strategic Goals.

1) Develop and implement a comprehensive Health Equity framework that transforms practices, policies and systems at the member, organizational and community levels.
2) Improve quality of care and member experience by attaining an NCQA Health Plan Rating of 5.0, and at least a Four-Star Rating for Medicare.
3) Engage providers through the provision of Pay for Value (P4V) programs for Medi-Cal, OneCare and Hospital Quality.

These

~~PROGRAM INITIATIVES~~

~~Improve Health Equity and Mitigate Impact: COVID-19 Public Health Emergency (COVID-19 PHE)~~

~~COVID-19 pandemic created a Public Health Emergency (PHE) that has changed the landscape of delivering quality health care to our members. The 2021 QI Program goals and initiatives are designed to address the COVID-19 PHE and include initiatives to mitigate the impact of the pandemic. Examples include the Orange County COVID-19 Nursing Home Prevention Program, the LTC Facility Transfer Plan due to COVID-19 pandemic, the Health Equity strategy, as well as the COVID-19 Vaccination and Communication strategy. Additionally, UM requirements for COVID-19 PHE screening, vaccination and COVID-19 PHE related care are waived during the PHE. Also, authorizations approved during the PHE have been and will continue to be updated until the end of the COVID-19 PHE.~~

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~~Health care disparities play a major role in quality outcomes. Historic and academic publications have shown that health care disparities in race and ethnicity existed for decades. The COVID-19 pandemic shined a bright light on the health disparities and inequity. The California Department of Public Health COVID-19 analysis by race and ethnicity in September 2021 revealed that Latinx account for 45.9% of coronavirus deaths, in a state where they make up 38.9% of the population; and Blacks account for 6.7% of the deaths but make up only 6% of the population. Since health care disparities play a major role in quality outcomes, CalOptima identified opportunities to improve health equity as detailed in its QI Work Plan.~~

~~Department of Health Care Services (DHCS) Comprehensive Quality Strategy (CQS)~~

~~The 2022 Draft CQS lays out DHCS' quality and health equity strategy to support a 10-year vision for Medi-Cal, where people served by Medi-Cal should have longer, healthier and happier lives. The goals and guiding principles summarized below are built upon the Population Health Management (PHM) framework that is the foundation of California Advancing and Innovating Medi-Cal (CalAIM), and stresses DHCS' commitment to health equity, member involvement, and accountability in all program and initiatives.~~

~~Quality Strategy Goals~~

- ~~Engaging members as owners of their own care~~
- ~~Keeping families and communities healthy via prevention~~
- ~~Providing early interventions for rising risk and patient-centered chronic disease management~~
- ~~Providing whole person care for high-risk populations, addressing drivers of health~~

~~Quality Strategy Guiding Principles~~

- ~~Eliminating health disparities through anti-racism and community-based partnerships~~
- ~~Data-driven improvements that address the whole person~~
- ~~Transparency accountability, and member involvement~~

~~Health Equity Framework is a depiction of how DHCS intends to approach the elimination of health disparities. The following domains represent DHCS' multipronged vision to building analytic, workforce and programmatic capacity, at all levels, to eliminate health disparities.~~top three priority goals were chosen to be aligned with CalOptima Health's strategic objectives as well as continued goals related to access to care and NCQA accreditation. The 2023 QI Work Plan details the strategies for childhood, COVID-19 and other immunizations, including targeted communication and member incentives. The planned activities related to members' ability to access care are captured as a communication and corrective action strategy for providers not meeting timely access standards (as measured by the annual Timely Access study). All goals and sub-goals will be measured and monitored in the QI Work Plan, reported to QIC quarterly and evaluated annually.

Comprehensive Community Cancer Screening and Support Program

- CalOptima Health strives to be the health care exemplar for all Orange County residents. The goal is for all of Orange County to have the lowest in the nation late-stage cancer incidence

rate for breast, cervical, colon and lung cancer in certain smokers.

- CalOptima Health seeks to create a new Orange County health ethos with respect to cancer care by a laser on detection and diagnosis of these four specific cancers. \

The Comprehensive Community Cancer Screening and Support Program will increase early detection through improved awareness and access to cancer screening, decrease late-stage cancer diagnoses rates and mortality, and improve quality and member experience during cancer screening and treatment procedures among Medi-Cal members.

It will create a culture of cancer prevention, early detection and collaboration with partners toward a shared goal of dramatically decreasing late-stage cancer incidence and ensuring that all Medi-Cal members have equitable access to high quality care. The program will use a phased-in approach to invest over the next five years in the following three pillars:

1) Community and member awareness and engagement
2) Access to cancer screening
3) Improved member experience throughout cancer treatment

As of November 14, 2022, 3,925 CalOptima Health members were newly diagnosed with cancer. Increasing cancer screening rates is crucial for the early diagnosis and treatment of cancer, ultimately increasing life expectancy, quality of life and reducing health care costs.

Five-Year Hospital Quality Program

CalOptima Health's hospitals and their affiliated physicians are integral components of the delivery of health services to members and play a critical role in the delivery of care to members. For many years, CalOptima Health has been providing quality driven incentive payments to its Health Networks to drive improvement in quality outcomes and member satisfaction. Beginning January 1, 2023, CalOptima Health has established a Hospital Quality Program for its contracted hospitals to improve quality of care to members through increased patient safety efforts and performance-driven processes. Hospital performance measures serve to:

- Support hospital quality standards for Orange County in support of CalOptima Health's mission
- Provide industry benchmarks and data-driven feedback to hospitals on their quality improvement efforts
- Recognize hospitals demonstrating quality performance
- Provide comparative information on CalOptima Health hospital performance
- Identify areas for improvement and for working collaboratively with these hospitals to ensure the provision of quality care for CalOptima Health members

The program launches January 1, 2023, and extends through December 31, 2027. It includes two initiatives: Hospital Incentive Quality Pool and Hospital Reporting Incentive Payments.

This initiative will include the following principles:

1. Leverage publicly available, industry-standard measures from the Centers for Medicare & Medicaid Services (CMS) and the Leapfrog Group including:
   - CMS Quality
   - CMS Patient Experience
   - Leapfrog Hospital and Surgery Center Rating
   - Leapfrog Hospital Safety Grade
2. Require contracted hospital participation in CMS quality reporting programs (hospital inpatient, hospital outpatient, prospective payment systems-exempt cancer, or inpatient psychiatric) or Leapfrog Group Hospital and Surgery Center Rating for measurement as follows:
   - Contracted hospitals will be assessed on CMS quality reporting programs as reported on CMS Care Compare
   - Contracted hospitals not listed on CMS Care Compare for quality and patient experience will be assessed using the Leapfrog Hospital and Surgery Center Rating
   - Contracted hospitals not listed on either CMS Care Compare or Leapfrog Hospital
   - Surgery Center Rating will not qualify for incentive payments
3. Require contracted hospital participation in Leapfrog Hospital Safety Grade reporting
4. Allocate a maximum amount of a budget for a five-year period from 2023–2027 to fund the hospital incentive pool. The amount that each hospital may earn will be based on their proportion of services provided to CalOptima Health members, i.e., proportion of total bed days. Funding will be used to reward performance and unearned incentive dollars will be forfeited.

Incentive awards will be based on performance compared with quality thresholds and allocated based on the sum of claims and encounter inpatient days gathered six months after the end of the measurement period, to allow for data lag.

CalOptima Health recognizes that hospitals may not currently participate in CMS/Leapfrog public reporting programs. To promote hospital participation, CalOptima Health will provide a ramp-up period to allow hospitals to participate in CMS/Leapfrog reporting. During the ramp-up period, CalOptima Health will provide hospital reporting incentive payments to eligible hospitals.

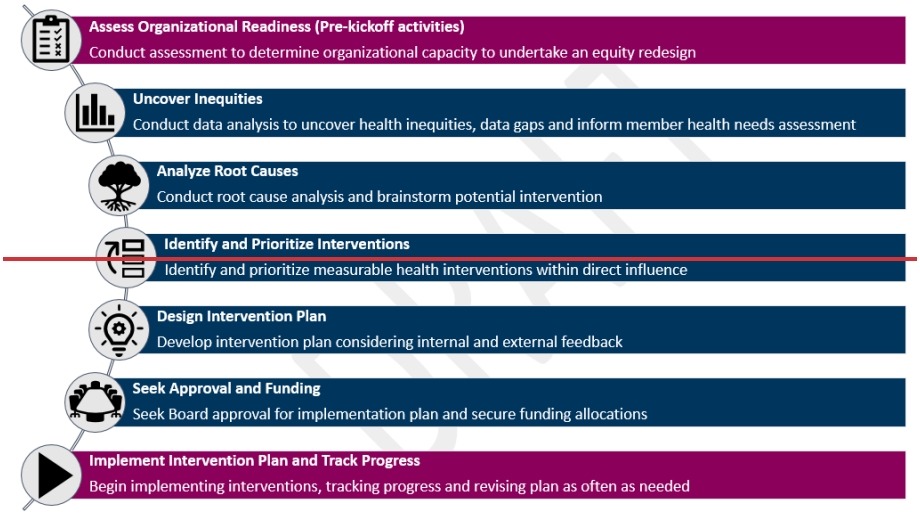
- ~~**Data** collection and stratification~~
- ~~Workforce diversity and cultural responsiveness~~
- ~~Reducing health care disparity~~

~~Health Equity Framework~~

~~Health equity is achieved when an individual has the opportunity to "attain his or her full health potential" and no one is "disadvantaged from achieving this potential because of social position or other socially determined circumstances." (Centers for Disease Control and Prevention)~~

~~Social determinants of health (SDOH) are the conditions that exist in the places where people are born, live, learn, work, play, worship, and age that affect health outcomes. (Henry J. Kaiser Family Foundation)~~

~~In response to CalOptima' strategic plan, staff began the process to identify and address health equity and social determinants of health (SDOH) for vulnerable populations throughout Orange County. The framework includes several milestones from uncovering inequities, looking at root causes, designing comprehensive intervention plan, to planning and tracking progress. It begins with a comprehensive Readiness Assessment to determine organizational capacity to undertake a health equity redesign. As the framework is developed, there will be opportunities to obtain feedback from internal and external stakeholders and include their input in the intervention and design process.~~



Whole-Child Model

California Children's Services (CCS) is a statewide program for children with certain serious medical conditions. CCS provides medical care, case management, physical/occupational therapy and financial assistance. As of July 1, 2019, through SB 586, the state ~~required~~integrated CCS services ~~to become a~~into CalOptima Health's Medi-Cal managed care plan benefit~~.~~, now called Whole Child Model (WCM). The goal of this transition and integration was to improve health care coordination by providing all needed care (~~most~~ CCS and non-CCS services~~) under one entity~~ including utilization management, transportation, care coordination, case management and complex case management) into a managed care plan (MCP), rather than providing CCS services separately. The ~~Whole Child Model (~~WCM~~)~~ services successfully transitioned to CalOptima Health in 2019 ~~and will continue indefinitely. Under~~as the 5th MCP awarded this pilot program. The HCA in Orange County~~,~~ continues to have the CCS program operate the medical eligibility determination processes, the Medical Therapy Unit and Program and CCS service authorizations for non- CalOptima Health enrollees ~~will remain~~. CalOptima works closely with

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~~HCA.~~

THE COUNTY CCS OFFICE TO ALIGN PROTOCOLS AND ENSURE CONTINUITY OF CARE FOR CCS-ELIGIBLE MEMBERS.CALIFORNIA ADVANCING AND INNOVATING MEDI-CAL (CALAIM)

California Advancing and Innovating Medi-Cal (CalAIM) is a multiyear initiative, spanning from 2022 to 2027, by DHCS to improve the quality of life and health outcomes of our population by implementing broad delivery system, program and payment reforms across Medi-Cal. CalOptima health implemented CalAim on 1/1/2022 and continues to work on expanding member access to services and supports. CalOptima's CalAIM program was established based upon three primary goals:

~~CalAIM has three primary goals:~~

1. ~~Identify~~Identification and ~~manage~~management of member risk and need through whole person care approaches and addressing social determinants of health.
2. ~~1.~~ ~~Move Medi-Cal to~~Development of a ~~more~~ consistent and seamless ~~system by reducing~~delivery of care and services through reduction of complexity and ~~increasing flexibility~~increase inflexibility.
3. ~~2.~~ ~~Improve quality~~Improved outcomes, ~~reduce~~reduction of health disparities, and ~~drive delivery system~~ transformation and innovation through value-based initiatives, modernization of systems and payment reform.

Enhanced Care Management and Community Supports

~~On~~In a phased approach since January ~~1,~~ 2022, CalOptima ~~implemented two CalAIM components:~~Health has launched Enhanced Care Management (ECM) ~~and~~as well as all 14 Community Supports. ECM provides a whole-person approach to care that addresses the clinical and non-clinical circumstances of high-need Medi-Cal members. ~~Community Supports are medically appropriate, flexible, wrap-around services that addresses the member's complex medical and social needs. Community Supports are alternatives to covered services, which are provided to reduce or avoid admissions to a hospital or skilled nursing facility admission, emergency department visits, and discharge delays~~Members are identified to participate in ECM services through either a risk stratification approach that proactively identifies members as falling into one of the 10 DHCS identified Populations of Focus (POF) or members who meet the DHCS eligibility criteria can be referred in so that they can receive the services.

~~CalOptima's implementation of ECM and Community Supports builds upon the Health Homes Program (HHP) and Whole Person Care (WPC) Pilot infrastructures by preserving existing member relationships with HHP and WPC service providers. CalOptima's HHP Community-Based Care Management Entities have transitioned to become ECM providers. This means that CalOptima and its delegated health networks (HNs) are providing ECM services as ECM providers to eligible populations.~~ ECM providers are responsible for coordinating care with members' existing providers and other agencies to deliver the following seven core service components:

1. Outreach and Engagement

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2. Comprehensive Assessment and Care Management Plan
3. Enhanced Coordination of Care
4. Health Promotion
5. Comprehensive Transitional Care
6. Member and Family Supports
7. Coordination of and Referral to Community and Social Support Services

~~On January 1, 2022, ECM went live for the following populations of focus:~~

- ~~Members experiencing homelessness (adults and children)~~
- ~~High utilizer adults~~
- ~~Adults with Serious Mental Illness (SMI)/substance use disorder (SUD)~~

~~Additionally, members participating in WPC and/or HHP will automatically transition into ECM.~~

~~HHP and WPC service providers will continue~~CalOptima Health has partnered with several local Community Based Organizations to provide ~~services under~~the 14 Community Supports ~~as CalOptima works~~ to ~~expand its network of~~our members in a medically appropriate, cost-effective manner. Community Supports ~~providers that have the expertise and capacity~~are alternatives to ~~provide the specific types of services needed. Members eligible for Community Services must consent~~covered services, which are provided to ~~participate and receive services.~~reduce or avoid admissions to a hospital or skilled nursing facility admission, emergency department visits, and discharge delays.

The 14 Community ~~Support services include the following~~Supports are:

1. Housing Transition Navigation Services
2. Housing Deposits
3. Housing Tenancy and Sustaining Services
4. Short-Term Post-Hospitalization Housing
5. Recuperative Care (Medical Respite)
6. Respite Services
7. Day Habilitation Programs
8. Nursing Facility Transition/Diversion to Assisted Living Facilities
9. Community Transition Services/Nursing Facility Transition to a Home
10. Personal Care and Homemaker Services
11. Environmental Accessibility Adaptations (Home Modifications) includes Personal Emergency Response Systems (PERS)
12. Medically Tailored Meals/Medically Supportive Foods
13. Sobering Centers
14. Asthma Remediation

~~Beginning January 1, 2022, CalOptima will offer the following four, distinct~~ All authorizations for ECM and Community Supports are requested through the CalOptima Connect Portal and are managed by CalOptima's LTSS CalAIM team to determine eligibility

OneCare Connect

The OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) was launched in 2015 for people who qualify for both Medicare and Medi-Cal. The OneCare Connect (OCC) program, as part of Cal MediConnect, a demonstration program operating in seven counties throughout California was discontinued 12/31/2022 and all members were bridged into

OneCare ensuring continuity of care for their existing services~~:~~

~~1. Housing Transition Navigation Services~~
~~1. Housing Deposits~~
~~2. Housing Tenancy and Sustaining Services~~
~~3. Recuperative Care~~

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

In 2013, CalOptima ~~will~~Health launched the PACE program that provides coordinated and integrated health care services to frail elders to help them continue ~~to assess the needs the members and collaborate with~~ living independently in the community ~~stakeholders to add new Community Supports~~.

To be a CalOptima Health PACE participant, members must be at least 55 years old, live in Orange County and be determined to be:

- Eligible for nursing facility services by the State of California.
- Able to live safely at home or in a community setting with proper support.
- Able to receive all non-emergent services within the CalOptima Health network.

Scope of Services

PACE provides all the acute and long-term care services covered by Medicare and Medi-Cal through an Interdisciplinary Team (IDT). The IDT is made up of physicians, nurses, social workers, dietitians, physical therapists, occupational therapists, home-care staff, activity staff and transportation staff who are committed to planning, coordinating and delivering the most fitting and personalized health care to our participants.~~**2021-22 CalOptima Community Network (CCN) Pilot Program — Diabetes Mellitus (DM) Program to Improve Health Care Quality for Medi-Cal Members with Poorly Controlled Diabetics**~~

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

CalOptima Health's Utilization Management team is the designated lead for administrative and nursing clinical review functions for PACE program inpatient admissions and works directly with the IDT for clinical determinations and transition coordination.

~~To address high rates of poorly controlled diabetics identified in CCN, the following pilot program was proposed and approved by the CalOptima Board.~~

~~1. Pharmacist Involvement and Intervention~~
~~CalOptima Pharmacists' role will be extended to include individual member outreach and provider consultations. CalOptima believes that our internal pharmacists can promote and support behavior changes needed for diabetic members with a multidisciplinary team approach, including collaboration with PCPs and health coaches/registered dietitians/case managers.~~
~~2. Health Coach/Registered Dietitian Management Intervention~~
~~CalOptima Health Coaches will provide CCN-focused interventions, such as assessment/care planning, motivational interviewing, member education materials, referral to other community resources based on needs. Health Coaches/Registered Dietitians would also~~

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participate in Interdisciplinary Care Team (ICT) meetings, as applicable, and connect members to case management if other acute needs are identified during an intervention.

1. Non-Monetary Member Incentives

CalOptima would like to support member engagement and compliance by providing members with health rewards (non-monetary incentives). The non-monetary incentives will be provided as gift cards subject to DHCS approval in the near future.

2. Provider Incentives

In order to have successful provider buy-in, CalOptima proposes offering provider incentives for their dedicated participation in this multidisciplinary DM program. Providers are eligible for incentives when they participate in the program to manage a member with known or potentially poorly controlled diabetes and meet the eligibility criteria for participation year.

Pharmacy Administration Changes

Effective January 1, 2022, DHCS carved out the outpatient pharmacy benefit for Medi-Cal beneficiaries from managed care plans and moved it to a state fee-for-service program (Medi-Cal Rx). Outpatient pharmacy claims processing/prior authorizations, formulary administration and pharmacy-related grievances will beare the responsibility of Medi-Cal Rx. CalOptima Health Pharmacy Management staff continue to assist members with medication-related access issues. CalOptima Health-retained responsibilities willto include physician-administered drug claims processing/prior authorizations, pharmacy care coordination, clinical aspects of pharmacy adherence, disease and medication management, and participation on the Medi-Cal Global Drug Utilization Review (DUR) Board. This change is for the Medi-Cal program only and does not affect OneCare, OneCare Connect or PACE.

Population Health Management (PHM) Program

CalOptima strives to provide integrated care of physical health, behavioral health, LTSS, care coordination and complex case management to improve coordination of care between health care departments. This streamlined interaction will ultimately result in optimized member care. CalOptima's PHM strategy outlines programs that will focus on four key strategies:

1. Keeping members healthy
2. l.Managing members with emerging risks
3. CalOptima Health's PHM ProgramConsidering patient safety or outcomes across settings
4. Managing multiple chronic conditions

This is achieved through functions described in Health Promotion, Health Management, Care Coordination and Members with Complex Needs, LTSS, Behavioral Health Services and telehealth areas.

CalOptima developed a comprehensive PHM Strategy for 2019, which was adopted again in 2020. The PHM Strategy will continue into 2021, including a plan of action for addressing our culturally diverse member needs across the continuum of care. CalOptima's PHM Strategy aims to ensure the care and services provided to our members are delivered in a whole-person-centered, safe, effective, timely, efficient, and equitable manner across the entire health care continuum and life span.

The PHM Program integrates physical health, behavioral health, LTSS, care coordination and

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complex case management to improve coordination of care between health care departments. The PHM includes basic population health management, care management, complex care management, ECM, and transitional care services.

CalOptima Health's PHM Program address the following four key strategies:

1. Keeping members healthy
2. Managing members with emerging risks
3. Considering patient safety or outcomes across settings
4. Managing multiple chronic conditions

The ~~The PHM Strategy is based on numerous efforts to assess the health and well-being of CalOptima members, such as the Member Health Needs Assessment that was completed in March 2018. It focused on ethnic and linguistic minorities within the Medi-Cal population from birth to age 101. Additionally, CalOptima's annual Population Needs Assessment (requirement for California Medi-Cal Managed Care Health Plans) will aid the PHM strategy further in identifying member health status and behaviors, member health education and cultural and linguistic needs, health disparities, and gaps in services related to these issues.~~

~~The PHM plan of action addresses the unique needs and challenges of specific ethnic communities, including economic, social, spiritual and environmental stressors, to improve health outcomes. CalOptima will conduct quality initiatives designed to achieve, through ongoing measurement and intervention, demonstrable and sustained improvement in significant aspects of clinical and non-clinical services that can be expected to have a beneficial effect on health outcomes and member satisfaction. Quality initiatives that are conducted to improve quality of care and health services delivery to members may include QIPs, PIPs, PDSAs, and CCIPs. Quality Initiatives for 2021 are tracked in the QI Work Plan and reported to the QIC.~~

~~In 2021, the PHM Strategy was focused on expanding the MOC while integrating CalOptima's existing services, such as care coordination, case management, health promotion, preventive services and new programs with broader population health focus with an integrated model.~~

~~Additionally, as one of the high performing Medi-Cal managed care plans of California, CalOptima is positioned to increase provider awareness and support of the Office of the California Surgeon General's (CA-OSG) statewide effort to cut Adverse Childhood Experiences (ACE) and toxic stress in half in one generation starting with Medi-Cal members. Identifying and addressing ACE in adults could improve treatment adherence through seamless medical and behavioral health integration and reduce further risk of developing co-morbid conditions. Addressing ACE upstream as a public health issue in children can reverse the damaging epigenetic effect of ACE, improve population health outcomes and promote affordable health care for the next generation. Implementing the evidence-based ACE screening and Trauma-Informed Care in the primary care setting will require CalOptima's commitment to promote awareness and consider proactive practice transformation and care delivery system to improve member-focused trauma informed care to be consistent with NCQA Population Health Management (PHM) Standards and Guidelines. The CalOptima Health Improvement Project (CHIP) is a Trauma-Informed Care Plan of Action that aims to promote awareness and reduce the impact of ACE.~~

~~The PHM team also focuses on improvement projects such as QIPs, PIPs, CCIPs and PDSAs to improve processes and outcomes for our members.~~

~~For each QI Project, specific interventions to achieve stated goals and objectives are developed and~~

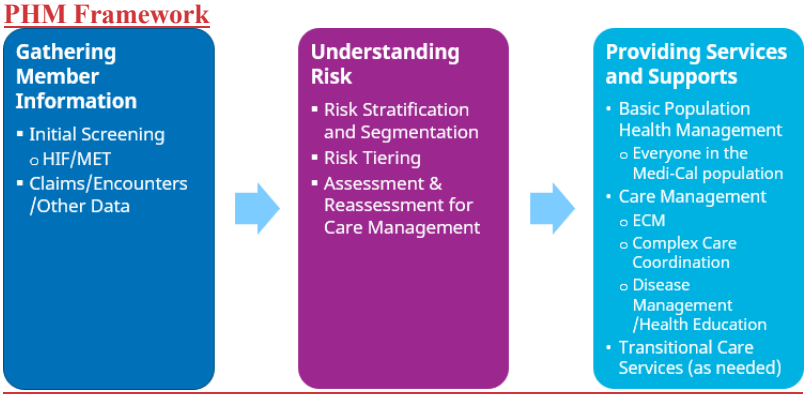
~~implemented, as part of the PHM program. Interventions for each project must:~~

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

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

~~With Whom We Work~~

PHM Framework outlines three key components for operationalizing the program: gathering information, understanding risk, and providing services.



The goals of the PHM program are to establish:

- Trust and meaningful engagement with members
- Data-driven risk stratification and predictive analytics to address gaps in care
- Revisions to standardize assessment processes
- Care management services for all high-risk members
- Robust transitional care services (TCS)
- Effective strategies to address health disparities, Social Determinants of Health (SDOH) and upstream drivers of health
- Interventions to support health and wellness for all members

CalOptima Health analyzes the PHM Program annually and uses key performance indicators, such as Primary Care, ambulatory care, ED visit and inpatient utilization and quality measures, such as HEDIS, to measure the effectiveness of the PHM Program.

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CalOptima Health Direct Network and Health Network Entities

Direct Network and Contracted Health Networks~~/Contracted Network Providers~~ Entities
Providers have several options for participating in ~~CalOptima's~~CalOptima Health's programs providing health care to CalOptima Health members. Providers can participate through CalOptima Health Direct~~ Administration and/~~ (COD) network or through a Health Network (HN).

CalOptima Health members can choose a Primary Care Provider (PCP) in CalOptima's Community Network (CCN) ~~and/or contract with a CalOptima health network (HN). CalOptima members can choose CCN~~ or one of 12 HNs, representing more than 10,000 practitioners. CalOptima members that do not choose a PCP are provisionally assigned to CalOptima's Direct Administrative network for forty-five (45) days until they choose a HN and PCP.

CalOptima Health Direct (COD)
CalOptima **Health** Direct (COD) ~~CalOptima Direct~~ network is composed of two elements: CalOptima Health Direct- Administrative (COD-A) and the CalOptima Health Community Network- (CCN).

- ~~CalOptima Direct Administrative (COD-A)~~
  - ~~CalOptima~~Health Direct-Administrative (COD-A) is a self-directed program administered by CalOptima Health to serve Medi-Cal members in special situations, including dual-eligibles (those with both Medicare and Medi-Cal who elect not to participate in ~~CalOptima's OneCare Connect or~~CalOptima Health's OneCare programs), share of cost members, newly eligible members transitioning to a HN from CCN, and members residing outside of Orange County.

- CalOptima Health Community Network (CCN)

  - ~~The CalOptima Community Network~~ provides doctors with an alternate path to contract directly with CalOptima Health to serve our members. CCN is administered directly by CalOptima Health and available for HN eligible members ~~to select~~, supplementing the existing HN delivery model and creating additional capacity for access for certain covered services that are not the financial risk of the HN.

CalOptima Health Contracted Health Networks
CalOptima Health has contracts with HNs that are delegated ~~HNs~~to perform certain clinical and administrative functions on behalf of CalOptima Health through a variety of risk models to provide care to members. The following contract risk models are currently in place with HNs:

- Health Maintenance Organization (HMO)
- Physician/Hospital Consortia (PHC)
- Shared-Risk Group (SRG)

Through our delegated HNs, CalOptima Health members have access to 1,~~500~~293

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primary care providers (PCPs), ~~more than~~ 8,~~900~~160 specialists, ~~41~~45 hospitals, 34 Community Health Centers clinics and ~~99~~98 long-term care facilities.

Provider Network Data (as of January 31, 2023)

	Number of Providers
Primary Care Providers	1,293
Specialists	8,160
Pharmacies	565
Acute and Rehab Hospitals	45
Community Health Centers	34
Long-Term Care Facilities	98

CalOptima Health contracts with the following HNs benefit programs:

Health Network/Delegate	Medi-Cal	OneCare
AltaMed Health Services~~-~~	SRG	SRG
AMVI/Prospect Medical Group		SRG
AMVI Care ~~Health Network~~Medical Group	PHC	PHC
Arta ~~–~~ Optum Care Network~~— Arta~~	SRG	SRG
CHOC Health Alliance~~-~~	PHC	
Family Choice Medical Group	~~PHC~~	SRG
Family Choice Health Services	HMO	
HPN~~-~~ ~~–~~ Regal Medical Group~~-~~	HMO	HMO
Kaiser Permanente	HMO	

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Monarch – Optum Care Network- ~~– Monarch~~	HMO	HMO

Noble Mid-Orange County	SRG	SRG
Prospect ~~Health Plan~~Medical Group	HMO	HMO
Talbert – Optum Care Network~~— Talbert~~	SRG	SRG
United Care Medical Group	SRG	SRG

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

- Utilization management-
- Basic and complex case management-
- Claims-
- Contracting and Provider Network development
- Provider Relations
- Credentialing of practitioners
- Customer services

- ~~Membership~~ membership Demographics

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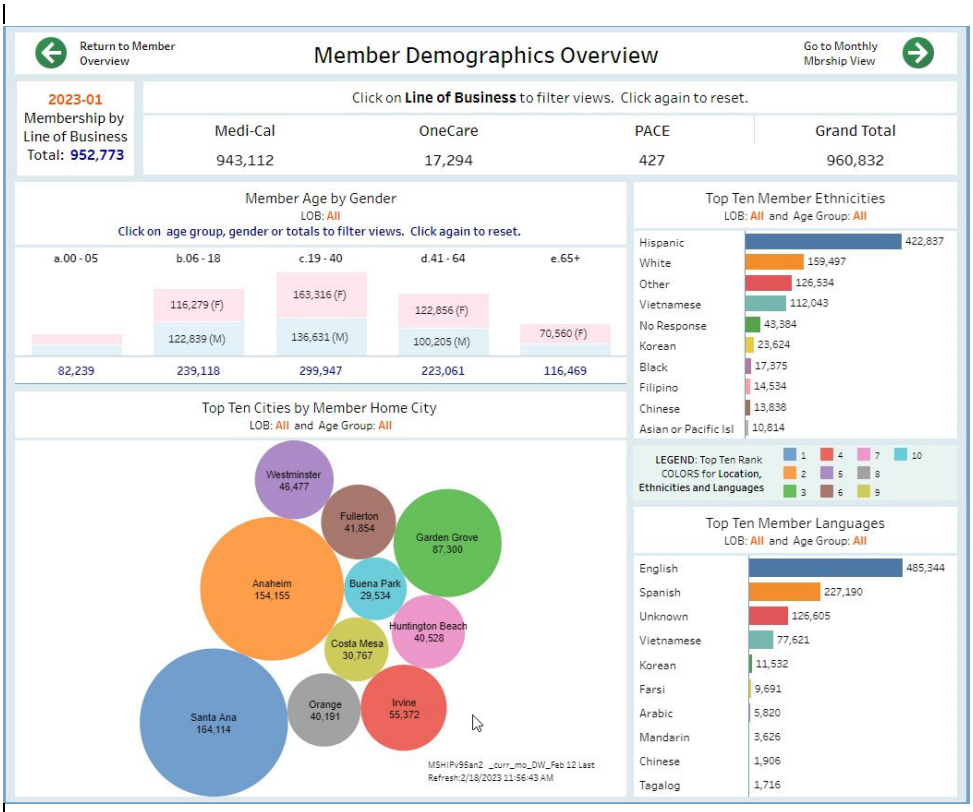

UTILIZATION MANAGEMENT PROGRAM

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CalOptima
A Public Agency
Better. Together.

Fast Facts: January 2022

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

Membership Data from November 30, 2021, Financial Information

Total CalOptima Membership
867,182

Program	Members
Medi-Cal*	849,616
OneCare Connect	14,877
~~**OneCare (HMO SNP)**~~	~~2,274~~
Program of All-Inclusive Care for the Elderly (PACE)	415

Note: Fiscal Year 2021–22 Membership Data began on July 1, 2021.
* Based on unaudited financial report and includes prior year adjustment

Member Age (All Programs)		Languages Spoken (All Programs)		Medi-Cal Aid Categories	
10%	0 to 5	59%	English	41%	Temporary Assistance for Needy Families
27%	6 to 18	26%	Spanish	35%	Expansion
33%	19 to 44	10%	Vietnamese	9%	Optional Targeted Low-Income Children
18%	45 to 64	2%	Other	9%	Seniors
12%	65+	1%	Korean	5%	People with Disabilities
		1%	Farsi	<1%	Long-Term Care
		<1%	Chinese	<1%	Other
		<1%	Arabic		

UTILIZATION MANAGEMENT ~~PROGRAM~~

~~UM~~ Purpose

The purpose of the Utilization Management (UM) Program ~~Description~~ is to define ~~CalOptima's~~the oversight and delivery of CalOptima Health's structure ~~and~~, clinical processes ~~for~~, and programmatic approach to review ~~of~~ health care services, treatment, and supplies, ~~including assignment of responsibility to appropriate individuals, to deliver~~and provide quality, coordinated health care services to CalOptima Health members. ~~All~~ The Utilization Management Program includes review and analysis of utilization trends including identification of under and over-utilization to determine members are receiving appropriate services ~~are designed to~~. All health care services serve the culturally diverse needs of the CalOptima Health population and are delivered at the appropriate level of care, in an effective, ~~cost effective~~ and timely manner by delegated and non-delegated providers.

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UM Scope

The scope of the UM Program is comprehensive and applies to all eligible members across all product types, age categories and range of diagnoses~~.~~ within CalOptima Health's membership. Additionally, the scope of the UM program is to oversee continuity of care and access to appropriate services, providers and care settings. The UM Program incorporates physical and behavioral health, pharmacy services, ~~and post-stabilization care across all~~long term care ~~settings~~and long-term services and supports. This includes preventive, emergency, primary, specialty, home- and community-based services, as well as acute, subacute, short-term and long-term facility and ancillary care services.

UM PROCESS

The UM process includes but is not limited to the following program components: referral/prior authorization, inpatient and concurrent review, post-stabilization services, ambulatory care review, retrospective review, discharge planning, care coordination and second opinions. All requests are reviewed against hierarchical guideline criteria and approved services must meet medical necessity criteria. The clinical decision process initiates upon receipt of a treatment authorization request. Request types include authorization of specialty services, second opinions, outpatient services, ancillary services, post-stabilization inpatient services, or scheduled inpatient services. The process is complete when the requesting practitioner and member (when applicable) have been notified of the determination.

UM policies and processes serve as integral components in preventing, detecting, and responding to utilization trends and opportunities as well as identifying potential fraud and abuse among practitioners and members. The UM department works closely with the Compliance Officer and the Fraud, Waste and Abuse Unit to resolve any potential issues that may be identified. All UM team members and oversight committees sign an annual attestation and are expected to abide by and uphold, CalOptima's policy for ensuring all medical decisions are made based within regulatory requirements and are not unduly influenced by financial considerations.

CalOptima Health provides Continuity of Care services up to 12 months to requesting member's primary care providers, specialists and some ancillary providers for Medi-Cal beneficiaries transitioning to CalOptima Health or transitioning from a Managed Care Plan with contracts expiring to CalOptima or a Health Network.

UM Program Goals

The goal of the UM Program is to manage appropriate utilization of medically necessary, covered services and to ensure access to quality and cost-effective health care for CalOptima Health members. This includes but is not limited to:

- ~~Assist~~Assisting in the coordination of medically necessary ~~medical and behavioral~~physical health ~~care~~ , behavioral health, Long-Term Services and Supports (LTSS), Long Term Care (LTC) and pharmacy services in accordance with benefit and clinical criteria and hierarchy, state and federal laws, regulations, contract requirements, NCQA standards and other evidence-based clinical criteria.
- ~~Enhance~~Enhancing the quality of care for members by promoting coordination

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and continuity of care and service, especially during member transitions between different levels of care.

- ~~Provide~~Providing a mechanism to address concerns about access, availability and timeliness of care.
- Clearly ~~define~~defining staff responsibility for activities regarding decisions based on medical necessity including non-clinical, clinical and Medical Director staff roles and responsibilities.
- ~~Establish~~Establishing and ~~maintain~~maintaining processes used to review medical and behavioral health care and pharmacy service requests, including timely notification to members and/or providers of appeal rights when an adverse determination is made based on medical necessity and/or benefit coverage.
- ~~Identify~~Identifying and ~~refer high need~~referring members to Care Coordination, Case Management ~~programs, including,~~ Complex ~~and Enhanced~~ Case Management~~,~~ and Enhanced Care Management programs, LTSS, Behavioral Health and/or Population Health Management services, as appropriate.
- ~~Promote~~Promoting a high level of member, practitioner and stakeholder satisfaction.
- ~~Protect~~Protecting the confidentiality of ~~member protected~~members health ~~information~~ and ~~other~~ personal information.
- ~~Identify~~Identifying and ~~report~~reporting potential quality of care issues (PQIs) and Provider Preventable Conditions (PPCs) and refer them to the Quality Improvement (QI) department for further action.
- ~~Identify~~Identifying and address over- and underutilization of services.
- ~~Monitor~~ Monitoring utilization practice patterns of practitioners to identify variations from the standard practice that may indicate need for additional education or support.
- ~~Promote~~Promoting improved member ~~health and well being~~outcomes by coordinating services with appropriate county/state sponsored programs such as In-Home Supportive Services (IHSS), and County Specialty Mental Health.
- ~~Educate, monitor and evaluate practitioners and other providers, including delegated HNs on delivery of CalOptima's UM Program, policies and procedures on an ongoing basis.~~
- The LTSS team works collaboratively with CalOptima Health's HN's to coordinate care for complex discharge needs and CalAIM services.
- Provide continuous identification of UM ~~staff~~staffing needs~~,~~ including clinical, non-clinical and ~~appropriate training delivered~~medical directors to address ~~those~~the needs of the members we serve.
- Provide continuous training for competency, as well as ensure staff are well versed in UM processes, regulatory requirement changes and workflow/process changes within the department.

UM Program Structure

~~UM Program~~ Structure

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

The UM Program is reviewed ~~and~~, evaluated and revised as needed for effectiveness and compliance with

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the standards of CMS, DHCS, California Department of Aging (CDA), NCQA and established best practice standards/ internal benchmarks at least annually. ~~The UM Program is revised and improved, as appropriate.~~ The structure of the UM Program is designed to promote organizational accountability and responsibility in the identification, evaluation, and appropriate utilization of health care services delivered by the CalOptima ~~health care delivery~~Health's network.

Additionally, the program structure is designed to enhance communication and collaboration on UM issues that affect delegated entities and multiple disciplines within the organization. The organization chart and the UM Program reflect the Board of Directors as the governing body, identifies senior management responsibilities, as well as committee reporting structure and lines of authority. Position job descriptions and policies and procedures define associated responsibilities and accountability. The composition and functions of the Utilization Management Committee (UMC) and Quality Improvement Committee (QIC), which serve as the oversight committees for UM functions, are contained and delineated in the committee's charters.

The UM Program is overseen by the Chief Medical Officer and evaluated on an ongoing basis for efficacy and appropriateness of content by the Medical Management and Quality leadership team that may include but is not limited to the Deputy Chief Medical Officer; Medical Director(s) of UM; Behavioral Health Medical Director; Executive Director of Behavioral Health Integration; Executive Director, Clinical Operations; UMC; and QIC.

Delegation of UM functions

CalOptima Health delegates UM activities for a portion of the CalOptima membership to ~~entities~~Health Networks that demonstrate the ability to meet ~~CalOptima's~~CalOptima Health's standards, as outlined in the UM Program Description and CalOptima Health policies and procedures. ~~Delegation is dependent upon the following factors:~~

- ~~A pre-delegation review to determine the ability to accept assignment of the delegated function(s).~~
- ~~Executed Delegation Agreement with the organization to which the UM activities have been delegated to clarify the responsibilities of the delegated group and CalOptima. This agreement specifies the standards of performance to which the contracted group has agreed.~~
- ~~Conformation to CalOptima's UM standards as documented in the UM policies and procedures, including timeframes outlined in CalOptima's policies and procedures.~~

~~CalOptima~~

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

- Frequent reporting of key performance metrics that are required and/or developed by ~~CalOptima's~~CalOptima Health's Audit & Oversight department~~, Utilization Management~~ and reported to the Delegation Oversight Committee ~~(UMC)~~ and/or Quality Improvement Committee (QIC).
- ~~Regular~~ Annual and ad-hoc audits of delegated HNs' UM activities by ~~the~~CalOptima Health's Audit & Oversight department to ensure accurate and timely completion of delegated activities. Annual or more frequent evaluation to determine whether the delegated activities are being carried out according to DHCS, Centers for Medicare & Medicaid Services (CMS), NCQA, and

CalOptima Health standards and program requirements.
- Annual approval of the delegate's UM Program (or portions of the program that are delegated); as well as any significant program changes that occur during the contract year.

In the event the delegated provider does not adequately perform contractually specified delegated duties, CalOptima Health takes further action, including increasing the frequency or number of focused audits, requiring the delegate to implement corrective actions, imposing sanctions, capitation review, or de- delegation.

LONG-TERM SUPPORT SERVICES -(LTSS)

CalOptima Health ensures LTSS services are available to members who have health care needs and meet the program eligibility criteria and guidelines. The LTSS program includes both institutional and community- based nursing and sub-acute facility services. for both adults and pediatrics. CalOptima Health's LTSS department monitors and reviews the quality and outcomes of services provided to members in both settings.

Nursing Facility Services for Long Term Care:

- CalOptima is responsible for clinical review and medical necessity determination for the following levels of care:
  - Nursing Facility Level B (NF-B)
  - Nursing Facility Level A (NF-A)
  - Subacute: Adult and Pediatric
- Medical necessity for LTC is evaluated based upon the DHCS Medi-Cal Criteria Chapter, Criteria for Long Term Care Services, and Title 22, CCR, Sections 51118, 51120, 51121, 51124, 51212, 51215, 51334, 51335, 51343, 51343.1 and 51343.2.
- In April 2020, all LTC member facility clinical reviews and medical necessity nursing facility visits were suspended due to the COVID-19 PHE. All clinical review is now performed electronically and telephonically.

HOME- AND COMMUNITY-BASED SERVICES:

- CBAS: An outpatient, facility-based program that offers health and social services to seniors and peopel with disabilities. CalOptima LTSS monitors the levels of member access to, utilization, level of, access and satisfaction with the program, as well as its role inCommunity Based Adult Services (CBAS) and Multipurpose Senior Services Programs (MSSP) focusing on diverting members from institutionalization. CalOptima evaluates medical necessity for services using the CBAS Eligibility Determination Tool (CEDT). In April 2020, all CBAS member and facility clinical reviews and medical necessity visits were suspended due to the COVID-19 PHE. All clinical and medical necessity review is now performed electronically and telephonically, when appropriate.
- MSSP: Home- and community-based care coordination of a wide range of services and equipment to support members in their home and avoid the need for long-term nursing facility care. CalOptima LTSS monitors the level of member access to the program as well as its role in diverting members from institutionalization. The CalOptima MSSP site adheres to the California Department of Aging contract and eligibility determination criteria. Starting in April 2020, all MSSP member and facility clinical reviews and medical necessity visits were suspended due to

~~the COVID-19 PHE. All clinical and medical necessity review is now performed electronically and telephonically.~~

Behavioral Health Services

~~**Medi-Cal**~~

CalOptima Health offers outpatient mental health services to Medi-Cal 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.~~ Services include but are not limited to individual, family and group psychotherapy, psychiatric consultation, medication management, and psychological testing when clinically indicated to evaluate a mental health condition. CalOptima Health also covers ~~Alcohol Misuse Screening~~alcohol and ~~Counseling (AMSC) services~~drug use screening, assessment, brief interventions, and referral to treatment (SABIRT) provided to members ~~18~~11 years and older ~~in the primary care setting~~, including pregnant women by providers within their scope of practice.

CalOptima Health covers medically necessary behavioral health treatment (BHT) for members 20 years and younger under Early and Periodic Screening, Diagnostic and Treatment (EPSDT). BHT services include applied behavior analysis (ABA) and a variety of other behavioral interventions that have been identified as evidence-based approaches that prevent or minimize the adverse effects of behaviors that interfere with learning and social interaction.

CalOptima does not require members, or their practitioners undergo triage and referral when seeking information about or approval of BH services. Most mental health services do not require a physician referral. Members may access mental health services by calling the CalOptima Health Behavioral Health Line at **855-877-3885**. A CalOptima Health representative will conduct a brief ~~mental health~~ telephonic screening. to determine the reason for the call and the assistance needed. Mental health screenings are conducted by CalOptima Health's Behavioral Health Integration licensed clinicians using the most recent DHCS approved screening tool. The screening is used to make an initial determination of the member's impairment level. due to a mental health condition. If the member has mild to moderate impairments, the member will be offered behavioral health ~~practitioners~~ providers within the CalOptima ~~provider~~Health network. If the member has significant to severe impairments, the member will be referred to Specialty Mental Health Services (SMHS) through the Orange County Mental Health Plan (OCMHP) managed by the Orange County Health Care Agency.

CalOptima Health directly manages all administrative functions of the Medi-Cal behavioral health benefits including UM, claims, provider network credentialing, member services and QI.

One Care (OC ~~and OCC~~)

CalOptima Health offers the following mental health services to OC ~~and OCC~~ members:

- ~~•~~ Inpatient psychiatric hospitalization
- Intensive outpatient program (IOP) and partial hospitalization program (PHP)
- I Outpatient ~~mental health care including but not limited to~~ individual and group psychotherapy.

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- Outpatient medication management~~, psychological~~
- Psychological testing~~, intensive outpatient program (IOP), and partial hospitalization program (PHP).~~

~~• Inpatient mental health care in either a psychiatric or general hospital.~~

- ~~•~~ Opioid Treatment Program (OTP) services~~.~~

~~• Alcohol Misuse Screening and Counseling (AMSC) services.~~

- Electro Convulsive Therapy (ECT)
- Transcranial Magnetic Stimulation (TMS)
- Alcohol and drug use screening, assessment, brief interventions, and referral to treatment (SABIRT)

Most mental health services do not require a physician referral. Members may access mental health services by calling the CalOptima Health Behavioral Health Line at 855-877-3885. A CalOptima Health representative will conduct a brief ~~mental health~~ telephonic screening~~.~~ to determine the reason for the call and the assistance needed. Mental health screenings are conducted by CalOptima Health's Behavioral Health Integration licensed clinicians using the most recent approved screening tool. The screening is to make an initial determination of the member's impairment level. If the member has mild to moderate impairments due to a mental health condition, the member will be offered behavioral health practitioners within the CalOptima Health provider network. If the member has significant to severe impairments, the member will be referred to (SMHS)~~Specialty Mental Health Services~~ through the ~~Orange County Mental Health Plan~~OCMHP.

CalOptima Health directly manages all administrative functions of the OC ~~and OCC~~ behavioral health benefits including UM, claims, provider network credentialing, member services and QI.

~~AUTHORITY, BOARDS OF DIRECTORS' COMMITTEES, AND RESPONSIBILITIES~~

AUTHORITY, BOARDS OF DIRECTORS' COMMITTEES, AND RESPONSIBILITIES

Board of Directors

~~The~~ CalOptima Health's Board of Directors has ultimate accountability and responsibility for overseeing the quality of care and service provided to CalOptima Health members. The responsibility to oversee the UM Program is delegated by the Board of Directors to the Board's Quality Assurance Committee (QAC) — which oversees the functions of the QI Committee described in ~~CalOptima's~~CalOptima Health's state and federal contracts — and to ~~CalOptima's~~CalOptima Health's Chief Executive Officer (CEO), as described below.

The Board holds the CEO and the Chief Medical Officer (CMO) accountable and responsible for the quality of care and ~~services~~services provided to members. The Board ensures 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 UM Program annually.

The responsibility for the direction and management of the UM Program has been delegated to the CMO. Before coming to the Board of Directors for approval, the UM Program is reviewed and approved by the UMC, the QIC and the QAC on an annual basis.

CalOptima Health 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~~CalOptima Health's Board meetings are open to the public.

Board of Directors' Quality Assurance Committee

The Board of Directors appoints the QAC to conduct annual evaluation, provide strategic direction, and make recommendations to the Board regarding the overall QI Program. QAC routinely receives progress reports from the QIC describing improvement actions taken, progress in meeting objectives, and quality performance results. The QAC also makes recommendations to the Board for annual approval with modifications and appropriate resource allocations of the QI Program ~~aimed to achieve the Institute for Healthcare Improvement's Quadruple Aim expanding on the CMS' Triple Aim:~~.

~~1. Enhancing patient experience~~
~~2. Improving population health~~
~~3. Reducing per capita cost~~
~~4. Enhancing provider satisfaction~~

Member Advisory Committee

The Member Advisory Committee (MAC) has 15 voting members, each seat represents a constituency served by CalOptima Health. The MAC ensures that CalOptima Health members' values and needs are integrated into the design, implementation, operation and evaluation of the overall QI program. The MAC provides advice and recommendations on community outreach, cultural and linguistic needs and needs assessment, member survey results, access to health care, and preventive services. The MAC meets on a bi-monthly basis and reports directly to the CalOptima Health Board of Directors. MAC meetings are open to the public.

The MAC membership has representatives from the following constituencies:

- Adult Beneficiaries
- Children
- Consumer
- Family Support
- Foster Children
- Long-Term Care Representative
- Medi-Cal Beneficiaries
- Medical Safety Net Representative
- Orange County Health Care Agency (standing seat~~)~~)
- Orange County Social Services Agency (standing seat~~)~~)
- People with Disabilities
- Behavioral/Mental Health Representative
- People with Special Needs
- Recipients of CalWORKs

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- Seniors

~~**OneCare Connect Member Advisory Committee**~~

~~The OCC Member Advisory Committee (OCC MAC) reports directly to the CalOptima Board of Directors, and has 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 has 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:~~
  - ~~HCA, Behavioral Health~~
  - ~~SSA~~
  - ~~OC Community Resources Agency, Office on Aging~~
  - ~~OC IHSS Public Authority~~

Provider Advisory Committee

The Provider Advisory Committee (PAC) was established in 1995 by the CalOptima Health Board of Directors to advise the Board on issues impacting the CalOptima Health provider community. PAC members represent a broad provider community that serves CalOptima Health members. The PAC ~~has 15 members, 14 of whom serve three-year terms with two consecutive term limits, along with a representative of HCA, which maintains a standing seat. PAC~~ meets at least quarterly and is open to the public. The ~~15 seats~~members include:

- Health networks~~-~~
- Hospitals~~-~~
- Physicians ~~(three seats)~~
- Nurse~~-~~
- Allied health services ~~(two seats)~~
- Community health centers~~-~~
- Health Care Agency (HCA ~~(one standing seat~~)
- LTSS (LTC facilities and CBAS) ~~(one seat)~~
- Non-physician medical practitioner~~-~~
- Traditional safety net provider
- Behavioral/mental health~~-~~
- Pharmacy~~-~~

Whole-Child Model Family Advisory Committee
Whole-Child Model Family Advisory Committee (WCM FAC) has been required by the state as part of California Children's Services (CCS) when it became a Medi-Cal managed care plan benefit. The WCM FAC provides advice and recommendations to the Board and staff on issues concerning the WCM program, serves as a liaison between interested parties and the Board, and assists the Board and staff in obtaining public opinion on issues relating to ~~CalOptima's~~CalOptima Health's WCM program. The committee can initiate recommendations on issues for study and facilitate community outreach.~~-~~

~~The~~Members of WCM FAC ~~has 11 voting seats:~~include~~-~~

- Family representatives:~~ seven seats~~
  - Authorized representatives, which includes parents, foster parents and caregivers of a CalOptima Health member who is a current recipient of CCS services; or
  - CalOptima Health members ~~age~~ages 18–21 who are current recipients of CCS services; or
  - Current CalOptima Health members over the age of 21 who transitioned from CCS services.
- Interests of children representatives:~~ four seats~~
  - Community-based organizations; or
  - Consumer advocates

~~Role of~~
CalOptima Health Officers~~ for UM Program~~
~~CalOptima's~~ Chief Medical Officer (CMO~~,~~), Chairperson of the Utilization Management Committee (UMC~~,~~), Executive Director of Clinical Operations, and/or any designee as assigned by ~~CalOptima's~~ CalOptima Health's Chief Executive Officer (CEO) are the senior ~~executives~~leaders responsible for implementing the UM Program, including appropriate use of health care resources, medical and behavioral health QI, medical and behavioral health utilization review and authorization, case management, PHM and health education program implementations.

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

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

Chief Medical Officer (CMO) oversees strategies, programs, policies and procedures as they relate to ~~CalOptima's~~CalOptima Health's quality and safety of clinical care delivered to members. At least quarterly, the CMO presents reports on QI activities to the Board of Directors' Quality Assurance Committee.~~–~~

Deputy Chief Medical Officer (DCMO), along with the CMO, oversees the strategies, programs, policies and procedures as they relate to ~~CalOptima's~~CalOptima Health's

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medical care delivery system. The DCMO and CMO oversee Quality Analytics (QA), Quality Improvement (QI), Utilization Management (UM), Case Management (CM), Population Health Management (PHM), Pharmacy Management (PM), Behavioral Health Integration (BHI), Long-Term Support Services (LTSS) and Enterprise Analytics (EA).

Executive Director, Clinical Operations (EDCO) is responsible for oversight of all operational aspects of key Medical Affairs functions including the UM, Care Coordination, Complex Case Management, and Managed LTSS (MLTSS) programs, along with all new program implementations related to initiatives in these areas. The EDCO serves as a member of the executive team, and, with the CMO, DCMO and the ED of Quality and Population Health Management (Q&PHM), makes certain that Medical Affairs is aligned with ~~CalOptima's~~CalOptima Health's strategic and operational priorities. This position is a key leader within the health plan and has the accountability to lead the areas assigned to next level capabilities and operational efficiencies consistent with ~~CalOptima's~~CalOptima Health's strategic plan, goals and objectives. The EDCO is expected to anticipate, continuously improve, communicate, and leverage resources, as well as balance achieving set accountabilities within constraints of limited resources. Executive Director, Behavioral Health Integration (ED of BHI) is responsible for the management and oversight of CalOptima's Behavioral Health Integration department, along with new implementation related to state and county behavioral health initiatives. The ED of BHI strategies for integrating behavioral health across the health care delivery system and populations served.

Executive Director, ~~**Quality &**~~ Population Health Management (ED ~~of Q&~~PHM) ~~is responsible for facilitating~~oversees the ~~companywide QI Program deployment, driving performance results in Healthcare Effectiveness Data~~development and ~~Information Set (HEDIS), DHCS, CMS Star measures and ratings, and maintaining accreditation standing as a high performing~~implementation of company wide Population Health Management strategy to improve member experience, promote optimal health ~~plan with NCQA.~~outcomes, ensure efficient care and improve health equity. The ED ~~of Q&~~PHM serves as a member of the executive team, and with the CMO, DCMO and ~~ED of~~Executive Director, Clinical Operations, supports efforts to promote adherence to established quality improvement strategies and ~~integrating~~integrate behavioral health across the ~~health care~~ delivery system and populations served. The Director of Population Health Management reports to the ED PHM.

Physical and Behavioral Health Medical Directors *(hereinafter referred to "Medical Directors")* have primary assigned roles but may provide coverage and back up to other specialties as needed. All medical directors are appointed by the CMO and/or DCMO and are responsible to adhere to and oversee the direction of the UM Program and objectives, as well as evaluation of the UM Program.

- The medical director who oversees UM ensures quality medical service delivery to members managed directly by CalOptima Health and is responsible for medical direction and clinical decision making in UM. The medical director ensures that an appropriately licensed professional conducts reviews on cases that do not meet medical necessity and uses evidence-based review criteria/guidelines for any potential adverse determinations of care and/or service, as well as monitors documentation for adequacy. In collaboration with the CMO and/or DCMO, the medical director also provides supervisory

oversight and administration of the UM Program and oversees the UM activities and clinical decisions of staff that work in concurrent, prospective and retrospective medical management activities, monitors for documentation adequacy, and works with the clinical staff that support the UM process. The medical director provides clinical education and in-service training to staff, presenting key topics on clinical pathways and treatments relating to actual cases being worked in UM, as well as educates on industry trends and community standards in the clinical setting. The medical director of UM ensures physician availability to staff during normal business hours and on-call after hours. Also serves as the Chair of the UMC and the Benefit Management Subcommittee, facilitates the biweekly UM Workgroup meetings and participates in the CalOptima Health Medical Directors Forum and QIC.

- The medical director who oversees the behavioral health program is a participating member of the UMC, QIC and CPRC. The medical director provides consultation and oversight to the UM Program, including guidance on criteria review and development to ensure parity. The medical director is also the chair of the Pharmacy & Therapeutics committee (P&T). The medical director supports the behavioral health aspects of the UM Program. The medical director also provides leadership and program development ~~expertise~~ in the creation~~, expansion~~ and/or improvement of services and systems ensuring the integration of physical and BH care services for CalOptima Health members. Clinical oversight is also provided for BH benefits and services provided to members. The medical director works closely with all departments to ensure appropriate access and coordination of behavioral health care services, improves member and provider satisfaction with services and ensures quality BH outcomes. ~~Additionally, the medical director is involved in the implementation, monitoring, evaluating and directing of the behavioral health aspects of the UM Program.~~

- The medical director who oversees specialty programs and services is a key member of the medical management team and is responsible for the Medi-Medi programs, MLTSS programs, and Case Management programs. The medical director provides physician leadership in the Medical Affairs division, including acting as liaison to other CalOptima Health operational and support departments, including PHM, disease management and health education programs, while also providing clinical quality oversight of the Program of All-Inclusive Care for the Elderly (PACE) Center.

Director, Utilization Management is responsible for the planning, organization, implementation and evaluation of all activities and personnel engaged in UM departmental operations. This position provides leadership and direction to the UM department to ensure compliance with all local, state and federal regulations, that accreditation standards are current, and all policies and procedures meet current requirements. The incumbent will have oversight of ~~CalOptima's~~CalOptima Health's UM Program for CalOptima Health Community Network, CalOptima Health Direct and the delegated HNs. The Director is expected to serve as a liaison for various internal and external committees, workgroups and operational meetings.

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Director, Behavioral Health ~~Services~~**Integration** is responsible for the planning, organization monitoring, and evaluation of all activities and personnel engaged in the BH UM ~~Program~~operations. The director tracks, analyzes ~~and reports to senior staff on~~ changes in the behavioral health care delivery environment and program opportunities affecting or available to assist CalOptima Health in integrating physical and BH care services. ~~The director is responsible for~~This position provides leadership and direction to the ~~day-to-day operation of the program overseeing a team of care managers, medical case managers and medical authorization assistants who support all~~ BH UM ~~functions.~~team to ensure compliance with all local, state and federal regulations, that accreditation standards are current, and all policies and procedures meet current requirements. This position plays a key leadership role in coordinating with all levels of CalOptima Health staff, including the Board of Directors, executive staff, members, providers, HN management, state and federal officials, and representatives of other agencies.

Director, Quality Improvement is responsible for assigned day-to day operations of the QI department, including Credentialing, Facility Site Reviews~~,~~ for both physical and behavioral health (including onsite visits and process evaluation), Physical Accessibility Compliance and working with the ED of Q&PHM to oversee the QI Program and maintain NCQA accreditation. This position is also responsible for implementation of the QI Program and QI Work Plan implementation.

Director, Quality Analytics provides data 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. This position provides coordination and support to the QIC and other committees to support compliance with regulatory and accreditation agencies.

Director, Population Health Management provides direction for program development and implementation for agencywide population health initiatives while ensuring linkages supporting a whole- person perspective to health and health care with Case Management, UMC, Pharmacy and BHI. This position provides direct care coordination and health education for members participating in non- delegated health programs, such as Perinatal Support Services (Bright Steps) and Childhood Obesity Prevention Program (Shape Your Life). Also, supports the MOC implementation for members. Reports program progress and effectiveness to QIC and other committees to support compliance with regulatory and accreditation agency requirements.

Director, Audit & Oversight oversees and conducts independent performance audits of CalOptima Health operations, Pharmacy Benefits Manager (PBM) operations and SRG delegated functions with an emphasis on efficiency and effectiveness and in accordance with state/federal requirements, CalOptima Health policies, and industry best practices. The director ensures that CalOptima Health and subcontracted HNs perform consistently with both CMS and state requirements for all programs. Specifically, the director leads the department in developing audit protocols for all internal and delegated functions to ensure adequate performance relative to both quality and timeliness. Additionally, the director is responsible to ensure the implementation of strategic and tactical direction to improve the efficiency and effectiveness of internal processes and controls, as well as delegated

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functions. The position interacts with the Board of Directors, CalOptima Health executives, departmental management, HN management and legal counsel.

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UM Staffing Resources

~~UM Resources~~

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

CalOptima Health uses appropriate licensed health care professionals to process and/or supervise UM activities. The following UM Program roles

- provide day-to-day supervision of assigned UM staff.
- Participate in staff training.
- Monitor for consistent application of UM criteria by UM staff, for each level and type of UM decision.
- Monitor documentation for adequacy.
- Are available to UM staff on site or by telephone.

Manager, Utilization Management RN/LVN (Concurrent Review [CCR]) manages the day-to-day operational activities of the department to ensure staff compliance with company policies and procedures, and regulatory and accreditation agency requirements. The manager develops, implements and maintains processes and strategies to ensure the delivery of quality health care services to members while establishing and maintaining collaborative working relationships with internal and external resources to ensure appropriate support for utilization activities.

Supervisor, Utilization Management RN/LVN(CCR) provides day-to-day supervision of assigned staff, monitors and oversees daily work activities to ensure that service standards are met, makes recommendations regarding assignments based on assessment of workload. The supervisor is a resource to the CCR staff regarding CalOptima Health policies and procedures, as well as regulatory and accreditation requirements governing inpatient concurrent review and authorization processing, while providing ongoing monitoring and development of staff through training activities. The supervisor also monitors for documentation adequacy, including appropriateness of clinical documentation to make a clinical determination, and audits documentation to assure consistent application of the appropriate clinical guideline to the member's clinical condition. Supervisory staff are available both on-site and telephonically for all UM staff during regular business hours.

Manager, Utilization Management RN/LVN (Prior Authorization [PA]) manages the day-to-day operational activities of the department to ensure staff compliance with CalOptima Health policies and procedures, and regulatory and accreditation agency requirements. The manager develops, implements and maintains processes and strategies to ensure the delivery of quality health care services to members while establishing and maintaining collaborative working relationships with internal and external resources in order to ensure appropriate support for utilization activities.

Supervisor, Utilization Management RN/LVN (PA) provides day-to-day supervision of assigned staff, monitors and oversees assigned daily work activities to ensure that service standards are met. The supervisor makes recommendations regarding assignments based on assessment of workload and is a resource to the Prior Authorization staff — regarding CalOptima Health policies and procedures as well as regulatory requirements governing prior and retrospective authorization processing — while providing ongoing monitoring and development of staff through training activities. The supervisor also monitors for documentation adequacy, including clinical documentation to make a clinical determination, and audits documentation to assure consistent application of the appropriate clinical guideline to the member's clinical condition. ~~Supervisory staff are available both on-site and telephonically for all UM staff during regular business hours.~~

Supervisory staff are available both on-site and telephonically for all UM staff during regular business hours.

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

Notice of Action Medical Case Managers (RN/LVN) draft and evaluate denial letters for adequate documentation and utilization of appropriate criteria~~. These positions audit clinical documentation and components of the denial letter to assure denial reasons are free from undefined acronyms, and that all reasons are specific to which particular criteria the member does not meet, ensures denial reason is written in plain language that a lay person understands, is specific to the clinical information presented and criteria referenced and is prepared using the appropriate threshold language template. They work with physician reviewers and nursing staff to clarify criteria and documentation should discrepancies be identified.~~, and is written in plain language that a layperson understands.

Medical Case Managers (RN/LVN) provide inpatient and outpatient utilization review and authorization of services in support of members. They are responsible for assessing the medical appropriateness, quality and cost effectiveness of proposed inpatient hospital and outpatient medical/surgical services, in accordance with established evidence-based criteria.~~ This activity is conducted prospectively, concurrently or retrospectively. They also provide concurrent oversight of referral/prior authorization and inpatient case management functions performed at the HMOs, PHCs and SRGs, and act as liaisons to Orange County based community agencies in the delivery of health care services. All potential denial and/or modifications of provider service requests are discussed with the appropriate Medical Director, who makes the final determination.~~

All potential denial and/or modifications of provider service requests are discussed with the appropriate Medical Director, who makes the final determination.

Medical Authorization Assistants are responsible for ~~effective, efficient and courteous interaction~~interacting with practitioners, members, family and other customers~~.~~. Staff members who are not qualified health care professionals are under the ~~direction~~direct supervision of ~~the~~a licensed ~~Case Manager.~~ clinician. Non-licensed team members process service requests that do not require clinical judgement be applied.
They perform routine medical administrative tasks specific to the assigned unit and office support functions. They ~~also~~can administratively authorize ~~requested~~ services according to departmental guidelines~~. All potential denial,~~ and~~/or modifications of provider service requests are discussed with~~ under the ~~appropriate Medical Director, who makes the final determination~~oversight of UM nurse reviewers and medical directors.

~~**Program Specialist** provides high level administrative support to the Director, UM, the UM Managers, Supervisors and the UM Medical Directors.~~

Manager, Utilization Management (RN/LVN) (UM Monitoring) responsible for management of the day-to-day monitoring of UM activities, including monitoring of UM processes of Prior Authorization and Inpatient. Ensure that service standards are met, and operations are consistent with all regulatory requirements, accreditation standards and CalOptima Health policies and procedures.

Monitoring Nurses – UM (~~Medical Care Manager (~~Clinical Auditors,~~ LVN)) ~~provide~~conducts

routine oversight, monitoring ~~of referrals~~ and ~~specific~~auditing of internal UM ~~initiatives~~activities to ensure compliance with ~~UM requirements.~~state, federal and accreditation standards. ~~-~~ Monitoring activities include ~~monitoring referrals including~~ prior authorization and inpatient ~~and outpatient, WCM, findings on~~file reviews, addressing Correction Action Plans (~~CAPs) from both internal and external audits~~CAPS) findings, as well as identify opportunity for process improvement ~~when identified~~ during the monitoring process.~~—~~

Pharmacy ~~Department~~Staffing Resources

The following staff positions provide support for Pharmacy operations:

Director, Clinical Pharmacy develops, implements and administers all aspects of the CalOptima Health pharmacy management program as part of the managed care system, with closed formulary rebate programs, Drug Utilization Evaluation (DUE) and Drug Utilization Review (DUR) programs, and oversees the day-to-day functions of the contracted pharmacy benefit management vendor (PBM). The director is also responsible for administration of pharmacy services delivery, and has frequent interaction with external contacts, including local and state agencies, contracted service vendors, pharmacies and pharmacy organizations.

Manager, Clinical Pharmacist assists the Pharmacy director and pharmacy staff with the ongoing development and implementation of targeted drug utilization and disease state management strategies to control costs and improve the quality and outcomes of health care provided to members enrolled in the CalOptima Health delegated health plans and CalOptima Health Direct. Through various modalities (e.g., provider/plan profiling, member drug profile reviews, development and updating of drug utilization criteria, and case-by-case intervention), the Pharmacy manager promotes clinically appropriate prescribing practices that conform to CalOptima Health, as well as national practice guidelines and on an ongoing basis, research, develops, and updates drug UM strategies and intervention techniques. The Pharmacy manager develops and implements methods to measure the results of these programs, assists the Pharmacy director in preparing drug monographs and reports for the Pharmacy & Therapeutics (P&T) Committee, interacts frequently and independently with other department directors, managers, and staff, as needed to perform the duties of the position, and has frequent ~~interaction~~interactions with external contacts, including the pharmacy benefit managers' clinical department staff.

Clinical Pharmacists assist the Pharmacy director and pharmacy staff with the ongoing development and implementation of targeted drug utilization and disease state management strategies to control costs and improve the quality and outcomes of health care provided to members enrolled in CalOptima Health delegated health plans and CalOptima Health Direct. Through various modalities (e.g., provider/plan profiling, member drug profile reviews, development and updating of drug utilization criteria, and case-by-case intervention), they promote clinically appropriate prescribing practices that conform to CalOptima Health, as well as national, practice guideline. On an ongoing basis, research, develop, and update drug UM strategies and intervention techniques, and develop and implement methods to measure the results of these programs.~~-~~
They assist the Pharmacy director in preparing drug monographs and reports for the P&T Committee, interact frequently and independently with other department ~~directors, managers, and~~ staff as needed to perform the duties of the position, and have frequent ~~interaction~~interactions with external contacts, including the pharmacy benefit managers'

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clinical department.

Pharmacy Resident program occurs within an integrated managed care setting. The residents are trained in the role of the pharmacist in the development and implementation of clinical practice guidelines, formulary development, medication use management, pharmacy benefit design, pharmacy network management, pharmacy benefit management, and drug-use policy development. In addition, residents are trained to function as leaders in developing and implementing pharmaceutical care plans for specific patients in an integrated health plan and delivery system setting.

~~Pharmacy Benefits Manager (PBM) staff evaluates pharmacy prior authorization requests in accordance with established drug Clinical Review Criteria that are consistent with current medical practice and appropriate regulatory definitions of medical necessity and that have been approved by CalOptima's P&T. CalOptima pharmacists with a current license to practice without restriction, review all pharmacy prior authorization requests that do not meet drug Clinical Review Criteria, and perform all denials.~~

LTSS Staffing Resources

~~The following staff positions provide support for LTSS operations:~~

Director, Long-Term Support Services develops, manages and implements LTSS, including Long-Term Care (LTC) facilities authorization services for room and board, CBAS and MSSP, and staff associated with those programs. ~~The director is responsible for ensuring high-quality and responsive service for CalOptima members residing in LTC facilities (all levels of care) and to those members enrolled in other LTSS programs. The director also develops and evaluates programs and policy initiatives affecting seniors and (SNF/Subacute/ICF) and other LTSS services.~~

Manager, Long-Term Support Services (CBAS/LTC) ~~is expected to develop~~develops and ~~manage~~manages the LTSS department's work activities and ~~personnel~~team. The manager ensures that service standards are met, and operations are consistent with ~~CalOptima's~~CalOptima Health's policies and regulatory and accrediting agency requirements to ensure high quality and responsive services for ~~CalOptima's~~CalOptima Health's members who are eligible for and/or receiving LTSS. ~~This position must have strong team leadership, problem solving, organizational and time management skills with the ability to work effectively with management, staff, providers, vendors, HNs, and other internal and external customers in a professional and competent manner. The manager works in conjunction with various department managers and staff to coordinate, develop, and evaluate programs and policy initiatives affecting members receiving LTSS services.~~

Supervisor, Long-Term Support Services (CBAS/LTC) is responsible for planning, organizing, developing and implementing the principles, programs, policies and procedures employed in the delivery of LTSS to members in the community and institutionalized setting. ~~This position is responsible for the management of the day-to-day operational activities for LTSS programs: LTC, CBAS, and personnel, while interacting with internal/external management staff, providers, vendors, health networks, and other internal and external customers in a professional, positive and competent manner. The position's primary responsibilities are the supervision and monitoring of the ongoing and daily activities of the department's staff. In addition, the supervisor resolves member and provider issues and barriers, ensuring excellent customer service. Additional responsibilities include managing staff coverage in all areas of LTSS to complete assignments, and~~

~~orientation and training of new employees to ensure contractual and regulatory requirements are met.~~

Medical Case Managers, Long-Term Support Services (MCM LTSS), are part of an advanced specialty collaborative practice responsible for case management, care coordination and function, providing coordination of care, and ongoing case management services for qualified CalOptima Health members in LTC facilities and members receiving CBAS. ~~They review and determine medical eligibility based on approved criteria/guidelines, Medicare and Medi-Cal guidelines, and facilitate communication and coordination amongst all participants of the health care team and the member, to ensure services are provided to promote quality and cost-effective outcomes.~~ They provide case management in a collaborative process that includes assessment, planning, implementation, coordination, monitoring and evaluation of the member's needs. ~~These positions are the subject matter experts and act~~The MCM LTSS acts as liaisons to Orange County community agencies, CBAS centers, skilled nursing facilities, members and providers.

~~**Program Manager, LTSS** is responsible for assisting the LTSS management with the day-to-day operations of the LTSS department, specifically with regard to operational and regulatory reports. The manager 1) leads collaborative efforts as an LTSS liaison, educator and coach with the CBAS centers, LTC Nursing Facilities, MSSP and the IHSS program to meet regulatory compliance procedures; 2) works with the LTSS Manager to lead the implementation and ongoing maintenance of the LTSS program policies and desktop procedures to ensure reporting requirements are met; 3) gathers and validates LTSS data to submit for DHCS reporting requirements and CalOptima QI Program; 4) works with other LTSS staff to coordinate the LTSS Stakeholder Advisory and Subcommittee meetings and workgroups; 5) supports long-term departmental sustainability efforts; and 6) completes other activities related to the development and implementation of the LTSS program.~~

Program Manager, Sr., LTSS is responsible for assisting the LTSS management with the day-to-day operations of the LTSS department.

Behavioral Health Integration Staffing Resources

~~The following staff positions provide UM support for~~

Manager, **Behavioral Health** ~~Integration (BHI) operations:~~

~~**Manager, Behavioral**~~ **CalOptima Health** ~~**(Care Management)** is responsible for overseeing the development, implementation, and daily operations of the Care Management teams including Transitional Care Management and BHT services. The position ensures the delivery of quality and consistent concurrent review, recommendations, and referrals in accordance with~~ manages the day-to-day operational activities of the BH UM team to ensure staff compliance with CalOptima ~~policies and procedures as well as collaborates with other internal CalOptima departments to ensure all regulatory requirements are met.~~

~~**Program Manager, Sr. (BH)** is responsible for regulatory requirements governing authorization processing, monitoring utilization patterns, and developing BH UM goals and activities. The position works under the direction of the Director, Behavioral~~ Health ~~Services, Medical Director of Behavioral Health and/or other department leadership to support the department's UM activities~~policies and procedures, and regulatory and accreditation agency requirements.

~~**Supervisor, Behavioral Health, (BHT)** is responsible for the daily operation of the BHT services program. The position oversees Applied Behavior Analysis (ABA) Member Liaison Specialists ensuring members receive appropriate provider linkage. The supervisor will also oversee and assist Care Managers with reviewing assessments and treatment plans submitted by providers for adherence to BHT "best~~

~~practice" guidelines. The supervisor is accountable for establishing and achieving quality and productivity standards for the teams and for ensuring compliance with department policies and procedures.~~

~~**Medical Case Managers (BH-RN)** are responsible for reviewing and processing authorization requests for inpatient and outpatient behavioral health services. Medical Case Managers adhere to CalOptima's prior authorization approval process, which includes reviewing authorization requests for medical necessity and consulting with managers and CalOptima medical directors as needed. The position is responsible for learning and utilizing CalOptima's medical criteria, UM criteria, and related policies/procedures for authorization and referral requests from BH and ABA providers.~~

~~**Medical Case Manager (BH)** is responsible for reviewing and processing requests for authorization and notification of psychological testing and psychiatric inpatient services from health professionals, clinical facilities and ancillary providers. The position is responsible for prior authorization and referral related processes related to transitional care. The manager uses medical criteria, and policies and procedures to authorize referral requests from BH professionals, clinical facilities and ancillary providers.~~

~~**Care Manager** is responsible for the oversight and review of BHT services offered to members that meet medical necessity criteria. The manager is responsible for reviewing and processing requests for authorization of ABA services from BH providers. This position is also responsible for UM and monitoring activities of autism services provided in community-based setting. The manager directly interacts with provider callers, acting as a resource for their needs.~~

~~**Member Liaison Specialist (Autism)** is responsible for providing care management support to members that meet medical necessity criteria seeking BHT services, including ABA. This position assists members in linking BHT services, following up with members before and after appointment, providing members information and referral to community resources, conducting utilization review, and navigating the BH system of care. This position will act as a consultative liaison to assist members, HNs and community agencies to coordinate BHT services.~~

Supervisor, Behavioral Health, (BH) provides day-to-day supervision of assigned staff, monitors and oversees assigned daily work activities to ensure that service standards are met.

Medical Case Managers (BH-RN/LVN or Licensed BH Clinician) provide inpatient and outpatient utilization review and authorization of services in support of members. They are responsible for assessing the medical appropriateness, quality and cost effectiveness of proposed inpatient psychiatric hospital and outpatient BH services, in accordance with established evidence-based criteria. All potential denial and/or modifications of provider service requests are discussed with the appropriate Medical Director, who makes the final determination.

Care Manager (BH) provide utilization review and authorization of services in support of members. They are responsible for assessing the medical appropriateness, quality and cost effectiveness of proposed BH services, in accordance with established evidence-based criteria. All potential denial and/or modifications of provider service requests are discussed with the appropriate Medical Director, who makes the final determination.

Medical Authorization Assistants (MAA BH) are responsible for interacting with practitioners or other customers, under the direction of the licensed Medical Case Manager and or Care Manager. They perform routine medical administrative tasks specific to the assigned unit and office support

functions.

Qualifications and Training

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

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

- CalOptima Health New Employee Orientation
- HIPAA and Privacy/Corporate Compliance
- Use of technical equipment (phones, computers, printers, facsimile machines, etc.)
- UM Program, policies/procedures, etc.
- ~~MIS~~Medical Management information system data entry
- ~~Application of Review Criteria/Guidelines~~
- ~~Appeals Process~~
- ~~Seniors and Persons with Disabilities Awareness Training~~
- ~~OC and OCC Training~~

- Application of Review Criteria/Guidelines
- Appeals process
- Seniors and Persons with Disabilities (SPD) awareness training
- OneCare (OC) training

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

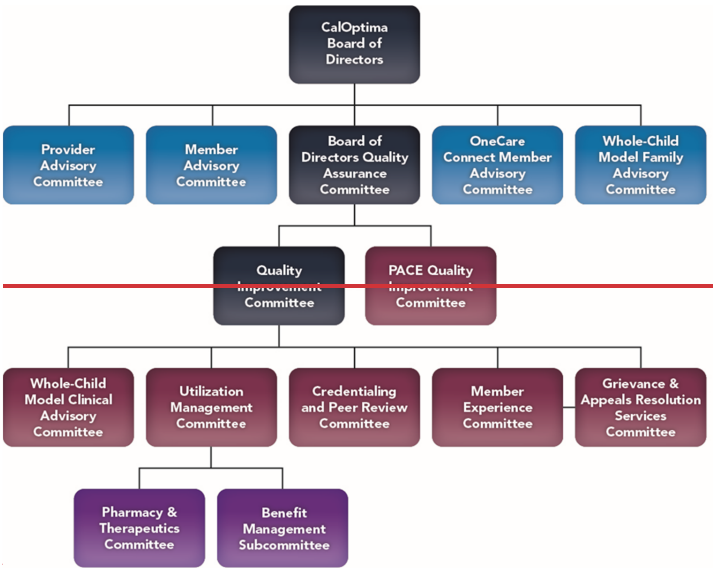
~~Appropriately licensed, qualified health care professionals provide day-to-day supervision of assigned UM staff, as well as oversight of the UM process and all medical necessity decisions. The supervisor also participates in UM staff training to ensure understanding of UM concepts and practices and monitor for consistent application of criteria, for each level and type of UM decision. The supervisors perform monthly quality audits for each teammate who reports to them to monitor and ensure adequacy of documentation and consistent application of criteria. UM supervisors are available to UM staff either on-site or telephone during normal business hours. A physician or other appropriately licensed health care professional (as indicated by case type) reviews all medical necessity denials of health care services offered under CalOptima's medical and BH benefits. Personnel employed by or under contract to perform utilization review are appropriately qualified, trained and hold current unrestricted professional licensure from the State of California. Compensation or incentives to staff or agents based on the amount or volume of adverse determinations; reductions or limitations on lengths of stay, benefits, services; or frequency of telephone calls or other contacts with health care practitioners or patients, is prohibited. All medical~~

~~management staff are required to sign an Affirmative Statement regarding this prohibition annually.~~

CalOptima Health and its delegated ~~Utilization Review agents~~HN UM staff do not permit or provide compensation or anything of value to its employees, agents or contractors based on the percentage or the amount by which a claim is reduced for payment, or the number of claims or the cost of services for which the person has denied authorization or payment; or any other method that encourages the rendering of an adverse determination.

~~2022~~2023 UM Committee ~~Organization~~(UMC) Committee Structure

— Diagram



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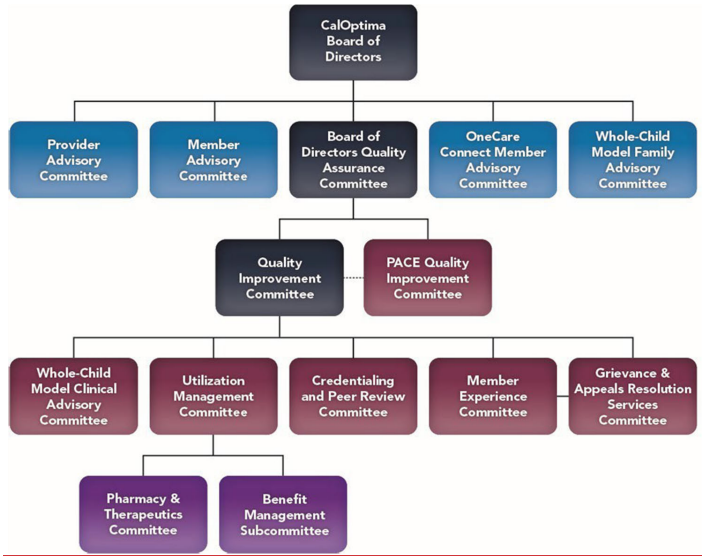

UMC-

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

The UMC monitors the utilization of health care services by CalOptima Health Direct and through the delegated HMOs, PHCs and SRGs, to identify areas of under or over utilization that may adversely impact member care and is responsible for the annual review and approval of medical necessity criteria and protocols, the UM policies and procedures. The UMC monitors and analyzes relevant data to detect and correct patterns of under or over utilization, ensure coordination of care, ensure appropriate use of services and resources, and improve member and practitioner satisfaction with the UM process.

The UMC meets at least quarterly and coordinates an annual review and revision of the UM Program Description, as well as reviews and approves the Annual UM Program Evaluation.

Before going to the Board of Directors for approval, the documents are reviewed and approved by the QIC and QAC. With the assistance of the UM Program specialist, the director of UM maintains detailed records of all UMC meeting minutes and recommendations for UM improvement activities made by the UMC. The UMC routinely submits meeting minutes as well as written reports regarding analyses of the above tracking and monitoring processes and the status of corrective action plans to the QIC. Oversight and operating authority of UM activities is delegated to the UMC, which reports up to QIC and ultimately to QAC and the Board of Directors.

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Conflict of Interest

CalOptima Health maintains a Conflict-of-Interest policy addressing the process to identify and evaluate potential social, economic and professional conflicts of interest and take appropriate actions. CalOptima Health requires that all individuals who serve on the UMC or who otherwise make decisions on UM, quality oversight and activities, disclose any actual, perceived, or potential conflicts of interest that arise in the course and scope of serving in such capacity.

All employees who make or participate in the making of decisions that may foreseeably have a material effect on economic interests file a Statement of Economic Interests form on an annual basis.

Confidentiality

CalOptima Health has policies and procedures to protect and promote proper handling of confidential and privileged medical record information that are overseen by the department of compliance and assigned privacy officer. During the onboarding process, all CalOptima Health employees — including contracted professionals who have access to confidential or member information — sign a written statement for maintaining confidentiality. In addition, all non-employee Committee members are required to sign a Confidentiality Agreement on an annual basis. Invited guests must sign a Confidentiality Agreement at the time of Committee attendance.

UMC Scope and Responsibilities

Provides oversight and overall direction for the continuous improvement of the UM Program, consistent with ~~**UMC Scope and** Responsibilities~~

- ~~Provides oversight and overall direction for the continuous improvement of the UM Program, consistent with CalOptima's~~CalOptima Health's strategic goals and priorities. This includes oversight and direction relative to UM functions and activities performed by both CalOptima Health and its delegated HNs.
- Oversees the UM activities and compliance with federal and state statutes and regulations, as well as contractual and NCQA requirements that govern the UM process.
- Reviews and approves the UM Program Description, Medical Necessity Criteria, UMC Charter and UM Program Evaluation on an annual basis.
- Reviews and analyzes UM Operational and Outcome data; reviews trends and/or utilization patterns presented at committee meetings and makes recommendations for further action.
- Reviews and approves annual UM Metric targets and goals.
- Reviews progress toward UM Program Goals on a quarterly basis, providing input for improving the effectiveness of initiatives and projects.
- Promotes a high level of satisfaction with the UM Program across members, practitioners, stakeholders, and client organizations by examining results of annual member and practitioner satisfaction surveys to determine overall satisfaction with the UM Program, identify areas for performance improvement, and evaluate performance improvement initiatives.
- Reviews, assesses and recommends utilization management best practices used for selected diagnoses or disease classes.

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- Conducts review of under/over utilization monitoring and makes recommendations in accordance with UM Policy and Procedure GG.1532: Over and Under Utilization Monitoring; makes recommendations for improving performance on identified over/under utilization.
- Reviews and provides recommendations for improvement, as needed, to reports submitted by the following:

~~**Direct Subcommittee Reports:**~~

- ~~○~~ Benefit Management Subcommittee (BMSC)
- ~~○~~ P&T Committee

~~Departments Reporting Relevant Information on UM Issues:~~

- ~~Delegation Oversight~~
- ~~Behavioral Health~~
  - ~~Grievance and Appeals~~.
- ~~UM Workgroup~~
- ~~LTSS~~

- Reports to the QIC on a quarterly basis, communicates significant findings and makes recommendations related to UM issues.

Departments Reporting Relevant Information on UM Issues:

- Delegation Oversight
- Behavioral Health
- Grievance and Appeals
- UM Workgroup
- LTSS

UMC Membership

Voting Members:

- CMO
- Medical Director who oversees UM Program
- Medical Director who oversees Behavioral Health Program
- Medical Director who oversees Specialty Programs
- Medical Director who oversees Whole-Child Model Program
- Executive Director, Clinical Operations
- Up to six participating practitioners from the community*

*- Participating practitioners from the community are selected to be representative of the health care delivery system, and include primary care, high volume specialists and administrative practitioners. At least six outside practitioners are assigned to the committee to ensure that at least three are present each meeting as part of the quorum requirements.

The UMC is supported by:

- Executive Director, Behavioral Health Integration
- Director, UM
- Director, Quality Improvement
- Director, Pharmacy
- Manager, Prior Authorization
- Manager, Concurrent Review

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Benefit Management Subcommittee (BMSC)
The BMSC is a subcommittee of the UMC. The BMSC was chartered by the UMC and directed to establish a process for maintaining a consistent set of benefits and benefit interpretations for all lines of business, and revise and update ~~CalOptima's~~CalOptima Health's authorization rules based on benefit updates. Benefit sources include, but are not limited to, Medi-Cal Managed Care Division (MMCD), local and national coverage determinations, All Plan Letters (APLs) and the Medi-Cal Manual.

BMSC Scope
The BMSC is responsible for the following:

- Maintaining a consistent benefit set for all lines of business.
- Revising and updating ~~CalOptima's~~CalOptima Health's authorization rules.
- Making recommendations regarding the need for prior authorization for specific services.
- Clarifying financial responsibility of the benefit, when needed.
- Recommending benefit decisions to the UMC.
- Communicating benefit changes to staff responsible for implementation.

BMSC Membership

- Medical Director who oversees UM services— Chairperson
- Executive Director, Clinical Operations
- Director, UM
- Director, Behavioral Health Integration
- Director, Claims Management
- Director, Claims
- Director, Coding Initiatives

The BMSC meets quarterly, at minimum, and recommendations from the BMSC are reported to the UMC on a quarterly basis.

Integration with the QI Program

The UM Program is evaluated and submitted for review and approval annually by UMC, QIC and QAC, with final review and approval by the Board of Directors.

- The UM Program is evaluated, revised and prepared for approval by the UM and Behavioral Health (BHI) Director in conjunction with the Executive Director of Clinical Services, Executive Director of Behavioral Health Integration, Chief Medical Officer, Deputy Chief Medical Director prior to submission for committee review and approval.
- Utilization data including, but not limited to, denials, unused authorizations, provider preventable conditions, and trends representing potential over or underutilization is collected, aggregated and analyzed.
- UM staff may identify potential quality issues and/or provider preventable conditions during utilization review activities. These issues are referred to the QI staff for evaluation.
- The UMC is a subcommittee of the QIC and routinely reports activities to the QIC.
- The QIC reports to the Board QAC.

Integration with Other Processes

The UM Program, Case Management Program, BH Program, LTSS Programs, P&T, QI,

Credentialing, Compliance and Audit & Oversight are closely linked in function and process. The UM process uses quality indicators as a part of the review process and provides the results to the QI department. As case managers perform the functions of UM, quality indicators, prescribed by CalOptima Health as part of the patient safety plan, are identified. The required information is documented on the appropriate form and forwarded to the QI department for review and resolution. As a result, the utilization of services is inter- related with the quality and outcome of the services.

Any adverse information that is gathered through interaction between the UM staff and the practitioner or facility staff is also vital to the re-credentialing process. Such information may relate, for example, to specific case management decisions, discharge planning, prior authorization of non-covered benefits, etc. The information is forwarded to the QI department in the format prescribed by CalOptima Health for review and resolution as needed. The CMO or Medical Director determines if the information warrants additional review by ~~CalOptima's~~CalOptima Health's Credentialing and Peer Review Committee (CPRC). If committee review is not warranted, the information is filed in the practitioner's folder and is reviewed at the time of the practitioner's re-credentialing.

UM policies and processes also serve as integral components in preventing, detecting and responding to Fraud and Abuse among practitioners and members. The UM department works closely with the Compliance Officer and the Fraud and Abuse Unit to resolve any potential issues that may be identified. In addition, CalOptima Health coordinates utilization/care management activities with local community practitioners for activities that include, but are not limited to:

- Early childhood intervention
- State protective and regulatory services
- Women, Infant and Children Services (WIC)
- Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Health Check
- Services provided by local public health departments

REVIEW AND AUTHORIZATION OF SERVICES

~~Conflict of Interest~~

~~CalOptima maintains a Conflict of Interest policy that addresses the process to identify and evaluate potential social, economic and professional conflicts of interest and take appropriate actions so that they do not compromise or bias professional judgment and objectivity in quality, credentialing and peer review matters. CalOptima requires that all individuals who serve on UMC or who otherwise make decisions on UM, quality oversight and activities, timely and fully disclose any actual, perceived, or potential conflicts of interest that arise in the course and scope of serving in such capacity. Potential conflicts of interest may occur when an individual who is able to control or influence a business or clinical decision has a personal, financial, or otherwise competing interest in the outcome of the decision.~~

~~This policy precludes using proprietary or confidential CalOptima information for personal gain or the gain of others, as well as direct or indirect financial interests in, or relationships with, current or potential providers, suppliers, or members, except when it is determined that the financial interest does not create a conflict. All employees who make or participate~~

in the making of decisions that may foreseeably have a material effect on economic interests file a Statement of Economic Interests form on an annual basis.

Confidentiality

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

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

~~UM Process~~

~~The UM process encompasses the following program components: referral/prior authorization, concurrent review, post-stabilization inpatient services, ambulatory review, retrospective review, discharge planning and care coordination and second opinions. All approved services must meet medical necessity criteria. The clinical decision process begins when a request for authorization of service is received. Request types may include authorization of specialty services, second opinions, outpatient services, ancillary services, post-stabilization inpatient services, or scheduled inpatient services. The process is complete when the requesting practitioner and member (when applicable) have been notified of the determination.~~

~~UM policies and processes serve as integral components in preventing, detecting, and responding to fraud and abuse among practitioners and members. The UM department works closely with the Compliance Officer and the Fraud, Waste and Abuse Unit to resolve any potential issues that may be identified.~~

~~Benefits~~

~~CalOptima administers health care benefits for members, as defined by contracts with the DHCS and CMS. A variety of program documents, regulations, policy letters and all CMS benefit guidelines are maintained by CalOptima to support UM decisions. Benefit coverage for a requested service is verified by the UM staff during the authorization process. CalOptima has standardized authorization processes in place and requires that all delegated entities to have similar program processes. Routine auditing of delegated entities is performed by the Audit & Oversight department via its delegation oversight team for compliance.~~

~~Review and Authorization of Services~~

Medical Necessity Review

Medical necessity review requires consideration of the members' ~~circumstances appropriate~~ clinical ~~criteria and CalOptima polices, applying current evidence-based guidelines, and consideration of~~needs, evaluating available services within the local delivery system ~~on a case-by-case basis. These decisions are consistent with current evidence-based clinical practice guidelines~~and applying evidenced based guidelines and CalOptima Health policies to provide quality care in the most appropriate setting.

Covered services are those medically necessary health care services provided to members as outlined in ~~CalOptima's~~CalOptima Health's contract with CMS and the State of California for Medi-Cal~~, OC~~ and ~~OCC~~OC. Medically necessarily means all covered services or supplies that:

- ~~For Medi-Cal, covered services that~~ are reasonable and necessary to protect life, prevent illness or disability, alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. ~~For Medi-Cal members receiving MLTSS, medical necessity is determined in accordance with member's current needs assessment and consistent with person-centered planning. When determining the medical necessity for Medi-Cal members under the age of 21, medical necessity is expanded to include the standards set forth in 42 U.S.C. Section 1396d® and California Welfare and Institutions Code sections 14132(v).~~
- ~~For children under 21, Medi-Cal covers all medically necessary services, including those to "correct or ameliorate" defects and physical and mental illness conditions may be approved under Early and Periodic Screening, Diagnosis and Treatment (EPSDT).~~
- Medical necessity for members receiving MLTSS is determined by using a

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member's current needs assessment and is consistent with person-centered planning.

- For Medicare, covered services that are reasonable and necessary for diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C section 1395y.

The CalOptima Health UM process uses active, ongoing coordination and evaluation of requested or provided health care services, performed by licensed health care professionals, to ensure quality medically necessary~~, appropriate health care or health~~ services are ~~rendered~~provided in the most ~~cost-efficient manner, without compromising quality~~appropriate setting. Physicians, or pharmacists or psychologists in appropriate situations, review and determine all final denial or modification decisions for requested medical and BH care services. The review of the denial of a pharmacy prior authorization, may be completed by a qualified physician or pharmacist.

~~CalOptima's~~CalOptima Health's UM department is responsible for the review and authorization of health care services for CalOptima Health Direct Administrative (COD-A) and CCN members utilizing the following medical determination review processes:

- Referral/Prior Authorization for selected conditions/services
- Admission Review
- Post-stabilization review
- Concurrent/Continued Stay Review for selected conditions
- Discharge Planning Review
- Retrospective Review
- Evaluation for potential transplant services for HN members

The following standards and considerations are applied ~~to all~~when reviewing prior ~~authorization,~~authorizations, inpatient and outpatient concurrent review, and retrospective review ~~determinations~~requests:

- Qualified health care professionals supervise review decisions, including care or service reductions, modifications or termination of services.
- ~~There is a set of written~~Evidenced based clinical criteria or guidelines ~~for Utilization Review that is based on sound medical evidence, is~~are applied consistently ~~applied~~, regularly reviewed and updated.
- Member circumstances and characteristics are considered when applying criteria to address the individual needs of the member. These characteristics include, but are not limited to:
    - Age
    - Co-morbidities
    - Complications
    - Progress of treatment
    - Psychological/Psychosocial situation
    - Home environment, when applicable
- Availability of facilities and services in the local area to address the needs of the members are considered when making determinations consistent with the current benefit set. If member circumstances or the local delivery system prevent the application of approved criteria or guidelines in making an organizational determination, the request is forwarded to the UM

Medical Director to determine an appropriate course of action ~~per CalOptima Policy and Procedure CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers and CalOptima Policy GG.1508: Authorization and Processing of Referrals~~.

- ~~Reasons~~Clinical rationale and reasons for decisions are clearly documented in the medical management system, including the criteria used to make the determination.
- The Medical Director may be contacted by calling their direct dial number listed at the bottom of the provider denial notification or through contacting the UM department during the review process. A CalOptima Health Case Manager may also coordinate communication between the CalOptima Health Medical Director and requesting practitioner. All peer-to-peer discussions are documented within clinical documentation platform.
- Notification to members regarding denied, deferred, or modified referrals is made in accordance with mandated regulatory and accreditation agency timeframes, and members and providers are notified of appeals and grievance procedures.
- Decisions related to appeals or grievances are made in a timely manner in accordance with ~~timelines established by CalOptima's GARS process, and as the member's condition requires, for medical conditions requiring time sensitive services in accordance with CalOptima Policy and Procedure HH.1102: CalOptima Member Complaint. The appeal process is in accordance with CalOptima Policy GG.1510: Appeal Process.~~

  timelines established by CalOptima Health's Grievance and Appeals Resolution Services (GARS) process, and as the member's condition requires.
- Medical conditions requiring time sensitive services are reviewed in accordance with the appropriate CalOptima Health Policy and Procedure.
- Prior Authorization requirements are not applied to Emergency Services, Minor Consent/Sensitive Services, Family Planning, Preventive Services, basic Prenatal Care, Sexually Transmitted Disease services, and HIV testing.
- Records, including documentation of an oral notification or written Notice of Action, are retained for a minimum of 10 years from the end of the fiscal year in which the date of service occurred, unless a longer period is required by law.
- The requesting provider is notified, orally or in writing, of any decision to deny, approve, modify, or delay a service authorization request.
- All Medi-Cal members are notified in writing of any decision to deny, modify, or delay a service ~~authorization request; for OC/OCC all member notifications as listed above and notice of approval~~.
- OneCare members are notified in writing of any and all determinations.
- All providers are encouraged to request information regarding the criteria used in making a clinical determination. Contact can be made directly with the Medical Director involved in the decision, utilizing the contact information included in the Notice of Action. A provider may request a discussion with the Medical Director (Peer-to-Peer), or a copy of the specific criteria utilized.

~~The information that may be~~Supporting documents used to make medical necessity determinations includes, but is not limited to:

- Office and hospital records
- A history of the presenting problem
- A clinical examination
- Diagnostic test results
- Treatment plans and progress notes

- Patient's psychological history
- Information on consultations with the treating provider
- Evaluations from other health care providers
- Photographs
- Operative and pathological experts
- Rehabilitation evaluations
- A printed copy of criteria related to the request
- Information regarding benefits for services or procedures
- Information regarding the local delivery system
- Patient characteristics, circumstances and information
- Information from responsible family members

UMC/ BMSC reviews the Prior Authorization List regularly, in conjunction with ~~CalOptima's~~CalOptima Health's CMO, Medical Directors and Executive Director, Clinical Operations, to determine if any services should be added or removed from the list. The Provider Services, Member Services and Network Management areas are also consulted on proposed revisions to the Prior Authorization List. Such decisions are based on CalOptima Health program requirements, or to meet federal or state statutory or regulatory requirements. Practitioners are appropriately notified when such modifications occur.

Prior Authorization

Prior Authorization requires the provider or practitioner to submit a formal medical necessity determination request and all relevant clinical information related to the request to CalOptima Health prior to the service being rendered. Upon receipt, the prior authorization request is screened for eligibility and benefit coverage and assessed for medical necessity and appropriateness of the health care services proposed, including the setting in which the proposed care will take place.

Prior Authorization is required for selected services, such as non-emergency inpatient admissions, elective out- of-network services, and certain outpatient services, ancillary services and specialty injectables as described on the Prior Authorization Required List located in the provider section on the CalOptima Health website at www.caloptima.org. Clinical information submitted by the provider justifies the rationale for the requested service through the authorization process, which assesses medical necessity and appropriateness utilizing evidence-based guidelines upon which a determination is made.

~~CalOptima's~~CalOptima Health's medical management system is a member-centric system utilizing evidence-based clinical guidelines and allows each member's care needs to be directed from a single integrated care plan that is shared with internal and external care team members to enable collaboration, minimize barriers, and support continuity and coordination of care. The system captures data on medical, behavioral, social, and personal care needs of members supporting the identification of cultural diversity and complex care needs.

The CalOptima Health Provider Portal allows for non-urgent and urgent online authorizations to be submitted by providers and processed electronically. ~~Some referrals are auto adjudicated through~~The provider portal functionality includes referral intelligence rules ~~(RIR).~~, approved by clinical leadership to auto adjudicate when criteria is met. The referral intelligence rules and auto-adjudication trends are reviewed quarterly at a minimum to identify potential misuse or utilization

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issues that require follow up.
Practitioners may also submit referrals and requests to the UM department by mail, fax and/or telephone based on the urgency of the request.

Referrals
A referral is considered a request to CalOptima for authorization of services as listed on the Prior Authorization List. PCPs are required to direct the member's care and must obtain a prior authorization for referrals to certain specialty physicians, as noted on the Prior Authorization Required List, and all non-emergency out-of-network practitioners.

Second Opinions
A second opinion may be requested when there is a question concerning the diagnosis, options for surgery or other treatment of a health condition, or when requested by any member of the member's health care team, including the member, member representative, parent and/or guardian. A social worker exercising a custodial responsibility may also request a second opinion. Authorization for a second opinion is granted to a network practitioner or an out-of-network practitioner if there is no in-network practitioner available.

Extended Specialist Services
Established processes are in place by which a member requiring ongoing care from a specialist may request a standing authorization. Additionally, the "CalOptima policy and procedure, GG.1112: Standing Referral to Specialist Practitioner or Specialty Care Center, includesHealth provides guidance on how members with life- threatening conditions or diseases that require specialized medical care over a prolonged period can request and obtain access to specialists and specialty care centers.

Out-of-Network Providers
If a member or provider requires or requests an out-of-network provider for services that are not available from a qualified network provider, theThe decision to authorize use of an out-of-network provider is based on a number of factors including, but not limited to, continuity of care, availability and location of an in-network-
provider of the same specialty and expertise, lack of network expertise

Appropriate Professionals for UM Decision Process
The UM decision process requires that qualified, licensed health professionals assess the clinical information used to support UM decisions. If the clinical information included with a request for services does not meet the appropriate clinical criteria, the UM Nurse Case Managers (NCM) and Medical Authorization Assistants are instructed to forward the request to the appropriate qualified, licensed health practitioner for a determination. Only practitioners or pharmacists can make decisions/determinations for denial or modification of care based on medical necessity, and must have education, training, and professional experience in medical or clinical practice, and have ana current unrestricted license to practice in the specific discipline for which an adverse determination is being rendered.

CalOptima Health distributes an affirmative statement about incentives to members in the Member Handbook, annually to all members in the Annual Notices Newsletter, and at least annually to all practitioners and employees who make UM decisions, affirming that UM decision making is based only on appropriateness of care and services and existence of

coverage and that CalOptima Health does not specifically reward practitioners or other individuals for issuing denials of coverage. CalOptima Health ensures that UM decision makers are not unduly influenced by fiscal and administrative management by requiring that UM decisions be based on evidence-based clinical criteria, the member's unique medical needs, and benefit coverage.

~~PHARMACEUTICAL MANAGEMENT~~

PHARMACEUTICAL MANAGEMENT

Pharmacy Management is overseen by the CMO, and ~~CalOptima's~~CalOptima Health's Director, Clinical Pharmacy Management. All policies and procedures utilized by CalOptima Health related to pharmaceutical management include the criteria used to adopt the procedure, as well as a process that uses clinical evidence from appropriate external organizations. The program is reviewed at least annually by P&T and updated as new pharmaceutical information becomes available.

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

The P&T Committee is responsible for development of the Medi-Cal physician-administered drug prior authorization list and the OneCare~~Connect (OC/OCC)~~ Formulary, which is based on sound clinical evidence, and is reviewed at least annually by practicing practitioners and pharmacists. Updates to the Formulary are communicated to both members and providers.

Pharmacy Determinations

Medi-Cal
Effective January 1, 2022, the outpatient pharmacy benefit moved to the Medi-Cal fee-for-service program, Medi-Cal Rx.

Medi-Cal/Medicare
CalOptima Health does not delegate OneCare Pharmacy UM responsibilities. Pharmacy coverage determinations follow required CMS timeliness guidelines and medical necessity review criteria.

Pharmacy Benefit Manager (PBM)
The PBM is responsible for pharmaceutical administrative and clinical operations, including pharmacy network contracting and credentialing, pharmacy claims processing system and data operations, pharmacy help desk, ~~prior authorization,~~ clinical services and quality improvement functions. The PBM follows and maintains compliance with health plan policies and all pertinent state and federal statutes and regulations. As a delegated entity, the PBM is monitored according to the Audit & Oversight department's policies and procedures.

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~~Behavioral Health Determinations~~

Behavioral Health Determinations

Medi-Cal
~~CalOptima's BH~~CalOptima Health's BHI department performs prior authorization review for ~~BHT~~BH services and psychological testing. Prior authorization requests are reviewed by BH UM staff that consist of Medical Case Managers and Care Managers (BCBA).

Determinations are based on criteria from MCG Guidelines, DHCS All Plan Letters (APL) and CalOptima Health policy (approved by DHCS).

Medi-Cal/Medicare
CalOptima ~~has previously delegated Magellan Health Inc. to directly manage the BH UM functions for OneCare/OneCare Connect. Effective January 1, 2020, CalOptima's~~Health's BHI department ~~performed~~performs prior authorization review functions for OC~~/OCC~~ covered BH services. Services require prior authorization include inpatient psychiatric care, partial hospitalization program, intensive outpatient program ~~and~~, psychological testing~~.~~, electro convulsive therapy (ECT), and transcranial magnetic stimulation (TMS). Prior authorization requests are reviewed by BH Medical Case Managers. ~~Determinations are based on criteria from MCG Guidelines, Dual Plan Letters (DPL) and CalOptima policies.~~

Determinations are based on criteria from MCG Guidelines, Dual Plan Letters (DPL) and CalOptima Health policies.

- The BH UM staff may approve or defer for additional information, but final determinations of modification, denial, or appeal may ~~only~~ be made by a ~~Licensed CalOptima Psychologist or~~ Medical Director~~. CalOptima's~~ or a qualified health care profession with appropriate clinical expertise in treating the behavioral health condition. CalOptima Health's written notification of BH modifications and denials to members and their treating practitioners contains:
- A description of appeal rights, including the member's right to submit written comments, documents or other information relevant to the appeal.
- An explanation of the appeal process, including the appeal timeframes and the member's right to representation.
- A description of the expedited appeal process for urgent pre-service or urgent concurrent denials.
- Notification that expedited external review can occur concurrently with the internal appeal process for urgent care.

CalOptima Health gives practitioners the opportunity to discuss BH UM denial decisions.

UM ~~Criteria~~Criteria

CalOptima Health conducts Utilization Review using UM hierarchical criteria for medical, BH, and pharmacy medical necessity decisions that are objective, nationally recognized, evidence-based standards of care and include input from recognized experts in the development, adoption and review of the criteria. UM criteria and the policies for application

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are reviewed and approved at least annually and updated as appropriate. Such criteria and guidelines include, but are not limited to: [RJ12]

Medi-Cal

1. Federal and State Law Mandates (i.e., Department of Health Care Services — Provider Manuals/Medi-Cal Benefits Guidelines, EPSDT)
   a. ~~http://files.medi-cal.ca.gov/pubsdoco/manuals_menu.asp~~

2. ~~National Evidence-Based Guidelines~~ (e.g., MCG, National Comprehensive Cancer Network, etc.)~~-~~
   a. ~~https://www.nccn.org/professionals/physician_gls/default.aspx~~

3. Society Guidelines (e.g., American Medical Association, American Congress of Obstetricians and Gynecologists, etc.)

4. Other: US Preventative Services Task Force, Guideline Central
   a. ~~https://www.uspreventiveservicestaskforce.org/~~
   b. ~~https://www.guidelinecentral.com/library/~~

5. CalOptima Health Policy and Procedures and/or Clinical Benefits and Guidelines

~~5.~~

Whole-Child Model/CCS (Medi-Cal)

1. CCS Numbered Letters (N.L.s) and CCS Program Information Notices for decisions related to CCS and Whole-Child Model
   a. ~~https://www.dhcs.ca.gov/services/ccs/Pages/CCSNL.aspx~~

2. Follow Medi-Cal hierarchy listed above.

Medicare (OneCare and OneCare Connect)

1. Federal and State Law Mandates — CMS, DMHC
   a. CMS Guidelines National and Local Coverage Determinations (LCD first, followed by NCD)
      i. ~~https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx~~

2. CMS Provider Manuals
   a. Internet-Only Manuals (IOMs) | CMS

~~2.~~3. Department of Health Care Services
   a. ~~Medi-Cal Provider Manual~~
   b. ~~http://files.medi-cal.ca.gov/pubsdoco/manuals_menu.asp~~

~~3.~~4. National Evidence-Based Guidelines (e.g., MCG, National Comprehensive Cancer Network, etc.)
   a. ~~https://www.nccn.org/professionals/physician_gls/default.aspx~~

~~4.~~5. Society Guidelines (e.g., American Medical Association, American Congress of Obstetricians

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and Gynecologists, Guideline Central, etc.)

~~a. https://www.guidelinecentral.com/library/~~

~~5.~~6. CalOptima Health Policy and Procedures and/or Clinical Benefits and Guidelines

~~Delegated HNs must utilize Medi-Cal & Medicare Guidelines, Title 22, and national evidenced based guidelines.~~

Due to the dynamic state of medical/health care practices, each medical decision must be case-specific, and based on current medical knowledge and practice, regardless of available practice guidelines, as well as based on the member's individual needs. Listed criteria in fields other than primary care, such as OB/GYN, surgery, etc., are primarily appended for guidance concerning medical care of the condition or the need for a referral.

~~While clinical~~Clinical practice guidelines (such as those distributed by American Diabetes Association, American Academy of Pediatrics, and the American College of Obstetrics and Gynecology) are ~~not~~ used ~~as~~in conjunction with national guideline criteria in review for medical necessity~~ determinations, the Medical Director and UM staff make UM decisions that are consistent with~~. Additional guidelines ~~distributed to network practitioners. Such guidelines~~may include, but are not limited to, Adult and Child Preventive Health, Asthma, Prenatal Care, Diabetes, World Professional Association for Transgender Health (WPATH), Lead Screening, Immunizations, and ADHD/ADD guidelines for both adults and children.

Authorization Types

Review Roles

Authorization Type*	Criteria Utilized	Medical Authorization Assistant*	UM Nurse**	Medical Director/ Physician Reviewer (Denials and Modifications)
Chemotherapy – all request types reviewed by Pharmacy department	MCG, updated annually/Medi-Cal and Medicare Manuals/CalOptima Pharmacy Authorization Guidelines			X
DME (Custom & Standard)	MCG/Medi-Cal and Medicare Manuals/CCS Numbered Letters for WCM		X	X
Diagnostics	MCG/Medi-Cal and Medicare Manuals/CCS Numbered Letters for WCM		X	X
Hearing Aids	Medi-Cal and Medicare Manuals/CCS Numbered Letters for WCM	X	X	X
Home Health	MCG/Medi-Cal and Medicare Manuals/CCS Numbered Letters for WCM		X	X
Imaging	MCG/Medi-Cal and Medicare Manua		X	X
In Home Nursing (EPSDT)	Medi-Cal and Medicare Manuals/CCS Numbered Letters for WCM		X	X
Incontinence Supplies	Medi-Cal and Medicare Manuals/CCS Numbered Letters for WCM	X	X	X
Injectables	MCG/Medi-Cal and Medicare Manua		X	X
Inpatient Hospital Services	MCG/Medi-Cal and Medicare Manuals/CCS Numbered Letters for WCM		X	X
Medical Supplies (DME Related)	MCG/Medi-Cal and Medicare Manuals/CCS Numbered Letters for WCM	X	X	X
NEMT	Title 22 Criteria		X	X
Office Consultations	MCG/Medi-Cal and Medicare Manua	X	X	X

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Office Visits (Follow-up)	MCG/Medi-Cal and Medicare Manua	X	X	X
Orthotics	MCG/Medi-Cal and Medicare Manua		X	X
Pharmaceuticals	CalOptima Pharmacy Authorization Guidelines/CCS Numbered Letters fo WCM	Pharmacy Technician		Pharmacists Physician Reviewer
Procedures	MCG/Medi-Cal and Medicare Manuals/CCS Numbered Letters for WCM		X	X
Prosthetics	MCG/Medi-Cal and Medicare Manuals/CCS Numbered Letters for WCM		X	X
Radiation Oncology	MCG/Medi-Cal and Medicare Manua		X	X
Therapies (OT/PT/ST)	MCG/Medi-Cal and Medicare Manuals/CCS Numbered Letters for WCM		X	
Transplants	DHCS Guidelines/MCG		X	X

* If Medical Necessity criteria is not met, the request is referred to a UM Nurse Reviewer for further review and determination. Staff who are not qualified health care professionals and are under the supervision of appropriately licensed health professionals, when there are explicit UM criteria, and no clinical judgment is required.

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

Long Term Support Services

Authorization Type*	Criteria Utilized	Medical Assistant	Nurse	Medical Director/ Physician Reviewer (Denials and Modifications)
Community-Based Adult Services (CBAS)	DHCS CBAS Eligibility Determinatio Tool (CEDT)		X	X
Long-Term Care: Nursing Facility B Level	Medi-Cal Criteria Manual Chapter 7: Criteria for Long Term Care Services/Title 22, CCR, Section 5133		X	X
Long-Term Care: Nursing Facility A Level	Medi-Cal Criteria Manual Chapter 7: Criteria for Long Term Care Services/Title 22, CCR, Section 5133		X	X
Long-Term Care: Subacute	Medi-Cal Criteria Manual Chapter 7: Criteria for Long Term Care Services/Title 22, CCR, Sections 510 and 51303		X	X

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Long-Term Care: Intermediate Care Facility/Developmentally Disabled	Medi-Cal Criteria Manual Chapter 7: Criteria for Long Term Care Services/Title 22, CCR, Sections 513 and 51164	X DDS or DMH Certified	X	X
Hospice Services	Medi-Cal Criteria Manual Chapter 11 Criteria for Hospice Care/Title 22, California Code of Regulations	X	X	X

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

Behavioral Health Services

Authorization Type*	Criteria Utilized	Medical Case Manager	Care Manager (BCBA)	Medical Physician Reviewer/ Licensed Psychologist
Psychological Testing	Title 22, MCG, Medi-Cal and Medicare Manuals, CalOptima policy	X		X
Behavioral Health Treatmen (BHT) services (Medi-Cal only)	Title 22, WIC Section 14132, MCG, H&S Code 1374.73, Medi-Cal Manual, CalOptima policy DHCS APL 18-006	X	X	X

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

Board Certified Clinical Consultants:
In some cases, such as for authorization of a specific procedure or service, BH, or certain appeal reviews, the clinical judgment needed for a UM decision is specialized. In these instances, the Medical Director may consult with a board-certified physician from the appropriate specialty or qualified BH professionals as determined by the Medical Director, for additional or clarifying information when making medical necessity determinations or denial decisions. Clinical experts outside CalOptimaHealth may be contacted, when necessary to avoid a conflict of interest. CalOptima Health defines conflict of interest to include situations in which the practitioner who would normally advise on an UM decision made the original request for authorization or determination, or is in, or is affiliated with, the same practice group as the practitioner who made the original request or determination.

Practitioner and Member Access to Criteria
At any time, members or treating practitioners may request UM criteria pertinent to a specific authorization request by contacting the UM department or may discuss the UM decision with CalOptimaHealth Medical Director per the peer-to-peer process. Each contracted practitioner receives a Provider Manual, a quick reference guide, and a comprehensive orientation that contains critical information about how and when to interact with the UM department. The manual also outlines CalOptima's CalOptima Health's UM policies and procedures. On an annual basis, all contracted hospitals receive an in-

service to review all required provider trainings, including operational and clinical information such as UM timeliness of decisions. In addition, Provider Relations also provides any related policies regarding UM timeliness of decisions, as needed. Similar information is found in the Member Handbook and on the ~~CalOptima~~health website at www.~~caloptima~~CalOptima Health.org.

Inter-Rater Reliability (IRR)

At least annually, the CMO and ~~Executive Director,~~ Clinical Operations leadership assess the consistency with which Medical Directors and other ~~UM staff making~~ clinical ~~decisions~~decision makers apply UM criteria in decision-making. The assessment is performed as ~~a periodic~~an annual review ~~by the Executive Director, Clinical Operations or designee~~ to compare how ~~staff members manage~~reviewers' decision the same case ~~or some forum in which the staff members and physicians evaluate determinations, or they may perform periodic audits against criteria. When~~. If an opportunity for improvement is identified through this process, UM and MD leadership takes corrective action. New UM staff ~~is~~are required to successfully complete inter-rater reliability testing prior to being released from training oversight. The IRR is reported to the UMC on an annual basis and any actions taken for performance below the established benchmark of 90% are discussed and recommendations taken from the Committee.

Provider and Member Communication

Members and practitioners can access UM staff through a toll-free telephone number **888-587-8088** at least eight hours a day during normal business hours for inbound or outbound calls regarding UM issues or questions about the UM process. TTY services for deaf, hard of hearing or speech impaired members are available toll free at **711**. The phone numbers for these are included in the Member Handbook, on the CalOptima Health website, and in all member letters and materials. Additionally, language assistance for members to discuss UM issues is provided either by bilingual staff or through Language Line services. Except as otherwise provided below, communications received after normal business hours are returned on the next business day and communications received after midnight on Monday–Friday are responded to on the same business day. CalOptima Health has MD and UM coverage 24 hours a day, 7 days a week through after-hours answering services.

Inbound and outbound communications ~~may include~~includes directly speaking with practitioners and members, ~~faxing~~fax correspondence, electronic or ~~telephone~~telephonic communications (e.g., sending email messages or leaving voicemail messages). Staff ~~identifies~~identify themselves by name, title and CalOptima Health UM department when both making and receiving phone calls regarding UM processes. After normal business hours and on holidays, calls to the UM department are automatically routed to an on-call contracted vendor. The vendor is not a delegated UM entity and therefore, does not make authorization decisions. The vendor staff takes authorization information for the next business day response by CalOptima Health. In cases requiring immediate response the vendor staff notifies CalOptima Health on-call nurse. CalOptima Health will review and process authorizations outside business hours, as necessary, including decisions to approve, deny or modify authorization requests which are made by CalOptima Health on-call UM ~~physician~~MD. A log is ~~forwarded by the vendor to the UM department~~shared daily identifying ~~those issues that need~~activity and follow-up ~~by the UM staff~~needed the following day.

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Access to Physician Reviewer
The CalOptima Health Medical Director or appropriate practitioner reviewer (BH and clinical pharmacy) serves as the point of contact for practitioners calling in with questions about the UM process and/or case determinations. Providers are notified of the availability of the appropriate practitioner reviewer to discuss any UM denial decisions through the Provider Manual, New Provider Orientation and the provider newsletter. Notification of the availability of an appropriate practitioner reviewer to discuss any UM denial decision, and how to contact a reviewer for specific cases, is also provided verbally and/or in the written notification at the time of an adverse determination. The CalOptima Health Medical Director may be contacted by calling ~~the~~their direct dial number ~~for the Medical Director~~listed at the bottom of the provider denial notification~~.~~ or through contacting the UM department during the review process. A CalOptima Health Case Manager may also coordinate communication between the ~~CalOptima~~ Medical Director and requesting practitioner. ~~Whenever a~~All peer-to-peer ~~request is made,~~discussions are documented within clinical documentation ~~is added to the denied referral within Guiding Care, our UM system.~~platform

UM Staff Access to Clinical Expertise
~~The Medical Directors are responsible for providing clinical expertise to the UM staff and exercising sound professional judgment during review determinations regarding health care and services.~~ The CMO and Medical Directors, have the authority, accountability, and responsibility for denial determinations~~. For those contracted delegated~~ and following sound clinical and professional judgment. Contracted HNs that are delegated for UM responsibilities, ~~that entity's~~utilize a Medical Director, or designee, ~~has~~as the sole ~~responsibility and~~ authority to deny coverage. The Medical Director may also provide clarification of policy and procedure issues, and communicate with delegated entity practitioners regarding referral issues, policies, procedures, processes, etc.

Requesting Copies of Medical Records
During prospective, retrospective, inpatient and concurrent review, copies of medical records are required to validate medical necessity for the requested service. In those cases, only the necessary or pertinent sections of the record are required to determine medical necessity and appropriateness of the services requested. Medical records may also be requested to complete an investigation of a member grievance or when a potential quality of care issue is identified through the UM process~~.~~ Confidentiality of information necessary to conduct UM activities is maintained at all times.

Sharing Information
~~CalOptima's~~CalOptima Health's UM staff share all clinical and demographic information on individual patients among various areas of the agency (e.g., discharge planning, case management, PHM, health education, etc.) to avoid duplicate requests for information from members or practitioners.

Provider Communication to Member~~-~~
~~CalOptima's~~CalOptima Health's UM Program ~~in no way prohibits~~does not prohibit or ~~otherwise restricts a~~restrict health care ~~professional~~ professionals from acting within the lawful scope of practice ~~from~~or advising or advocating on behalf of a member ~~who is his or her patient for~~including but not limited to the following:

- The member's health status, medical care, or treatment options, including any alternative treatments that may be self-administered.
- Any information the member needs in order to decide among all relevant treatment options.
- The risks, benefits and consequences of treatment or absence of treatment.
- The member's right to participate in a decision regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

TIMELINESS OF UM DECISIONS

UM decisions are made in a timely manner to accommodate the clinical urgency of the situation and to minimize any disruption in the provision of health care. Established timelines are in place for providers to notify ~~CalOptima~~Health of a service request and for the health plan to make UM decisions and subsequent notifications to the member and practitioner.

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Attachment A TIMELINES FOR MEDI-CAL

UM Decision and Notification Timelines

~~Medi-Cal (Excludes Pharmacy Requests)~~

Medi-Cal Decision and Notification Timelines			
Type of Request	**Decision**	**Initial Notification ~~Timeframes~~(May be electronic or written)**	**Electronic/Written Notification of ADVERSE DETERMINATIONS to Practitioner and Member**
Routine (Non-~~Urgent~~urgent) Pre-Service~~*~~: Prospective or ~~concurrent~~outpatient service requests~~where no extension is requested or needed~~ ~~*Non pharmacy requests~~.	Approve, Modify, or Deny within 5 ~~working~~business days ~~1 of~~from receipt of ~~"all~~the information~"~~ reasonably necessary ~~and requested~~ to render a decision, and ~~in all circumstances~~ no ~~later~~longer than 14 calendar days ~~following~~from the receipt of the request. ~~"all information" means: Service requested (CPT/HCPC code and description), complete clinical information from any external entity necessary to provide an accurate clinical presentation for services being requested.~~	**Practitioner:** Within 24 hours of making the decision.	**Practitioner:** **Electronic ~~or written communication within~~**Within 24 hours of making the decision. **Member:** ~~ADVERSE DETERMINATIONS ONLY~~ **Written ~~notice~~** Notice must be ~~dated and~~ postmarked within 2 ~~working~~business days of ~~making the~~ decision~~,~~ not to exceed 14 calendar days from receipt of the request ~~for service~~.

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Routine (Non-~~Urgent)~~ urgent) Pre-~~Service (Deferral),~~ Service – Extension ~~needed:~~ * Needed • Additional clinical information required. • ~~Requires~~Require consultation • by an ~~expert reviewer~~Expert Reviewer. • Additional examination or tests to be performed • ~~Extension is allowed ***only*** if member or provider requests the extension, or the Plan justifies a need for additional information and can demonstrate how the extension is in the member's best interest. There is reasonable likelihood that receipt of such information would lead to approval of the request. *.~~	~~May extend up to an additional 14 calendar days.~~ **~~Additional Requested Information is Received:~~** ~~A decision must be made~~Approve, Modify, or Deny within 5 ~~working days of receipt of requested information, not to exceed 28 calendar~~business days from receipt of the ~~original referral~~ information reasonably necessary to render a decision, and no longer than 14 calendar days from the receipt of the request. • **~~Additional Information Incomplete or Not Received~~** ~~within the required timeframe, it will be considered a denial and therefore constitutes an Adverse Benefit Determination on the date the timeframe expires not to exceed 28 days~~The decision may be deferred, and the time limit extended an additional 14 calendar days only where the member or member's provider requests an extension, or CalOptima Health can provide justification upon request by the State for the need for additional information and how it is in the member's interest. • CalOptima Health will notify the member and practitioner of decision to defer, in writing, within 5 business days of receipt of information reasonably necessary to render a decision and no longer than 14 calendar days from the receipt of initial request.	**Practitioner:** Within 24 hours of making the decision.	**~~Extension~~** **Practitioner:** ~~Oral or electronic notification within~~ **Electronic** Within 24 hours of making the decision ~~to delay~~. **Member: Written** Within 2 business days of making the decision, not to exceed 28 calendar days from the receipt of the request for service. **Practitioner/Member:** Written ~~NOA "delay~~Notice of Action "Delay" notification ~~within 14~~within 14 calendar days of receipt of the request for services. • ~~The extension must include: 1) Justification for the delay 2) The right to file an expedited grievance (oral or written) if they disagree with the decision to grant an extension. 3) The anticipated date when a decision will be rendered.~~ .

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	• Notice of deferral should include the additional information needed to render the decision, the type of expert reviewed and/or the additional examinations or tests required and the anticipated date on which a decision will be rendered.		
	Additional information received	**Practitioner:**	**Practitioner: Electronic**

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	• If requested information is received, decision must be made within 5 business days of receipt of information, not to exceed 28 calendar days from the date of receipt of the request for service.	Within 24 hours of making the decision.	Within 24 hours of making the decision **Member: Written** Within 2 business days of making the decision, not to exceed 28 calendar days from the receipt of the request for service.
	Additional information incomplete or not received • If after 28 calendar days from the receipt of the request for prior authorization, the provider has not complied with the request for additional information, the plan shall provide the member notice of denial.	**Practitioner:** Within 24 hours of making the decision.	**Practitioner: Electronic** Within 24 hours of making the decision **Member: Written** Within 2 business days of making the decision, not to exceed 28 calendar days from the receipt of the request for service.

Working days = Monday through Friday excluding California State Holidays–
https://www.ftb.ca.gov/aboutftb/holidays.shtml

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Attachment A TIMELINES FOR MEDI-CAL

Medi-Cal Decision and Notification Timelines			
Type of Request	**Decision**	**Initial Notification ~~Timeframes~~(May be electronic or written)**	**Electronic/Written Notification of ADVERSE DETERMINATIONS to Practitioner and Member**
Expedited ~~Requests~~Authorization (Pre-Service~~)*~~) ~~No extension requested~~Provider or ~~needed~~ • ~~Requests where a provider indicates or the Plan~~CalOptima Health determines that the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function. ~~function.~~ • All necessary information received at time of initial request.	Approve, ~~modify~~Deny, or ~~deny the request~~Modify within 72 hours from receipt of the request.	**Practitioner:** Within 24 hours of making the decision.	**Practitioner:** ~~Oral or~~ **Electronic** ~~(fax) notification within~~Within 24 hours of making the decision not to exceed 72 hours from receipt of request. **Member:** ~~ADVERSE DETERMINATIONS ONLY~~**Written** Written notice within 72 hours of the receipt of the request for services.

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~~Expedited~~Expediated **Authorization (Pre-Service~~)*~~) -** Extension ~~needed:~~Needed Extension is ~~allowed only if~~extended when member or provider requests the extension, or ~~the Plan~~CalOptima Health justifies ~~the~~a need for additional information and ~~is able to~~can demonstrate how the ~~delay~~extension is i the member's best interest ~~of the member.~~ • . There is reasonable likelihood that receipt of such information would lead to approval of the request.	~~May extend up to 14 calendar days upon expiration of the 72 hour timeframe.~~ Approve, Deny, or Modify ~~Additional Requested Information is Received:~~ ~~A decision must be made~~ within ~~24~~72 hours ~~of~~from receipt of the request **Additional** ~~requested~~**clinical information~~.~~ required:** ~~**Additional Information Incomplete or not Received:** It will be considered a denial and therefore constitutes an Adverse Benefit Determination on the date the timeframe expires.~~Upon the expiration of the 72 hours or as soon as you become aware that you will not meet the 72-hour timeframe, whichever occurs first, notify practitioner and member using the "Delay" written notification, and insert specifics about what has not been received,, what consultation is needed and/or the additional examinations or tests required to make a decision and the anticipated date on which a decision will be rendered. **Note:** The time limit may be extended by up to 14 calendar days if the member requests an extension, or CalOptima Health can provide justification upon request by the State for the need for additional information and how it is in the member's interest.	**Practitioner:** Within 24 hours of making the decision.	**Practitioner~~/~~: Electronic** Within 24 hours of making the decision not to exceed 72 hours from receipt of request. **Member: Written** ~~NOA "delay" notification~~ Written notice within 72 hours of the receipt of the request for services. ~~The extension must include:~~ ~~1. Justification for the delay, specifying the information requested but not received or the expert reviewer to be consulted, or the additional examinations or tests required.~~ ~~2. The right to file an expedited grievance (oral o written) if they disagree wi the decision to grant an extension~~ ~~3. The anticipated date when a decision will be rendered.~~

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	~~Additional information received~~ • If requested information is received, decision must be made within 1 business day of receipt of information.	**Practitioner:** Within 24 hours of making the decision.	**Practitioner: Electronic** Within 24 hours of making the decision **Member: Written** Within 2 business days of making the decision

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	~~Additional information incomplete or not received~~ • Any decision delayed beyond the time limits is considered a denial and must be processed immediately as such.	**Practitioner:** Within 24 hours of making the decision.	**Practitioner: Electronic** Within 24 hours of making the decision **Member: Written** Within 2 business days of making the decision.
Urgent Concurrent (Inpatient) Requests where a provider indicates or CalOptima Health determines that the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function.	Approve, Modify, or Deny within 72 hours of the receipt of the request. **Extension:** CalOptima Health may extend the time frame, by up to 14 calendar days, under the following conditions: Additional supporting clinical information is needed.	**Practitioner:** Within 24 hours of making the decision.	**Practitioner: Electronic** Within 24 hours of making the decision. **Member: Written** Within 2 business days of making the decision.
Concurrent (Inpatient) Concurrent review of treatment regimen already in place, (inpatient, ongoing ambulatory services). In the case of concurrent review, care shall not be discontinued until the enrollee's treating provider has been notified of CalOptima Health's decision, and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient.	Approve, Modify, or Deny within 72 hours of last approved day or decision consistent with urgency of member's medical condition. Extension: CalOptima Health may extend the timeframe 48 hours of up to 14 calendar days under the following conditions: • Additional supporting clinical information is needed.	**Practitioner:** Within 24 hours of making the decision.	**Practitioner: Electronic or Oral:** Within 24 hours of receipt of the request. **Member: Written** Written notification within 2 calendar days of decision. **Note:** If oral notification is given within 24 hours of request, then written/electronic notification must be given no later than 2 calendar days after the oral notification.
Post-Service / Retrospective Review- All necessary information received at time of request (decision and notification is required within 30 calendar days from request).	Decision within 30 calendar days from receipt of information that is reasonably necessary to make a decision.	**Practitioner:** Within 24 hours of making the decision.	**Practitioner: Electronic** Within 30 calendar days of receipt of the request. **Member: Written** Within 30 calendar days of receipt of request.

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Hospice - Inpatient Care	~~Within 24 hours of receipt of request.~~	**Practitioner:** Within 24 hours of making the decision.	**Practitioner: Electronic** Within 24 hours of making the decision. **Member: Written** Within 2 business days of making the decision.

[1] Working days=Monday through Friday excluding California State Holidays
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Attachment B TIMELINES FOR OneCare

OneCare Decisions and Notification Timelines		
Type of Request	**Decision**	**Notification Timeframe**
Standard Integrated Organization Determinations Prospective or outpatient service requests.	Approve, Modify or Deny no later than 14 calendar days from receipt of request. **Extensions: CalOptima Health may not extend the deadlines for Integrated Organization Determinations.**	**Practitioner:** **Decision: Electronic or Written** Within 24 hours of making the decision. **Practitioner/Member: Written** Within 2 business days of decision. **Issue the Coverage Decision Notice for written notification of denial decision.**
Expedited Integrated Organization Determinations Prospective or outpatient service requests.	Approve, Modify or Deny expeditiously but no later than 72 hours from receipt of the request. CalOptima Health must request the necessary information from the noncontracted provider within 24 hours of the receipt request. **Extensions: CalOptima Health may not extend the deadlines for Integrated Organization Determinations.**	**Practitioner:** **Decision: Electronic or Oral Notification** Within 24 hours of making the decision. **Member: Oral** Within 24 hours of determination. **Practitioner/Member: Written** Within 2 business days of making the decision. When oral notification is given, it must be followed by written notification within 3 calendar days of the oral notification.

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Expedited Authorization (Pre-Service) **If Expedited Criteria are not met**	~~If submitted as expedited but determined not to be~~ expedited, then standard initial organization determination timeframe applies: • Automatically transfer the request to the standard timeframe. The 14-day period begins with the day the request was received for an expedited determination.	If request is not deemed to be expedited, CalOptima Health must notify member (within 72 hours) oral notification of the denial of expedited status including the member's rights followed by written notice within 3 calendar days of the oral notification. **Use the Expedited Criteria Not Met** template to provide written notice. The written notice must include: 1. Explain that CalOptima Health will automatically transfer and process the request using the 14-day timeframe for standard determinations. 2. Inform the member of the right to file an expedited grievance if he/she disagrees with the organization's decision not to expedite the determination. 3. Inform the member of the right to resubmit a request for an expedited determination and that if the member gets any
		physician's support indicating that applying the standard timeframe for making determinations could seriously jeopardize the life or health of the member. 4. Provide instructions about the expedited grievance process and its time frames.

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Urgent Concurrent (Inpatient) Requests where a provider indicates or CalOptima Health determines that the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function.	~~Approve, Modify or Deny within 72 hours of the~~ receipt of the request. **Extension:** CalOptima Health may extend the time frame, by up to 14 calendar days, under the following conditions: • Additional supporting clinical information is needed.	**Practitioner: Electronic** Within 24 hours of making the decision. **Member: Written** Within 2 business days of making the decision.
Concurrent (Inpatient) Concurrent review of treatment regimen already in place, (inpatient, ongoing ambulatory services). In the case of concurrent review, care shall not be discontinued until the enrollee's treating provider has been notified of CalOptima Health's decision, and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient.	Approve, Modify or Deny within 72 hours of last approved day or decision consistent with urgency of member's medic al condition. **Extension:** CalOptima Health may extend the time frame 48 hours or up to 14 calendar days, under the following conditions: • Additional supporting clinical information is needed.	**Practitioner/Member: Electronic or Oral** Within 24 hours of receipt of the request. **Practitioner/Member: Written** Within 3 calendar days of decision.
Post-Service / Retrospective Review- All necessary information received at time of request (decision and notification is required within 30 calendar days from request)	Decision within 30 calendar days from receipt of information that is reasonably necessary to make a decision.	**Practitioner: Written** Within 30 calendar days of receipt of the request **Member: Written** Within 30 calendar days of receipt of request.
Hospice - Inpatient Care	Within 24 hours of receipt of request.	**Practitioner: Electronic or Oral** Within 24 hours of making the decision **Practitioner /Member: Written** Within 2 business days of making the decision

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Type of Request	Decision	Important Message (IM) from Medicare	Detailed Notice of Discharge (DND)
Hospital Discharge Appeal Notices (Concurrent)	Hospitals are responsible for delivery of the Important Message from Medicare (IM): 1. Within 2 calendar days of admission to a hospital inpatient setting. 2. No more than 2 calendar days prior to discharge from a hospital inpatient setting. 3. CalOptima Health is responsible for the delivery of the Detailed Notice of Discharge (DND) when members appeal a discharge. 4. DND must be delivered no later than noon of the day after notification by QIO (Quality Improvement Organization)	Hospitals must issue IM within 2 calendar days of admission. Hospitals must issue IM no more than 2 calendar days prior to discharge from an inpatient stay.	CalOptima Health must issue the DND to both the member and QIO as early as possible but no later than noon of the day after notification by the QIO.

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~~TIMEFRAMES FOR MEDI-CAL DECISIONS AND~~ **Medi-Cal Pharmacy Prior Authorization Determination Timelines**

*Timelines for determination apply to pharmacy authorization requests managed by CalOptima Health and Magellan Rx

Type of Request	Determination Timeline
Standard (Non-urgent) Preservice - All necessary information received at time of initial request.	A decision to approve, modify, or deny is required within 24 hours of receipt of the request.
Standard (Non-urgent) Preservice - Information Needed - Additional clinical information required.	- A deferral response is required within 24 hours of receipt of the request. - A decision to approve, modify, or deny is required within 24 hours of receiving the additional information reasonably necessary to render a decision, but no longer than 14 calendar days from receipt of the original request.
Standard (Non-urgent) Preservice – Delay Needed	- CalOptima Health may delay the timeframe for an additional 14 calendar days if the requested information was not received within 14 calendar days of receipt of the original request, under the following conditions: ▪ The member or the member's provider may request for an extension, or CalOptima Health can provide justification upon request by DHCS for the need for additional information and how it is in the member's interest. ▪ The delay notice shall include the additional information needed to render the decision, the type of expert needed to review and/or the additional examinations or tests required and the anticipated date on which a decision will be rendered.
Expedited (Urgent) Preservice/Concurrent - All necessary information received at time of initial request.	- A decision to approve, modify, or deny is required within 24 hours of receipt of the request.
Expedited (Urgent) Preservice/Concurrent - Information Needed - Additional clinical information required.	- A deferral response is required within 24 hours of receipt of the request. - A decision to approve, modify, or deny is required within 24 hours of receiving the additional information reasonably necessary to render a decision, but no longer than 72 hours from receipt of the original request.

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Expedited (Urgent) Preservice/Concurrent - Delay Needed	- ~~CalOptima Health may delay the~~ timeframe for an additional 14 calendar days if the requested information was not received within 72 hours of receipt of the original request, under the following conditions: ▪ The member or the member's provider may request for an extension, or CalOptima Health can provide justification upon request by DHCS for the need for additional information and how it is in the member's interest. ▪ The delay notice shall include the additional information needed to render the decision, the type of expert needed to review and/or the additional examinations or tests required and the anticipated date on which a decision will be rendered.
Post-Service/Retrospective	- A decision to approve, modify, or deny is required within 30 calendar days of receipt of the request.

Type of Request	~~Decision~~	Notification ~~Timeframes~~Timeline
~~**Concurrent*:**~~ ~~Concurrent review of treatment regimen already in place, (inpatient, ongoing ambulatory services).~~ ~~In the case of concurrent review, car shall not be discontinued until the enrollee's treating provider has been notified of the plan's decision, and a care plan has been agreed upon by th treating provider that is appropriate f the medical needs of that patient.~~ ~~**CA H&SC 1367.01 (h)(3)**~~	~~Within 5 working days or less, consistent with urgency of member's medical condition.~~ ~~The decision, based on medical necessity, shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed 5 business days from the plan's receipt of the information reasonably necessary, and requested by the plan to make the determination.~~**Standard (Non-urgent) Preservice** - All necessary information received at time of initial request.	~~**Practitioner / Member:**~~ ~~Oral or electronic notification within 24 hours of the decision, consistent with the urgency of the Member's medical condition and in accordance with Health and Safety Code Section 1367.01 (h)(3).~~ ~~**Practitioner/Member:** Written notice within 3 calendar days after the oral notification.~~ ~~For terminations, suspensions, or reductions of previously authorized services, Plans must notify beneficiaries at leas ten days before the date of the action with the exception o~~ - ~~circumstances permitted under Title 42, CFR, Sections 431.213 and 431.214.~~**Provider:** Within 24 hours of receipt of the request. - **Member (modify or deny only):** Within 24 hours of receipt of the request.

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Post-Service / Retrospective Review*: All necessary information received at time of the request.	Approve, modify or deny within 30 calendar days from receipt of information that is reasonably necessary to make a determination.	**Practitioner:** Written notice within 30 calendar days from receipt of request. **Member:** Adverse Determination Only within 30 days of receipt of request
Post-Service*: Extension needed	**Additional Clinical Information Required (Deferral):** Decision to defer must be made as soon as the pla is aware that additional information i required to render a decision, but no more than 30 days from the receipt the request. **Additional Information Received:** If requested information is received, decision must be made within 30 calendar days from receipt of request for information.	**Practitioner:** Written notice within 30 calendar days from receipt of the Request. **Member:** Within 30 days of receipt of request

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~~TIMEFRAMES FOR MEDI-CAL DECISIONS AND~~

Standard (Non-urgent) Preservice - Information Needed - Additional clinical information required.	- ~~**Type of Request**~~**Provider:** Within 24 hours of receipt of the additional information reasonably necessary to render a decision. - **Member (modify or deny only):** Within 24 hours of receipt of the additional information reasonably necessary to render a decision.
Standard (Non-urgent) Preservice- Delay Needed - Additional clinical information not received within initial 14 calendar days.	~~**Additional Clinical Information Incomplete or Not Received:**~~ - ~~Decision must be made with the information that is available by the end of the 30th~~**Provider:** Delay notice sent within 14 calendar ~~day given~~days of receipt of the original request to ~~provide~~delay the timeframe for an additional ~~information~~14 calendar days. - **Member:** Delay notice sent within 14 calendar days of receipt of the original request to delay the timeframe for an additional 14 calendar days.
Expedited (Urgent) Preservice/Concurrent - All necessary information received at time of initial request.	- **Provider:** Within 24 hours of receipt of the request. - **Member (modify or deny only):** Within 24 hours of receipt of the request.
Expedited (Urgent) Preservice/Concurrent - Information Needed - Additional clinical information required.	- **Provider:** Within 24 hours of receipt of the additional information reasonably necessary to render a decision. - **Member (modify or deny only):** Within 24 hours of receipt of the additional information reasonably necessary to render a decision.
~~Within 24 hours of making the decision.~~**Expedited (Urgent) Preservice/Concurrent - Delay Needed** - Additional clinical information not received within initial 72 hours.	~~**Practitioner:**~~ - ~~Oral or electronic notification~~**Provider:** Delay notice sent within ~~24~~72 hours of ~~making~~receipt of the ~~decision~~original request to delay the timeframe for up to an additional 14 calendar days. - **Member**~~ Adverse Determination Only: Written~~**:** Delay notice sent within ~~2 working days~~72 hours of ~~making~~receipt of the ~~decision~~original request to delay the timeframe for up to an additional 14 calendar days.

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	~~Attachment A~~ ~~TIMEFRAMES FOR MEDI-CAL DECISIONS AND~~
Post-Service/Retrospective	- **Provider:** Within 30 calendar days of receipt of the request. - **Member:** Within 30 calendar days of receipt of the request.

Medicare

Type of Request	Decision	Notification Timeframes
Routine (Non-Urgent) Pre-Service: No extension requested or needed	Within 5 working days of receipt "all information" reasonably necessary to render a decision, and in all circumstances no longer than 14 calendar days. "all information" means: Complete clinical information from any external entity necessary to provide an accurate clinical presentation for services being requested.	**Practitioner:** Oral or electronic notification within 24 hours of making the decision. **Practitioner/Member:** Written notice 2 working days of making the decision, not to exceed 14 calendar days from receipt of the request for service.
Routine (Non-Urgent) Pre-Service (Deferral) Extension needed • Additional clinical information required • Requires consultation by an expert reviewer • Additional examination or tests to be performed Extension is allowed ***only*** if member or provider requests and justifies the need for additional information and is able to demonstrate how the delay is in the interest of the member. There is reasonable likelihood that receipt of such information would lead to approval of the request. An extension ***must not*** be used to pend organization determinations while waiting for medical records from contracted providers.	May extend up to an additional 1 calendar days. **Additional Requested Information is Received:** A decision must be made within 5 working days of receipt of requested information, not to exceed 1 calendar days from receipt of the original referral request. **Additional Information Incomplete or Not Received** A written member notice of denial issued within 28 calendar days from the receipt of the original referral request.	**Extension - Practitioner:** Oral or electronic notification within 24 hours of making the decision. **Practitioner/Member:** • Written notice within 14 calendar days of receipt of request. The extension must include: 1) Justification for the delay 2) The right to file an expedited grievance (oral or written) if the disagree with the decision to grant an extension **Note:** The health plan must respond to an expedited grievance within 24 hours of receipt. **Decision Notification After an Extension -** **Practitioner/Member:** Written notice within 2 working days of making the decision, not to exceed 28 calendar days from receipt of the request.

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OneCare Pharmacy Part D Determination Timelines

Type of Request	~~Decision~~Determination Timeline
~~**Expedited Authorization (Pre-Service):**~~ ~~No extension requested or needed~~ ~~Requests where provider indicates or the Plan determines that the standard timeframes could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function.~~ ~~All necessary information received at time of initial request.~~**Standard (Non-urgent) Preservice/Concurrent**	~~**Practitioner:**~~ ~~Oral or electronic notification within 24 hours of making the~~ A decision ~~not to exceed~~ to approve or deny is required within 72 hours ~~from~~of receipt of the request~~.~~ ~~**Member, OCC and OC Medicare Services Only:**~~ ~~Oral notification within 72 hours from receipt of request.~~ ~~**Practitioner /**~~ or prescriber supporting statement for exception requests (not to exceed seven calendar~~**Member: Written** notice within 2 working~~ days of making~~ from when the ~~decision.~~request was received).

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Expedited ~~Authorization (Pre Service):~~ **~~Extension needed~~** ~~Requests where provider indicates or the Plan determines that the standard timeframes could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function.~~(Urgent) Preservice/Concurrent	~~May extend up to 14 calendar days upon expiration of the 72 hour timeframe.~~ ~~Notify practitioner and member using the "delay" template and insert specifics including~~ ~~1. Justification for the delay, information that has not been received, what consultation is needed and/or the additional examination or testes required to make a decision.~~ ~~2. The right to file an expedited grievance (oral or written) if they disagree with the decision to grant an extension.~~ ~~3. The anticipated date when a decision will be rendered.~~ **~~Additional Requested Information is Received:~~** A decision ~~must be made~~ to approve or deny is required within ~~1 working day~~24 hours of receipt of ~~requested information.~~the request or prescriber supporting statement for exception requests (not to exceed seven calendar days **~~Additional Information Incomplete or not Received~~** ~~Any decision delayed beyond the timeframe limits is considered a denial and must be processed immediately as such.~~from when the request was received).

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Post-service/Retrospective	A decision to approve or deny is required within 14 calendar days of the initial receipt of the request.

Type of Request	Notification ~~Timeframes~~Timeline (Member and Prescriber)
Standard (Non-urgent) Preservice/Concurrent~~:~~ ~~Concurrent review of treatment regimen already in place, (inpatient, ongoing/ambulatory services).~~ ~~In the case of concurrent review, care shall not be discontinued until the enrollee's treating provider has been notified of the plan's decision, and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient.~~ ~~CA H&SC 1367.01 (h)(3)~~	Within ~~5 working days or less, consistent with urgency~~72 hours of ~~member's medical condition.~~ ~~The decision, based on medical necessity, shall be made in a timely fashion appropriate~~receipt of the request or prescriber supporting statement for ~~the nature of the enrollee's condition,~~ exception requests (not to exceed ~~5 business~~seven calendar days from the ~~plan's receipt of the information reasonably necessary, and requested by the plan to make the determination.~~date of the original request).

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~~**Post-Service/Retrospective Review:**~~ ~~All necessary information received at time of the request.~~**Expedited (Urgent) Preservice/Concurrent**	Within ~~30~~24 hours of receipt of the request or prescriber supporting statement for exception requests (not to exceed seven calendar days from ~~receipt~~the date of the original request~~.~~).

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Post-~~Service:~~ ~~Extension needed~~service/Retrospective	~~**Additional Clinical Information Required (Deferral):**~~ ~~Decision to defer must be made as soon as the plan is aware that additional information is required to render a decision, but no more than 30 days from the receipt of the request.~~ ~~**Additional Information Received:**~~ ~~If requested information is received, decision must be made within 30 calendar days from receip of request for information.~~ ~~**Additional Clinical Information Incomplete or Not Received:**~~ ~~Decision must be made with the information that is available by the end of the 30th calendar day given to provide the additional information.~~Within 14 calendar days of the initial receipt of the request.

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Type of Request	Decision	Notification Timeframes
Hospice – Inpatient Care:	Within 24 hours of making the decision.	**Practitioner:** Oral or electronic notification within 24 hours of making the decision. **Practitioner/Member:** Written notice within 2 working days or making the decision.

Pharmacy for Medi-Cal, OC & OCC

Medi-Cal Pharmacy Timeframes for Determinations	OC and OCC Pharmacy Timeframes for Determinations (Part D)
Standard (Non-urgent) Pre-Service: Within 24 hours a decision to approve, modify, deny or defer is required. Standard (Non-urgent) Pre-Service, Extension Needed: Within 5 working days of receiving needed information, but no longer than 14 calendar days Expedited (Urgent) Pre-Service/ Concurrent: Within 24 hours a decision to approve, modify, deny or defer is required. Expedited (Urgent) Pre-Service/ Concurrent, Extension Needed: Within 72 hours of the initia request Post-Service/Retrospective: Within 30 days of receipt	Routine: 72 hours Urgent: 24 hours Retrospective: 14 days
Pre-Service and Concurrent Approvals: Provider: Electronic/written: Within 24 hours of making the decision. Pre-Service and Concurrent Denials: Provider: Electronic/written: Within 24 hours of making the decision. Member: Written: Within 2 business days of making the decision. Post Service/ Retrospective Approvals: Practitioner: Written: Within 30 days of receipt of request. Post Service/ Retrospective Denials: Practitioner: Written: Within 30 days of receipt of request. Member: Written: Within 30 days of receipt of request.	**Authorization Request Type:** **For expedited requests:** **Written notification must be provided to the member within 24 hours from the receipt of the request. If initial notification is made orally, then written notification must be provided within 3 calendar days of the oral notification.**

~~Medi-Cal Pharmacy~~ ~~Timeframes for Determinations~~	~~OC and OCC Pharmacy~~ ~~Timeframes for Determinations (Part D)~~
	~~For standard requests:~~ ~~Written notification must be provided to the member within 72 hours from the receipt of the request. If initial notification is made orally, then written notification must be provided within 3 calendar~~ ~~days of the oral notification.~~ ~~For retrospective requests:~~ ~~Written notification must be provided to the member within 14 calendar days from the receipt of the request. If initial notification is made orally, then written notification must be provided within 3 calendar days of the oral notification.~~

Emergency Services

~~Emergency room services are available 24 hours per day, 7 days per week. Prior authorization is not required for emergency services and coverage is based on the severity of the symptoms at the time of presentation. Emergency services are covered when furnished by a qualified provider and are needed to evaluate or stabilize an emergency medical condition.~~

An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairments of bodily functions, or serious dysfunction of any bodily organ or part. An emergency medical condition is not defined on the basis of lists of diagnoses or symptoms.
Emergency room services are available 24 hours per day, 7 days per week. Prior authorization is not required for emergency services and coverage is based on the severity of the symptoms at the time of presentation. Emergency services are covered when furnished by a qualified provider and are needed to evaluate or stabilize an emergency medical condition.

Emergency services are covered when furnished by a qualified practitioner, including non-network practitioners, and are covered until the member is stabilized. CalOptima Health also covers any screening examination services conducted to determine whether an emergency medical condition exists.

If a plan network practitioner, or plan representative, instructs a member to seek emergency services, the medical screening examination and other medically necessary emergency services are covered without regard to whether the condition meets the prudent layperson standard. Once the member's emergency medical condition is stabilized, certification for hospital admission or prior authorization for follow-up care is required as follows:

Authorization for Post-Stabilization Inpatient Services

A ~~non-contracted~~ hospital must ~~submit~~notify CalOptima Health of a ~~Prior Authorization Request for~~ Post-Stabilization ~~Services when~~request for services prior to admission. Once a member ~~who has received~~is stabilized after emergency services ~~for an emergency medical condition is determined to have reached medical stability,~~ but requires additional, medically necessary inpatient ~~covered services that are related to the emergency medical condition, and provided to maintain, improve or resolve the member's stabilized medical condition.~~services The attending emergency physician, or the provider treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge.

According to DHCS, the requirements of Title 28 CCR Section 1300.71.4 (the 30-minute rule) ~~do not~~ apply to both contracted and noncontracted providers in ~~CalOptima's~~CalOptima Health's Medi-Cal program. CalOptima Health or a HN shall approve or deny a prior authorization request for post-stabilization services ~~and~~if all information reasonably necessary ~~and requested~~ to render a decision is received from a ~~non-contracted~~ hospital within 30 minutes ~~after receiving such request and information for Medi-Cal members, and within~~ or 60 minutes ~~after receiving such request and information from a non-contracted hospital~~ for OC ~~or OCC~~ members. If CalOptima Health or the HN does not respond within the prescribed timeframe, medically necessary post-stabilization inpatient services are considered approved.

~~PRIOR AUTHORIZATION SERVICES~~

~~UM Urgent/Expedited Prior Authorization Services~~

~~For all pre-scheduled services requiring prior authorization, the provider must notify CalOptima at least 5 days prior to the requested service date. A determination for urgent pre-service care (expedited prior authorization) will be issued within 72 hours of receiving the request for service. Prior authorization is never required for emergency or urgent care services.~~

~~UM Routine/Standard Prior Authorization Services~~

~~CalOptima makes determinations for standard, non-urgent, pre-service prior authorization requests within 5 business days of receipt of necessary information, not to exceed 14 calendar days of receipt of the request for Medi-Cal members and within 14 calendar days for OC/OCC.~~

Retrospective Review

Retrospective review is an initial review of services that require prior authorization and have already been rendered. This process encompasses services performed by a participating or non-participating provider without CalOptima Health notification and/or authorization and when there was no opportunity for ~~concurrent~~pre-service review. ~~The Director of UM, or designee, reviews the request for retrospective authorization.~~

Retrospective Authorization ~~shall~~is only ~~be~~ permitted in accordance with CalOptima Health Policy and Procedure GG.1500: Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers which is as follows:

The request is made within sixty (60) calendar days after the initial date of service and one of the following conditions apply:

1. The Member has Other Health Coverage (OHC); or
2. The Member's medical condition is such that the Provider or Practitioner is unable to verify the Member's eligibility for Medi-Cal, or OneCare program, as applicable, at the time of service.

If supporting documentation satisfies the administrative waiver of notification requirements of the policy, the request is reviewed utilizing the standard medical necessity review process. If the supplied documentation meets medical necessity criteria, the request is authorized. If the supporting documentation is questionable, the Director of UM or designee requests a Medical Director review. The request for a retrospective review must be made within 60 days of the service provided. Medical necessity of post-service decisions (retrospective review) and subsequent member/practitioner notification will occur no later than 30 calendar days from receipt of request.

Admission/~~Concurrent~~Inpatient Review Process

Contracted facilities are required to notify CalOptima Health of all inpatient ~~prior-authorized~~ admissions within ~~one (1) business day following the actual~~24 hours of admission. The ~~admission/concurrent~~inpatient review process assesses the clinical status of the member, verifies the need for continued hospitalization~~, facilitates the implementation of the practitioner's plan of care, validates the appropriateness of the treatment rendered and the level of care, and monitors the quality of care to verify professional standards of care are met.~~ Information assessed during the review includes but is not limited to:

- Clinical information to support the appropriateness and level of service ~~proposed~~being provided
- Validating the diagnosis

- Assessment of the clinical status of the member to determine special requirements to facilitate a safe discharge to another level of care
- Additional days/service/procedures ~~proposed~~requested
- Reasons for extension of the treatment or service

~~A request made while a member is in the process of receiving care is considered to be an urgent concurrent request if the care requested meets the definition of urgent, even if the earlier care was not previously approved by CalOptima. If the request does not meet the definition of urgent care, the request may be handled as a new request and decided within the timeframe appropriate for the type of decision (i.e., pre-service and post-service).~~

~~Concurrent review for inpatient hospitalization is conducted throughout the~~Utilizing evidenced based clinical guidelines, inpatient and concurrent review is conducted throughout the members inpatient stay, with each hospital day approved based on review of the patient's condition and evaluation of medical necessity. ~~Concurrent~~Inpatient review can occur on-site or telephonically. The frequency of reviews is based on the severity/complexity of the member's condition and/or necessary treatment, and discharge planning activity.

If, at any time, services cease to meet inpatient clinical criteria, discharge criteria are met, and/or alternative care options exist, the nurse case manager ~~contacts the attending physician and obtains additional information to justify the continuation of services. When the medical necessity for a continued inpatient stay cannot be determined,~~refers the case ~~is referred~~ to the Medical Director for review. ~~When an acceptable discharge plan is mutually agreed upon by the attending physician and the UM~~ If the Medical Director determines the case no longer meets medical necessity for inpatient care, a Notice of Action (NOA) letter is issued immediately by fax ~~or via overnight certified mail~~and telephone to the attending physician, hospital and mailed to the member for OC members verbal notification is also provided.

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

Discharge Planning Review

Discharge planning begins at the time of an inpatient admission and is designed to identify and initiate a safe, ~~cost-effective,~~ quality-driven treatment intervention for post-hospital care needs. It is a ~~cooperative~~coordinated effort among the facility and CalOptima Health and includes but is not limited to attending physician, hospital discharge planner, UM staff, complex discharge team, Case Management team, health care delivery organizations, and community resources to coordinate care and services.

Objectives of the Discharge Planning Review are:

- Early identification during a member's hospitalization of medical/psycho-social issues with potential for post-hospital intervention.
- Development of an individual care plan involving an appropriate multidisciplinary team and family members involved in the member's care.

- Communication to the attending physician and member, when appropriate, to suggest alternate health care resources.
- Communication to attending physician and member regarding covered benefits, to reduce the possibility of a financial discrepancy regarding non-covered services and denied days of hospitalization.
- Coordination of care between the member, PCP, attending physician, specialists, hospital UM/Discharge planning staff, and UM staff.

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

Denials

A denial of services, also called an adverse organization determination, is a reduction, modification, suspension, denial or termination of any service based on medical necessity or benefit limitations.

Upon any adverse determination for medical or behavioral health services made by a CalOptima Health Medical Director or other appropriately licensed health care professional (as indicated by case type) a written notification, at a minimum, will be communicated to the member and requesting practitioner.

Verbal notification of any adverse determination is provided when applicable.

All notifications are provided within the timeframes as noted in CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization. The written notification is written in lay language that is easily understandable at ~~the~~a sixth grade reading level and includes the member-specific reason/rationale for the determination, specific criteria and availability of the criteria used to make the decision as well as the availability, process and timeframes for appeal of the decision. All templates for written notifications of decision making are DHCS and CMS approved prior to implementation.

Practitioners are provided with the opportunity to discuss any medical or behavioral health UM denial decisions with a physician or other appropriate reviewer. A CalOptima Health Medical Director or appropriate practitioner reviewer (BH practitioner, pharmacist, etc.) serves as the point of contact for the peer-to- peer discussion. This is communicated to the practitioner at the time of verbal notification of the denial, as applicable, and is included in the standard denial letter template.

~~Grievance and Appeal Process~~

Grievance and Appeal Process

CalOptima Health has a comprehensive review system to address matters when Medi-Cal,

OC ~~or OCC~~ members wish to exercise their right to review the UM decision to deny, delay or modify a request for services, or terminate a previously approved service. This process is initiated by contact from a member, a member's representative or practitioner to CalOptima Health. Grievances and Appeals for members enrolled in COD, or one of the contracted HMOs, PHCs and SRGs are submitted to ~~CalOptima's~~CalOptima Health's Grievance and Appeals Resolution Services (GARS). The process is designed to handle individual disagreements in a timely fashion, and to ensure an appropriate resolution.

The grievance process is in accordance with CalOptima Health Member Complaint Policy. HH.1102: CalOptima Member Complaint. The appeal process is in accordance with CalOptima Health Appeal Policy GG.1510: Appeal Process. ~~This process includes~~These processes include but are not limited to:

- Collection of information and/or medical records related to the grievance or appeal.
- Communication to the member and provider.
- Thorough evaluation of the substance of the grievance or appeal.
- Review of the investigation for a grievance or medical records for an appeal.
- Resolution of operational or systems issues and of medical review decision.
- Referral to an appropriately licensed professional in Medical Affairs for evaluation and further management of clinical issues, such as timeliness of care, access to care, and appropriateness of care, including review of the clinical judgments involved in the case.

The grievance and appeal process for ~~COD, HMOs, PHCs and SRGs is~~all of CalOptima Health Networks except Kaiser are handled by CalOptima Health GARS. CalOptima Health works collaboratively with the community provider or delegated entity in gathering information and supporting documentation. If a member is not satisfied with the appeal decision, he/she may file for a State Hearing with the California Department of Social Services. Grievances and appeals can be initiated by a member, a member's representative or a practitioner. Pre-service appeals may be processed as expedited or standard appeals, while post- service appeals will be processed as standard appeals only.

All medical necessity decisions are made by a licensed physician reviewer. Grievances and appeals are reviewed by an objective reviewer~~,~~ other than the reviewer who made the initial denial determination.

The ~~UM or CM~~ Medical Director or designee evaluates grievances regarding the denial, delay, termination, or modification of care or service. The ~~UM or CM~~ Medical Director or designee may request a review by a board-certified, specialty-matched Peer Reviewer to evaluate the determination. An "Expert Panel" roster is maintained from which, either via Letter of Agreement or Contract, a Board-Certified Specialist reviewer is engaged to complete a review and provide a recommendation regarding the appropriateness of a pending and/or original decision that is now being appealed.

CalOptima Health sends written notification to the member and/or practitioner of the outcome of the review within the regulatory time limits. If the denial was upheld, even in part, the letter includes the appropriate appeal language to comply with applicable regulations.

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

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

Expedited Appeals and Grievances

A member, member's authorized representative or provider may request the grievance or appeal process to be expedited if ~~it is felt that~~ there is an imminent and serious threat to the health of the member, including, but not limited to, severe pain, risk for adverse health outcome if not decisioned quickly, or potential loss of life, limb, or major bodily function. All expedited grievance or appeal requests that meet the expedited criteria shall be reviewed and resolved in an expeditious manner as the matter requires, but no later than 72 hours after receipt.

At the time of the request, the information is reviewed, and a decision is made ~~as to whether or not the appeal meets~~regarding the expedited appeal criteria. ~~Under certain circumstances, where a delay in an appeal decision may adversely affect the outcome of treatment, or the member is terminally ill, an appeal may be determined to be urgent in nature and will be considered expedited. These~~Expedited appeals and grievances are managed in an accelerated fashion ~~in an effort~~ to provide appropriate, timely care to members when the regular timeframes of the review process could seriously jeopardize the life or health of the member or could jeopardize the member's ability to regain maximum functionality.

State Fair Hearing

CalOptima Health Medi-Cal members have the right to request a State Hearing from the California Department of Social Services after exhausting the appeal process. A member may file a request for a State Hearing within 120 days from the Notice of Appeal Resolution. CalOptima Health and ~~the HMOs, PHCs and SRGs~~delegated HNs comply with State Aid Paid Pending requirements, as applicable. Information and education on filing a State Fair Hearing is included annually in the member newsletter, in the member's evidence of coverage, and with each adverse Notice of Appeal Resolution sent to the member or the member's representative.

Independent Medical Review

OC ~~and OCC~~ members have a right to request an independent review if they disagree with the termination of services from a SNF, home health agency ~~(HHA)~~ or a comprehensive outpatient rehabilitation facility ~~(CORF).~~. CMS contracts with a Quality Improvement Organizations (QIO) to conduct the reviews. CalOptima Health is notified when a request is made by a member or member representative. CalOptima Health supports the process with providing the medical records for the QIO's review. The QIO notifies the member or member representative and CalOptima Health of the outcome of their review. If the decision is overturned, CalOptima Health complies by issuing a reinstatement notice ensuring services will continue as determined by the QIO.

Provider Preventable Conditions

The federal Affordable Care Act (ACA) requires that providers report all Provider Preventable Conditions (PPCs) that are associated with claims for Medi-Cal payment or with courses of treatment furnished to a Medi-Cal patient for which Medi-Cal payment

would otherwise be available. The ACA also prohibits Medi-Cal from paying for treatment of PPCs.

There are two types of PPCs:

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

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

~~LONG-TERM SERVICES AND SUPPORTS~~

LONG-TERM SERVICES AND SUPPORTS

LTC

The LTC case management program includes authorizations for the following facilities:~~-~~

- NF-A, NF-B , subacute care

~~It excludes institutions for mental disease, special treatment programs, residential care facilities, board and care, congregate living health facilities and assisted living facilities.~~ Facilities are required to notify CalOptima Health of admissions within 21 days. ~~There are two types of NFs: On-site NFs where CalOptima nurses make monthly or bimonthly visits, and "FAX-IN" NFs (includes all out of county NFs) where NCMs do not visit but do review medical records sent to them via email or fax. Either an on-site visit or FAX-IN process is scheduled to~~Nurse Case Managers assess a member's needs through review of the Minimum Data Set, member's care plan, medical records, and social service notes~~, as well as bedside evaluation of the member and support system (for on-site only). Ongoing case management is provided for members whose needs are changing or complex.~~ . LTC services also include coordination of care for members transitioning out of a facility, such as education regarding community service options, or a referral to MSSP, IHSS, CalAIM or ~~to a~~ CBAS ~~facility~~. Referrals to case management can also be made upon discharge when a ~~member~~member's needs indicate a referral is appropriate. In addition, the LTC staff provides education to facilities and staff ~~through monthly on-site visits, quarterly and annual workshops, or~~ in response to individual facility requests, and when new programs are implemented.

CBAS

An outpatient, facility-based program offering day-time care and health and social services, to frail seniors and adults with disabilities to enable participants to remain living at home instead of in a nursing facility. Services may include health care coordination; meal service (at least one per day at center); medication management; mental health services; nursing services; personal care and social services; physical, occupational and speech therapy; recreational activities; training and support for family and caregivers; and transportation to and from the center. A new benefit launched in October 2022 allow for members to receive

Emergency Remote Services (ERS) in lieu of attending the center when they are experiencing an event that precludes them from attending the center in person. By allowing for ongoing support while the member is experiencing a public or personal emergency, the CBAS can continue to coordinate care and services on the member's behalf.

MSSP

~~CalOptima has responsibility for the payment of MSSP in the County of Orange for individuals who have Medi-Cal.~~CalOptima Health is an approved MSSP site through California Department of Aging (CDA).. The program provides services and support to help people 65 and older who have a disability that puts them at risk of going to a nursing home. Services include, but are not limited to, senior center programs, case management, money management and counseling, respite, housing assistance, assistive devices, legal services, transportation, nutrition services, home health care, meals, personal care assistance with hygiene, personal safety, and activities of daily living.

~~Transitions of Care~~

~~Transitions of Care (TOC) is a patient-centered intervention, managed by the Case Management department, which employs a coaching, rather than doing, approach. It provides OC and OCC members discharged from acute care hospitals (or their caregivers) with tools and support to encourage and sustain self-management skills in an effort to minimize the potential of a readmission and optimize the member's quality of life.~~

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

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

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

~~Case Management Process~~

~~The Case Manager is responsible for planning, organizing and coordinating all necessary services required or requested, and facilitating communication between the member's PCP, the member, family members (at the member's discretion), other practitioners, facility personnel, other health care delivery organizations and community resources, as applicable.~~ ~~For further details of the structure, process, staffing, and overall program management please refer to the current Case Management Program~~

~~document.~~

~~Transplant Program~~

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

~~Coordination of Care~~

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

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Over/Under Utilization

Over/under utilization monitoring is tracked by UM leadership team, the ~~Clinical Performance Excellence Committee~~UM workgroup, identified stakeholders, Medical Director Team and reported to UMC. The UMC reviews the Over/Under Utilization ~~Dashboard~~report on a quarterly basis and approves and monitors metrics, discusses performance, address identify trends, contributes to the analysis, and identifies action plan for decreasing over and underutilization.-
Over/under utilization monitoring and performance are reported to the QIC and QAC on a quarterly basis.

~~The following are measures~~Under and Over Utilization is tracked and monitored ~~for over/under utilization~~through the following areas and trends:

- ER ~~admissions~~visits per 1000
- Bed days per 1000
- Admits per 1000

- Average length of stay per 1000
- Readmission rates
- ~~Denial rates~~
- Pharmacy utilization measures
- ~~Appeal overturn rates – provider per 1,000 per year~~
- Member grievances per ~~thousand~~1000
- ~~Outliers~~Identified Trends from Fraud, Waste and Abuse investigations
- Select HEDIS rates for selected measures
- PCP and specialist referral pattern analysis
- Member utilization patterns
- Trends in UM-related complaints
- Potential quality issues
- Behavioral health measures
- Other areas as identified

PROGRAM EVALUATION

The UM Program is evaluated at least annually and modifications made as necessary. The ~~UM~~Deputy Medical Director and Director, UM evaluate the impact of the UM Program by using:

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

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

SATISFACTION WITH THE UM PROCESS

CalOptima Health provides an explanation of the GARS process, State Fair Hearing and Independent Review processes to newly enrolled members upon enrollment and annually thereafter. The process is explained in the Member Handbook and Provider Manual and may also be highlighted in member newsletter articles, member educational flyers and postings at provider offices. Complaints or grievances regarding potential quality of care issues are referred to CalOptima Health QI department for investigation and resolution.

Annually, CalOptima Health evaluates both members' and providers' satisfaction with the UM process. Mechanisms of information gathering may include but are not limited to member satisfaction survey results such as Consumer Assessment of Healthcare Providers

and Systems (CAHPS); member/provider complaints and appeals that relate specifically to UM; provider satisfaction surveys with specific questions about the UM process; and soliciting feedback from members/providers who have been involved in appeals related to UM. When analysis of the information gathered indicates areas of dissatisfaction, CalOptima Health develops an action plan and interventions to improve the areas of concern, which may include staff retraining and member/provider education.

CASE MANAGEMENT PROCESS

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

Each year, based upon the evaluation and review of member satisfaction and effectiveness data, CalOptima Health updates the Complex Case Management process to better address member needs. Evaluation results are shared with staff and training is provided to ensure understanding of any programmatic changes to the current process for the upcoming year.

Updates and/or changes to the CCM program and process include but are not limited to the following:

- Ongoing development of the clinical documentation platform to enhance functionality of assessments, care plans, and outputs and provide continued training in clinical standards of care, NCQA PHM 5: Complex Case Management Standards, and techniques for effective case management to both CalOptima Health and Health Network staff.
- Provide targeted outreach and case management to support members who utilize primarily the emergency department for care and develop best practices for outreaching these members and improving their overall care.
- Continue development of specialized outreach and management for special populations, such as members struggling with homelessness, pain, or behavioral health issues. Enhance training in resources and engagement to care management staff, with the goal of increasing member engagement in case management.
- California Children's Services (CCS) managed by CalOptima through the Whole-Child Model (WCM) Program went into effect in 2019.
- Beginning on January 1, 2022, CalOptima Health implemented two CalAIM components: Enhanced Care Management (ECM) and Community Supports. Enhanced Care Management provides a whole- person approach to care that addresses the clinical and non-clinical circumstances of high need Medi-Cal members.
- Effective January 1, 2022, DHCS carved out the outpatient pharmacy benefit for Medi-Cal beneficiaries from managed care plans and moved it to a state fee-for-service program, known as Medi-Cal Rx.
- The OneCare Connect program ended effective December 31, 2022 and members transitioned to the OneCare (D-SNP) program effective January 1, 2023.
- Another component of CalAIM, Population Health Management was launched effective January 1, 2023 with a phased implementation.

Team Composition and Roles

The Case Management Department consists of functional teams that focus on specific program activities. The teams are multidisciplinary, and are composed of nurse Case

Managers, Social Workers, Medical Assistants, Personal Care Coordinators, and Member Liaison Specialists, as appropriate, to meet the needs of the member. Case Managers are assigned caseloads that are variable depending on the complexity of the cases managed. The Case Management Teams include a Triage Team, Health Risk Assessment Team, Health Network Liaison Team, an Oversight Clinical Team and a Direct Clinical Team.

The following staff positions provide support for organizational/operational CM Department's functions and activities:

Sr Director, Clinical Operations oversees the Case Management and Long-Term Services and Supports (LTSS) programs within CalOptima to ensure that these functions are properly implemented by all CalOptima Health Networks and contracted provider groups, including CalOptima Community Network and CalOptima Direct. The incumbent is responsible for programmatic oversight, strategic planning and ongoing compliance with all local, state and federal regulations and accreditation standards according to the CalOptima mission and vision.

Director of Care Management directs all Case Management programs for CalOptima members to ensure that these functions are properly implemented by all CalOptima Health Networks and contracted provider groups, including CalOptima Community Network and CalOptima Direct. The incumbent is responsible for all departmental compliance with all local, state, and federal regulations and ensures that accreditation standards are current, and all policies and procedures meet current requirements.

Manager of Case Management provides shared responsibility for the daily operations, activities, and projects for the Case Management department. The incumbent works under the general direction of the Director of Case Management and in partnership with the other department managers to provide performance management and development of the case management staff and projects associated with the department to ensure compliance with department policies and procedures, along with the implementation of assigned projects. The incumbent may be required to attend joint operational and community meetings. The incumbent is responsible for monitoring of case management reports and reporting to management or committees.

Case Management Supervisor is responsible for the daily operation of case management activities, the implementation of new programs and compliance with regulations. The incumbent will provide guidance to staff or will directly handle complex case management referrals. The incumbent will be accountable for establishing quality and productivity standards for the team and ensuring compliance with department policies and procedures in collaboration with the manager. The incumbent will serve as a resource for CalOptima Health's providers, health networks and community partners.

Medical Case Manager (Ambulatory) responsible for providing ongoing case management services for CalOptima Health's members. The Medical Case Manager will facilitate communication and coordination among all participants of the health care team and the member to ensure the services provided promote quality and cost-effective outcomes.

Medical Case Manager (Oversight) is responsible for providing ongoing case

management services for CalOptima members. The position facilitates communication and coordination among all participants of the health care team and the member to ensure that the services are provided to promote quality, cost-effective outcomes. The Oversight Case Manager completes intensive investigation of cases that are referred to the Case Management Team. The position serves as a resource for members, delegated plan case managers, Personal Care Coordinators (PCCs) and community partners to address medical, behavior, and psychosocial concerns. In conjunction with other team members, the incumbent may make recommendations for a comprehensive individualized care plan at all levels of care.

Medical Assistants are responsible for effective, efficient and courteous interaction with practitioners, members, family and other customers, under the direction of the licensed Case Manager or the Gerontology Resource Coordinator. The Medical Assistant performs medical and administrative routine tasks specific to the assigned unit, and office support functions. The Medical Assistant may also authorize requested services according to departmental guidelines.

Social Worker provides administrative case management and coordination of benefits for carved-out services. The Medical Social Worker serves as a departmental resource regarding benefits and available resources for the aged, behavioral health, foster care and the disabled population. The Medical Social Worker also serves as a liaison to Orange County based community agencies.

Personal Care Coordinator support CalOptima Health members in completing a Health Risk Assessment (HRA) and ensure communication of the HRA and care plan with the member, Primary Care Provider (PCP) and health care team. The PCC will identify barriers to members' care and assist in in improving these barriers for all levels of care. The incumbent will work closely with the PCP and health care team to ensure member access to timely services and coordination of care.

Program Assistant provides support to staff, including but not limited to preparing meeting materials, maintaining minutes, routing documents, conducting data entry and handling of incoming and outgoing correspondence per administrative policy. Provides administrative support for specific and/or ongoing projects, such as generating reports, logs, calendars, and mailings, applying general business practices, as well as CalOptima policies and procedures under the direction of the Director.

Data Analyst performs analysis and reports data related to Case Management projects, and ensures that case management goals and objectives are accomplished within specified time frames, through the judicious and efficient use of CalOptima Health resources.

QI Nurse Specialist is responsible for overseeing regulatory reports and audits for the entire Case Management department to ensure regulatory compliance, implementing and monitoring policy changes to case management reporting, and providing quality review of submitted health network data to meet Centers for Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), and National Committee for Quality Assurance (NCQA) requirements. In addition, the incumbent performs analysis and reports data related to the Case Management projects and ensures that Case Management goals and objectives are accomplished within specified time frames. The incumbent interacts with

other internal CalOptima departments, health networks, and external agencies.

While CalOptima Health enjoys a robust array of internal case management resources, case management activities are also performed by the Health Networks. The Health Networks utilize their own case management staff to manage CalOptima Health's members who are assigned to them. Case management departments at the Health Networks are staffed with Licensed Case Managers, Social Workers, Pharmacists, and unlicensed support staff. While these staff are supervised by the Health Networks, they participate in CalOptima Health specific training and are overseen by CalOptima Health.

Staff Training/Education

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

Each new employee is provided an intensive orientation and job specific training with a staff member. The following topics are covered during the introductory period, with specific training, as applicable to individual job description:

- CalOptima Health New Employee Orientation and Boot Camp (CalOptima programs)
- HIPAA and Privacy
- Fraud, Waste and Abuse, Compliance and Code of Conduct training
- Use of technical equipment (phones, computers, printers, facsimile machines, etc.)
- Workplace Harassment Prevention training
- Cultural Competency, Bias or Inclusion and Trauma-Informed Care training
- Seniors and Persons with Disabilities Awareness Training
- OneCare Model of Care Training
- CM Program: policies/procedures and desk top processes, etc.
- Medical Information System data entry
- Application of Review Criteria/Guidelines
- Appeals Process
- QI Referral Process

CalOptima Health 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 Health. Each year, a specific budget is set for continuing education for each licensed CM employee. Licensed nursing staff is monitored for appropriate application of Review Criteria/Guidelines, NCQA requirements, and case management documentation. Training opportunities are addressed immediately as they are identified through regular administration of proficiency evaluations. Any employee who fails the evaluation is provided additional training and provided with a work improvement process. Formal training, including seminars and workshops, are provided to all Case Management staff on an annual basis. Delegated Health Network staff participates annually in CalOptima Health model of care training.

Coordination of Care

Coordination of services and benefits is a key function of Case Management, both during inpatient acute episodes of care as well as for complex or special needs cases that are referred to the Case Management department for follow-up after discharge. Coordination of

care encompasses synchronization of medical, social, and financial services, and may include management across payer sources. The Case Manager must promote continuity of care by ensuring appropriate referrals and linkages are made for the member to the applicable provider or community resource, even if these services are outside of the required core benefits of the health plan or the member has met the benefit limitation. Because Medi-Cal is always the payer of last resort, CalOptima Health must coordinate benefits with other payers including Medicare, Worker's Compensation, commercial insurance, etc. in order to maintain access to appropriate services.

Other attempts to promote continuity and coordination of care include member notifications to those affected by a PCP or practice group termination from CalOptima Health. CalOptima Health assists the member as needed to choose a new PCP and transfer the medical records to the new PCP. If the provider is not termed due to a quality issue, continuity of care may also be explored to continue treatment with the provider in certain situations. CalOptima Health also coordinates continuity of care with other Managed Care Plans when a new member comes into CalOptima Health or a member terminates from CalOptima Health to a new health plan.

CalOptima Health uses the following data sources to identify a member for case management:

- Pharmacy data
- Health Risk/Needs Assessment
- Claims or encounter data
- Hospital Discharge data
- Utilization Management data
- Laboratory results
- Data supplied by purchasers
- Data supplied by member or caregiver
- Data supplied by practitioners
- Risk stratification process or Predictive Modeling Tool
- Health Information Form (HIF) or Member Evaluation Tool (MET), if available

The avenues for referring a member for case management are:

- Member self-referral
- Member's authorized representative/family referral
- Practitioner/Provider referral
- Customer Service referral
- Discharge Planner referral
- Disease Management program referral
- Community Agency referral
- HN/SRG/PMG referral
- Utilization Management referral
- Long Term Services and Supports referral

The case management program includes:

- Documented process to assess the needs of member population.
- Development of the program through use of evidenced based guidelines.
- Defined program goals.
- Standardized mechanisms for member identification through use of data.
- Multiple avenues for referrals to case management.
- Following members across the continuum of health care from outpatient or ambulatory to inpatient

settings.

- Process to inform eligible members of case management services, and the ability to elect or decline services.
- Documentation in a case management system that supports automatic documentation of case manager's name, date, time of action and prompts for required follow up.
- Use of evidenced-based clinical practice guidelines or algorithms.
- Initial assessment and ongoing management process.
- Developing, implementing and modifying an individualized care plan through an interdisciplinary and collaborative team process, in conjunction with the provider, member and/or their family/caregiver.
- Developing prioritized goals that consider the member or caregiver's goals and preferences.
- Developing member self-management plans.
- Coordinating services for members for appropriate levels of care and resources.
- Documenting all findings.
- Monitoring, reassessing, and modifying the plan of care to ensure quality, timeliness, and effectiveness of services.
- Analyzing data and member feedback to identify opportunities for improvement.
- Mechanism for identification and referral of quality-of-care issues to QI Department.
- Coordination of carved out services, such as Denti-Cal
- Identification of mental health needs and referral to Behavioral Health
- Identification of educational needs and referral to Population Health Management
- Referral to LTSS
- Assess and identify continuity of care needs and work collaboratively with UM department

Initial assessment of member's health care status and needs, including condition-specific issues:

- Member's right to accept or decline case management services
- Review of past medical history and co-morbidities
- Medication reconciliation and compliance
- Assessing member's support systems/caregiver resources and involvement
- Evaluation of behavioral health, cognitive function, and substance use disorder
- Evaluation of cultural and linguistic needs, preferences or limitations
- Member's motivational status or readiness to learn
- Assessment of visual and hearing needs, preferences or limitations
- Assessment of life-planning activities
- Assessment of functional status - activities of daily living (ADLs) and instrumental activities of daily living (iADLs)
- Assessment of social drivers of health (SDOH)
- Review current status and treatment plan
- Identifies barriers to quality, cost-effective care and fulfilling the treatment plan
- Determines implications of resources, and availability and limitations of benefit coverage
- Assessment of need for referrals to community resources
- Evidence-based clinical guidelines or algorithms to conduct assessment and management

Upon acceptance of a member into the CM Program, the Case Manager will develop a Case Management Plan that identifies the interventions required to provide appropriate care to the member.

A Case Management Plan includes the following:

- Development of prioritized SMART goals that take into account:
- Member or caregiver's goals or preferences
- Member or caregiver's desired level of involvement in case management plan
- Barriers to meeting goals and complying with self-management plan

- Scheduled time frame for follow-up and communication with members
- Assessment of progress towards goal, with modifications as needed
- Resources to be utilized, including the appropriate level of care
- Planning for continuity of care, including transition of care and transfer
- Collaborative approaches to be used, including family/caregiver participation

Coordination of Carved Out Services

CalOptima Health provides linkages with community programs to ensure that members with special health care needs, or high risk or complex medical and developmental conditions, receive wrap-around services that enhance their medical benefits.

Memorandum of Understanding (MOU) with other community agencies and programs, such as the HCA/California Children's Services, Orange County Department of Mental Health, and the Regional Center of Orange County. The CM staff and delegated entity practitioners are responsible for identification of such cases and coordination of referrals to appropriate State agencies and specialist care when the benefit coverage of the member dictates. The Case Management Department assists members with the transition to other care, if necessary, when benefits end. This may include informing the member about ways to obtain continued care through other sources, such as community resources.

Case Management Programs include identification and referral of a member eligible for community and/or Federal Medicaid Waiver programs, including, but not limited to:

- Specialty Mental Health Services
- California Children's Services (CCS)
- Regional Center of Orange County (RCOC)
- Local Education Agency (LEA)
- Genetically Handicapped Persons Program (GHPP)
- AIDS Waiver Program
- 1915 (c) Home and Community Based Services
- Assisted Living Waiver (ALW)
- Home and Community-Based Alternative (HCBA) Waiver (formerly NF/AH Waiver)
- Home and Community-Based Services Waiver for the Developmentally Disabled (HCBS-DD) Waiver
- Multipurpose Senior Services Program (MSSP)
- Tuberculosis Program (Direct Observation Therapy)
- Collaborate with the HCA/PDS TB Control Officer

Clinical Protocols

CalOptima Health is committed to serving the needs of all members assigned and places additional emphasis on the coordination of care for the vulnerable population. Approved clinical practice guidelines and nationally recognized protocols are used to guide treatment and care provided to the members. The use of clinical practice guidelines or nationally recognized protocols is challenging for the CalOptima Health membership as many of their needs are socioeconomic in nature. These guidelines do not address many of the supplemental benefits or community-based resources that may be critical to a comprehensive care plan for these individuals. Members with end stage renal disease (ESRD) and a comorbid condition of prostate cancer may not meet criteria for transplant based on guidelines. Lack of transportation may create obstacles to care, yet the member

may not meet criteria for non-emergency medical transportation. Members who are at the end-of-life may be inappropriate for certain preventive care screenings.

When use of a clinical practice guideline or nationally recognized protocol is challenging or inappropriate for an individual member the following steps may be taken:

- ICT is convened with the member, PCP, and specialists (if appropriate).
- Participants of the ICT review the case and mutually develop an ICP, prioritized per member's preferences.
- PCP or Case Manager facilitates referrals and linkages to identified supplemental benefits, community referrals and resources.

When a member's specific clinical requirements indicate the need for an alternative approach, decisions to modify clinical practice guidelines or nationally recognized protocols are made by the member, PCP or specialists, in consultation with other members of the health care team. The care team members review the member's current health status, limitations, social support, barriers, and treatment approach, which include any modifications needed in the clinical practice guidelines that support the ICP. Timeframes are established for each of the action items of the ICP to ensure successful completion of these tasks, identification of barriers, and attainment of goals. Updated ICP is shared with the care team members including but not limited to the member, caregivers, and PCP.

To address the unique needs of our members, CalOptima Health offers supplemental benefits, which can be accessed either through self-referral or via referral by a treating practitioner. These benefits are intended to aid members in maintaining optimal health status, either by providing health care services not covered by Medicare or Medi-Cal (e.g., vision care), by addressing barriers to access to care (e.g., Non-Medical Transportation), or by promoting regular physical activity (gym benefit).

Types of Case Management Services

Basic Case Management

Basic case management activities by the primary care practitioner may include, but are not limited to:

- A health assessment of member's current acute, chronic and preventive health needs
- Development of the member's treatment plan
- Communication between the practitioner and member/authorized representative to ensure compliance with established treatment plan
- Identification of the need for medical, specialty or ancillary referrals
- Referrals to case management and/or disease management

Complex Case Management

Complex Case Management Services are provided by CalOptima Health, in collaboration with the Primary Care Provider, and includes, at minimum:

1. Basic Case Management Services
2. Management of acute or chronic illness, including emotional and social support issues by a multidisciplinary case management team
3. Intense coordination of resources to ensure member regains optima health or improved functionality
4. With member and PCP input, development of care plans specific to individual needs, and updating of the care plans at least annually

Complex Case Management is the coordination of care and services provided to a member who has experienced a critical event, or diagnosis that requires the extensive use of resources, and

who needs assistance in facilitating the appropriate delivery of care and services.

The members in Complex Case Management usually:

1. Are at high risk; or
2. Have medically complex or frequently managed conditions or diseases, including, but are not limited to, the following:
3. Spinal Injuries
4. Transplants
5. Cancer
6. Serious Trauma
7. AIDS
8. Multiple chronic illnesses
9. Chronic illnesses that result in high utilization
10. Have a complex social situation that affects the medical management of their care; or
11. Require extensive use of resources; or
12. Have an illness or condition that is severe, and the level of management necessary is very intensive.

CalOptima uses this criteria when data mining and as a guideline for internal and external referral sources to identify appropriate CCM cases.

Children with Special Health Care Needs

Children with Special Health Care Needs (CSHCN) are those who have, or are at increased risk for, a chronic physical, developmental, behavioral, or emotional condition. They may have a disability or chronic medical condition due to complications of prematurity, metabolic disorder, chromosomal abnormalities, or congenital abnormalities. They require health and related services of a type or amount beyond that required by children generally.

Case Management staff ensures coordination of care with other entities that provide services for Children with Special Health Care Needs (e.g. mental health, substance abuse, Regional Center, CCS, local education agency, child welfare agency).

The goals of CSHCN Case Management are to:

- Collaborate with family and providers to develop an Individualized Care Plan
- Facilitate member access to needed services and resources
- Prevent duplication of services
- Optimize member's physical and emotional health and well-being
- Improve member's quality of life

Whole Child Model

The Whole-Child Model is a program that aims to help California Children's Services (CCS) children and their families get better care coordination, access to care, and health results. The WCM program combines a qualified member's Medi-Cal and CCS benefits under CalOptima. CCS is a statewide program that arranges and pays for medical care, equipment and other services for children and young adults under 21 years of age who have certain serious medical conditions.

Provides access for families so that families know where to go for ongoing information, education, and support in order that they understand the goals, treatment plan, and course of care for their child or youth and their role in the process, what it means to have primary or

specialty care for their child or youth, when it is time to call a specialist, primary, urgent care, or emergency room, what an Interdisciplinary Care Team (ICT) is, and what the community resources are.

The Whole Child Model program includes:

- Personal Care Coordinator (PCC) will be assigned to each CCS-eligible Member.
- Perform initial and periodic outreach to assist the Member with Care Coordination
- Provide information, education and support continuously, as appropriate
- Assist the Member and the Member's family in understanding the CCS-eligible Member's health, other available services, and how to access those services.
- Improve coordination of services to meet the needs of the child and family
- Maintain existing patient-provider relationships when possible
- Retain CCS program standards
- Improve overall health results

Transitional Care Services (TCS)

Transitional Care Services (TCS) are provided to members transitioning from levels of care, including hospitalizations and skilled nursing facility. For members enrolled with Case Management, Case Managers will support recently discharged members with tools and support to encourage and sustain self-management skills to help minimize the potential of a readmission and optimize the member's quality of life. TCS is provided to ensure members are supported from discharge planning until they have been successfully connected to all needed services and supports.

The Case Manager is responsible for coordinating and verifying that assigned members receive all appropriate TCS, regardless of setting and including, but not limited to, inpatient facilities, discharging facilities, and community-based organizations. The Case Manager is also responsible for ensuring collaboration, communication, and coordination with members and their families/support persons/guardians, hospitals, EDs, LTSS, physicians (including the member's PCP), nurses, social workers, discharge planners, and service providers to facilitate safe and successful transitions. While the Case Manager does not need to perform all activities directly, they must ensure all transitional care management activities occur, including the discharge risk assessment, discharge planning documentation, and necessary post-discharge services.

Special Programs

Transplant Program

The CalOptima Health Transplant Program is coordinated by the Medical Director and Medi-Cal members are managed in collaboration with the Case Management department. Transplants for Medi- Cal only members are not delegated to the HMOs, PHCs or SRGs, other than Kaiser Foundation Health Plan.

The Transplant Program provides the resources and tools needed to proactively manage members identified as potential transplant candidates. The Case Management department works in conjunction with the contracted practitioners and the DHCS Center(s) of Excellence or CMS certified Centers for OneCare. Case Management will follow the member and assist as needed through the transplant evaluation process, while they are waiting to procure an organ, and post-transplant for one year.

Members are monitored on an inpatient and outpatient basis and followed the transplant continuum. The member, physician and facilities are assisted in order to assure timely, efficient and coordinated access to the appropriate level of care and services within the member's benefit structure. In this manner, the Transplant Program benefits the member, the community of transplant staff and the facilities. CalOptima Health monitors and maintains oversight of the Transplant Program and report to UM Committee to oversee the accessibility, timeliness, and quality of the transplant protocols.

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2023
INTEGRATED UTILIZATION MANAGEMENT AND CASE MANAGEMENT PROGRAM DESCRIPTION

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2023 UTILIZATON MANAGEMENT PROGRAM SIGNATURE PAGE

Utilization Management Committee Chair:

_____ _____

Dabbah, Zeinab, M.D. ***Date***
Deputy Chief Medical Officer

Board of Directors' Quality Assurance Committee Chairperson:

_____ _____

Trieu Tran, M.D. ***Date***

Board of Directors Chair:

Clayton M. Corwin **Date:**

_____ _____

Contents

CASE MANAGEMENT PROCESS

WE ARE CALOPTIMA HEALTH

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

Our Mission

To serve member health with excellence and dignity, respecting the value and needs of each person.

Our Vision

By 2027, remove barriers to health care access for our members, implement same day treatment authorizations and real-time claims payments for our providers, and annually assess members' social determinants of health.

We are "Better. Together."

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

Our Strategic Plan

In 2022, CalOptima Health's Board and executive team worked together to develop the 2023 Strategic Plan. After engaging a wide variety of stakeholders and collecting feedback, the strategic plan was approved by the CalOptima Health Board of Directors in June 2022. The core strategy of the Strategic Plan is an inter-agency co-creation of services and programs, together with our delegated networks, providers, and community partners, to support the mission and vision and our Priorities and Objectives are designed to enhance the programs and services provided to members by CalOptima Health.

The five Strategic Priorities and Objectives are:

- Organizational and Leadership Development
- Overcoming Health Disparities
- Finance and Resource Allocation
- Accountabilities and Results Tracking
- Future Growth

WHAT IS CALOPTIMA HEALTH?

Our Unique Dual Role

CalOptima Health operates as both a public agency and a community health plan.

In this dual role, CalOptima Health must:

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

WHAT WE OFFER

Medi-Cal

In California, Medicaid is known as Medi-Cal. Medi-Cal covers low-income adults, families with children, seniors, people with disabilities, Affordable Care Act (ACA) expansion members, children in foster care (as well as former foster youth up to age 26), pregnant women, and low-income people with specific diseases, such as tuberculosis, breast cancer or HIV/AIDS. A Medi-Cal member must reside in Orange County to be enrolled in CalOptima Health Medi-Cal.

Scope of Services

CalOptima Health provides a comprehensive scope of acute and preventive care services for Orange County's Medi-Cal and dual eligible population, including eligible conditions under California Children's Services (CCS) managed by CalOptima Health through the Whole-Child Model (WCM) Program that began in 2019.

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

- Specialty mental health and substance use disorder services are administered by the Orange County Health Care Agency (HCA).
- Dental services are provided through the Medi-Cal Dental Program.

Members with Special Health Care Needs

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

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

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

These integrated LTSS benefits include three programs:

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

OneCare (HMO D-SNP)

Our OneCare (OC) members have Medicare and Medi-Cal benefits covered in one single plan, making it easier for our members to get the health care they need. Since 2005, CalOptima Health has been offering OC to low- income seniors and people with disabilities who qualify for both Medicare and Medi-Cal. OC has extensive experience serving the complex needs of the frail, disabled and dual eligible members in Orange County.

OC provides a comprehensive scope of services for dual eligible members enrolled in Medi-Cal and Medicare Parts A and B and reside in Orange County. Enrollment in OC is by member choice and voluntary. OC has an innovative Model of Care, which is the structure for supporting consistent provision of quality of care. Each member has a Case Management single point of contact, a case manager or 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 case management team works with our members and their doctors to create an individualized health care plan that fits each member's needs. Addressing individual needs results in a better, more efficient, and higher quality health care experience for the member.

OneCare Connect

The OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) was launched in 2015 for people who qualify for both Medicare and Medi-Cal. The OneCare Connect (OCC) program, as part of Cal MediConnect, a demonstration program operating in seven counties throughout California, was discontinued 12/31/2022 and all members were bridged into OneCare ensuring continuity of care for their existing services.

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

In 2013, CalOptima Health launched the PACE program that provides coordinated and integrated health care services to frail elders to help them continue living independently in the community.
To be a CalOptima Health PACE participant, members must be at least 55 years old, live in Orange County and be determined to be:

- Eligible for nursing facility services by the State of California.
- Able to live safely at home or in a community setting with proper support.
- Able to receive all non-emergent services within the CalOptima Health network.

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

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

CalOptima Health's Utilization Management team is the designated lead for administrative and nursing clinical review functions for PACE program inpatient admissions and works directly with the IDT for clinical determinations and transition coordination.

Quality PROGRAM INITIATIVES

CalOptima Health's QI Goals and Objectives are aligned with CalOptima Health's 2022–25 Strategic Goals.

1) Develop and implement a comprehensive Health Equity framework that transforms practices, policies and systems at the member, organizational and community levels.
2) Improve quality of care and member experience by attaining an NCQA Health Plan Rating of 5.0, and at least a Four-Star Rating for Medicare.
3) Engage providers through the provision of Pay for Value (P4V) programs for Medi-Cal, OneCare and Hospital Quality.

These top three priority goals were chosen to be aligned with CalOptima Health's strategic objectives as well as continued goals related to access to care and NCQA accreditation. The 2023 QI Work Plan details the strategies for childhood, COVID-19 and other immunizations, including targeted communication and member incentives. The planned activities related to members' ability to access care are captured as a communication and corrective action strategy for providers not meeting timely access standards (as measured by the annual Timely Access study). All goals and sub-goals will be measured and monitored in the QI Work Plan, reported to QIC quarterly and evaluated annually.

Comprehensive Community Cancer Screening and Support Program

- CalOptima Health strives to be the health care exemplar for all Orange County residents. The goal is for all of Orange County to have the lowest in the nation late-stage cancer incidence rate for breast, cervical, colon and lung cancer in certain smokers.
- CalOptima Health seeks to create a new Orange County health ethos with respect to cancer care by a laser on detection and diagnosis of these four specific cancers. \

The Comprehensive Community Cancer Screening and Support Program will increase early detection through improved awareness and access to cancer screening, decrease late-stage cancer diagnoses rates and mortality, and improve quality and member experience during cancer screening and treatment procedures among Medi-Cal members.

It will create a culture of cancer prevention, early detection and collaboration with partners toward a shared goal of dramatically decreasing late-stage cancer incidence and ensuring that all Medi-Cal members have equitable access to high quality care. The program will use a phased-in approach to invest over the next five years in the following three pillars:

1) Community and member awareness and engagement
2) Access to cancer screening
3) Improved member experience throughout cancer treatment

As of November 14, 2022, 3,925 CalOptima Health members were newly diagnosed with cancer. Increasing cancer screening rates is crucial for the early diagnosis and treatment of cancer, ultimately increasing life expectancy, quality of life and reducing health care costs.

Five-Year Hospital Quality Program

CalOptima Health's hospitals and their affiliated physicians are integral components of the delivery of health services to members and play a critical role in the delivery of care to members. For many years, CalOptima Health has been providing quality driven incentive payments to its Health Networks to drive improvement in quality outcomes and member satisfaction. Beginning January 1, 2023, CalOptima Health has established a Hospital Quality Program for its contracted hospitals to improve quality of care to members through increased patient safety efforts and performance-driven processes. Hospital performance measures serve to:

- Support hospital quality standards for Orange County in support of CalOptima Health's mission
- Provide industry benchmarks and data-driven feedback to hospitals on their quality improvement efforts
- Recognize hospitals demonstrating quality performance
- Provide comparative information on CalOptima Health hospital performance
- Identify areas for improvement and for working collaboratively with these hospitals to ensure the provision of quality care for CalOptima Health members

The program launches January 1, 2023, and extends through December 31, 2027. It includes two initiatives: Hospital Incentive Quality Pool and Hospital Reporting Incentive Payments.

This initiative will include the following principles:

1. Leverage publicly available, industry-standard measures from the Centers for Medicare & Medicaid Services (CMS) and the Leapfrog Group including:
    - CMS Quality
    - CMS Patient Experience
    - Leapfrog Hospital and Surgery Center Rating
    - Leapfrog Hospital Safety Grade

2. Require contracted hospital participation in CMS quality reporting programs (hospital inpatient, hospital outpatient, prospective payment systems-exempt cancer, or inpatient psychiatric) or Leapfrog Group Hospital and Surgery Center Rating for measurement as follows:
    - Contracted hospitals will be assessed on CMS quality reporting programs as reported on CMS Care Compare
    - Contracted hospitals not listed on CMS Care Compare for quality and patient experience will be assessed using the Leapfrog Hospital and Surgery Center Rating
    - Contracted hospitals not listed on either CMS Care Compare or Leapfrog Hospital
    - Surgery Center Rating will not qualify for incentive payments
3. Require contracted hospital participation in Leapfrog Hospital Safety Grade reporting
4. Allocate a maximum amount of a budget for a five-year period from 2023–2027 to fund the hospital incentive pool. The amount that each hospital may earn will be based on their proportion of services provided to CalOptima Health members, i.e., proportion of total bed days. Funding will be used to reward performance and unearned incentive dollars will be forfeited.

Incentive awards will be based on performance compared with quality thresholds and allocated based on the sum of claims and encounter inpatient days gathered six months after the end of the measurement period, to allow for data lag.

CalOptima Health recognizes that hospitals may not currently participate in CMS/Leapfrog public reporting programs. To promote hospital participation, CalOptima Health will provide a ramp-up period to allow hospitals to participate in CMS/Leapfrog reporting. During the ramp-up period, CalOptima Health will provide hospital reporting incentive payments to eligible hospitals.

Whole-Child Model

California Children's Services (CCS) is a statewide program for children with certain serious medical conditions. CCS provides medical care, case management, physical/occupational therapy and financial assistance. As of July 1, 2019, through SB 586, the state integrated CCS services into CalOptima Health's Medi-Cal managed care plan benefit, now called Whole Child Model (WCM). The goal of this transition and integration was to improve health care coordination by providing all needed care (CCS and non-CCS services including utilization management, transportation, care coordination, case management and complex case management) into a managed care plan (MCP), rather than providing CCS services separately. The WCM services successfully transitioned to CalOptima Health in 2019 as the 5th MCP awarded this pilot program. The HCA in Orange County continues to have the CCS program operate the medical eligibility determination processes, the Medical Therapy Unit and Program and CCS service authorizations for non- CalOptima Health enrollees. CalOptima works closely with the county CCS office to align protocols and ensure continuity of care for CCS-eligible members. California Advancing and Innovating Medi-Cal (CalAIM)California Advancing and Innovating Medi-Cal (CalAIM) is a multiyear initiative, spanning from 2022 to 2027, by DHCS to improve the quality of life and health outcomes of our population by implementing broad delivery system, program and payment reforms across Medi-Cal. CalOptima health implemented CalAim on

1/1/2022 and continues to work on expanding member access to services and supports. CalOptima's CalAIM program was established based upon three primary goals:

1. Identification and management of member risk and need through whole person care approaches and addressing social determinants of health.
2. Development of a consistent and seamless delivery of care and services through reduction of complexity and increase inflexibility.
3. Improved outcomes, reduction of health disparities, and transformation and innovation through value-based initiatives, modernization of systems and payment reform.

Enhanced Care Management and Community Supports

In a phased approach since January 2022, CalOptima Health has launched Enhanced Care Management (ECM) as well as all 14 Community Supports. ECM provides a whole-person approach to care that addresses the clinical and non-clinical circumstances of high-need Medi-Cal members. Members are identified to participate in ECM services through either a risk stratification approach that proactively identifies members as falling into one of the 10 DHCS identified Populations of Focus (POF) or members who meet the DHCS eligibility criteria can be referred in so that they can receive the services.

ECM providers are responsible for coordinating care with members' existing providers and other agencies to deliver the following seven core service components:

1. Outreach and Engagement
2. Comprehensive Assessment and Care Management Plan
3. Enhanced Coordination of Care
4. Health Promotion
5. Comprehensive Transitional Care
6. Member and Family Supports
7. Coordination of and Referral to Community and Social Support Services

CalOptima Health has partnered with several local Community Based Organizations to provide the 14 Community Supports to our members in a medically appropriate, cost-effective manner. Community Supports are alternatives to covered services, which are provided to reduce or avoid admissions to a hospital or skilled nursing facility admission, emergency department visits, and discharge delays.

The 14 Community Supports are:

1. Housing Transition Navigation Services
2. Housing Deposits
3. Housing Tenancy and Sustaining Services
4. Short-Term Post-Hospitalization Housing
5. Recuperative Care (Medical Respite)
6. Respite Services
7. Day Habilitation Programs
8. Nursing Facility Transition/Diversion to Assisted Living Facilities
9. Community Transition Services/Nursing Facility Transition to a Home
10. Personal Care and Homemaker Services
11. Environmental Accessibility Adaptations (Home Modifications) includes Personal Emergency Response Systems (PERS)
12. Medically Tailored Meals/Medically Supportive Foods

13. Sobering Centers
14. Asthma Remediation

All authorizations for ECM and Community Supports are requested through the CalOptima Connect Portal and are managed by CalOptima's LTSS CalAIM team to determine eligibility

OneCare Connect

The OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) was launched in 2015 for people who qualify for both Medicare and Medi-Cal. The OneCare Connect (OCC) program, as part of Cal MediConnect, a demonstration program operating in seven counties throughout California was discontinued 12/31/2022 and all members were bridged into OneCare ensuring continuity of care for their existing services

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

In 2013, CalOptima Health launched the PACE program that provides coordinated and integrated health care services to frail elders to help them continue living independently in the community.

To be a CalOptima Health PACE participant, members must be at least 55 years old, live in Orange County and be determined to be:

- Eligible for nursing facility services by the State of California.
- Able to live safely at home or in a community setting with proper support.
- Able to receive all non-emergent services within the CalOptima Health network.

Scope of Services

PACE provides all the acute and long-term care services covered by Medicare and Medi-Cal through an Interdisciplinary Team (IDT). The IDT is made up of physicians, nurses, social workers, dietitians, physical therapists, occupational therapists, home-care staff, activity staff and transportation staff who are committed to planning, coordinating and delivering the most fitting and personalized health care to our participants.
PACE participants must receive all needed services — other than emergency care — from CalOptima Health PACE providers and are personally responsible for any unauthorized or out-of-network services.

CalOptima Health's Utilization Management team is the designated lead for administrative and nursing clinical review functions for PACE program inpatient admissions and works directly with the IDT for clinical determinations and transition coordination.

Pharmacy Administration Changes

Effective January 1, 2022, DHCS carved out the outpatient pharmacy benefit for Medi-Cal beneficiaries from managed care plans and moved it to a state fee-for-service program (Medi-Cal Rx). Outpatient pharmacy claims processing/prior authorizations, formulary administration and pharmacy-related grievances are the responsibility of Medi-Cal Rx. CalOptima Health Pharmacy Management staff continue to assist members with medication-related access issues. CalOptima Health-retained responsibilities to include physician-administered drug claims processing/prior authorizations, pharmacy care coordination, clinical aspects of pharmacy adherence, disease and medication

management, and participation on the Medi-Cal Global Drug Utilization Review (DUR) Board. This change is for the Medi-Cal program only and does not affect OneCare or PACE.

Population Health Management (PHM) Program

CalOptima Health's PHM Program aims to ensure the care and services provided to our members are delivered in a whole-person-centered, safe, effective, timely, efficient, and equitable manner across the entire health care continuum and life span.

The PHM Program integrates physical health, behavioral health, LTSS, care coordination and complex case management to improve coordination of care between health care departments. The PHM includes basic population health management, care management, complex care management, ECM, and transitional care services.

CalOptima Health's PHM Program address the following four key strategies:

1. Keeping members healthy
2. Managing members with emerging risks
3. Considering patient safety or outcomes across settings
4. Managing multiple chronic conditions

The PHM Framework outlines three key components for operationalizing the program: gathering information, understanding risk, and providing services.

PHM Framework

The goals of the PHM program are to establish:

- Trust and meaningful engagement with members
- Data-driven risk stratification and predictive analytics to address gaps in care
- Revisions to standardize assessment processes
- Care management services for all high-risk members
- Robust transitional care services (TCS)
- Effective strategies to address health disparities, Social Determinants of Health (SDOH) and upstream drivers of health
- Interventions to support health and wellness for all members

CalOptima Health analyzes the PHM Program annually and uses key performance indicators, such as Primary Care, ambulatory care, ED visit and inpatient utilization and quality measures, such as HEDIS, to measure the effectiveness of the PHM Program.

CalOptima Health Direct Network and Health Network Entities

Direct Network and Contracted Health Networks Entities
Providers have several options for participating in CalOptima Health's programs providing health care to CalOptima Health members. Providers can participate through CalOptima Health Direct (COD) network or through a Health Network (HN).

CalOptima Health members can choose a Primary Care Provider (PCP) in CalOptima's Community Network (CCN) or one of 12 HNs, representing more than 10,000 practitioners. CalOptima members that do not choose a PCP are provisionally assigned to CalOptima's Direct Administrative network for forty-five (45) days until they choose a HN and PCP.

CalOptima Health Direct (COD)
CalOptima Health Direct (COD) network is composed of two elements: CalOptima Health Direct- Administrative (COD-A) and the CalOptima Health Community Network (CCN).

- CalOptima Health Direct-Administrative (COD-A) is a self-directed program administered by CalOptima Health to serve Medi-Cal members in special situations, including dual-eligibles (those with both Medicare and Medi-Cal who elect not to participate in CalOptima Health's OneCare programs), share of cost members, newly eligible members transitioning to a HN from CCN, and members residing outside of Orange County.
- CalOptima Health Community Network (CCN)provides doctors with an alternate path to contract directly with CalOptima Health to serve our members. CCN is administered directly by CalOptima Health and available for HN eligible members, supplementing the existing HN delivery model and creating additional capacity for access for certain covered services that are not the financial risk of the HN.

CalOptima Health Contracted Health Networks
CalOptima Health has contracts with HNs that are delegated to perform certain clinical and administrative functions on behalf of CalOptima Health through a variety of risk models to provide care to members. The following contract risk models are currently in place with HNs:

- Health Maintenance Organization (HMO)
- Physician/Hospital Consortia (PHC)
- Shared-Risk Group (SRG)

Through our delegated HNs, CalOptima Health members have access to 1,293 primary care providers (PCPs), 8,160 specialists, 45 hospitals, 34 Community Health Centers clinics and 98 long-term care facilities.

Provider Network Data (as of January 31, 2023)

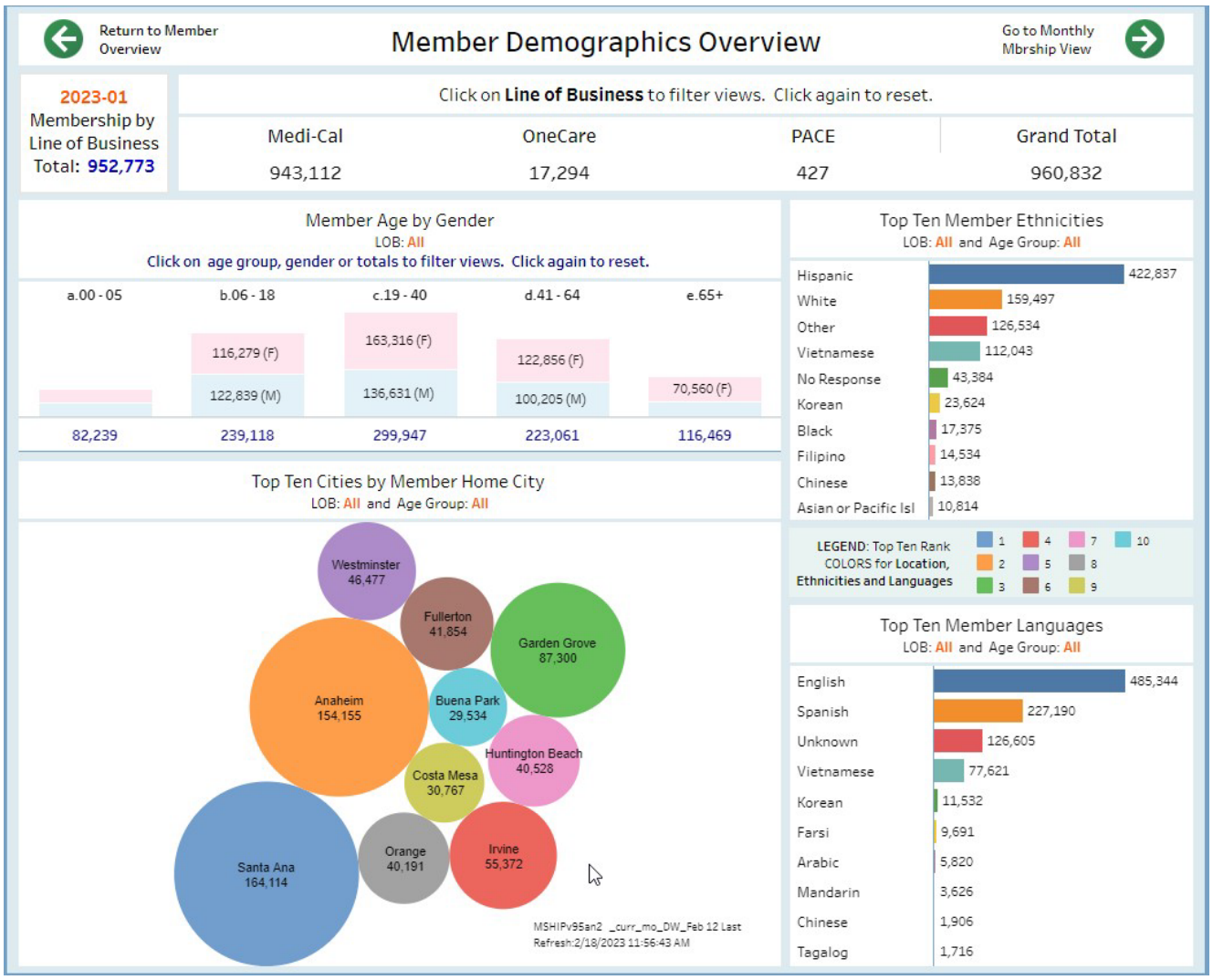
	Number of Providers
Primary Care Providers	1,293
Specialists	8,160
Pharmacies	565
Acute and Rehab Hospitals	45
Community Health Centers	34
Long-Term Care Facilities	98

CalOptima Health contracts with the following HNs benefit programs:

Health Network/Delegate	Medi-Cal	OneCare
AltaMed Health Services	SRG	SRG
AMVI/Prospect Medical Group		SRG
AMVI Care Medical Group	PHC	PHC
Arta – Optum Care Network	SRG	SRG
CHOC Health Alliance	PHC	
Family Choice Medical Group		SRG
Family Choice Health Services	HMO	
HPN – Regal Medical Group	HMO	HMO
Kaiser Permanente	HMO	
Monarch – Optum Care Network	HMO	HMO
Noble Mid-Orange County	SRG	SRG
Prospect Medical Group	HMO	HMO
Talbert – Optum Care Network	SRG	SRG
United Care Medical Group	SRG	SRG

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

- Utilization management
- Basic and complex case management
- Claims
- Contracting and Provider Network development
- Provider Relations
- Credentialing of practitioners
- Customer services membership Demographics



UTILIZATION MANAGEMENT PROGRAM

Utilization Management Purpose

The purpose of the Utilization Management (UM) Program is to define the oversight and delivery of CalOptima Health's structure, clinical processes, and programmatic approach to review health care services, treatment, and supplies, and provide quality, coordinated health care services to CalOptima Health members. The Utilization Management Program includes review and analysis of utilization trends including identification of under and over-utilization to determine members are receiving appropriate services. All health care services serve the culturally diverse needs of the CalOptima Health population and are delivered at the appropriate level of care, in an effective, and timely manner by delegated and non-delegated providers.

UM Scope

The scope of the UM Program is comprehensive and applies to all eligible members across all product types, age categories and range of diagnoses within CalOptima Health's membership. Additionally, the scope of the UM program is to oversee continuity of care and access to appropriate services, providers and care settings. The UM Program incorporates physical and behavioral health, pharmacy services, long term care and long-term services and supports. This includes preventive, emergency, primary, specialty, home- and community-based services, as well as acute, subacute, short-term and long-term facility and ancillary care services.

UM PROCESS

The UM process includes but is not limited to the following program components: referral/prior authorization, inpatient and concurrent review, post-stabilization services, ambulatory care review, retrospective review, discharge planning, care coordination and second opinions. All requests are reviewed against hierarchical guideline criteria and approved services must meet medical necessity criteria. The clinical decision process initiates upon receipt of a treatment authorization request. Request types include authorization of specialty services, second opinions, outpatient services, ancillary services, post-stabilization inpatient services, or scheduled inpatient services. The process is complete when the requesting practitioner and member (when applicable) have been notified of the determination.

UM policies and processes serve as integral components in preventing, detecting, and responding to utilization trends and opportunities as well as identifying potential fraud and abuse among practitioners and members. The UM department works closely with the Compliance Officer and the Fraud, Waste and Abuse Unit to resolve any potential issues that may be identified. All UM team members and oversight committees sign an annual attestation and are expected to abide by and uphold, CalOptima's policy for ensuring all medical decisions are made based within regulatory requirements and are not unduly influenced by financial considerations.

CalOptima Health provides Continuity of Care services up to 12 months to requesting member's primary care providers, specialists and some ancillary providers for Medi-Cal beneficiaries transitioning to CalOptima Health or transitioning from a Managed Care Plan with contracts expiring to CalOptima or a Health Network.

UM Program Goals

The goal of the UM Program is to manage appropriate utilization of medically necessary, covered services and to ensure access to quality and cost-effective health care for CalOptima Health members. This includes but is not limited to:

- Assisting in the coordination of medically necessary physical health, behavioral health, Long-Term Services and Supports (LTSS), Long Term Care (LTC) and pharmacy services in accordance with benefit and clinical criteria and hierarchy, state and federal laws, regulations, contract requirements, NCQA standards and other evidence-based clinical criteria.
- Enhancing the quality of care for members by promoting coordination and continuity of care and service, especially during member transitions between

different levels of care.

- Providing a mechanism to address concerns about access, availability and timeliness of care.
- Clearly defining staff responsibility for activities regarding decisions based on medical necessity including non-clinical, clinical and Medical Director staff roles and responsibilities.
- Establishing and maintaining processes used to review medical and behavioral health care and pharmacy service requests, including timely notification to members and/or providers of appeal rights when an adverse determination is made based on medical necessity and/or benefit coverage.
- Identifying and referring members to Care Coordination, Case Management, Complex Case Management and Enhanced Care Management programs, LTSS, Behavioral Health and/or Population Health Management services, as appropriate.
- Promoting a high level of member, practitioner and stakeholder satisfaction.
- Protecting the confidentiality of members health and personal information.
- Identifying and reporting potential quality of care issues (PQIs) and Provider Preventable Conditions (PPCs) and refer them to the Quality Improvement (QI) department for further action.
- Identifying and address over- and underutilization of services. Monitoring utilization practice patterns of practitioners to identify variations from the standard practice that may indicate need for additional education or support.
- Promoting improved member outcomes by coordinating services with appropriate county/state sponsored programs such as In-Home Supportive Services (IHSS), and County Specialty Mental Health.
- The LTSS team works collaboratively with CalOptima Health's HN's to coordinate care for complex discharge needs and CalAIM services.
- Provide continuous identification of UM staffing needs including clinical, non-clinical and medical directors to address the needs of the members we serve.
- Provide continuous training for competency, as well as ensure staff are well versed in UM processes, regulatory requirement changes and workflow/process changes within the department.

UM Program Structure

The CalOptima Health UM Program is designed to work in alignment with delegated entities, for optimal health outcomes and includes but is not limited to, physicians, hospitals, health care delivery organizations, and ancillary service providers in the community to ensure that the member receives appropriate, cost-efficient, quality-based health care.

The UM Program is reviewed, evaluated and revised as needed for effectiveness and compliance with the standards of CMS, DHCS, California Department of Aging (CDA), NCQA and established best practice standards/ internal benchmarks at least annually. The structure of the UM Program is designed to promote organizational accountability and responsibility in the identification, evaluation, and appropriate utilization of health care services delivered by the CalOptima Health's network. Additionally, the program structure is designed to enhance communication and collaboration on UM issues that affect delegated entities and multiple disciplines within the organization. The organization chart and the UM Program reflect the Board of Directors as the governing body, identifies senior management responsibilities, as well as committee reporting structure and lines of authority. Position job

descriptions and policies and procedures define associated responsibilities and accountability. The composition and functions of the Utilization Management Committee (UMC) and Quality Improvement Committee (QIC), which serve as the oversight committees for UM functions, are contained and delineated in the committee's charters.

The UM Program is overseen by the Chief Medical Officer and evaluated on an ongoing basis for efficacy and appropriateness of content by the Medical Management and Quality leadership team that may include but is not limited to the Deputy Chief Medical Officer; Medical Director(s) of UM; Behavioral Health Medical Director; Executive Director of Behavioral Health Integration; Executive Director, Clinical Operations; UMC; and QIC.

Delegation of UM functions

CalOptima Health delegates UM activities for a portion of the CalOptima membership to Health Networks that demonstrate the ability to meet CalOptima Health's standards, as outlined in the UM Program Description and CalOptima Health policies and procedures.

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

- Frequent reporting of key performance metrics that are required and/or developed by CalOptima Health's Audit & Oversight department and reported to the Delegation Oversight Committee and/or Quality Improvement Committee (QIC).
- Annual and ad-hoc audits of delegated HNs' UM activities by CalOptima Health's Audit & Oversight department to ensure accurate and timely completion of delegated activities. Annual or more frequent evaluation to determine whether the delegated activities are being carried out according to DHCS, Centers for Medicare & Medicaid Services (CMS), NCQA, and CalOptima Health standards and program requirements.
- Annual approval of the delegate's UM Program (or portions of the program that are delegated); as well as any significant program changes that occur during the contract year.

In the event the delegated provider does not adequately perform contractually specified delegated duties, CalOptima Health takes further action, including increasing the frequency or number of focused audits, requiring the delegate to implement corrective actions, imposing sanctions, capitation review, or de- delegation.

LONG-TERM SUPPORT SERVICES (LTSS)

CalOptima Health ensures LTSS services are available to members who have health care needs and meet the program eligibility criteria and guidelines. The LTSS program includes both institutional and community- based nursing and sub-acute facility services for both adults and pediatrics. CalOptima Health's LTSS department monitors and reviews the quality and outcomes of services provided to members in both settings.

HOME- AND COMMUNITY-BASED SERVICES:

CalOptima LTSS monitors member utilization, level of access and satisfaction with

Community Based Adult Services (CBAS) and Multipurpose Senior Services Programs (MSSP) focusing on diverting members from institutionalization, when appropriate.

Behavioral Health Services

CalOptima Health offers outpatient mental health services to Medi-Cal members with mild to moderate impairment of mental, emotional or behavioral functioning, Services include but are not limited to individual, family and group psychotherapy, psychiatric consultation, medication management, and psychological testing when clinically indicated to evaluate a mental health condition. CalOptima Health also covers alcohol and drug use screening, assessment, brief interventions, and referral to treatment (SABIRT) provided to members 11 years and older, including pregnant women by providers within their scope of practice.

CalOptima Health covers medically necessary behavioral health treatment (BHT) for members 20 years and younger under Early and Periodic Screening, Diagnostic and Treatment (EPSDT). BHT services include applied behavior analysis (ABA) and a variety of other behavioral interventions that have been identified as evidence-based approaches that prevent or minimize the adverse effects of behaviors that interfere with learning and social interaction.

CalOptima does not require members, or their practitioners undergo triage and referral when seeking information about or approval of BH services. Most mental health services do not require a physician referral. Members may access mental health services by calling the CalOptima Health Behavioral Health Line at **855-877-3885**. A CalOptima Health representative will conduct a brief telephonic screening to determine the reason for the call and the assistance needed. Mental health screenings are conducted by CalOptima Health's Behavioral Health Integration licensed clinicians using the most recent DHCS approved screening tool. The screening is used to make an initial determination of the member's impairment level due to a mental health condition. If the member has mild to moderate impairments, the member will be offered behavioral health providers within the CalOptima Health network. If the member has significant to severe impairments, the member will be referred to Specialty Mental Health Services (SMHS) through the Orange County Mental Health Plan (OCMHP) managed by the Orange County Health Care Agency.

CalOptima Health directly manages all administrative functions of the Medi-Cal behavioral health benefits including UM, claims, provider network credentialing, member services and QI.

One Care (OC)
CalOptima Health offers the following mental health services to OC members:

- Inpatient psychiatric hospitalization
- Intensive outpatient program (IOP) and partial hospitalization program (PHP)
- I Outpatient individual and group psychotherapy
- Outpatient medication management
- Psychological testing
- Opioid Treatment Program (OTP) services
- Electro Convulsive Therapy (ECT)
- Transcranial Magnetic Stimulation (TMS)
- Alcohol and drug use screening, assessment, brief interventions, and referral to treatment (SABIRT)

Most mental health services do not require a physician referral. Members may access mental health services by calling the CalOptima Health Behavioral Health Line at 855-877-3885. A CalOptima Health representative will conduct a brief telephonic screening to determine the reason for the call and the assistance needed. Mental health screenings are conducted by CalOptima Health's Behavioral Health Integration licensed clinicians using the most recent approved screening tool. The screening is to make an initial determination of the member's impairment level. If the member has mild to moderate impairments due to a mental health condition, the member will be offered behavioral health practitioners within the CalOptima Health provider network. If the member has significant to severe impairments, the member will be referred to (SMHS) through the OCMHP.

CalOptima Health directly manages all administrative functions of the OC behavioral health benefits including UM, claims, provider network credentialing, member services and QI.

AUTHORITY, BOARDS OF DIRECTORS' COMMITTEES, AND RESPONSIBILITIES

Board of Directors
CalOptima Health's Board of Directors has ultimate accountability and responsibility for overseeing the quality of care and service provided to CalOptima Health members. The responsibility to oversee the UM Program is delegated by the Board of Directors to the Board's Quality Assurance Committee (QAC) — which oversees the functions of the QI Committee described in CalOptima Health's state and federal contracts — and to CalOptima Health's Chief Executive Officer (CEO), as described below.

The Board holds the CEO and the Chief Medical Officer (CMO) accountable and responsible for the quality of care and services provided to members. The Board ensures 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 UM Program annually.

The responsibility for the direction and management of the UM Program has been delegated to the CMO. Before coming to the Board of Directors for approval, the UM Program is reviewed and approved by the UMC, the QIC and the QAC on an annual basis.

CalOptima Health 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 Health's Board meetings are open to the public.

Board of Directors' Quality Assurance Committee
The Board of Directors appoints the QAC to conduct annual evaluation, provide strategic direction, and make recommendations to the Board regarding the overall QI Program. QAC routinely receives progress reports from the QIC describing improvement actions taken, progress in meeting objectives, and quality performance results. The QAC also makes recommendations to the Board for annual approval with modifications and appropriate resource allocations of the QI Program.

Member Advisory Committee
The Member Advisory Committee (MAC) has 15 voting members, each seat represents a constituency served by CalOptima Health. The MAC ensures that CalOptima Health members' values and needs are integrated into the design, implementation, operation and evaluation of the overall QI program. The MAC provides advice and recommendations on community outreach, cultural and linguistic needs and needs assessment, member survey results, access to health care, and preventive services. The MAC meets on a bi-monthly basis and reports directly to the CalOptima Health Board of Directors. MAC meetings are open to the public.

The MAC membership has representatives from the following constituencies:

- Adult Beneficiaries
- Children
- Consumer
- Family Support
- Foster Children
- Long-Term Care Representative
- Medi-Cal Beneficiaries
- Medical Safety Net Representative
- Orange County Health Care Agency (standing seat)
- Orange County Social Services Agency (standing seat)
- People with Disabilities
- Behavioral/Mental Health Representative
- People with Special Needs
- Recipients of CalWORKs
- Seniors

Provider Advisory Committee
The Provider Advisory Committee (PAC) was established in 1995 by the CalOptima Health Board of Directors to advise the Board on issues impacting the CalOptima Health provider community. PAC members represent a broad provider community that serves CalOptima Health members. The PAC meets at least quarterly and is open to the public. The members include:

- Health networks
- Hospitals
- Physicians
- Nurse
- Allied health services
- Community health centers
- Health Care Agency (HCA)
- LTSS (LTC facilities and CBAS)
- Non-physician medical practitioner
- Traditional safety net provider
- Behavioral/mental health

- Pharmacy

Whole-Child Model Family Advisory Committee
Whole-Child Model Family Advisory Committee (WCM FAC) has been required by the state as part of California Children's Services (CCS) when it became a Medi-Cal managed care plan benefit. The WCM FAC provides advice and recommendations to the Board and staff on issues concerning the WCM program, serves as a liaison between interested parties and the Board, and assists the Board and staff in obtaining public opinion on issues relating to CalOptima Health's WCM program. The committee can initiate recommendations on issues for study and facilitate community outreach.

Members of WCM FAC include-

- Family representatives:
  - Authorized representatives, which includes parents, foster parents and caregivers of a CalOptima Health member who is a current recipient of CCS services; or
  - CalOptima Health members ages 18–21 who are current recipients of CCS services; or
  - Current CalOptima Health members over the age of 21 who transitioned from CCS services.
- Interests of children representatives:
  - Community-based organizations; or
  - Consumer advocates

CalOptima Health Officers
Chief Medical Officer (CMO), Chairperson of the Utilization Management Committee (UMC), Executive Director of Clinical Operations, and/or any designee as assigned by CalOptima Health's Chief Executive Officer (CEO) are the senior leaders responsible for implementing the UM Program, including appropriate use of health care resources, medical and behavioral health QI, medical and behavioral health utilization review and authorization, case management, PHM and health education program implementations.

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

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

Chief Medical Officer (CMO) oversees strategies, programs, policies and procedures as they relate to CalOptima Health's quality and safety of clinical care delivered to members. At least quarterly, the CMO presents reports on QI activities to the Board of Directors' Quality Assurance Committee.

Deputy Chief Medical Officer (DCMO), along with the CMO, oversees the strategies,

programs, policies and procedures as they relate to CalOptima Health's medical care delivery system. The DCMO and CMO oversee Quality Analytics (QA), Quality Improvement (QI), Utilization Management (UM), Case Management (CM), Population Health Management (PHM), Pharmacy Management (PM), Behavioral Health Integration (BHI), Long-Term Support Services (LTSS) and Enterprise Analytics (EA).

Executive Director, Clinical Operations (EDCO) is responsible for oversight of all operational aspects of key Medical Affairs functions including the UM, Care Coordination, Complex Case Management, and Managed LTSS (MLTSS) programs, along with all new program implementations related to initiatives in these areas. The EDCO serves as a member of the executive team, and, with the CMO, DCMO and the ED of Quality and Population Health Management (Q&PHM), makes certain that Medical Affairs is aligned with CalOptima Health's strategic and operational priorities. This position is a key leader within the health plan and has the accountability to lead the areas assigned to next level capabilities and operational efficiencies consistent with CalOptima Health's strategic plan, goals and objectives. The EDCO is expected to anticipate, continuously improve, communicate, and leverage resources, as well as balance achieving set accountabilities within constraints of limited resources. Executive Director, Behavioral Health Integration (ED of BHI) is responsible for the management and oversight of CalOptima's Behavioral Health Integration department, along with new implementation related to state and county behavioral health initiatives. The ED of BHI strategies for integrating behavioral health across the health care delivery system and populations served.

Executive Director, Population Health Management (ED PHM) oversees the development and implementation of company wide Population Health Management strategy to improve member experience, promote optimal health outcomes, ensure efficient care and improve health equity. The ED PHM serves as a member of the executive team, and with the CMO, DCMO and Executive Director, Clinical Operations, supports efforts to promote adherence to established quality improvement strategies and integrate behavioral health across the delivery system and populations served. The Director of Population Health Management reports to the ED PHM.

Physical and Behavioral Health Medical Directors *(hereinafter referred to "Medical Directors")* have primary assigned roles but may provide coverage and back up to other specialties as needed. All medical directors are appointed by the CMO and/or DCMO and are responsible to adhere to and oversee the direction of the UM Program and objectives, as well as evaluation of the UM Program.

- The medical director who oversees UM ensures quality medical service delivery to members managed directly by CalOptima Health and is responsible for medical direction and clinical decision making in UM. The medical director ensures that an appropriately licensed professional conducts reviews on cases that do not meet medical necessity and uses evidence-based review criteria/guidelines for any potential adverse determinations of care and/or service, as well as monitors documentation for adequacy. In collaboration with the CMO and/or DCMO, the medical director also provides supervisory oversight and administration of the UM Program and oversees the UM activities and clinical decisions of staff that work in concurrent, prospective and retrospective medical management activities, monitors for documentation

adequacy, and works with the clinical staff that support the UM process. The medical director provides clinical education and in-service training to staff, presenting key topics on clinical pathways and treatments relating to actual cases being worked in UM, as well as educates on industry trends and community standards in the clinical setting. The medical director of UM ensures physician availability to staff during normal business hours and on-call after hours. Also serves as the Chair of the UMC and the Benefit Management Subcommittee, facilitates the biweekly UM Workgroup meetings and participates in the CalOptima Health Medical Directors Forum and QIC.

- The medical director who oversees the behavioral health program is a participating member of the UMC, QIC and CPRC. The medical director provides consultation and oversight to the UM Program, including guidance on criteria review and development to ensure parity. The medical director is also the chair of the Pharmacy & Therapeutics committee (P&T). The medical director supports the behavioral health aspects of the UM Program. The medical director also provides leadership and program development in the creation and/or improvement of services and systems ensuring the integration of physical and BH care services for CalOptima Health members. Clinical oversight is also provided for BH benefits and services provided to members. The medical director works closely with all departments to ensure appropriate access and coordination of behavioral health care services, improves member and provider satisfaction with services and ensures quality BH outcomes.

- The medical director who oversees specialty programs and services is a key member of the medical management team and is responsible for the Medi-Medi programs, MLTSS programs, and Case Management programs. The medical director provides physician leadership in the Medical Affairs division, including acting as liaison to other CalOptima Health operational and support departments, including PHM, disease management and health education programs, while also providing clinical quality oversight of the Program of All-Inclusive Care for the Elderly (PACE) Center.

Director, Utilization Management is responsible for the planning, organization, implementation and evaluation of all activities and personnel engaged in UM departmental operations. This position provides leadership and direction to the UM department to ensure compliance with all local, state and federal regulations, that accreditation standards are current, and all policies and procedures meet current requirements. The incumbent will have oversight of CalOptima Health's UM Program for CalOptima Health Community Network, CalOptima Health Direct and the delegated HNs. The Director is expected to serve as a liaison for various internal and external committees, workgroups and operational meetings.

Director, Behavioral Health Integration is responsible for the planning, organization monitoring, and evaluation of all activities and personnel engaged in the BH UM operations. The director tracks, analyzes changes in the behavioral health care delivery environment and program opportunities affecting or available to assist CalOptima Health in integrating physical and BH care services. This position provides leadership and direction to the BH UM team to ensure compliance with all local, state and federal regulations, that

accreditation standards are current, and all policies and procedures meet current requirements. This position plays a key leadership role in coordinating with all levels of CalOptima Health staff, including the Board of Directors, executive staff, members, providers, HN management, state and federal officials, and representatives of other agencies.

Director, Quality Improvement is responsible for assigned day-to day operations of the QI department, including Credentialing, Facility Site Reviews for both physical and behavioral health (including onsite visits and process evaluation), Physical Accessibility Compliance and working with the ED of Q&PHM to oversee the QI Program and maintain NCQA accreditation. This position is also responsible for implementation of the QI Program and QI Work Plan implementation.

Director, Quality Analytics provides data 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. This position provides coordination and support to the QIC and other committees to support compliance with regulatory and accreditation agencies.

Director, Population Health Management provides direction for program development and implementation for agencywide population health initiatives while ensuring linkages supporting a whole- person perspective to health and health care with Case Management, UMC, Pharmacy and BHI. This position provides direct care coordination and health education for members participating in non- delegated health programs, such as Perinatal Support Services (Bright Steps) and Childhood Obesity Prevention Program (Shape Your Life). Also, supports the MOC implementation for members. Reports program progress and effectiveness to QIC and other committees to support compliance with regulatory and accreditation agency requirements.

Director, Audit & Oversight oversees and conducts independent performance audits of CalOptima Health operations, Pharmacy Benefits Manager (PBM) operations and SRG delegated functions with an emphasis on efficiency and effectiveness and in accordance with state/federal requirements, CalOptima Health policies, and industry best practices. The director ensures that CalOptima Health and subcontracted HNs perform consistently with both CMS and state requirements for all programs. Specifically, the director leads the department in developing audit protocols for all internal and delegated functions to ensure adequate performance relative to both quality and timeliness. Additionally, the director is responsible to ensure the implementation of strategic and tactical direction to improve the efficiency and effectiveness of internal processes and controls, as well as delegated functions. The position interacts with the Board of Directors, CalOptima Health executives, departmental management, HN management and legal counsel.

UM Staffing Resources

CalOptima Health uses appropriate licensed health care professionals to process and/or supervise UM activities. The following UM Program roles

- provide day-to-day supervision of assigned UM staff.
- Participate in staff training.
- Monitor for consistent application of UM criteria by UM staff, for each level and type of UM decision.
- Monitor documentation for adequacy.
- Are available to UM staff on site or by telephone.

Manager, Utilization Management RN/LVN (Concurrent Review [CCR]) manages the day-to-day operational activities of the department to ensure staff compliance with company policies and procedures, and regulatory and accreditation agency requirements. The manager develops, implements and maintains processes and strategies to ensure the delivery of quality health care services to members while establishing and maintaining collaborative working relationships with internal and external resources to ensure appropriate support for utilization activities.

Supervisor, Utilization Management RN/LVN(CCR) provides day-to-day supervision of assigned staff, monitors and oversees daily work activities to ensure that service standards are met, makes recommendations regarding assignments based on assessment of workload. The supervisor is a resource to the CCR staff regarding CalOptima Health policies and procedures, as well as regulatory and accreditation requirements governing inpatient concurrent review and authorization processing, while providing ongoing monitoring and development of staff through training activities. The supervisor also monitors for documentation adequacy, including appropriateness of clinical documentation to make a clinical determination, and audits documentation to assure consistent application of the appropriate clinical guideline to the member's clinical condition. Supervisory staff are available both on-site and telephonically for all UM staff during regular business hours.

Manager, Utilization Management RN/LVN (Prior Authorization [PA]) manages the day-to-day operational activities of the department to ensure staff compliance with CalOptima Health policies and procedures, and regulatory and accreditation agency requirements. The manager develops, implements and maintains processes and strategies to ensure the delivery of quality health care services to members while establishing and maintaining collaborative working relationships with internal and external resources in order to ensure appropriate support for utilization activities.

Supervisor, Utilization Management RN/LVN (PA) provides day-to-day supervision of assigned staff, monitors and oversees assigned daily work activities to ensure that service standards are met. The supervisor makes recommendations regarding assignments based on assessment of workload and is a resource to the Prior Authorization staff — regarding CalOptima Health policies and procedures as well as regulatory requirements governing prior and retrospective authorization processing — while providing ongoing monitoring and development of staff through training activities. The supervisor also monitors for documentation adequacy, including clinical documentation to make a clinical determination, and audits documentation to assure consistent application of the appropriate clinical guideline to the member’s clinical condition.
Supervisory staff are available both on-site and telephonically for all UM staff during regular business hours.

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

Notice of Action Medical Case Managers (RN/LVN) draft and evaluate denial letters for adequate documentation and utilization of appropriate criteria, and is written in plain language that a layperson understands.

Medical Case Managers (RN/LVN) provide inpatient and outpatient utilization review and authorization of services in support of members. They are responsible for assessing the medical appropriateness, quality and cost effectiveness of proposed inpatient hospital and outpatient medical/surgical services, in accordance with established evidence-based criteria.

All potential denial and/or modifications of provider service requests are discussed with the appropriate Medical Director, who makes the final determination.

Medical Authorization Assistants are responsible for interacting with practitioners, members, family and other customers. Staff members who are not qualified health care professionals are under the direct supervision of a licensed clinician. Non-licensed team members process service requests that do not require clinical judgement be applied. They perform routine medical administrative tasks specific to the assigned unit and office support functions. They can administratively authorize services according to departmental guidelines and under the oversight of UM nurse reviewers and medical directors.

Manager, Utilization Management (RN/LVN) (UM Monitoring) responsible for management of the day-to-day monitoring of UM activities, including monitoring of UM processes of Prior Authorization and Inpatient. Ensure that service standards are met, and operations are consistent with all regulatory requirements, accreditation standards and CalOptima Health policies and procedures.

Monitoring Nurses – UM (Clinical Auditors, LVN)) conducts routine oversight, monitoring and auditing of internal UM activities to ensure compliance with state, federal and accreditation standards. - Monitoring activities include prior authorization and inpatient file reviews, addressing Correction Action Plans (CAPS) findings, as well as identify opportunity for process improvement during the monitoring process.

Pharmacy Staffing Resources

The following staff positions provide support for Pharmacy operations:

Director, Clinical Pharmacy develops, implements and administers all aspects of the CalOptima Health pharmacy management program as part of the managed care system, with closed formulary rebate programs, Drug Utilization Evaluation (DUE) and Drug Utilization Review (DUR) programs, and oversees the day-to- day functions of the contracted pharmacy benefit management vendor (PBM). The director is also responsible for administration of pharmacy services delivery, and has frequent interaction with external contacts, including local and state agencies, contracted service vendors, pharmacies and pharmacy organizations.

Manager, Clinical Pharmacist assists the Pharmacy director and pharmacy staff with the ongoing development and implementation of targeted drug utilization and disease state management strategies to control costs and improve the quality and outcomes of health care provided to members enrolled in the CalOptima Health delegated health plans and CalOptima Health Direct. Through various modalities (e.g., provider/plan profiling, member drug profile reviews, development and updating of drug utilization criteria, and case- by- case intervention), the Pharmacy manager promotes clinically appropriate prescribing practices that conform to CalOptima Health, as well as national practice guidelines and on an ongoing basis, research, develops, and updates drug UM strategies and intervention techniques. The Pharmacy manager develops and implements methods to measure the results of these programs, assists the Pharmacy director in preparing drug monographs and reports for the Pharmacy & Therapeutics (P&T) Committee, interacts frequently and independently with other department directors, managers, and staff, as needed to perform the duties of the position, and has frequent interactions with external contacts, including the pharmacy benefit managers' clinical department staff.

Clinical Pharmacists assist the Pharmacy director and pharmacy staff with the ongoing development and implementation of targeted drug utilization and disease state management strategies to control costs and improve the quality and outcomes of health care provided to members enrolled in CalOptima Health delegated health plans and CalOptima Health Direct. Through various modalities (e.g., provider/plan profiling, member drug profile reviews, development and updating of drug utilization criteria, and case-by-case intervention), they promote clinically appropriate prescribing practices that conform to CalOptima Health, as well as national, practice guideline. On an ongoing basis, research, develop, and update drug UM strategies and intervention techniques, and develop and implement methods to measure the results of these programs.
They assist the Pharmacy director in preparing drug monographs and reports for the P&T Committee, interact frequently and independently with other department staff as needed to perform the duties of the position, and have frequent interactions with external contacts, including the pharmacy benefit managers' clinical department.

Pharmacy Resident program occurs within an integrated managed care setting. The residents are trained in the role of the pharmacist in the development and implementation of clinical practice guidelines, formulary development, medication use management, pharmacy benefit design, pharmacy network management, pharmacy benefit management, and drug-use policy development. In addition, residents are trained to function as leaders in developing and implementing pharmaceutical care plans for specific patients in an integrated health plan and delivery system setting.

LTSS Staffing Resources

Director, Long-Term Support Services develops, manages and implements LTSS, including Long-Term Care (LTC) facilities authorization services for room and board, CBAS and MSSP, and staff associated with those programs.

Manager, Long-Term Support Services (CBAS/LTC) develops and manages the LTSS department's work activities and team. The manager ensures that service standards are met, and operations are consistent with CalOptima Health's policies and regulatory and

accrediting agency requirements to ensure high quality and responsive services for CalOptima Health's members who are eligible for and/or receiving LTSS.

Supervisor, Long-Term Support Services (CBAS/LTC) is responsible for planning, organizing, developing and implementing the principles, programs, policies and procedures employed in the delivery of LTSS to members in the community and institutionalized setting.

Medical Case Managers, Long-Term Support Services (MCM LTSS), are part of an advanced specialty collaborative practice responsible for case management, care coordination and function, providing coordination of care, and ongoing case management services for qualified CalOptima Health members in LTC facilities and members receiving CBAS. They provide case management in a collaborative process that includes assessment, planning, implementation, coordination, monitoring and evaluation of the member's needs. The MCM LTSS acts as liaisons to Orange County community agencies, CBAS centers, skilled nursing facilities, members and providers.

Program Manager, Sr., LTSS is responsible for assisting the LTSS management with the day-to-day operations of the LTSS department.

Behavioral Health Integration Staffing Resources

Manager, Behavioral Health CalOptima Health manages the day-to-day operational activities of the BH UM team to ensure staff compliance with CalOptima Health policies and procedures, and regulatory and accreditation agency requirements.

Supervisor, Behavioral Health, (BH) provides day-to-day supervision of assigned staff, monitors and oversees assigned daily work activities to ensure that service standards are met.

Medical Case Managers (BH-RN/LVN or Licensed BH Clinician) provide inpatient and outpatient utilization review and authorization of services in support of members. They are responsible for assessing the medical appropriateness, quality and cost effectiveness of proposed inpatient psychiatric hospital and outpatient BH services, in accordance with established evidence-based criteria. All potential denial and/or modifications of provider service requests are discussed with the appropriate Medical Director, who makes the final determination.

Care Manager (BH) provide utilization review and authorization of services in support of members. They are responsible for assessing the medical appropriateness, quality and cost effectiveness of proposed BH services, in accordance with established evidence-based criteria. All potential denial and/or modifications of provider service requests are discussed with the appropriate Medical Director, who makes the final determination.

Medical Authorization Assistants (MAA BH) are responsible for interacting with practitioners or other customers, under the direction of the licensed Medical Case Manager and or Care Manager. They perform routine medical administrative tasks specific to the assigned unit and office support functions.

Qualifications and Training

CalOptima Health hires highly qualified clinical individuals with extensive experience and expertise in UM for staff positions. Qualifications and educational requirements are delineated in the position descriptions of the respective position.

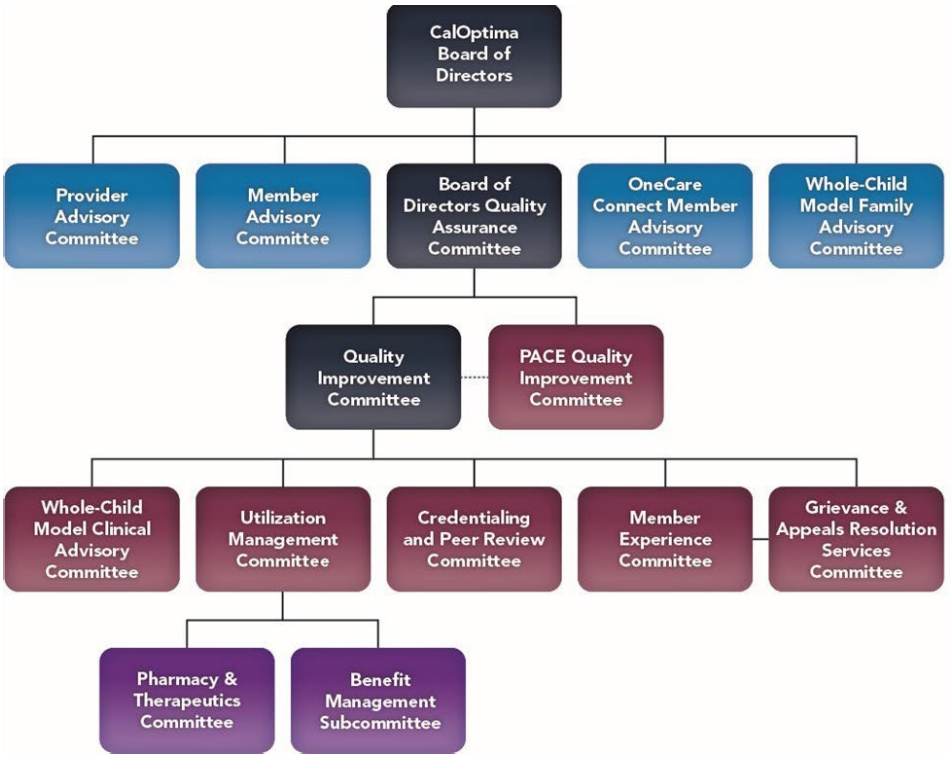
Each new employee is provided an intensive hands-on training and orientation program with a staff preceptor. The following topics are covered during the program, as applicable to specific job descriptions:

- CalOptima Health New Employee Orientation
- HIPAA and Privacy/Corporate Compliance
- Use of technical equipment (phones, computers, printers, facsimile machines, etc.)
- UM Program, policies/procedures, etc.
- Medical Management information system data entry
- Application of Review Criteria/Guidelines
- Appeals process
- Seniors and Persons with Disabilities (SPD) awareness training
- OneCare (OC) training

CalOptima Health 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 Health.

CalOptima Health and its delegated HN UM staff do not permit or provide compensation or anything of value to its employees, agents or contractors based on the percentage or the amount by which a claim is reduced for payment, or the number of claims or the cost of services for which the person has denied authorization or payment; or any other method that encourages the rendering of an adverse determination.

2023 UM Committee (UMC) Committee Structure — Diagram



UMC

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

The UMC monitors the utilization of health care services by CalOptima Health Direct and through the delegated HMOs, PHCs and SRGs, to identify areas of under or over utilization that may adversely impact member care and is responsible for the annual review and approval of medical necessity criteria and protocols, the UM policies and procedures. The UMC monitors and analyzes relevant data to detect and correct patterns of under or over utilization, ensure coordination of care, ensure appropriate use of services and resources, and improve member and practitioner satisfaction with the UM process.

The UMC meets at least quarterly and coordinates an annual review and revision of the UM Program Description, as well as reviews and approves the Annual UM Program Evaluation.

Before going to the Board of Directors for approval, the documents are reviewed and approved by the QIC and QAC. With the assistance of the UM Program specialist, the director of UM maintains detailed records of all UMC meeting minutes and recommendations for UM improvement activities made by the UMC. The UMC routinely submits meeting minutes as well as written reports regarding analyses of the above tracking and monitoring processes and the status of corrective action plans to the QIC. Oversight and operating authority of UM activities is delegated to the UMC, which reports up to QIC and ultimately to QAC and the Board of Directors.

Conflict of Interest

CalOptima Health maintains a Conflict-of-Interest policy addressing the process to identify and evaluate potential social, economic and professional conflicts of interest and take appropriate actions. CalOptima Health requires that all individuals who serve on the UMC or who otherwise make decisions on UM, quality oversight and activities, disclose any actual, perceived, or potential conflicts of interest that arise in the course and scope of serving in such capacity.

All employees who make or participate in the making of decisions that may foreseeably have a material effect on economic interests file a Statement of Economic Interests form on an annual basis.

Confidentiality

CalOptima Health has policies and procedures to protect and promote proper handling of confidential and privileged medical record information that are overseen by the department of compliance and assigned privacy officer. During the onboarding process, all CalOptima Health employees — including contracted professionals who have access to

confidential or member information — sign a written statement for maintaining confidentiality. In addition, all non-employee Committee members are required to sign a Confidentiality Agreement on an annual basis. Invited guests must sign a Confidentiality Agreement at the time of Committee attendance.

UMC Scope and Responsibilities

- Provides oversight and overall direction for the continuous improvement of the UM Program, consistent with CalOptima Health's strategic goals and priorities. This includes oversight and direction relative to UM functions and activities performed by both CalOptima Health and its delegated HNs.
- Oversees the UM activities and compliance with federal and state statutes and regulations, as well as contractual and NCQA requirements that govern the UM process.
- Reviews and approves the UM Program Description, Medical Necessity Criteria, UMC Charter and UM Program Evaluation on an annual basis.
- Reviews and analyzes UM Operational and Outcome data; reviews trends and/or utilization patterns presented at committee meetings and makes recommendations for further action.
- Reviews and approves annual UM Metric targets and goals.
- Reviews progress toward UM Program Goals on a quarterly basis, providing input for improving the effectiveness of initiatives and projects.
- Promotes a high level of satisfaction with the UM Program across members, practitioners, stakeholders, and client organizations by examining results of annual member and practitioner satisfaction surveys to determine overall satisfaction with the UM Program, identify areas for performance improvement, and evaluate performance improvement initiatives.
- Reviews, assesses and recommends utilization management best practices used for selected diagnoses or disease classes.
- Conducts review of under/over utilization monitoring and makes recommendations in accordance with UM Policy and Procedure GG.1532: Over and Under Utilization Monitoring; makes recommendations for improving performance on identified over/under utilization.
- Reviews and provides recommendations for improvement, as needed, to reports submitted by the following:
    - Benefit Management Subcommittee (BMSC)
    - P&T Committee
- Reports to the QIC on a quarterly basis, communicates significant findings and makes recommendations related to UM issues.

Departments Reporting Relevant Information on UM Issues:

- Delegation Oversight
- Behavioral Health
- Grievance and Appeals
- UM Workgroup
- LTSS

UMC Membership

Voting Members:

- CMO
- Medical Director who oversees UM Program
- Medical Director who oversees Behavioral Health Program
- Medical Director who oversees Specialty Programs
- Medical Director who oversees Whole-Child Model Program
- Executive Director, Clinical Operations
- Up to six participating practitioners from the community*
    * Participating practitioners from the community are selected to be representative of the health care delivery system, and include primary care, high volume specialists and administrative practitioners. At least six outside practitioners are assigned to the committee to ensure that at least three are present each meeting as part of the quorum requirements.

The UMC is supported by:

- Executive Director, Behavioral Health Integration
- Director, UM
- Director, Quality Improvement
- Director, Pharmacy
- Manager, Prior Authorization
- Manager, Concurrent Review

Benefit Management Subcommittee (BMSC)

The BMSC is a subcommittee of the UMC. The BMSC was chartered by the UMC and directed to establish a process for maintaining a consistent set of benefits and benefit interpretations for all lines of business, and revise and update CalOptima Health's authorization rules based on benefit updates. Benefit sources include, but are not limited to, Medi-Cal Managed Care Division (MMCD), local and national coverage determinations, All Plan Letters (APLs) and the Medi-Cal Manual.

BMSC Scope

The BMSC is responsible for the following:

- Maintaining a consistent benefit set for all lines of business.
- Revising and updating CalOptima Health's authorization rules.
- Making recommendations regarding the need for prior authorization for specific services.
- Clarifying financial responsibility of the benefit, when needed.
- Recommending benefit decisions to the UMC.
- Communicating benefit changes to staff responsible for implementation.

BMSC Membership

- Medical Director who oversees UM services— Chairperson
- Executive Director, Clinical Operations
- Director, UM
- Director, Behavioral Health Integration
- Director, Claims Management
- Director, Claims
- Director, Coding Initiatives

The BMSC meets quarterly, at minimum, and recommendations from the BMSC are reported to the UMC on a quarterly basis.

Integration with the QI Program

The UM Program is evaluated and submitted for review and approval annually by UMC, QIC and QAC, with final review and approval by the Board of Directors.

- The UM Program is evaluated, revised and prepared for approval by the UM and Behavioral Health (BHI) Director in conjunction with the Executive Director of Clinical Services, Executive Director of Behavioral Health Integration, Chief Medical Officer, Deputy Chief Medical Director prior to submission for committee review and approval.
- Utilization data including, but not limited to, denials, unused authorizations, provider preventable conditions, and trends representing potential over or underutilization is collected, aggregated and analyzed.
- UM staff may identify potential quality issues and/or provider preventable conditions during utilization review activities. These issues are referred to the QI staff for evaluation.
- The UMC is a subcommittee of the QIC and routinely reports activities to the QIC.
- The QIC reports to the Board QAC.

Integration with Other Processes

The UM Program, Case Management Program, BH Program, LTSS Programs, P&T, QI, Credentialing, Compliance and Audit & Oversight are closely linked in function and process. The UM process uses quality indicators as a part of the review process and provides the results to the QI department. As case managers perform the functions of UM, quality indicators, prescribed by CalOptima Health as part of the patient safety plan, are identified. The required information is documented on the appropriate form and forwarded to the QI department for review and resolution. As a result, the utilization of services is inter- related with the quality and outcome of the services.

Any adverse information that is gathered through interaction between the UM staff and the practitioner or facility staff is also vital to the re-credentialing process. Such information may relate, for example, to specific case management decisions, discharge planning, prior authorization of non-covered benefits, etc. The information is forwarded to the QI department in the format prescribed by CalOptima Health for review and resolution as needed. The CMO or Medical Director determines if the information warrants additional review by CalOptima Health's Credentialing and Peer Review Committee (CPRC). If committee review is not warranted, the information is filed in the practitioner's folder and is reviewed at the time of the practitioner's re-credentialing.

UM policies and processes also serve as integral components in preventing, detecting and responding to Fraud and Abuse among practitioners and members. The UM department works closely with the Compliance Officer and the Fraud and Abuse Unit to resolve any potential issues that may be identified. In addition, CalOptima Health coordinates utilization/care management activities with local community practitioners for activities that include, but are not limited to:

- Early childhood intervention
- State protective and regulatory services
- Women, Infant and Children Services (WIC)
- Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Health Check
- Services provided by local public health departments

REVIEW AND AUTHORIZATION OF SERVICES

Medical Necessity Review

Medical necessity review requires consideration of the members' clinical needs, evaluating available services within the local delivery system and applying evidenced based guidelines and CalOptima Health policies to provide quality care in the most appropriate setting. Covered services are those medically necessary health care services provided to members as outlined in CalOptima Health's contract with CMS and the State of California for Medi-Cal and OC. Medically necessarily means all covered services or supplies that:

- are reasonable and necessary to protect life, prevent illness or disability, alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity.
- Medical necessity for members receiving MLTSS is determined by using a member's current needs assessment and is consistent with person-centered planning.
- For Medicare, covered services that are reasonable and necessary for diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C section 1395y.

The CalOptima Health UM process uses active, ongoing coordination and evaluation of requested or provided health care services, performed by licensed health care professionals, to ensure quality medically necessary services are provided in the most appropriate setting. Physicians, or pharmacists or psychologists in appropriate situations, review and determine all final denial or modification decisions for requested medical and BH care services. The review of the denial of a pharmacy prior authorization, may be completed by a qualified physician or pharmacist.

CalOptima Health's UM department is responsible for the review and authorization of health care services for CalOptima Health Direct Administrative (COD-A) and CCN members utilizing the following medical determination review processes:

- Referral/Prior Authorization for selected conditions/services
- Admission Review
- Post-stabilization review
- Concurrent/Continued Stay Review for selected conditions
- Discharge Planning Review
- Retrospective Review
- Evaluation for potential transplant services for HN members

The following standards and considerations are applied when reviewing prior authorizations, inpatient and outpatient concurrent review, and retrospective review requests:

- Qualified health care professionals supervise review decisions, including care or service reductions, modifications or termination of services.
- Evidenced based clinical criteria or guidelines are applied consistently,

regularly reviewed and updated.

- Member circumstances and characteristics are considered when applying criteria to address the individual needs of the member. These characteristics include, but are not limited to:
    - Age
    - Co-morbidities
    - Complications
    - Progress of treatment
    - Psychological/Psychosocial situation
    - Home environment, when applicable
- Availability of facilities and services in the local area to address the needs of the members are considered when making determinations consistent with the current benefit set. If member circumstances or the local delivery system prevent the application of approved criteria or guidelines in making an organizational determination, the request is forwarded to the UM Medical Director to determine an appropriate course of action.
- Clinical rationale and reasons for decisions are clearly documented in the medical management system, including the criteria used to make the determination.
- The Medical Director may be contacted by calling their direct dial number listed at the bottom of the provider denial notification or through contacting the UM department during the review process. A CalOptima Health Case Manager may also coordinate communication between the CalOptima Health Medical Director and requesting practitioner. All peer-to-peer discussions are documented within clinical documentation platform.
- Notification to members regarding denied, deferred, or modified referrals is made in accordance with mandated regulatory and accreditation agency timeframes, and members and providers are notified of appeals and grievance procedures.
- Decisions related to appeals or grievances are made in a timely manner in accordance with timelines established by CalOptima Health's Grievance and Appeals Resolution Services (GARS) process, and as the member's condition requires.
- Medical conditions requiring time sensitive services are reviewed in accordance with the appropriate CalOptima Health Policy and Procedure.
- Prior Authorization requirements are not applied to Emergency Services, Minor Consent/Sensitive Services, Family Planning, Preventive Services, basic Prenatal Care, Sexually Transmitted Disease services, and HIV testing.
- Records, including documentation of an oral notification or written Notice of Action, are retained for a minimum of 10 years from the end of the fiscal year in which the date of service occurred, unless a longer period is required by law.
- The requesting provider is notified, orally or in writing, of any decision to deny, approve, modify, or delay a service authorization request.
- All Medi-Cal members are notified in writing of any decision to deny, modify, or delay a service.
- OneCare members are notified in writing of any and all determinations.
- All providers are encouraged to request information regarding the criteria used in making a clinical determination. Contact can be made directly with the Medical Director involved in the decision, utilizing the contact information included in the Notice of Action. A provider may request a discussion with the Medical Director (Peer-to-Peer), or a copy of the specific criteria utilized.

Supporting documents used to make medical necessity determinations includes, but is not limited to:

- Office and hospital records
- A history of the presenting problem
- A clinical examination
- Diagnostic test results
- Treatment plans and progress notes
- Patient's psychological history
- Information on consultations with the treating provider
- Evaluations from other health care providers
- Photographs
- Operative and pathological experts
- Rehabilitation evaluations
- A printed copy of criteria related to the request
- Information regarding benefits for services or procedures
- Information regarding the local delivery system
- Patient characteristics, circumstances and information
- Information from responsible family members

UMC/ BMSC reviews the Prior Authorization List regularly, in conjunction with CalOptima Health's CMO, Medical Directors and Executive Director, Clinical Operations, to determine if any services should be added or removed from the list. The Provider Services, Member Services and Network Management areas are also consulted on proposed revisions to the Prior Authorization List. Such decisions are based on CalOptima Health program requirements, or to meet federal or state statutory or regulatory requirements. Practitioners are appropriately notified when such modifications occur.

Prior Authorization

Prior Authorization requires the provider or practitioner to submit a formal medical necessity determination request and all relevant clinical information related to the request to CalOptima Health prior to the service being rendered. Upon receipt, the prior authorization request is screened for eligibility and benefit coverage and assessed for medical necessity and appropriateness of the health care services proposed, including the setting in which the proposed care will take place.

Prior Authorization is required for selected services, such as non-emergency inpatient admissions, elective out- of-network services, and certain outpatient services, ancillary services and specialty injectables as described on the Prior Authorization Required List located in the provider section on the CalOptima Health website at www.caloptima.org Clinical information submitted by the provider justifies the rationale for the requested service through the authorization process, which assesses medical necessity and appropriateness utilizing evidence-based guidelines upon which a determination is made.

CalOptima Health's medical management system is a member-centric system utilizing evidence-based clinical guidelines and allows each member's care needs to be directed from a single integrated care plan that is shared with internal and external care team members to enable collaboration, minimize barriers, and support continuity and coordination of care. The system captures data on medical, behavioral, social, and personal care needs of members

supporting the identification of cultural diversity and complex care needs.

The CalOptima Health Provider Portal allows for non-urgent and urgent online authorizations to be submitted by providers and processed electronically. The provider portal functionality includes referral intelligence rules, approved by clinical leadership to auto adjudicate when criteria is met. The referral intelligence rules and auto-adjudication trends are reviewed quarterly at a minimum to identify potential misuse or utilization issues that require follow up.
Practitioners may also submit referrals and requests to the UM department by mail, fax and/or telephone.

Second Opinions
A second opinion may be requested when there is a question concerning the diagnosis, options for surgery or other treatment of a health condition, or when requested by any member of the member's health care team, including the member, member representative, parent and/or guardian. A social worker exercising a custodial responsibility may also request a second opinion. Authorization for a second opinion is granted to a network practitioner or an out-of-network practitioner if there is no in-network practitioner available.

Extended Specialist Services
Established processes are in place by which a member requiring ongoing care from a specialist may request a standing authorization. Additionally, CalOptima Health provides guidance on how members with life- threatening conditions or diseases that require specialized medical care over a prolonged period can request and obtain access to specialists and specialty care centers.

Out-of-Network Providers
The decision to authorize use of an out-of-network provider is based on a number of factors including, but not limited to, continuity of care, availability and location of an in-network provider of the same specialty and expertise, lack of network expertise

Appropriate Professionals for UM Decision Process

The UM decision process requires that qualified, licensed health professionals assess the clinical information used to support UM decisions. If the clinical information included with a request for services does not meet the appropriate clinical criteria, the UM Nurse Case Managers (NCM) and Medical Authorization Assistants are instructed to forward the request to the appropriate qualified, licensed health practitioner for a determination. Only practitioners or pharmacists can make decisions/determinations for denial or modification of care based on medical necessity, and must have education, training, and professional experience in medical or clinical practice, and have a current unrestricted license to practice in the specific discipline for which an adverse determination is being rendered.

CalOptima Health distributes an affirmative statement about incentives to members in the Member Handbook, annually to all members in the Annual Notices Newsletter, and at least annually to all practitioners and employees who make UM decisions, affirming that UM decision making is based only on appropriateness of care and services and existence of coverage and that CalOptima Health does not specifically reward practitioners or other individuals for issuing denials of coverage. CalOptima Health ensures that UM decision

makers are not unduly influenced by fiscal and administrative management by requiring that UM decisions be based on evidence-based clinical criteria, the member's unique medical needs, and benefit coverage.

PHARMACEUTICAL MANAGEMENT

Pharmacy Management is overseen by the CMO, and CalOptima Health's Director, Clinical Pharmacy Management. All policies and procedures utilized by CalOptima Health related to pharmaceutical management include the criteria used to adopt the procedure, as well as a process that uses clinical evidence from appropriate external organizations. The program is reviewed at least annually by P&T and updated as new pharmaceutical information becomes available.

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

The P&T Committee is responsible for development of the Medi-Cal physician-administered drug prior authorization list and the OneCare Formulary, which is based on sound clinical evidence, and is reviewed at least annually by practicing practitioners and pharmacists. Updates to the Formulary are communicated to both members and providers.

Pharmacy Determinations Medi-Cal Effective January 1,2022, the outpatient pharmacy benefit moved to the Medi-Cal fee-for-service program, Medi-Cal Rx.

Medi-Cal/Medicare
CalOptima Health does not delegate OneCare Pharmacy UM responsibilities. Pharmacy coverage determinations follow required CMS timeliness guidelines and medical necessity review criteria.

Pharmacy Benefit Manager (PBM)
The PBM is responsible for pharmaceutical administrative and clinical operations, including pharmacy network contracting and credentialing, pharmacy claims processing system and data operations, pharmacy help desk, clinical services and quality improvement functions. The PBM follows and maintains compliance with health plan policies and all pertinent state and federal statutes and regulations. As a delegated entity, the PBM is monitored according to the Audit & Oversight department's policies and procedures.

BEHAVIORAL HEALTH DETERMINATIONS

Medi-Cal
CalOptima Health's BHI department performs prior authorization review for BH services and psychological testing. Prior authorization requests are reviewed by BH UM staff that consist of Medical Case Managers and Care Managers (BCBA).

Determinations are based on criteria from MCG Guidelines, DHCS All Plan Letters (APL)

and CalOptima Health policy (approved by DHCS).

Medi-Cal/Medicare
CalOptima Health's BHI department performs prior authorization review functions for OC covered BH services. Services require prior authorization include inpatient psychiatric care, partial hospitalization program, intensive outpatient program, psychological testing, electro convulsive therapy (ECT), and transcranial magnetic stimulation (TMS). Prior authorization requests are reviewed by BH Medical Case Managers.

Determinations are based on criteria from MCG Guidelines, Dual Plan Letters (DPL) and CalOptima Health policies.

- The BH UM staff may approve or defer for additional information, but final determinations of modification, denial, or appeal may be made by a Medical Director or a qualified health care profession with appropriate clinical expertise in treating the behavioral health condition. CalOptima Health's written notification of BH modifications and denials to members and their treating practitioners contains:
- A description of appeal rights, including the member's right to submit written comments, documents or other information relevant to the appeal.
- An explanation of the appeal process, including the appeal timeframes and the member's right to representation.
- A description of the expedited appeal process for urgent pre-service or urgent concurrent denials.
- Notification that expedited external review can occur concurrently with the internal appeal process for urgent care.

CalOptima Health gives practitioners the opportunity to discuss BH UM denial decisions.

UM CRITERIA

CalOptima Health conducts Utilization Review using UM hierarchical criteria for medical, BH, and pharmacy medical necessity decisions that are objective, nationally recognized, evidence-based standards of care and include input from recognized experts in the development, adoption and review of the criteria. UM criteria and the policies for application are reviewed and approved at least annually and updated as appropriate. Such criteria and guidelines include, but are not limited to: [RJ12]

Medi-Cal

1. Federal and State Law Mandates (i.e., Department of Health Care Services — Provider Manuals/Medi-Cal Benefits Guidelines, EPSDT)
2. (e.g., MCG, National Comprehensive Cancer Network, etc.)
3. Society Guidelines (e.g., American Medical Association, American Congress of Obstetricians and Gynecologists, etc.)
4. Other: US Preventative Services Task Force, Guideline Central

5. CalOptima Health Policy and Procedures and/or Clinical Benefits and Guidelines

Whole-Child Model/CCS (Medi-Cal)

1. CCS Numbered Letters (N.L.s) and CCS Program Information Notices for decisions related to CCS and Whole-Child Model
2. Follow Medi-Cal hierarchy listed above.

Medicare (OneCare and OneCare Connect)

1. Federal and State Law Mandates — CMS, DMHC
    a. CMS Guidelines National and Local Coverage Determinations (LCD first, followed by NCD)
2. CMS Provider Manuals
    a. Internet-Only Manuals (IOMs) | CMS
3. Department of Health Care Services
4. National Evidence-Based Guidelines (e.g., MCG, National Comprehensive Cancer Network, etc.)
5. Society Guidelines (e.g., American Medical Association, American Congress of Obstetricians and Gynecologists, Guideline Central, etc.)
6. CalOptima Health Policy and Procedures and/or Clinical Benefits and Guidelines

Due to the dynamic state of medical/health care practices, each medical decision must be case-specific, and based on current medical knowledge and practice, regardless of available practice guidelines, as well as based on the member's individual needs. Listed criteria in fields other than primary care, such as OB/GYN, surgery, etc., are primarily appended for guidance concerning medical care of the condition or the need for a referral.

Clinical practice guidelines (such as those distributed by American Diabetes Association, American Academy of Pediatrics, and the American College of Obstetrics and Gynecology) are used in conjunction with national guideline criteria in review for medical necessity. Additional guidelines may include, but are not limited to, Adult and Child Preventive Health, Asthma, Prenatal Care, Diabetes, World Professional Association for Transgender Health (WPATH), Lead Screening, Immunizations, and ADHD/ADD guidelines for both adults and children.

Board Certified Clinical Consultants:
In some cases, such as for authorization of a specific procedure or service, BH, or certain appeal reviews, the clinical judgment needed for a UM decision is specialized. In these instances, the Medical Director may consult with a board-certified physician from the appropriate specialty or qualified BH professionals as determined by the Medical Director, for additional or clarifying information when making medical necessity determinations or denial decisions. Clinical experts outside Health may be contacted, when necessary to avoid a conflict of interest. CalOptima Health defines conflict of interest to include situations in which the practitioner who would normally advise on an UM decision made the original request for authorization or determination, or is in, or is affiliated with, the

same practice group as the practitioner who made the original request or determination.

Practitioner and Member Access to Criteria
At any time, members or treating practitioners may request UM criteria pertinent to a specific authorization request by contacting the UM department or may discuss the UM decision with Health Medical Director per the peer-to-peer process. Each contracted practitioner receives a Provider Manual, a quick reference guide, and a comprehensive orientation that contains critical information about how and when to interact with the UM department. The manual also outlines CalOptima Health's UM policies and procedures. On an annual basis, all contracted hospitals receive an in-service to review all required provider trainings, including operational and clinical information such as UM timeliness of decisions. In addition, Provider Relations also provides any related policies regarding UM timeliness of decisions, as needed. Similar information is found in the Member Handbook and on the health website at www.CalOptima Health.org.

Inter-Rater Reliability (IRR)
At least annually, the CMO and Clinical Operations leadership assess the consistency with which Medical Directors and other clinical decision makers apply UM criteria in decision-making. The assessment is performed as an annual review to compare how reviewers' decision the same case. If an opportunity for improvement is identified through this process, UM and MD leadership takes corrective action. New UM staff are required to successfully complete inter-rater reliability testing prior to being released from training oversight. The IRR is reported to the UMC on an annual basis and any actions taken for performance below the established benchmark of 90% are discussed and recommendations taken from the Committee.

Provider and Member Communication
Members and practitioners can access UM staff through a toll-free telephone number **888-587-8088** at least eight hours a day during normal business hours for inbound or outbound calls regarding UM issues or questions about the UM process. TTY services for deaf, hard of hearing or speech impaired members are available toll free at **711**. The phone numbers for these are included in the Member Handbook, on the CalOptima Health website, and in all member letters and materials. Additionally, language assistance for members to discuss UM issues is provided either by bilingual staff or through Language Line services. Except as otherwise provided below, communications received after normal business hours are returned on the next business day and communications received after midnight on Monday–Friday are responded to on the same business day. CalOptima Health has MD and UM coverage 24 hours a day, 7 days a week through after-hours answering services.

Inbound and outbound communications includes directly speaking with practitioners and members, fax correspondence, electronic or telephonic communications (e.g., sending email messages or leaving voicemail messages). Staff identify themselves by name, title and CalOptima Health UM department when both making and receiving phone calls regarding UM processes. After normal business hours and on holidays, calls to the UM department are automatically routed to an on-call contracted vendor. The vendor is not a delegated UM entity and therefore, does not make authorization decisions. The vendor staff takes authorization information for the next business day response by CalOptima Health. In cases requiring immediate response the vendor staff notifies CalOptima Health on-call

nurse. CalOptima Health will review and process authorizations outside business hours, as necessary, including decisions to approve, deny or modify authorization requests which are made by CalOptima Health on-call UM MD. A log is shared daily identifying activity and follow-up needed the following day.

Access to Physician Reviewer

The CalOptima Health Medical Director or appropriate practitioner reviewer (BH and clinical pharmacy) serves as the point of contact for practitioners calling in with questions about the UM process and/or case determinations. Providers are notified of the availability of the appropriate practitioner reviewer to discuss any UM denial decisions through the Provider Manual, New Provider Orientation and the provider newsletter. Notification of the availability of an appropriate practitioner reviewer to discuss any UM denial decision, and how to contact a reviewer for specific cases, is also provided verbally and/or in the written notification at the time of an adverse determination. The CalOptima Health Medical Director may be contacted by calling their direct dial number listed at the bottom of the provider denial notification or through contacting the UM department during the review process. A CalOptima Health Case Manager may also coordinate communication between the Medical Director and requesting practitioner. All peer-to-peer discussions are documented within clinical documentation platform

UM Staff Access to Clinical Expertise

The CMO and Medical Directors, have the authority, accountability, and responsibility for denial determinations and following sound clinical and professional judgment. Contracted HNs that are delegated for UM responsibilities, utilize a Medical Director, or designee, as the sole authority to deny coverage. The Medical Director may also provide clarification of policy and procedure issues, and communicate with delegated entity practitioners regarding referral issues, policies, procedures, processes, etc.

Requesting Copies of Medical Records

During prospective, retrospective, inpatient and concurrent review, copies of medical records are required to validate medical necessity for the requested service. In those cases, only the necessary or pertinent sections of the record are required to determine medical necessity and appropriateness of the services requested. Medical records may also be requested to complete an investigation of a member grievance or when a potential quality of care issue is identified through the UM process Confidentiality of information necessary to conduct UM activities is maintained at all times.

Sharing Information

CalOptima Health's UM staff share all clinical and demographic information on individual patients among various areas of the agency (e.g., discharge planning, case management, PHM, health education, etc.) to avoid duplicate requests for information from members or practitioners.

Provider Communication to Member

CalOptima Health's UM Program does not prohibit or restrict health care professionals from acting within the lawful scope of practice or advising or advocating on behalf of a member including but not limited to the following:

- The member's health status, medical care, or treatment options, including any alternative treatments that may be self-administered.
- Any information the member needs in order to decide among all relevant treatment options.

- The risks, benefits and consequences of treatment or absence of treatment.
- The member's right to participate in a decision regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

TIMELINESS OF UM DECISIONS

UM decisions are made in a timely manner to accommodate the clinical urgency of the situation and to minimize any disruption in the provision of health care. Established timelines are in place for providers to notify Health of a service request and for the health plan to make UM decisions and subsequent notifications to the member and practitioner.

UM Decision and Notification Timelines

Medi-Cal Decision and Notification Timelines			
Type of Request	**Decision**	**Initial Notification (May be electronic or written)**	**Electronic/Written Notification of ADVERSE DETERMINATIONS to Practitioner and Member**
Routine (Non-urgent) Pre- Service Prospective or outpatient service requests.	Approve, Modify, or Deny within 5 business days from receipt of the information reasonably necessary to render a decision, and no longer than 14 calendar days from the receipt of the request.	**Practitioner:** Within 24 hours of making the decision.	**Practitioner: Electronic** Within 24 hours of making the decision. **Member: Written** Notice must be postmarked within 2 business days of decision not to exceed 14 calendar days from receipt of the request.

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Routine (Non-urgent) Pre- Service – Extension Needed • Additional clinical information required. • Require consultation by an Expert Reviewer. • Additional examination or tests to be performed.	Approve, Modify, or Deny within 5 business days from receipt of the information reasonably necessary to render a decision, and no longer than 14 calendar days from the receipt of the request. • The decision may be deferred, and the time limit extended an additional 14 calendar days only where the member or member's provider requests an extension, or CalOptima Health can provide justification upon request by the State for the need for additional information and how it is in the member's interest. • CalOptima Health will notify the member and practitioner of decision to defer, in writing, within 5 business days of receipt of information reasonably necessary to render a decision and no longer than 14 calendar days from the receipt of initial request. • Notice of deferral should include the additional information needed to render the decision, the type of expert reviewed and/or the additional examinations or tests required and the anticipated date on which a decision will be rendered.	**Practitioner:** Within 24 hours of making the decision.	**Practitioner: Electronic** Within 24 hours of making the decision. **Member: Written** Within 2 business days of making the decision, not to exceed 28 calendar days from the receipt of the request for service. **Practitioner/Member:** Written Notice of Action "Delay" notification within 14 calendar days of receipt of the request for services.
	Additional information received	**Practitioner:**	**Practitioner: Electronic**

	• If requested information is received, decision must be made within 5 business days of receipt of information, not to exceed 28 calendar days from the date of receipt of the request for service.	Within 24 hours of making the decision.	Within 24 hours of making the decision **Member: Written** Within 2 business days of making the decision, not to exceed 28 calendar days from the receipt of the request for service.
	Additional information incomplete or not received • If after 28 calendar days from the receipt of the request for prior authorization, the provider has not complied with the request for additional information, the plan shall provide the member notice of denial.	**Practitioner:** Within 24 hours of making the decision.	**Practitioner: Electronic** Within 24 hours of making the decision **Member: Written** Within 2 business days of making the decision, not to exceed 28 calendar days from the receipt of the request for service.

Working days = Monday through Friday excluding California State Holidays
https://www.ftb.ca.gov/aboutftb/holidays.shtml

Attachment A TIMELINES FOR MEDI-CAL

Medi-Cal Decision and Notification Timelines			
Type of Request	**Decision**	**Initial Notification (May be electronic or written)**	**Electronic/Written Notification of ADVERSE DETERMINATIONS to Practitioner and Member**
Expedited Authorization (Pre-Service) • Provider or CalOptima Health determines that the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function. • All necessary information received at time of initial request.	Approve, Deny, or Modify within 72 hours from receipt of the request.	**Practitioner:** Within 24 hours of making the decision.	**Practitioner: Electronic** Within 24 hours of making the decision not to exceed 72 hours from receipt of request. **Member: Written** Written notice within 72 hours of the receipt of the request for services.

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Expediated Authorization (Pre-Service) - Extension Needed • Extension is extended when member or provider requests the extension, or CalOptima Health justifies a need for additional information and can demonstrate how the extension is in the member's best interest. There is reasonable likelihood that receipt of such information would lead to approval of the request.	Approve, Deny, or Modify within 72 hours from receipt of the request **Additional clinical information required:** Upon the expiration of the 72 hours or as soon as you become aware that you will not meet the 72-hour timeframe, whichever occurs first, notify practitioner and member using the "Delay" written notification, and insert specifics about what has not been received,, what consultation is needed and/or the additional examinations or tests required to make a decision and the anticipated date on which a decision will be rendered. **Note:** The time limit may be extended by up to 14 calendar days if the member requests an extension, or CalOptima Health can provide justification upon request by the State for the need for additional information and how it is in the member's interest.	**Practitioner:** Within 24 hours of making the decision.	**Practitioner: Electronic** Within 24 hours of making the decision not to exceed 72 hours from receipt of request. **Member: Written** Written notice within 72 hours of the receipt of the request for services.
	Additional information received • If requested information is received, decision must be made within 1 business day of receipt of information.	**Practitioner:** Within 24 hours of making the decision.	**Practitioner: Electronic** Within 24 hours of making the decision **Member: Written** Within 2 business days of making the decision

	Additional information incomplete or not received • Any decision delayed beyond the time limits is considered a denial and must be processed immediately as such.	**Practitioner:** Within 24 hours of making the decision.	**Practitioner: Electronic** Within 24 hours of making the decision **Member: Written** Within 2 business days of making the decision.
Urgent Concurrent (Inpatient) Requests where a provider indicates or CalOptima Health determines that the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function.	Approve, Modify, or Deny within 72 hours of the receipt of the request. **Extension:** CalOptima Health may extend the time frame, by up to 14 calendar days, under the following conditions: Additional supporting clinical information is needed.	**Practitioner:** Within 24 hours of making the decision.	**Practitioner: Electronic** Within 24 hours of making the decision. **Member: Written** Within 2 business days of making the decision.
Concurrent (Inpatient) Concurrent review of treatment regimen already in place, (inpatient, ongoing ambulatory services). In the case of concurrent review, care shall not be discontinued until the enrollee's treating provider has been notified of CalOptima Health's decision, and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient.	Approve, Modify, or Deny within 72 hours of last approved day or decision consistent with urgency of member's medical condition. Extension: CalOptima Health may extend the timeframe 48 hours of up to 14 calendar days under the following conditions: • Additional supporting clinical information is needed.	**Practitioner:** Within 24 hours of making the decision.	**Practitioner: Electronic or Oral:** Within 24 hours of receipt of the request. **Member: Written** Written notification within 2 calendar days of decision. **Note:** If oral notification is given within 24 hours of request, then written/electronic notification must be given no later than 2 calendar days after the oral notification.
Post-Service / Retrospective Review- All necessary information received at time of request (decision and notification is required within 30 calendar days from request).	Decision within 30 calendar days from receipt of information that is reasonably necessary to make a decision.	**Practitioner:** Within 24 hours of making the decision.	**Practitioner: Electronic** Within 30 calendar days of receipt of the request. **Member: Written** Within 30 calendar days of receipt of request.

Hospice - Inpatient Care	Within 24 hours of receipt of request.	**Practitioner:** Within 24 hours of making the decision.	**Practitioner: Electronic** Within 24 hours of making the decision. **Member: Written** Within 2 business days of making the decision.

[1] Working days=Monday through Friday excluding California State Holidays https://www.ftb.ca.gov/aboutftb/holidays.shtml

Attachment B TIMELINES FOR OneCare

OneCare Decisions and Notification Timelines		
Type of Request	**Decision**	**Notification Timeframe**
Standard Integrated Organization Determinations Prospective or outpatient service requests.	Approve, Modify or Deny no later than 14 calendar days from receipt of request. **Extensions: CalOptima Health may not extend the deadlines for Integrated Organization Determinations.**	**Practitioner:** **Decision: Electronic or Written** Within 24 hours of making the decision. **Practitioner/Member: Written** Within 2 business days of decision. **Issue the Coverage Decision Notice for written notification of denial decision.**
Expedited Integrated Organization Determinations Prospective or outpatient service requests.	Approve, Modify or Deny expeditiously but no later than 72 hours from receipt of the request. CalOptima Health must request the necessary information from the noncontracted provider within 24 hours of the receipt request. **Extensions: CalOptima Health may not extend the deadlines for Integrated Organization Determinations.**	**Practitioner:** **Decision: Electronic or Oral Notification** Within 24 hours of making the decision. **Member: Oral** Within 24 hours of determination. **Practitioner/Member: Written** Within 2 business days of making the decision. When oral notification is given, it must be followed by written notification within 3 calendar days of the oral notification.

Expedited Authorization (Pre-Service) **If Expedited Criteria are not met**	If submitted as expedited but determined not to be expedited, then standard initial organization determination timeframe applies: • Automatically transfer the request to the standard timeframe. The 14-day period begins with the day the request was received for an expedited determination.	If request is not deemed to be expedited, CalOptima Health must notify member (within 72 hours) oral notification of the denial of expedited status including the member's rights followed by written notice within 3 calendar days of the oral notification. **Use the Expedited Criteria Not Met** template to provide written notice. The written notice must include: 1. Explain that CalOptima Health will automatically transfer and process the request using the 14-day timeframe for standard determinations. 2. Inform the member of the right to file an expedited grievance if he/she disagrees with the organization's decision not to expedite the determination. 3. Inform the member of the right to resubmit a request for an expedited determination and that if the member gets any
		physician's support indicating that applying the standard timeframe for making determinations could seriously jeopardize the life or health of the member. 4. Provide instructions about the expedited grievance process and its time frames.

Urgent Concurrent (Inpatient) Requests where a provider indicates or CalOptima Health determines that the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function.	Approve, Modify or Deny within 72 hours of the receipt of the request. **Extension:** CalOptima Health may extend the time frame, by up to 14 calendar days, under the following conditions: • Additional supporting clinical information is needed.	**Practitioner: Electronic** Within 24 hours of making the decision. **Member: Written** Within 2 business days of making the decision.
Concurrent (Inpatient) Concurrent review of treatment regimen already in place, (inpatient, ongoing ambulatory services). In the case of concurrent review, care shall not be discontinued until the enrollee's treating provider has been notified of CalOptima Health's decision, and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient.	Approve, Modify or Deny within 72 hours of last approved day or decision consistent with urgency of member's medic al condition. **Extension:** CalOptima Health may extend the time frame 48 hours or up to 14 calendar days, under the following conditions: • Additional supporting clinical information is needed.	**Practitioner/Member: Electronic or Oral** Within 24 hours of receipt of the request. **Practitioner/Member: Written** Within 3 calendar days of decision.
Post-Service / Retrospective Review- All necessary information received at time of request (decision and notification is required within 30 calendar days from request)	Decision within 30 calendar days from receipt of information that is reasonably necessary to make a decision.	**Practitioner: Written** Within 30 calendar days of receipt of the request **Member: Written** Within 30 calendar days of receipt of request.
Hospice - Inpatient Care	Within 24 hours of receipt of request.	**Practitioner: Electronic or Oral** Within 24 hours of making the decision **Practitioner /Member: Written** Within 2 business days of making the decision

Type of Request	Decision	Important Message (IM) from Medicare	Detailed Notice of Discharge (DND)
Hospital Discharge Appeal Notices (Concurrent)	Hospitals are responsible for delivery of the Important Message from Medicare (IM): 1. Within 2 calendar days of admission to a hospital inpatient setting. 2. No more than 2 calendar days prior to discharge from a hospital inpatient setting. 3. CalOptima Health is responsible for the delivery of the Detailed Notice of Discharge (DND) when members appeal a discharge. 4. DND must be delivered no later than noon of the day after notification by QIO (Quality Improvement Organization)	Hospitals must issue IM within 2 calendar days of admission. Hospitals must issue IM no more than 2 calendar days prior to discharge from an inpatient stay.	CalOptima Health must issue the DND to both the member and QIO as early as possible but no later than noon of the day after notification by the QIO.

Working days = Monday through Friday excluding California State Holidays
https://www.ftb.ca.gov/aboutftb/holidays.shtml

*Medi-Cal Pharmacy Prior Authorization Determination Timelines

*Timelines for determination apply to pharmacy authorization requests managed by CalOptima Health and Magellan Rx

Type of Request	Determination Timeline
Standard (Non-urgent) Preservice - All necessary information received at time of initial request.	A decision to approve, modify, or deny is required within 24 hours of receipt of the request.
Standard (Non-urgent) Preservice - Information Needed - Additional clinical information required.	- A deferral response is required within 24 hours of receipt of the request. - A decision to approve, modify, or deny is required within 24 hours of receiving the additional information reasonably necessary to render a decision, but no longer than 14 calendar days from receipt of the original request.
Standard (Non-urgent) Preservice – Delay Needed	- CalOptima Health may delay the timeframe for an additional 14 calendar days if the requested information was not received within 14 calendar days of receipt of the original request, under the following conditions: ▪ The member or the member's provider may request for an extension, or CalOptima Health can provide justification upon request by DHCS for the need for additional information and how it is in the member's interest. ▪ The delay notice shall include the additional information needed to render the decision, the type of expert needed to review and/or the additional examinations or tests required and the anticipated date on which a decision will be rendered.
Expedited (Urgent) Preservice/Concurrent - All necessary information received at time of initial request.	- A decision to approve, modify, or deny is required within 24 hours of receipt of the request.
Expedited (Urgent) Preservice/Concurrent - Information Needed - Additional clinical information required.	- A deferral response is required within 24 hours of receipt of the request. - A decision to approve, modify, or deny is required within 24 hours of receiving the additional information reasonably necessary to render a decision, but no longer than 72 hours from receipt of the original request.

Expedited (Urgent) Preservice/Concurrent - Delay Needed	- CalOptima Health may delay the timeframe for an additional 14 calendar days if the requested information was not received within 72 hours of receipt of the original request, under the following conditions: ▪ The member or the member's provider may request for an extension, or CalOptima Health can provide justification upon request by DHCS for the need for additional information and how it is in the member's interest. ▪ The delay notice shall include the additional information needed to render the decision, the type of expert needed to review and/or the additional examinations or tests required and the anticipated date on which a decision will be rendered.
Post-Service/Retrospective	- A decision to approve, modify, or deny is required within 30 calendar days of receipt of the request.

Type of Request	Notification Timeline
Standard (Non-urgent) Preservice - All necessary information received at time of initial request.	- **Provider:** Within 24 hours of receipt of the request. - **Member (modify or deny only):** Within 24 hours of receipt of the request.

Standard (Non-urgent) Preservice - Information Needed - Additional clinical information required.	- **Provider:** Within 24 hours of receipt of the additional information reasonably necessary to render a decision. - **Member (modify or deny only):** Within 24 hours of receipt of the additional information reasonably necessary to render a decision.
Standard (Non-urgent) Preservice- Delay Needed - Additional clinical information not received within initial 14 calendar days.	- **Provider:** Delay notice sent within 14 calendar days of receipt of the original request to delay the timeframe for an additional 14 calendar days. - **Member:** Delay notice sent within 14 calendar days of receipt of the original request to delay the timeframe for an additional 14 calendar days.
Expedited (Urgent) Preservice/Concurrent - All necessary information received at time of initial request.	- **Provider:** Within 24 hours of receipt of the request. - **Member (modify or deny only):** Within 24 hours of receipt of the request.

Expedited (Urgent) Preservice/Concurrent - Information Needed - Additional clinical information required.	- **Provider:** Within 24 hours of receipt of the additional information reasonably necessary to render a decision. - **Member (modify or deny only):** Within 24 hours of receipt of the additional information reasonably necessary to render a decision.
Expedited (Urgent) Preservice/Concurrent - Delay Needed - Additional clinical information not received within initial 72 hours.	- **Provider:** Delay notice sent within 72 hours of receipt of the original request to delay the timeframe for up to an additional 14 calendar days. - **Member:** Delay notice sent within 72 hours of receipt of the original request to delay the timeframe for up to an additional 14 calendar days.
Post-Service/Retrospective	- **Provider:** Within 30 calendar days of receipt of the request. - **Member:** Within 30 calendar days of receipt of the request.

OneCare Pharmacy Part D Determination Timelines

Type of Request	Determination Timeline
Standard (Non-urgent) Preservice/Concurrent	A decision to approve or deny is required within 72 hours of receipt of the request or prescriber supporting statement for exception requests (not to exceed seven calendar days from when the request was received).
Expedited (Urgent) Preservice/Concurrent	A decision to approve or deny is required within 24 hours of receipt of the request or prescriber supporting statement for exception requests (not to exceed seven calendar days from when the request was received).
Post-service/Retrospective	A decision to approve or deny is required within 14 calendar days of the initial receipt of the request.

Type of Request	Notification Timeline (Member and Prescriber)
Standard (Non-urgent) Preservice/Concurrent	Within 72 hours of receipt of the request or prescriber supporting statement for exception requests (not to exceed seven calendar days from the date of the original request).
Expedited (Urgent) Preservice/Concurrent	Within 24 hours of receipt of the request or prescriber supporting statement for exception requests (not to exceed seven calendar days from the date of the original request).
Post-service/Retrospective	Within 14 calendar days of the initial receipt of the request.

Emergency Services

An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairments of bodily functions, or serious dysfunction of any bodily organ or part. An emergency medical condition is not defined on the basis of lists of diagnoses or symptoms.
Emergency room services are available 24 hours per day, 7 days per week. Prior authorization is not required for emergency services and coverage is based on the severity of the symptoms at the time of presentation. Emergency services are covered when furnished by a qualified provider and are needed to evaluate or stabilize an emergency medical condition.

Emergency services are covered when furnished by a qualified practitioner, including non-network practitioners, and are covered until the member is stabilized. CalOptima Health also covers any screening examination services conducted to determine whether an emergency medical condition exists.

If a plan network practitioner, or plan representative, instructs a member to seek emergency services, the medical screening examination and other medically necessary emergency services are covered without regard to whether the condition meets the prudent layperson standard. Once the member's emergency medical condition is stabilized, certification for hospital admission or prior authorization for follow-up care is required as follows:

Authorization for Post-Stabilization Inpatient Services

A hospital must notify CalOptima Health of a Post-Stabilization request for services prior to admission. Once a member is stabilized after emergency services but requires additional, medically necessary inpatient services The attending emergency physician, or the provider treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge.

According to DHCS, the requirements of Title 28 CCR Section 1300.71.4 (the 30-minute rule) - apply to both contracted and noncontracted providers in CalOptima Health's Medi-Cal program. CalOptima Health or a HN shall approve or deny a prior authorization request for post-stabilization services if all information reasonably necessary to render a decision is received from a hospital within 30 minutes or 60 minutes for OC members. If CalOptima Health or the HN does not respond within the prescribed timeframe, medically necessary post-stabilization inpatient services are considered approved.

Retrospective Review

Retrospective review is an initial review of services that require prior authorization and have already been rendered. This process encompasses services performed by a participating or non-participating provider without CalOptima Health notification and/or authorization and when there was no opportunity for pre-service review. Retrospective Authorization is only permitted in accordance with CalOptima Health Policy and Procedure

GG.1500: Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers which is as follows:

The request is made within sixty (60) calendar days after the initial date of service and one of the following conditions apply:

1. The Member has Other Health Coverage (OHC); or
2. The Member's medical condition is such that the Provider or Practitioner is unable to verify the Member's eligibility for Medi-Cal, or OneCare program, as applicable, at the time of service.

If supporting documentation satisfies the administrative waiver of notification requirements of the policy, the request is reviewed utilizing the standard medical necessity review process. If the supplied documentation meets medical necessity criteria, the request is authorized. If the supporting documentation is questionable, the Director of UM or designee requests a Medical Director review. The request for a retrospective review must be made within 60 days of the service provided. Medical necessity of post-service decisions (retrospective review) and subsequent member/practitioner notification will occur no later than 30 calendar days from receipt of request.

Admission/Inpatient Review Process

Contracted facilities are required to notify CalOptima Health of all inpatient admissions within 24 hours of admission. The inpatient review process assesses the clinical status of the member, verifies the need for continued hospitalization Information assessed during the review includes but is not limited to:

- Clinical information to support the appropriateness and level of service being provided
- Validating the diagnosis
- Assessment of the clinical status of the member to determine special requirements to facilitate a safe discharge to another level of care
- Additional days/service/procedures requested
- Reasons for extension of the treatment or service

Utilizing evidenced based clinical guidelines, inpatient and concurrent review is conducted throughout the members inpatient stay, with each hospital day approved based on review of the patient's condition and evaluation of medical necessity. Inpatient review can occur on-site or telephonically. The frequency of reviews is based on the severity/complexity of the member's condition and/or necessary treatment, and discharge planning activity.

If, at any time, services cease to meet inpatient clinical criteria, discharge criteria are met, and/or alternative care options exist, the nurse case manager refers the case to the Medical Director for review. If the Medical Director determines the case no longer meets medical necessity for inpatient care, a Notice of Action (NOA) letter is issued immediately by fax and telephone to the attending physician, hospital and mailed to the member for OC members verbal notification is also provided.

The need for case management or discharge planning services is assessed during the admission review and each inpatient admission, focused on the most appropriate alternative to inpatient care. If at any time the UM staff become aware of potential quality of care issue, the concern is referred to CalOptima Health QI department for investigation and resolution.

Discharge Planning Review

Discharge planning begins at the time of an inpatient admission and is designed to identify and initiate a safe, quality-driven treatment intervention for post-hospital care needs. It is a coordinated effort among the facility and CalOptima Health and includes but is not limited to attending physician, hospital discharge planner, UM staff, complex discharge team, Case Management team, health care delivery organizations, and community resources to coordinate care and services.

Objectives of the Discharge Planning Review are:

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

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

Denials

A denial of services, also called an adverse organization determination, is a reduction, modification, suspension, denial or termination of any service based on medical necessity or benefit limitations.

Upon any adverse determination for medical or behavioral health services made by a CalOptima Health Medical Director or other appropriately licensed health care professional (as indicated by case type) a written notification, at a minimum, will be communicated to the member and requesting practitioner.

Verbal notification of any adverse determination is provided when applicable.

All notifications are provided within the timeframes as noted in CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization. The written notification is written in lay language that is easily understandable at a sixth grade reading level and includes the member-specific reason/rationale for the determination, specific criteria and availability of the criteria used to make the decision as well as the availability, process and timeframes for appeal of the decision. All templates for written notifications of decision making are DHCS and CMS approved prior to implementation.

Practitioners are provided with the opportunity to discuss any medical or behavioral health UM denial decisions with a physician or other appropriate reviewer. A CalOptima Health

Medical Director or appropriate practitioner reviewer (BH practitioner, pharmacist, etc.) serves as the point of contact for the peer-to- peer discussion. This is communicated to the practitioner at the time of verbal notification of the denial, as applicable, and is included in the standard denial letter template.

GRIEVANCE AND APPEAL PROCESS

CalOptima Health has a comprehensive review system to address matters when Medi-Cal, OC members wish to exercise their right to review the UM decision to deny, delay or modify a request for services, or terminate a previously approved service. This process is initiated by contact from a member, a member's representative or practitioner to CalOptima Health. Grievances and Appeals for members enrolled in COD, or one of the contracted HMOs, PHCs and SRGs are submitted to CalOptima Health's Grievance and Appeals Resolution Services (GARS). The process is designed to handle individual disagreements in a timely fashion, and to ensure an appropriate resolution.

The grievance process is in accordance with CalOptima Health Member Complaint Policy. HH.1102: CalOptima Member Complaint. The appeal process is in accordance with CalOptima Health Appeal Policy GG.1510: Appeal Process. These processes include but are not limited to:

- Collection of information and/or medical records related to the grievance or appeal.
- Communication to the member and provider.
- Thorough evaluation of the substance of the grievance or appeal.
- Review of the investigation for a grievance or medical records for an appeal.
- Resolution of operational or systems issues and of medical review decision.
- Referral to an appropriately licensed professional in Medical Affairs for evaluation and further management of clinical issues, such as timeliness of care, access to care, and appropriateness of care, including review of the clinical judgments involved in the case.

The grievance and appeal process for all of CalOptima Health Networks except Kaiser are handled by CalOptima Health GARS. CalOptima Health works collaboratively with the community provider or delegated entity in gathering information and supporting documentation. If a member is not satisfied with the appeal decision, he/she may file for a State Hearing with the California Department of Social Services. Grievances and appeals can be initiated by a member, a member's representative or a practitioner. Pre-service appeals may be processed as expedited or standard appeals, while post- service appeals will be processed as standard appeals only.

All medical necessity decisions are made by a licensed physician reviewer. Grievances and appeals are reviewed by an objective reviewer other than the reviewer who made the initial denial determination.

The Medical Director or designee evaluates grievances regarding the denial, delay, termination, or modification of care or service. The Medical Director or designee may request a review by a board-certified, specialty-matched Peer Reviewer to evaluate the determination. An "Expert Panel" roster is maintained from which, either via Letter of Agreement or Contract, a Board- Certified Specialist reviewer is engaged to complete a review and provide a recommendation regarding the appropriateness of a pending and/or original decision that is now being appealed.

CalOptima Health sends written notification to the member and/or practitioner of the outcome of the review within the regulatory time limits. If the denial was upheld, even in part, the letter includes the appropriate appeal language to comply with applicable regulations.

When quality of care issues are identified during the investigation process, further review of the matter is indicated. This portion of the review is a confidential and peer protected process.

All members have access to and copies of all documents relevant to the member's appeal by calling the CalOptima Health Customer Service department.

Expedited Appeals and Grievances

A member, member's authorized representative or provider may request the grievance or appeal process to be expedited if there is an imminent and serious threat to the health of the member, including, but not limited to, severe pain, risk for adverse health outcome if not decisioned quickly, or potential loss of life, limb, or major bodily function. All expedited grievance or appeal requests that meet the expedited criteria shall be reviewed and resolved in an expeditious manner as the matter requires, but no later than 72 hours after receipt. At the time of the request, the information is reviewed, and a decision is made regarding the expedited appeal criteria. Expedited appeals and grievances are managed in an accelerated fashion to provide appropriate, timely care to members when the regular timeframes of the review process could seriously jeopardize the life or health of the member or could jeopardize the member's ability to regain maximum functionality.

State Fair Hearing

CalOptima Health Medi-Cal members have the right to request a State Hearing from the California Department of Social Services after exhausting the appeal process. A member may file a request for a State Hearing within 120 days from the Notice of Appeal Resolution. CalOptima Health and delegated HNs comply with State Aid Paid Pending requirements, as applicable. Information and education on filing a State Fair Hearing is included annually in the member newsletter, in the member's evidence of coverage, and with each adverse Notice of Appeal Resolution sent to the member or the member's representative.

Independent Medical Review

OC members have a right to request an independent review if they disagree with the termination of services from a SNF, home health agency or a comprehensive outpatient rehabilitation facility. CMS contracts with a Quality Improvement Organizations (QIO) to conduct the reviews. CalOptima Health is notified when a request is made by a member or member representative. CalOptima Health supports the process with providing the medical records for the QIO's review. The QIO notifies the member or member representative and CalOptima Health of the outcome of their review. If the decision is overturned, CalOptima Health complies by issuing a reinstatement notice ensuring services will continue as determined by the QIO.

Provider Preventable Conditions

The federal Affordable Care Act (ACA) requires that providers report all Provider Preventable Conditions (PPCs) that are associated with claims for Medi-Cal payment or with courses of treatment furnished to a Medi-Cal patient for which Medi-Cal payment would otherwise be available. The ACA also prohibits Medi-Cal from paying for treatment of PPCs.

There are two types of PPCs:

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

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

LONG-TERM SERVICES AND SUPPORTS

LTC

The LTC case management program includes authorizations for the following facilities:

- NF-A, NF-B , subacute care

Facilities are required to notify CalOptima Health of admissions within 21 days. Nurse Case Managers assess a member's needs through review of the Minimum Data Set, member's care plan, medical records, and social service notes. LTC services also include coordination of care for members transitioning out of a facility, such as education regarding community service options, or a referral to MSSP, IHSS, CalAIM or CBAS. Referrals to case management can also be made upon discharge when a member's needs indicate a referral is appropriate. In addition, the LTC staff provides education to facilities and staff in response to individual facility requests, and when new programs are implemented.

CBAS

An outpatient, facility-based program offering day-time care and health and social services, to frail seniors and adults with disabilities to enable participants to remain living at home instead of in a nursing facility. Services may include health care coordination; meal service (at least one per day at center); medication management; mental health services; nursing services; personal care and social services; physical, occupational and speech therapy; recreational activities; training and support for family and caregivers; and transportation to and from the center. A new benefit launched in October 2022 allow for members to receive Emergency Remote Services (ERS) in lieu of attending the center when they are experiencing an event that precludes them from attending the center in person. By allowing for ongoing support while the member is experiencing a public or personal emergency, the CBAS can continue to coordinate care and services on the member's behalf.

MSSP

CalOptima Health is an approved MSSP site through California Department of Aging (CDA).. The program provides services and support to help people 65 and older who have a disability that puts them at risk of going to a nursing home. Services include, but are not

limited to, senior center programs, case management, money management and counseling, respite, housing assistance, assistive devices, legal services, transportation, nutrition services, home health care, meals, personal care assistance with hygiene, personal safety, and activities of daily living.

Over/Under Utilization

Over/under utilization monitoring is tracked by UM leadership team, the UM workgroup, identified stakeholders, Medical Director Team and reported to UMC. The UMC reviews the Over/Under Utilization report on a quarterly basis and approves and monitors metrics, discusses performance, address identify trends, contributes to the analysis, and identifies action plan for decreasing over and underutilization.
Over/under utilization monitoring and performance are reported to the QIC and QAC on a quarterly basis.

Under and Over Utilization is tracked and monitored through the following areas and trends:

- ER visits per 1000
- Bed days per 1000
- Admits per 1000
- Average length of stay per 1000
- Readmission rates
- Pharmacy utilization measures
- Member grievances per 1000
- Identified Trends from Fraud, Waste and Abuse investigations
- Select HEDIS rates for selected measures
- PCP and specialist referral pattern analysis
- Member utilization patterns
- Trends in UM-related complaints
- Potential quality issues
- Behavioral health measures
- Other areas as identified

PROGRAM EVALUATION

The UM Program is evaluated at least annually and modifications made as necessary. The Deputy Medical Director and Director, UM evaluate the impact of the UM Program by using:

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

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

SATISFACTION WITH THE UM PROCESS

CalOptima Health provides an explanation of the GARS process, State Fair Hearing and Independent Review processes to newly enrolled members upon enrollment and annually thereafter. The process is explained in the Member Handbook and Provider Manual and may also be highlighted in member newsletter articles, member educational flyers and postings at provider offices. Complaints or grievances regarding potential quality of care issues are referred to CalOptima Health QI department for investigation and resolution.

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

CASE MANAGEMENT PROCESS

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

Each year, based upon the evaluation and review of member satisfaction and effectiveness data, CalOptima Health updates the Complex Case Management process to better address member needs. Evaluation results are shared with staff and training is provided to ensure understanding of any programmatic changes to the current process for the upcoming year.

Updates and/or changes to the CCM program and process include but are not limited to the following:

- Ongoing development of the clinical documentation platform to enhance functionality of assessments, care plans, and outputs and provide continued training in clinical standards of care, NCQA PHM 5: Complex Case Management Standards, and techniques for effective case management to both CalOptima Health and Health Network staff.
- Provide targeted outreach and case management to support members who utilize primarily the emergency department for care and develop best practices for outreaching these members and improving their overall care.
- Continue development of specialized outreach and management for special populations, such as members struggling with homelessness, pain, or behavioral health issues. Enhance training in resources and engagement to care management staff, with the goal of increasing member engagement in case management.
- California Children's Services (CCS) managed by CalOptima through the Whole-Child Model (WCM) Program went into effect in 2019.

- Beginning on January 1, 2022, CalOptima Health implemented two CalAIM components: Enhanced Care Management (ECM) and Community Supports. Enhanced Care Management provides a whole- person approach to care that addresses the clinical and non-clinical circumstances of high need Medi-Cal members.
- Effective January 1, 2022, DHCS carved out the outpatient pharmacy benefit for Medi-Cal beneficiaries from managed care plans and moved it to a state fee-for-service program, known as Medi-Cal Rx.
- The OneCare Connect program ended effective December 31, 2022 and members transitioned to the OneCare (D-SNP) program effective January 1, 2023.
- Another component of CalAIM, Population Health Management was launched effective January 1, 2023 with a phased implementation.

Team Composition and Roles

The Case Management Department consists of functional teams that focus on specific program activities. The teams are multidisciplinary, and are composed of nurse Case Managers, Social Workers, Medical Assistants, Personal Care Coordinators, and Member Liaison Specialists, as appropriate, to meet the needs of the member. Case Managers are assigned caseloads that are variable depending on the complexity of the cases managed. The Case Management Teams include a Triage Team, Health Risk Assessment Team, Health Network Liaison Team, an Oversight Clinical Team and a Direct Clinical Team.

The following staff positions provide support for organizational/operational CM Department's functions and activities:

Sr Director, Clinical Operations oversees the Case Management and Long-Term Services and Supports (LTSS) programs within CalOptima to ensure that these functions are properly implemented by all CalOptima Health Networks and contracted provider groups, including CalOptima Community Network and CalOptima Direct. The incumbent is responsible for programmatic oversight, strategic planning and ongoing compliance with all local, state and federal regulations and accreditation standards according to the CalOptima mission and vision.

Director of Care Management directs all Case Management programs for CalOptima members to ensure that these functions are properly implemented by all CalOptima Health Networks and contracted provider groups, including CalOptima Community Network and CalOptima Direct. The incumbent is responsible for all departmental compliance with all local, state, and federal regulations and ensures that accreditation standards are current, and all policies and procedures meet current requirements.

Manager of Case Management provides shared responsibility for the daily operations, activities, and projects for the Case Management department. The incumbent works under the general direction of the Director of Case Management and in partnership with the other department managers to provide performance management and development of the case management staff and projects associated with the department to ensure compliance with department policies and procedures, along with the implementation of assigned projects. The incumbent may be required to attend joint operational and community meetings. The incumbent is responsible for monitoring of case management reports and reporting to management or committees.

Case Management Supervisor is responsible for the daily operation of case management activities, the implementation of new programs and compliance with regulations. The incumbent will provide guidance to staff or will directly handle complex case management referrals. The incumbent will be accountable for establishing quality and productivity standards for the team and ensuring compliance with department policies and procedures in collaboration with the manager. The incumbent will serve as a resource for CalOptima Health's providers, health networks and community partners.

Medical Case Manager (Ambulatory) responsible for providing ongoing case management services for CalOptima Health's members. The Medical Case Manager will facilitate communication and coordination among all participants of the health care team and the member to ensure the services provided promote quality and cost-effective outcomes.

Medical Case Manager (Oversight) is responsible for providing ongoing case management services for CalOptima members. The position facilitates communication and coordination among all participants of the health care team and the member to ensure that the services are provided to promote quality, cost-effective outcomes. The Oversight Case Manager completes intensive investigation of cases that are referred to the Case Management Team. The position serves as a resource for members, delegated plan case managers, Personal Care Coordinators (PCCs) and community partners to address medical, behavior, and psychosocial concerns. In conjunction with other team members, the incumbent may make recommendations for a comprehensive individualized care plan at all levels of care.

Medical Assistants are responsible for effective, efficient and courteous interaction with practitioners, members, family and other customers, under the direction of the licensed Case Manager or the Gerontology Resource Coordinator. The Medical Assistant performs medical and administrative routine tasks specific to the assigned unit, and office support functions. The Medical Assistant may also authorize requested services according to departmental guidelines.

Social Worker provides administrative case management and coordination of benefits for carved-out services. The Medical Social Worker serves as a departmental resource regarding benefits and available resources for the aged, behavioral health, foster care and the disabled population. The Medical Social Worker also serves as a liaison to Orange County based community agencies.

Personal Care Coordinator support CalOptima Health members in completing a Health Risk Assessment (HRA) and ensure communication of the HRA and care plan with the member, Primary Care Provider (PCP) and health care team. The PCC will identify barriers to members' care and assist in in improving these barriers for all levels of care. The incumbent will work closely with the PCP and health care team to ensure member access to timely services and coordination of care.

Program Assistant provides support to staff, including but not limited to preparing meeting materials, maintaining minutes, routing documents, conducting data entry and handling of incoming and outgoing correspondence per administrative policy. Provides administrative support for specific and/or ongoing projects, such as generating reports, logs, calendars, and

mailings, applying general business practices, as well as CalOptima policies and procedures under the direction of the Director.

Data Analyst performs analysis and reports data related to Case Management projects, and ensures that case management goals and objectives are accomplished within specified time frames, through the judicious and efficient use of CalOptima Health resources.

QI Nurse Specialist is responsible for overseeing regulatory reports and audits for the entire Case Management department to ensure regulatory compliance, implementing and monitoring policy changes to case management reporting, and providing quality review of submitted health network data to meet Centers for Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), and National Committee for Quality Assurance (NCQA) requirements. In addition, the incumbent performs analysis and reports data related to the Case Management projects and ensures that Case Management goals and objectives are accomplished within specified time frames. The incumbent interacts with other internal CalOptima departments, health networks, and external agencies.

While CalOptima Health enjoys a robust array of internal case management resources, case management activities are also performed by the Health Networks. The Health Networks utilize their own case management staff to manage CalOptima Health's members who are assigned to them. Case management departments at the Health Networks are staffed with Licensed Case Managers, Social Workers, Pharmacists, and unlicensed support staff. While these staff are supervised by the Health Networks, they participate in CalOptima Health specific training and are overseen by CalOptima Health.

Staff Training/Education

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

Each new employee is provided an intensive orientation and job specific training with a staff member. The following topics are covered during the introductory period, with specific training, as applicable to individual job description:

- CalOptima Health New Employee Orientation and Boot Camp (CalOptima programs)
- HIPAA and Privacy
- Fraud, Waste and Abuse, Compliance and Code of Conduct training
- Use of technical equipment (phones, computers, printers, facsimile machines, etc.)
- Workplace Harassment Prevention training
- Cultural Competency, Bias or Inclusion and Trauma-Informed Care training
- Seniors and Persons with Disabilities Awareness Training
- OneCare Model of Care Training
- CM Program: policies/procedures and desk top processes, etc.
- Medical Information System data entry
- Application of Review Criteria/Guidelines
- Appeals Process
- QI Referral Process

CalOptima Health 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 Health. Each year, a specific budget is set for continuing education for each licensed CM employee. Licensed nursing staff is monitored for appropriate application of Review Criteria/Guidelines, NCQA requirements, and case management documentation. Training opportunities are addressed immediately as they are identified through regular administration of proficiency evaluations. Any employee who fails the evaluation is provided additional training and provided with a work improvement process. Formal training, including seminars and workshops, are provided to all Case Management staff on an annual basis. Delegated Health Network staff participates annually in CalOptima Health model of care training.

Coordination of Care

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

Other attempts to promote continuity and coordination of care include member notifications to those affected by a PCP or practice group termination from CalOptima Health. CalOptima Health assists the member as needed to choose a new PCP and transfer the medical records to the new PCP. If the provider is not termed due to a quality issue, continuity of care may also be explored to continue treatment with the provider in certain situations. CalOptima Health also coordinates continuity of care with other Managed Care Plans when a new member comes into CalOptima Health or a member terminates from CalOptima Health to a new health plan.

CalOptima Health uses the following data sources to identify a member for case management:

- Pharmacy data
- Health Risk/Needs Assessment
- Claims or encounter data
- Hospital Discharge data
- Utilization Management data
- Laboratory results
- Data supplied by purchasers
- Data supplied by member or caregiver
- Data supplied by practitioners
- Risk stratification process or Predictive Modeling Tool
- Health Information Form (HIF) or Member Evaluation Tool (MET), if available

The avenues for referring a member for case management are:

- Member self-referral
- Member's authorized representative/family referral

- Practitioner/Provider referral
- Customer Service referral
- Discharge Planner referral
- Disease Management program referral
- Community Agency referral
- HN/SRG/PMG referral
- Utilization Management referral
- Long Term Services and Supports referral

The case management program includes:

- Documented process to assess the needs of member population.
- Development of the program through use of evidenced based guidelines.
- Defined program goals.
- Standardized mechanisms for member identification through use of data.
- Multiple avenues for referrals to case management.
- Following members across the continuum of health care from outpatient or ambulatory to inpatient settings.
- Process to inform eligible members of case management services, and the ability to elect or decline services.
- Documentation in a case management system that supports automatic documentation of case manager's name, date, time of action and prompts for required follow up.
- Use of evidenced-based clinical practice guidelines or algorithms.
- Initial assessment and ongoing management process.
- Developing, implementing and modifying an individualized care plan through an interdisciplinary and collaborative team process, in conjunction with the provider, member and/or their family/caregiver.
- Developing prioritized goals that consider the member or caregiver's goals and preferences.
- Developing member self-management plans.
- Coordinating services for members for appropriate levels of care and resources.
- Documenting all findings.
- Monitoring, reassessing, and modifying the plan of care to ensure quality, timeliness, and effectiveness of services.
- Analyzing data and member feedback to identify opportunities for improvement.
- Mechanism for identification and referral of quality-of-care issues to QI Department.
- Coordination of carved out services, such as Denti-Cal
- Identification of mental health needs and referral to Behavioral Health
- Identification of educational needs and referral to Population Health Management
- Referral to LTSS
- Assess and identify continuity of care needs and work collaboratively with UM department

Initial assessment of member's health care status and needs, including condition-specific issues:

- Member's right to accept or decline case management services
- Review of past medical history and co-morbidities
- Medication reconciliation and compliance
- Assessing member's support systems/caregiver resources and involvement
- Evaluation of behavioral health, cognitive function, and substance use disorder
- Evaluation of cultural and linguistic needs, preferences or limitations
- Member's motivational status or readiness to learn
- Assessment of visual and hearing needs, preferences or limitations
- Assessment of life-planning activities
- Assessment of functional status - activities of daily living (ADLs) and instrumental activities of daily living (iADLs)

- Assessment of social drivers of health (SDOH)
- Review current status and treatment plan
- Identifies barriers to quality, cost-effective care and fulfilling the treatment plan
- Determines implications of resources, and availability and limitations of benefit coverage
- Assessment of need for referrals to community resources
- Evidence-based clinical guidelines or algorithms to conduct assessment and management

Upon acceptance of a member into the CM Program, the Case Manager will develop a Case Management Plan that identifies the interventions required to provide appropriate care to the member.

A Case Management Plan includes the following:

- Development of prioritized SMART goals that take into account:
- Member or caregiver's goals or preferences
- Member or caregiver's desired level of involvement in case management plan
- Barriers to meeting goals and complying with self-management plan
- Scheduled time frame for follow-up and communication with members
- Assessment of progress towards goal, with modifications as needed
- Resources to be utilized, including the appropriate level of care
- Planning for continuity of care, including transition of care and transfer
- Collaborative approaches to be used, including family/caregiver participation

Coordination of Carved Out Services

CalOptima Health provides linkages with community programs to ensure that members with special health care needs, or high risk or complex medical and developmental conditions, receive wrap-around services that enhance their medical benefits.

Memorandum of Understanding (MOU) with other community agencies and programs, such as the HCA/California Children's Services, Orange County Department of Mental Health, and the Regional Center of Orange County. The CM staff and delegated entity practitioners are responsible for identification of such cases and coordination of referrals to appropriate State agencies and specialist care when the benefit coverage of the member dictates. The Case Management Department assists members with the transition to other care, if necessary, when benefits end. This may include informing the member about ways to obtain continued care through other sources, such as community resources.

Case Management Programs include identification and referral of a member eligible for community and/or Federal Medicaid Waiver programs, including, but not limited to:

- Specialty Mental Health Services
- California Children's Services (CCS)
- Regional Center of Orange County (RCOC)
- Local Education Agency (LEA)
- Genetically Handicapped Persons Program (GHPP)
- AIDS Waiver Program
- 1915 (c) Home and Community Based Services
- Assisted Living Waiver (ALW)
- Home and Community-Based Alternative (HCBA) Waiver (formerly NF/AH Waiver)
- Home and Community-Based Services Waiver for the Developmentally Disabled (HCBS-DD) Waiver
- Multipurpose Senior Services Program (MSSP)

- Tuberculosis Program (Direct Observation Therapy)
- Collaborate with the HCA/PDS TB Control Officer

Clinical Protocols

CalOptima Health is committed to serving the needs of all members assigned and places additional emphasis on the coordination of care for the vulnerable population. Approved clinical practice guidelines and nationally recognized protocols are used to guide treatment and care provided to the members. The use of clinical practice guidelines or nationally recognized protocols is challenging for the CalOptima Health membership as many of their needs are socioeconomic in nature. These guidelines do not address many of the supplemental benefits or community-based resources that may be critical to a comprehensive care plan for these individuals. Members with end stage renal disease (ESRD) and a comorbid condition of prostate cancer may not meet criteria for transplant based on guidelines. Lack of transportation may create obstacles to care, yet the member may not meet criteria for non-emergency medical transportation. Members who are at the end-of-life may be inappropriate for certain preventive care screenings.

When use of a clinical practice guideline or nationally recognized protocol is challenging or inappropriate for an individual member the following steps may be taken:

- ICT is convened with the member, PCP, and specialists (if appropriate).
- Participants of the ICT review the case and mutually develop an ICP, prioritized per member's preferences.
- PCP or Case Manager facilitates referrals and linkages to identified supplemental benefits, community referrals and resources.

When a member's specific clinical requirements indicate the need for an alternative approach, decisions to modify clinical practice guidelines or nationally recognized protocols are made by the member, PCP or specialists, in consultation with other members of the health care team. The care team members review the member's current health status, limitations, social support, barriers, and treatment approach, which include any modifications needed in the clinical practice guidelines that support the ICP. Timeframes are established for each of the action items of the ICP to ensure successful completion of these tasks, identification of barriers, and attainment of goals. Updated ICP is shared with the care team members including but not limited to the member, caregivers, and PCP.

To address the unique needs of our members, CalOptima Health offers supplemental benefits, which can be accessed either through self-referral or via referral by a treating practitioner. These benefits are intended to aid members in maintaining optimal health status, either by providing health care services not covered by Medicare or Medi-Cal (e.g., vision care), by addressing barriers to access to care (e.g., Non-Medical Transportation), or by promoting regular physical activity (gym benefit).

Types of Case Management Services

Basic Case Management

Basic case management activities by the primary care practitioner may include, but are not limited to:

- A health assessment of member's current acute, chronic and preventive health needs
- Development of the member's treatment plan

- Communication between the practitioner and member/authorized representative to ensure compliance with established treatment plan
- Identification of the need for medical, specialty or ancillary referrals
- Referrals to case management and/or disease management

Complex Case Management

Complex Case Management Services are provided by CalOptima Health, in collaboration with the Primary Care Provider, and includes, at minimum:

1. Basic Case Management Services
2. Management of acute or chronic illness, including emotional and social support issues by a multidisciplinary case management team
3. Intense coordination of resources to ensure member regains optima health or improved functionality
4. With member and PCP input, development of care plans specific to individual needs, and updating of the care plans at least annually

Complex Case Management is the coordination of care and services provided to a member who has experienced a critical event, or diagnosis that requires the extensive use of resources, and who needs assistance in facilitating the appropriate delivery of care and services.

The members in Complex Case Management usually:

1. Are at high risk; or
2. Have medically complex or frequently managed conditions or diseases, including, but are not limited to, the following:
3. Spinal Injuries
4. Transplants
5. Cancer
6. Serious Trauma
7. AIDS
8. Multiple chronic illnesses
9. Chronic illnesses that result in high utilization
10. Have a complex social situation that affects the medical management of their care; or
11. Require extensive use of resources; or
12. Have an illness or condition that is severe, and the level of management necessary is very intensive.

CalOptima uses this criteria when data mining and as a guideline for internal and external referral sources to identify appropriate CCM cases.

Children with Special Health Care Needs

Children with Special Health Care Needs (CSHCN) are those who have, or are at increased risk for, a chronic physical, developmental, behavioral, or emotional condition. They may have a disability or chronic medical condition due to complications of prematurity, metabolic disorder, chromosomal

abnormalities, or congenital abnormalities. They require health and related services of a type or amount beyond that required by children generally.

Case Management staff ensures coordination of care with other entities that provide services for Children with Special Health Care Needs (e.g. mental health, substance abuse, Regional Center, CCS, local education agency, child welfare agency).

The goals of CSHCN Case Management are to:

- Collaborate with family and providers to develop an Individualized Care Plan
- Facilitate member access to needed services and resources
- Prevent duplication of services
- Optimize member's physical and emotional health and well-being
- Improve member's quality of life

Whole Child Model

The Whole-Child Model is a program that aims to help California Children's Services (CCS) children and their families get better care coordination, access to care, and health results. The WCM program combines a qualified member's Medi-Cal and CCS benefits under CalOptima. CCS is a statewide program that arranges and pays for medical care, equipment and other services for children and young adults under 21 years of age who have certain serious medical conditions.

Provides access for families so that families know where to go for ongoing information, education, and support in order that they understand the goals, treatment plan, and course of care for their child or youth and their role in the process, what it means to have primary or specialty care for their child or youth, when it is time to call a specialist, primary, urgent care, or emergency room, what an Interdisciplinary Care Team (ICT) is, and what the community resources are.

The Whole Child Model program includes:

- Personal Care Coordinator (PCC) will be assigned to each CCS-eligible Member.
- Perform initial and periodic outreach to assist the Member with Care Coordination
- Provide information, education and support continuously, as appropriate
- Assist the Member and the Member's family in understanding the CCS-eligible Member's health, other available services, and how to access those services.
- Improve coordination of services to meet the needs of the child and family
- Maintain existing patient-provider relationships when possible
- Retain CCS program standards
- Improve overall health results

Transitional Care Services (TCS)

Transitional Care Services (TCS) are provided to members transitioning from levels of care, including hospitalizations and skilled nursing facility. For members enrolled with Case Management, Case Managers will support recently discharged members with tools and support to encourage and sustain self-management skills to help minimize the potential of a readmission and optimize the member's quality of life. TCS is provided to ensure members are supported from discharge planning until they have been successfully connected to all needed services and supports.

The Case Manager is responsible for coordinating and verifying that assigned members receive all appropriate TCS, regardless of setting and including, but not limited to, inpatient facilities, discharging facilities, and community-based organizations. The Case Manager is also responsible for ensuring collaboration, communication, and coordination with members and their families/support persons/guardians, hospitals, EDs, LTSS, physicians (including the member's PCP), nurses, social workers, discharge planners, and service providers to facilitate safe and successful transitions. While the Case Manager does not need to perform all activities directly, they must ensure all transitional care management activities occur, including the discharge risk assessment, discharge planning documentation, and necessary post-discharge services.

Special Programs

Transplant Program
The CalOptima Health Transplant Program is coordinated by the Medical Director and Medi-Cal members are managed in collaboration with the Case Management department. Transplants for Medi- Cal only members are not delegated to the HMOs, PHCs or SRGs, other than Kaiser Foundation Health Plan.

The Transplant Program provides the resources and tools needed to proactively manage members identified as potential transplant candidates. The Case Management department works in conjunction with the contracted practitioners and the DHCS Center(s) of Excellence or CMS certified Centers for OneCare. Case Management will follow the member and assist as needed through the transplant evaluation process, while they are waiting to procure an organ, and post-transplant for one year.

Members are monitored on an inpatient and outpatient basis and followed the transplant continuum. The member, physician and facilities are assisted in order to assure timely, efficient and coordinated access to the appropriate level of care and services within the member's benefit structure. In this manner, the Transplant Program benefits the member, the community of transplant staff and the facilities. CalOptima Health monitors and maintains oversight of the Transplant Program and report to UM Committee to oversee the accessibility, timeliness, and quality of the transplant protocols.

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Annual Review:
2022 UM Program Evaluation and 2023 UM/CM Integrated Program Description

Kelly Giardina, MSG, CCM Executive Director Clinical Operations

Stacie Oakley, RN Director Utilization Management

Our Mission

To serve member health with excellence and dignity, respecting the value and needs of each person.

Our Vision

By 2027, remove barriers to health care access for our members, implement same-day treatment authorizations and real-time claims payments for our providers, and annually assess members' social determinants of health.

Utilization Management (UM) Program Description and Program Evaluation

- CalOptima Health annually evaluates the effectiveness of the UM program:
  - Program Structure
  - Responsibility for the UM program
  - Significant changes, new initiatives and programs
  - Program Scope and processes used to determine coverage and medical necessity
- Program description is revised based on evaluation and updated for the following year

- The 2022 Program Evaluation and 2023 Integrated UM and CM program description approved by Utilization Management Committee (UMC) and Quality Improvement Health Equity Committee (QIHEC).

2022 UM Program Evaluation
Q4’2021-Q3’2022

Kelly Giardina, MSG CCM
Executive Director, Clinical Operations

2022 UM Program Evaluation

- Utilization Management Program Evaluation (Q4 ‘21- Q3 22)

  - **Q4’2021-Q1’22- backlog**: Short- and long-term accomplishments and interventions to mitigate further occurrences
    - Daily PA and inventory management protocols
    - Turnaround time monitoring (all layers of leadership)
    - Staff education and Inter-Rater Reliability (IRR) testing
    - Enhanced staff coaching with an added Clinical Trainer
    - Weekend non-clinical, Nursing and MD coverage
    - Command Center Monitoring for timely notification of determinations

2022 UM Program Evaluation

- Medical Directors responsibilities and capacity expanded:
  - Chairing of Utilization Management Work Group/Benefit Management Subcommittee
  - Internal Clinical and external provider education
  - Additional Medical Director Specialties (Transplant, Internal/Preventative Medicine and Family Practice)
  - Facility Rounding Weekly (complex discharge, outlier cases, peer-to-peer)

- Behavioral Health enhanced role in the development and oversight of the UM Program

2022 UM Program Evaluation

- 90 Day Emergency Department Pilot Program
  - CalOptima Health Prior-Authorization hybrid nurse embedded into the Emergency Department at St. Joseph Hospital
  - October through December 2022
  - **Pilot Goals**
    - Promote ED communication and member access to Prior authorization, specialty care across all CalOptima Networks
    - Increase CalAIM Community Supports / ECM Referrals
    - Increase PCP follow up visit within 30 days of ED visit
    - Decrease high inappropriate Emergency Department Utilization

2022 UM Program Evaluation

- 90 Day Emergency Department Pilot Program (con't)
  - Outcomes, successes, results and next steps
    - 72% of the members initially identified as high utilizers of ED services were successfully connected with ambulatory care and CalAIM ECM/ CS after pilot interventions

    - 190 members were seen as a part of the pilot program for the following successful interventions in real time:
      - PCP Appointments scheduled 16%
      - Specialty Appointments scheduled 11%
      - Other Case Management Referrals 4%
      - Prior Auth Referrals completed 9%
      - Transportation issues resolved 3%
      - Medication Issues resolved 8%
      - Community Support Referrals 13%

2022 UM Program Evaluation

90 Day Emergency Department Pilot Program (con't)

- Next steps:
  - Additional pilot analysis including claims review
  - Explore automation for specific and targeted services based on analysis and MD review
  - Continue program through real time remote communication (Teams channel, telephonic secure email)
  - Identify future opportunities programmatic and remote support to leverage economies of scale

2022 UM Program Evaluation

Summary Inpatient Utilization and ED					
Metric	**Goal**	**2021 Q4**	**2022 Q1**	**2022 Q2**	**2022 Q3**
ALOS	4.3	5.09	5.30	5.31	4.82
Admit PTMPY	284	120.4	114.2	116.6	126.0
Days PTMPY	358	613.1	605.4	619.5	607.1
Readmit %	25%	16.73%	15.96%	15.26%	16.79%

•2022 Performance Goals – MediCal roll up (excludes WCM and HN data)

Emergency Department Utilization by Aid Code line of business				
Line of Business	**2021 Q4**	**2022 Q1**	**2022 Q2**	**2022 Q3**
MediCal Expansion	489.6	483.6	511.6	529.9
TANF 18+	523.3	558.4	520.7	580.3
TANF <18	355.7	342.9	368.8	375.1.
SPD	772.6	700.1	688	748.3
LTC	480.9	487.4	385.7	386.2
WCM	519.7	491.2	278.1	293.2

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CalOptima Health

2022 UM Program Evaluation

Inpatient Utilization Details by Metric and Aid Category

ALOS					
Aid Category	**Goal**	**2021 Q4**	**2022 Q1**	**2022 Q2**	**2022 Q3**
TANF 18+	4.3	3.67 ↓	4.21 ↓	4.22 ↓	3.71 ↓
TANF <18	4.3	3.59 ↓	3.43 ↓	2.72 ↓	3.08 ↓
SPD	4.3	7.40 ↑	6.26 ↑	6.67 ↑	6.43 ↑
Long Term Care (LTC)	4.3	8.33 ↑	9.65 ↑	6.09 ↑	8.21 ↑
Whole Child Model	4.3	6.45 ↑	6.09 ↑	8.14 ↑	7.09 ↑

Admit PTMPY					
Aid Category	**Goal**	**2021 Q4**	**2022 Q1**	**2022 Q2**	**2022 Q3**
TANF 18+	284	165.3 ↓	158.0 ↓	160.2 ↓	188.4 ↓
TANF <18	284	12.2 ↓	11.9 ↓	10.1 ↓	11.4 ↓
SPD	284	281.5 ↓	273.6 ↓	257.8 ↓	265.7 ↓
Long Term Care (LTC)	284	786.9 ↑	753.2 ↑	457.1 ↑	692.6 ↑
Whole Child Model	284	219.9 ↓	208.1 ↓	113.9 ↓	120.3 ↓

2022 UM Program Evaluation

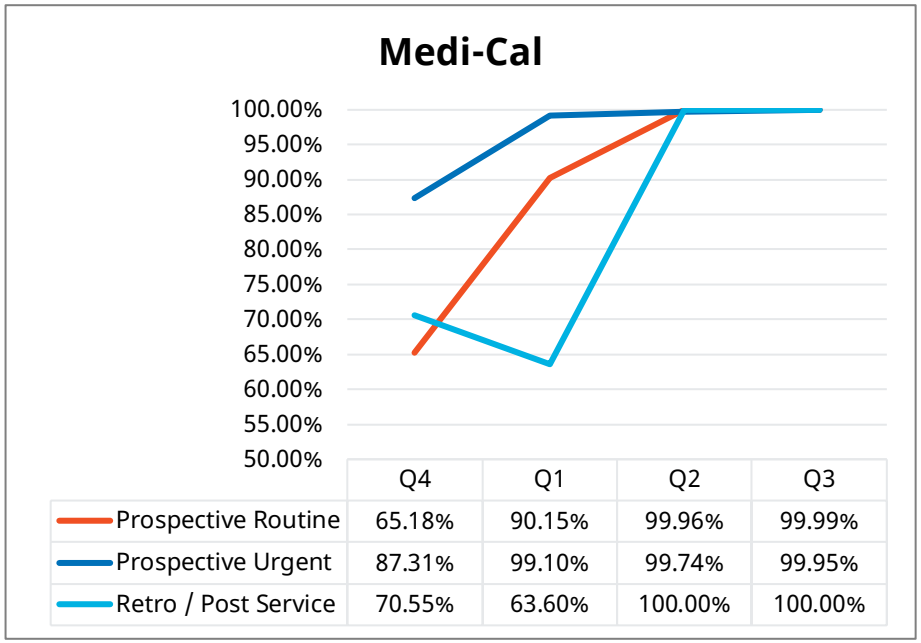
Inpatient Utilization Details by Metric and Aid Category

Days PTMPY					
Aid Category	**Goal**	**2021 Q4**	**2022 Q1**	**2022 Q2**	**2022 Q3**
TANF 18+	**358**	606.7 ↑	665.8 ↑	676.7 ↑	698.4 ↑
TANF <18	**358**	43.6 ↓	40.7 ↓	27.5 ↓	35.0 ↓
SPD	**358**	2,083.9 ↑	1,711.9 ↑	1,720.3 ↑	1,710.0 ↑
Long Term Care (LTC)	**358**	6,557.40 ↑	7,266.50 ↑	2,785.70 ↑	5,687.00 ↑
Whole Child Model	**358**	1,417.9 ↑	1,268.3 ↑	926.5 ↑	853.4 ↑

Readmit %					
Aid Category	**Goal**	**2021 Q4**	**2022 Q1**	**2022 Q2**	**2022 Q3**
TANF 18+	**25%**	12.38% ↓	13.44% ↓	11.98% ↓	11.83% ↓
TANF <18	**25%**	0.00%	0.00%	0.00%	0.00%
SPD	**25%**	19.13% ↓	19.38% ↓	17.70% ↓	21.80% ↓
Long Term Care (LTC)	**25%**	27.91% ↑	16.22% ↓	11.11% ↓	32.56% ↑
Whole Child Model	**25%**	11.06% ↓	7.63% ↓	8.50% ↓	4.33% ↓

2022 UM Program Evaluation

Prior Authorization Turnaround Time Compliance

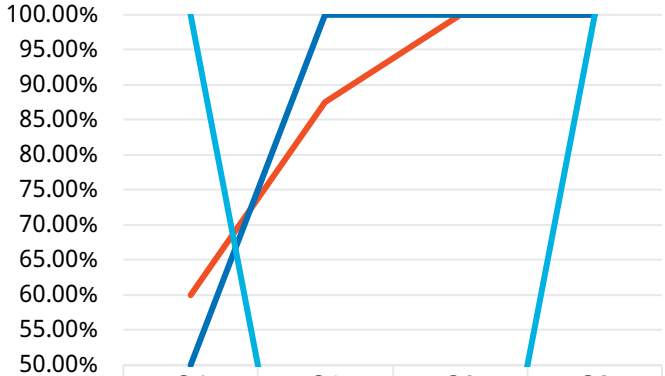


	Q4	Q1	Q2	Q3
Prospective Routine	65.18%	90.15%	99.96%	99.99%
Prospective Urgent	87.31%	99.10%	99.74%	99.95%
Retro / Post Service	70.55%	63.60%	100.00%	100.00%

2022 UM Program Evaluation

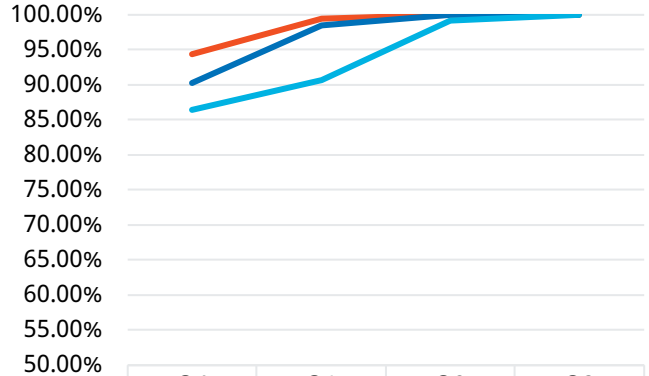
Prior Authorization Turnaround Time Compliance

OneCare



	Q4	Q1	Q2	Q3
Prospective Routine	60.00%	87.50%	100.00%	100.00%
Prospective Urgent	50.00%	100.00%	100.00%	100.00%
Retro / Post Service	100.00%	0	0	100.00%

OneCare Connect



	Q4	Q1	Q2	Q3
Prospective Routine	94.41%	99.43%	99.94%	100.00%
Prospective Urgent	90.32%	98.44%	100.00%	100.00%
Retro / Post Service	86.36%	90.65%	99.24%	100.00%

2022 UM Program Evaluation

Referrals Processed

Referrals Processed Q4 2021 - Q3 2022					
Year	**Quarter**	**LOB**	**Prospective Routine**	**Prospective Urgent**	**Retro / Post Service**
2021	**Qtr4**	Medi-Cal	**37,414**	**6,256**	**421**
		OneCare	5	2	2
		OneCare Connect	1,878	341	154
2022	**Qtr1**	Medi-Cal	44,678	5,857	684
		OneCare	8	4	-
		OneCare Connect	1,936	320	107
	Qtr2	Medi-Cal	47,626	7,682	1,180
		OneCare	9	2	-
		OneCare Connect	1,543	304	131
	Qtr3	Medi-Cal	42,298	8,359	611
		OneCare	11	2	2
		OneCare Connect	2,146	346	121
Grand Total			**179,552**	**29,475**	**3,413**

Referrals Received Q4 2021 - Q3 2022	
Faxes	251,346
COLAS	198,728
• COLAS Auto Approved	75,136
Total	450,074

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2022 UM Program Evaluation

Pharmacy Utilization

- Retail Pharmacy: $PMPM costs for CY22 are below expected spend for OneCare and above expected spend for OneCare Connect.
  - OneCare Connect drug cost increases are primarily driven by increased utilization of brand diabetes and chemotherapy medications.
- Goals were met for two of the three adherence measures. Interventions include provider faxes, member educational materials, medication therapy management-eligible member education, and individual member refill reminders phone calls.

Measure	Medication Adherence for Diabetes Medications	Medication Adherence for Hypertension (RAS antagonists)	Medication Adherence for Cholesterol (Statins)
Rate	87%	89%	88%
Goal	88%	89%	88%

•2022 Performance Goals – MediCal roll up (excludes WCM and HN data)

2022 UM Program Evaluation

Inter-Rater Reliability

- All staff who apply medical necessity guidelines successfully exceeded the annual goal of 90%.

Department	IRR Score
UM Clinical Staff: Prior Authorization	96%
UM Clinical Staff: Concurrent Review	96%
Physicians	99%
Pharmacy	94%
LTSS: LTC	97%
LTSS: CBAS	97%
LTSS: MSSP	97%
Behavioral Health	98%

2022 UM Program Evaluation

Member and Provider Satisfaction

Satisfaction with the UM Program is evaluated based upon analysis of Grievances and Appeals, Member and Provider Experience Surveys, and responses from the CAHPS survey, related to the UM Program.

- Member feedback obtained through Grievances and Appeals
  - Access to Providers/Specialist
    - Provider no longer contracted
    - Provider panel closed
    - Provider limitations due to type of required care for member, member age, or existing-affiliation requirements

2022 UM Program Evaluation

Member and Provider Satisfaction (con't)

- Member feedback obtained through 2022 CAHPS
  - Timeliness of specialist appointments
    - 71.3% of adult members and 73.0% of child members usually or always got an appointment with a specialist as soon as needed, with a decrease from 81.4% from the previous survey for adult members.
  - Access to care, tests, and treatment
    - 80.8% of child members felt it was usually or always easy to get the care, tests, or treatment child needed, with a decrease from 85.6% from the previous survey.
- In 2022, there were a total of 27 Potential Quality Issues (PQIs) related to the UM Program:

Potential Quality Issues (PQIs)					
	Q1	Q2	Q3	Q4	TOTAL
Authorization Denied or Delayed	0	5	9	13	27

2022 UM Program Evaluation

Member and Provider Satisfaction (con't)

- Provider feedback from the CalOptima Health Provider Satisfaction survey 2022
  - Review of UM Program Experience

55% of providers reported being satisfied or very satisfied with the UM Program experience, with further examples citing

- Rapid response to questions
- Access to direct referrals
- Timely processing of treatment requests

10% of providers reported being somewhat dissatisfied or very dissatisfied with the UM Program Experience, with examples citing.

- Challenges with the Authorization Dept processing retro-authorization requests for Private Duty Nursing
- Denial policy is not in guide with standards of care

Questions?

Integrated UM and CM Program Description

Stacie Oakley, RN
Director, Utilization Management

2023 Integrated UM and CM Program Description Updates

- Newly Integrated Utilization Management and Case Management program description.
  - Includes Quality, Pharmacy, Population Health and Behavioral Health initiatives and care delivery

  Quality Program:
  - Goals:
    - Comprehensive Health Equity framework
    - Further enhance and improve quality of care and member experience
  - Initiatives:
    - Comprehensive Community Cancer Screening and Support
    - Five-Year Hospital Quality Program

2023 Integrated UM and CM Program Description Updates

- Clinical Pharmacy updates
  - Transition to new model for MediCal Magellan Rx
  - CalOptima Health continues to manage the pharmacy benefits for OneCare and PACE
  - Turn-around timetables updated

- Population Health Management (PHM) Program Framework
  - PHM approach includes the following:
    - Gathering Member Information/ feedback
    - Understanding Risk
    - Implementing Services and Supports

2023 Integrated UM and CM Program Description Updates

- Population Health Management (PHM) Program framework (con't)
- Goals of programs;
  - Trust and meaningful engagement with members
  - Data-driven risk stratification and predictive analytics to address gaps in care
  - Revisions to standardize assessment processes
  - Care management services for all high-risk members
  - Robust transitional care services (TCS)
  - Effective strategies to address health disparities, Social Determinants of Health (SDOH) and upstream drivers of health
  - Interventions to support health and wellness for all members

2023 Integrated UM and CM Program Description Updates

- Utilization Management Program Goals
  - The goal of the UM Program is to manage appropriate utilization of medically necessary, covered services and to ensure access to quality and cost-effective health care for CalOptima Health members, including but not limited to:
    - Coordination of care across CalOptima Health programs to improve member outcomes
    - Protecting confidentiality of members
    - Identify staffing needs, including Medical directors
    - Provide continuous training and mentoring for UM staff
    - Clearly define roles and responsibilities for UM activities
    - Promote a high level of member and provider satisfaction

2023 Integrated UM and CM Program Description Updates

- CalAIM Goals
  - Utilize the Whole Person model to identify the most vulnerable members
  - Improve outcomes through value-based initiatives
  - Develop seamless and consistent delivery of care

- Case Management Program Goals include but are not limited to:
  - Establishment of multiple referral methods (No wrong door)
  - Increased member awareness of Case Management services
  - Collaboration with UM on early identification of members
  - Development data driven methods of identifying members
  - Early identification of members educational needs and referrals to Population Health

2023 Integrated UM and CM Program Description Updates

- UMC Updates
  - Behavioral Health clinician advisor with UMC voting Membership
  - Review and update automation and Prior Authorization list process to include work group discussion, BMSC and UMC
  - Updated the functionality and description of the provider portal and automation
  - Highlighted and refinement of requirements for retrospective request for services.

2023 Integrated UM and CM Program Description Updates

- Behavioral Health
  - Highlighted Behavioral Health's integration throughout the UM Process and care delivery system
- CBAS
  - Benefit continued to receive Emergency Remote Services in lieu of attending the center

- Reviewed standards related to the Program Description to ensure programmatic and care delivery alignment. (UM1A, 2A and 4B)

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CalOptima Health Board Action Agenda Referral

Action To Be Taken August 3, 2023
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

5. Ratify a Contract Amendment Related to Local Advocacy Services

Contact

Michael Hunn, Chief Executive Officer, (657) 900-1481

Recommended Action

Ratify an amendment to retroactively extend the contract with Whittingham Public Affairs Advisors (WPAA) for local advocacy services from June 3, 2023, through June 30, 2023.

Background

On June 2, 2022, the CalOptima Health Board of Directors (Board) authorized staff to negotiate the acquisition of real property at 14851 Yorba Street (Yorba site) and 165 North Myrtle Avenue in Tustin, California, for the purpose of developing two adjacent buildings into CalOptima Health's Community Living Center, which would combine a recuperative care program and a Program of All-Inclusive Care for the Elderly. Since the Yorba site's existing conditional use permit (CUP) does not explicitly include a use for recuperative care, CalOptima Health requires an amended CUP from the City of Tustin (City).

On August 4, 2022, the Board ratified a one-year contract with WPAA, a local advocacy firm, effective June 3, 2022, through June 2, 2023, to promote CalOptima Health's interests in the City through government affairs, strategic guidance, public relations, and community outreach and engagement. The services included monitoring and influencing policies, building and maintaining positive and mutually beneficial relationships, and providing CalOptima Health with necessary advocacy services.

Discussion

WPAA and CalOptima Health staff worked with the City for nearly one year to facilitate the application for and consideration of an amended CUP. However, on April 19, 2023, City staff determined that a zone change was necessary for the proposed site use before an amended CUP could be granted. CalOptima Health appealed the City's determination, and the Tustin Planning Commission scheduled a public hearing on June 26, 2023, to consider the appeal.

In order to support CalOptima Health's preparation for the scheduled hearing, the Chief Executive Officer authorized WPAA to continue providing services beyond the contract termination date of June 2, 2023. To compensate WPAA for the additional delivered services, the recommended action is to authorize the retroactive extension of the expired contract from June 3, 2023, through June 30, 2023, for an additional budgeted amount of $7,500. All other terms and conditions of the contract would remain unchanged.

Fiscal Impact

The administrative expense related to the contract for the period of June 3, 2023, through June 30, 2023, is an unbudgeted item. Unspent administrative funds in the Fiscal Year 2022-23 Operating Budget will fund up to $7,500 for this period.

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Rationale for Recommendation

Facilitating the approval of CalOptima Health's Community Living Center is necessary to address the urgent need for short-term housing and related support services for Orange County's older adult unhoused population and fully realize the goals of the California Advancing and Innovating Medi-Cal (CalAIM) initiative.

Concurrence

Troy R. Szabo, Outside General Counsel, Kennaday Leavitt

Attachments

1. Entities Covered by this Recommended Board Action
2. Proposed WPAA Contract Amendment No. 1
3. Expired WPAA Contract No. 22-10953

/s/ Michael Hunn *07/27/2023*
Authorized Signature **Date**

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Attachment to the August 3, 2023 Board of Directors Meeting – Agenda Item 5

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Whittingham Public Affairs Advisors	31441 Santa Margarita Pkwy, Suite A181	Rancho Santa Margarita	CA	92688

AMENDMENT NO. 1 TO CONTRACT 22-10953
BY AND BETWEEN
ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY,
dba ORANGE PREVENTION & TREATMENT INTEGRATED MEDICAL ASSISTANCE,
dba CalOptima Health
("CalOptima")
AND
WHITTINGHAM PUBLIC AFFAIRS ADVISORS
("CONTRACTOR")

THIS AMENDMENT NO. 1 TO Contract 22-10953 ("Amendment") is entered into by and between Orange County Health Authority dba CalOptima Health, a Public Agency ("CalOptima") and Whittingham Public Affairs Advisors ("CONTRACTOR") with a retroactive effective date of June 3, 2023, with respect to the following facts:

A. CalOptima and CONTRACTOR (hereinafter collectively referred to as the ("Parties") entered into Contract 22-10953 on June 3, 2022, under which CONTRACTOR agreed to provide Public Affairs and Advocacy Services (hereinafter, "Contract").

B. Pursuant to Section 17 of the Contract, the Contract may be amended only in writing executed by the Parties.

C. The Parties desire to amend the Contract to extend the term of the Contract, amend the Contract Payment Schedule, and amend CalOptima's naming conventions.

NOW, THEREFORE, THE PARTIES AGREE AS FOLLOWS:

1. All capitalized terms used herein shall have the same meanings given them in the Contract unless the context specifically provides otherwise herein.

2. The parties agree that all references to DBA CalOptima or CalOptima are now recognized as ("CalOptima Health").

3. The Parties now agree to amend section 15 of the Contract to extend the term of the contract through June 30, 2023.

4. Exhibit B (Payment) is modified to increase the maximum cumulative payment of the Contract by Seven Thousand Five Hundred Dollars ($7,500) to a new maximum cumulative payment obligation of Ninety-Seven Thousand Five Hundred Dollars ($97,500.00).

5. **Authority to Execute.** The persons executing this Amendment on behalf of the Parties warrant that they are duly authorized to execute this Amendment and that by executing this Amendment, the Parties are formally bound.

6. **Counterparts**. This Amendment may be executed in any number of counterparts, all of which taken together shall constitute one and the same instrument, and any of the Parties may execute the Amendment by signing any such counterpart.

7. **No Other Changes.** This Amendment No. 1 is by this reference made part of said Contract. Except as otherwise provided in this Amendment, all of the terms, conditions, and provisions of the Contract and prior amendments shall continue in full force and effect. In the event of any conflict or inconsistency between the provisions of this Amendment and any provisions of the Contract and prior amendments, if any, the provisions

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of this Amendment No. 1 shall in all respect govern and control. Unless otherwise specifically defined herein, terms used in this Amendment shall have the same meaning as ascribed to them in the Contract. The execution and delivery of this Amendment shall have the same meaning as ascribed to them in the Contract. The execution and delivery of this Amendment shall not operate as a waiver of or, except as expressly set forth herein, an amendment of any right, power or remedy of either party in effect prior to the date hereof.

IN WITNESS THEREOF, these Parties have, by their duly authorized representatives, executed this Amendment No. 1 on the day and year last shown below, retroactively agreeing that this Amendment is effective as of June 03, 2023.

"Whittingham Public Affairs Advisors"

Signature: _____

Name: Peter Whittingham

Title: CEO

Date: 7/25/2023

Orange County Health Authority dba "CalOptima Health"

Signature: DocuSigned by: Nancy Huang D22E3B87032946F...

Name: Nancy Huang

Title: CFO, CalOptima

Date: 07/26/2023

Signature: _____

Name: _____

Title: _____

Date: _____

Signature: _____

Name: _____

Title: _____

Date: _____

If VENDOR is a corporation, two officer signatures
or Corporate Resolution or Corporate Seal is required.

CONTRACT NO. 22-10953
BETWEEN
ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY, dba
ORANGE PREVENTION & TREATMENT INTEGRATED MEDICAL ASSISTANCE, dba
CALOPTIMA
And
WHITTINGHAM PUBLIC AFFAIRS ADVISORS
(CONTRACTOR)

THIS CONTRACT ("Contract") is made and entered into as of June 03, 2022 ("Effective Date"), by and between the Orange County Health Authority, dba CalOptima, a public agency, hereinafter referred to as "CalOptima" and Whittingham Public Affairs Advisors, hereinafter referred to as "CONTRACTOR." CalOptima and CONTRACTOR shall be referred to herein collectively as the "Parties" or individually as a "Party."

RECITALS

A. CalOptima desires to retain a contractor to provide Public Affairs and Advocacy Services, as described in the Scope of Work; and

B. CONTRACTOR provides such services; and

C. CONTRACTOR represents and warrants that it has the requisite personnel and experience and is capable of performing such services; and

D. CONTRACTOR desires to perform these services for CalOptima; and

E. CalOptima and CONTRACTOR desire to enter into this Contract on the terms and conditions set forth herein below.

NOW, THEREFORE, in consideration of their mutual and respective promises, and subject to the terms and conditions hereinafter set forth, the Parties agree as follows:

1. Documents Constituting Contract. This Contract shall include the following documents ("Contract Documents"), in the order of descending precedence: (i) this Contract, inclusive of all its exhibits and attachments, and any amendments thereto. Any new terms and conditions attached to CONTRACTOR's best and final offer, proposal, invoices, or request for payment, shall not be incorporated into the Contract Documents or be binding upon CalOptima unless expressly accepted by CalOptima in writing. All documents attached to this Contract and/or referenced herein as a "Contract Document" are incorporated into this Contract by this reference, with the same force and effect as if set forth herein in their entirety. Changes hereto shall not be binding upon CalOptima except when specifically confirmed in writing by an authorized representative of CalOptima and issued in accordance with Section 17, Modifications, herein. In the event of any conflict of provisions among the documents constituting the Contract, the provisions shall prevail in the above-referenced descending order of precedence.

2. Statement of Work.

2.1 CONTRACTOR shall perform the work necessary to complete, in a manner satisfactory to CalOptima, and if applicable, to the Centers for Medicare and Medicaid Services ("CMS"), the California Department of Health Care Services ("DHCS"), and/or the California Department of Managed Health Care ("DMHC"), as applicable, the services set forth in Exhibit A entitled "Scope of Work," which is attached hereto and incorporated herein by this reference.

2.2 CONTRACTOR shall provide the personnel listed below to perform the above-specified services, which persons are hereby designated as key personnel under this Contract. No person named in this Section 2, or his/her successor approved by CalOptima, shall be removed or replaced by CONTRACTOR, nor shall his/her agreed-upon function or level of commitment hereunder be changed without the prior written consent of CalOptima.

Name	Function/Title
Peter Whittingham	Founder & CEO

3. Insurance.

3.1 Prior to undertaking performance of services under this Contract and at all times during performance hereunder, and entirely at CONTRACTOR's sole expense, CONTRACTOR shall maintain the following insurance, which shall be full-coverage insurance not subject to self-insurance provisions, and CONTRACTOR shall not of its own initiative cause such insurance to be canceled or materially changed during the term of this Contract:

3.1.1 Required Insurance:

3.1.1.1 Commercial General Liability, including Contractual liability and coverage for Independent Contractors on an occurrence basis on an ISO form GC 00 01 or equivalent covering bodily injury and property damage with the following minimum liability limits:

3.1.1.2 Per Occurrence: $1,000,000

3.1.1.3 Personal Advertising Injury: $1,000,000

3.1.1.4 Products Completed Operations: $2,000,000

3.1.1.5 General Aggregate: $2,000,000

3.1.2 Commercial Automobile Liability covering any auto, whether owned, leased, hired, or rented, on an ISO form CA 0001 or equivalent in the amount of $1,000,000 combined single limit for bodily injury or property damage.

3.1.3 Workers' Compensation and Employers' Liability Policy written in accordance with the laws of the State of California ("State") and providing coverage for all of CONTRACTOR's employees:

3.1.3.1 This policy must provide statutory coverage for Workers' Compensation.

3.1.3.2 This policy must also provide coverage for $1,000,000 Employers' Liability for each employee, each accident, and in the general aggregate.

3.1.4 Professional Liability insurance covering the CONTRACTOR's professional errors and omissions with the following minimum limits of insurance:

3.1.4.1 Per occurrence: $1,000,000

3.1.4.2 General aggregate: $2,000,000

3.1.5 Commercial crime policy covering employee theft and dishonesty, forgery and alteration, money orders and counterfeit currency, credit card fraud, wire transfer fraud, and theft of client property, with the following minimum limits of $1,000,000 per occurrence:

3.1.5.1 Cyber and Privacy Liability insurance with the following minimum limits of insurance covering claims involving privacy violations, information theft, damage to or destruction of electronic information, intentional and/or unintentional release of private information, alteration of electronic information, extortion and network security. Such coverage is required only if any products and/or services related to information technology (including hardware and/or software) are provided to Insured and for claims involving any professional

services for which CONTRACTOR is engaged with Insured for such length of time as necessary to cover any and all claims.

a) Privacy and Network Liability: $1,000,000

b) Internet Media Liability: $1,000,000

c) Business Interruption & Expense: $1,000,000

d) Data Extortion: $1,000,000

e) Regulatory Proceeding: $1,000,000

f) Data Breach Notification & Credit Monitoring: $1,000,000

3.2 Prior to commencement of any work hereunder, CONTRACTOR shall furnish to CalOptima's Purchasing Department additional insured endorsements and also broker-issued Certificate(s) of Insurance showing the required insurance coverages for CONTRACTOR, and further providing that:

Certificate Requirements:

3.2.1 CalOptima's officers, officials, directors, employees, agents, and volunteers are to be covered as additional insureds with respect to liability arising out of work or operations performed by or on behalf of CONTRACTOR including materials, parts, or equipment furnished in connection with such work or operations. This provision applies to CONTRACTOR's General Liability and Auto Liability policies and must be on ISO form CG 20 10 or equivalent.

3.2.2 For any claims related to this Contract, the CONTRACTOR's insurance coverage shall be primary insurance as respects to CalOptima, its officers, officials, directors, employees, agents, and volunteers. This provision applies to the CONTRACTOR's General Liability, Auto Liability and Workers' Compensation and Employers' Liability policies.

3.2.3 CONTRACTOR's insurance carrier agrees to waive all rights of subrogation against CalOptima and its elected or appointed officers, officials, directors, agents, and employees for losses paid under the terms of any policy which arise from work performed by the CONTRACTOR for CalOptima. This provision applies to the CONTRACTOR's General Liability, Auto Liability and Workers' Compensation and Employers Liability policies.

3.2.4 Insurance is to be placed with insurers with a current A.M. Best rating of no less than A-VII, unless otherwise acceptable to CalOptima.

3.2.5 CONTRACTOR shall furnish CalOptima with original certificates and amendatory endorsements affecting coverage required by this section. All certificates and endorsements are to be received and approved by CalOptima before work commences. CalOptima reserves the right to require complete, certified copies of all required insurance policies, including endorsements affecting the coverage required by these specifications, at any time.

3.2.6 Any deductibles or self-insured retentions must be declared to and approved by CalOptima. CalOptima may require the CONTRACTOR to purchase coverage with a lower deductible or retention or provide proof of ability to pay losses and related

investigations, claim administration, and defense expenses within the retention or deductible.

3.2.7 All deductibles and retentions that the aforementioned policies contain are the responsibility of the CONTRACTOR and in no way shall CalOptima be responsible for payment of the deductibles/retentions.

3.2.8 If CONTRACTOR maintains higher limits than the minimums required above, CalOptima requires and shall be entitled to coverage for the higher limits maintained by CONTRACTOR. Any available insurance proceeds in excess of the specified minimum limits of insurance and coverage shall be available to CalOptima.

3.2.9 Thirty (30) days prior written notice of cancellation be given to CalOptima.

3.3 If CONTRACTOR fails or refuses to maintain or produce proof of the insurance required by this Section 3, CalOptima shall have the right, at its election, to terminate forthwith this Contract. Such termination shall not affect CONTRACTOR'S right to be paid for its time and materials expended prior to notification of termination. CONTRACTOR waives the right to receive compensation and agrees to indemnify CalOptima for any work performed prior to approval of insurance by CalOptima

3.4 The requirement for carrying the required insurance shall not derogate from the provisions for indemnification of CalOptima.

3.5 CONTRACTOR shall require each of its subcontractors who perform services related to this Contract, if any, to maintain insurance coverage that meets all of the requirements set forth herein.

3.6 "Occurrence," as used herein, means any event or related exposure to conditions that result in bodily injury or property damage.

4. Indemnification.

4.1 To the fullest extent permitted by law, CONTRACTOR agrees to and shall save, defend, indemnify, and hold harmless CalOptima and its respective officers, directors, agents, volunteers, consultants and employees (individually and collectively referred to as "Indemnified Parties") from and against any liability whatsoever, based or asserted upon any services of the CONTRACTOR, its officers, employees, subcontractors, agents, or representatives (individually and collectively referred to as "Indemnitors") arising out of or in any way relating to this Contract, including but not limited to property damage, bodily injury, or death or any other element of any kind or nature whatsoever arising from the performance of Indemnitors under this Contract. CONTRACTOR shall defend the Indemnified Parties in any claim or action based upon any such alleged acts or omissions, at its sole expense, which shall include all costs and fees, including, but not limited to, attorneys' fees, cost of investigation, defense, and settlement or awards. CalOptima may make all reasonable decisions with respect to its representation in any legal proceeding.

4.2 CONTRACTOR's obligation to indemnify hereunder is in addition to any liability CONTRACTOR may have to CalOptima for a breach by CONTRACTOR of any of the provisions of this Contract. Under no circumstances shall the insurance requirements and limits set forth in this Contract be construed to limit CONTRACTOR's indemnification and duty to defend obligation or other liability hereunder. The terms of this Contract are contractual and the result of negotiation between the Parties hereto. Accordingly, any rule of construction of contracts (including, without limitation, California Civil Code Section 1654) that ambiguities are to be construed against the drafting party, shall not be employed in the interpretation of this Contract.

4.3 CONTRACTOR's duty to defend herein is wholly independent of and separate from the duty to indemnify and such duty to defend shall exist regardless of any ultimate liability of CONTRACTOR, save and except Claims arising through the sole negligence or sole willful misconduct of CalOptima.

4.4 It is expressly understood and agreed that the foregoing provisions are intended to be as broad and inclusive as permitted by the law of the State of California and that CONTRACTOR's indemnification and duty to defend obligation hereunder shall survive the expiration or earlier termination of this Contract until such time as action against the Indemnified Parties for such matter indemnified hereunder is fully and finally barred by the applicable statute of limitations, including, but not limited to, those set forth under the California Government Claims Act (Cal. Gov. Code §900 et seq.).

4.5 The terms of this Section shall survive the termination of this Contract.

5. Independent Contractor. CalOptima and CONTRACTOR agree that CONTRACTOR, which term shall include any and all subcontractors, and any agents or employees of the CONTRACTOR, in performance of this Contract, shall act in an independent capacity, and not as officers or employees of CalOptima. CONTRACTOR's relationship with CalOptima in the performance of this Contract is that of an independent contractor. CONTRACTOR's personnel performing services under this Contract shall be at all times under CONTRACTOR's exclusive direction and control and shall be employees of CONTRACTOR and not employees of CalOptima. CONTRACTOR shall pay all wages, salaries and other amounts due its employees in connection with this Contract and shall be responsible for all reports and obligations respecting them, such as social security, income tax withholding, unemployment compensation, workers' compensation, and similar matters. At CONTRACTOR's expense as described herein, CONTRACTOR agrees to defend, indemnify, and hold harmless CalOptima, its officers, agents, employees, members, subsidiaries, joint venture partners, and predecessors and successors in interest from and against any claim, action, proceeding, liability, loss, damage, cost, or expense, including, without limitation, attorneys' fees as provided herein arising out of CONTRACTOR's alleged failure to pay, when due, all such taxes and obligations (collectively referred to for purposes of this paragraph as "Employment Claim(s)"). CONTRACTOR shall pay to CalOptima any expenses or charges relating to or arising from any such Employment Claim(s) as they are incurred by CalOptima.

6. Assignments; Subcontracts.

6.1 Except as specifically permitted hereunder, CONTRACTOR may not assign, transfer, delegate or subcontract any interest herein, either in whole or in part, without the prior written consent of CalOptima, which consent may be withheld in its sole and absolute discretion. In the event CalOptima provides such prior written consent, CONTRACTOR acknowledges and agrees that such assignment, transfer, delegation, or subcontract may additionally be subject to the prior written approval of DHCS. Any assignment, transfer, delegation, or subcontract made without CalOptima's express written consent shall be deemed void.

6.2 For purposes of this Section and this Contract, assignment is: (1) the change of more than twenty-five percent (25%) of the ownership or equity interest in CONTRACTOR (whether in a single transaction or in a series of transactions); (2) the change of more than twenty-five percent (25%) of the directors or trustees of CONTRACTOR (whether in a single transaction or in a series of transactions); (3) the merger, reorganization, or consolidation of CONTRACTOR with another entity with respect to which CONTRACTOR is not the surviving entity; and/or (4) a change in the management of CONTRACTOR from management by persons appointed, elected or otherwise selected by the governing body of CONTRACTOR (e.g. the Board of Directors) to a third-party management person, company, group, team or other entity.

6.3 In the event that CONTRACTOR is allowed to subcontract for services under this Contract, and does so subcontract, then CONTRACTOR shall, upon request, provide copies of such subcontracts to CalOptima or DHCS.

7. Non-Exclusive Relationship. It is understood by the parties that this is a non-exclusive relationship between CalOptima and CONTRACTOR. CalOptima shall have the right to have any of the services that are the subject of this Contract performed by CalOptima personnel or enter into contractual arrangements with one or more contractors who can provide CalOptima with similar or like services.

8. Compliance with Applicable Law and Policies. CONTRACTOR warrants that, in the performance of this Contract, it shall, at its own expense, observe and comply with all applicable federal, state, and local laws, and CalOptima policies relating to services under the Contract that are in effect when this Contract is signed, or which may come into effect during the term of this Contract.

9. Nondiscrimination Clause Compliance.

9.1 During the performance of this Contract, CONTRACTOR and its subcontractor(s) shall not unlawfully discriminate, harass, or allow harassment, against any employee or applicant for employment because of sex, race, color, ancestry, religious creed, national origin, physical disability, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), mental disability, medical condition (including cancer), age (over 40), marital status, and the use of family and medical care leave and pregnancy disability leave. CONTRACTOR and subcontractor(s) shall ensure that the evaluation and treatment of their employees and applicants for employment are free from discrimination and harassment. CONTRACTOR and subcontractor(s) shall comply with the provisions of the Fair Employment and Housing Act (Government Code, Section 12900 et seq. and the applicable regulations promulgated thereunder Title 2, CCR, Section 7285.0 et seq.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code, Section 12990 (a-f), set forth in Chapter 5 of Division 4, Title 2, CCR are incorporated into this Contract by reference and made a part hereof as if set forth in full. CONTRACTOR and its subcontractor(s) shall give notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreement. CONTRACTOR shall also fully comply with the following, to the extent applicable to the services provided by CONTRACTOR under this Contract: Title VI of the Civil Rights Act of 1964, 42 USC Section 2000d (race, color, national origin); Section 504 of the Rehabilitation Act of 1973 (29 USC §794) (nondiscrimination under Federal grants and programs); Title 45 CFR Part 84 (nondiscrimination on the basis of handicap in programs or activities receiving Federal financial assistance); Title 28 CFR Part 36 (nondiscrimination on the basis of disability by public accommodations and in commercial facilities); Title IX of the Education Amendments of 1973 (regarding education programs and activities); Title 45 CFR Part 91 and the Age Discrimination Act of 1975 (nondiscrimination based on age); as well as California Government Code Section 11135 (ethnic group identification, religion, age, sex, color, physical or mental handicap); California Civil Code Section 51 (all types of arbitrary discrimination); and all rules and regulations promulgated pursuant thereto.

9.2 CONTRACTOR shall include the nondiscrimination and compliance provisions of Section 9 in all subcontracts under this Contract.

10. Prohibited Interest.

10.1 CONTRACTOR shall comply with all applicable federal, state, and local laws and regulations pertaining to conflict-of-interest laws, including but not limited to CalOptima's Conflict of Interest Code, the California Political Reform Act (Government Code Section 81000 et seq.) and Government Code Section 1090 et seq. (collectively, the "Conflict of Interest Laws").

10.2 CONTRACTOR covenants that, for the term of the Contract, no director, officer, or employee of CalOptima during his tenure has any interest, direct or indirect, in this Contract or the proceeds thereof. CONTRACTOR further covenants that, for the term of this Contract, and consistent with the provisions of Title 22 California Code of Regulations (CCR) Section 53600(f), no state officer or state employee shall be employed in a management or contractor position by CONTRACTOR within one year after the state office or state employee has terminated state employment.

10.3 No employee, officer or agent of CalOptima shall participate in the selection, award or administration of an agreement, or in any decision that may have foreseeable impact on CONTRACTOR if a conflict of interest, real or implied, exists. Such a conflict arises when any of the following has a financial or other interest in the firm selected for award:

10.3.1 A CalOptima employee, officer or agent;

10.3.2 Any member of the employee, officer or agent's immediate family;

10.3.3 The employee, officer or agent's domestic or business partner; or

10.3.4 An organization that employs or is about to employ any of the above.

10.4 CONTRACTOR understands that, if this Contract is made in violation of Government Code Section 1090 et seq., the entire Contract is voidable, and CONTRACTOR will not be entitled to any compensation for Services performed pursuant to this Contract and CONTRACTOR will be required to reimburse CalOptima any sums paid to CONTRACTOR. CONTRACTOR further understands that, in addition to the foregoing, CONTRACTOR may be subject to criminal prosecution for a violation of Government Code Section 1090.

10.5 If CONTRACTOR hereinafter becomes aware of any facts, which might reasonably be expected to either create a conflict of interest under the Conflict-of-Interest laws or violate the provisions of this Section, CONTRACTOR shall immediately make full written disclosure of such acts to CalOptima. Full written disclosure shall include, without limitation, identification of all persons, entities and businesses implicated and a complete description of all relevant circumstances.

11. Disclosure of Officers, Owners, Stockholders and Creditors. On an annual basis and within thirty (30) days of any changes, CONTRACTOR shall identify the names of the following persons by listing them on Exhibit I, attached hereto and incorporated by this reference, and submitting the form to CalOptima:

11.1 All officers and owners who own greater than 5% of the CONTRACTOR; and

11.2 All stockholders owning greater than 5% of any stock issued by CONTRACTOR.

11.3 All creditors of CONTRACTOR's business if such interest is over 5%.

12. Equal Opportunity.

12.1 CONTRACTOR and its subcontractors will not discriminate against any employee or applicant for employment because of race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. CONTRACTOR and its subcontractors will take affirmative action to ensure that qualified applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Such action shall include, but not be limited to the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and career development opportunities and selection for training, including apprenticeship. CONTRACTOR and its subcontractors agree

to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the Federal Government or Department of Health Care Services ("DHCS"), setting forth the provisions of the Equal Opportunity clause, Section 503 of the Rehabilitation Act of 1973, and the affirmative action clause required by the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212). Such notices shall state CONTRACTOR and its subcontractors' obligation under the law to take affirmative action to employ and advance in employment qualified applicants without discrimination based on their race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era and the rights of applicants and employees.

12.2 CONTRACTOR and its subcontractors will, in all solicitations or advancements for employees placed by or on behalf of CONTRACTOR and its subcontractors, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era.

12.3 CONTRACTOR and its subcontractors will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding a notice, to be provided by the Federal Government or the State, advising the labor union or workers' representative of CONTRACTOR and its subcontractors' commitments under the provisions herein and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

12.4 CONTRACTOR and its subcontractors will comply with all provisions of and furnish all information and reports required by Section 503 of the Rehabilitation Act of 1973, as amended, the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212) and of the Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and of the rules, regulations, and relevant orders of the Secretary of Labor.

12.5 CONTRACTOR and its subcontractors will furnish all information and reports required by Federal Executive Order No. 11246, as amended, including by Executive Order 11375, "Amending Executive Order No. 11246, Relating to Equal Employment Opportunity," and as supplemented by regulation at 41 CFR part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and the Rehabilitation Act of 1973, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to its books, records, and accounts by the State and its designated representatives and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.

12.6 In the event of CONTRACTOR and its subcontractors' noncompliance with the requirements of the provisions herein or with any federal rules, regulations, or orders which are referenced herein, this Contract may be cancelled, terminated, or suspended in whole or in part, and CONTRACTOR and its subcontractors may be declared ineligible for further federal and state contracts, in accordance with procedures authorized in Federal Executive Order No. 11246, as amended, and such other sanctions may be imposed and remedies invoked as provided in Federal Executive Order No. 11246 as amended, including by Executive Order 11375, "Amending Executive Order No. 11246 Relating to Equal Employment Opportunity," and as supplemented by regulation at 41 CFR part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.

12.7 CONTRACTOR and its subcontractors will include the provisions of this section in every subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor, issued pursuant to Federal Executive Order No. 11246, as amended, including by Executive Order 11375, "Amending Executive Order No. 11246 Relating to Equal Employment Opportunity," and as supplemented by regulation at 41 CFR part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or Section 503 of the Rehabilitation Act of 1973 or (38 U.S.C. 4212) of the Vietnam Era Veteran's Readjustment Assistance Act, so that such provisions will be binding upon each subcontractor or CONTRACTOR. CONTRACTOR and its subcontractors will take such action with respect to any subcontract or purchase order as the Director of the Office of Federal Contract Compliance Programs or DHCS may direct as a means of enforcing such provisions, including sanctions for noncompliance; provided, however, that in the event CONTRACTOR and its subcontractors become involved in, or are threatened with litigation by a subcontractor or contractor as a result of such direction by DHCS, CONTRACTOR and its subcontractors may request in writing to DHCS, who, in turn, may request the United States to enter into such litigation to protect the interests of the State and of the United States.

13. Standard of Performance; Warranties.

13.1 CONTRACTOR agrees to perform all work under this Contract with the requisite skill and diligence consistent with professional standards for the industry and type of work performed under this Contract, and pursuant to the governing rules and regulations of the industry.

13.2 In the event that CONTRACTOR is allowed to subcontract for services under this Contract, and does so subcontract, then CONTRACTOR represents and warrants that any individual or entity acting as a subcontractor to this Contract has the appropriate skill and expertise to perform the subcontracted work.

13.3 CONTRACTOR expressly warrants that all material and work will conform to applicable specifications, drawings, description and samples, including, without limitation, CalOptima's designs, drawings, and specifications, and will be merchantable, of good workmanship and material, and free from defect. CONTRACTOR further warrants that all material covered by this Contract, if any, which is the product of CONTRACTOR will be new and unused unless otherwise specified and shall be fit and sufficient for the purpose intended by CalOptima, as disclosed to CONTRACTOR, CONTRACTOR shall promptly make whatever adjustments or corrections that may be necessary to cure any defects, including repairs of any damage to other parts of the system resulting from such defects. CalOptima shall give notice to CONTRACTOR of any observed defects. In the event that CONTRACTOR fails to make adjustments, repairs, corrections, or other work made necessary by such defects, CalOptima may do so and charge CONTRACTOR the costs incurred.

13.4 CONTRACTOR's warranties, together with its service guarantees, must run to CalOptima and its customers or users of the material and services, and must not be deemed exclusive. CalOptima's inspection, approval, acceptance, use of and payment for all or any part of the material and services must in no way affect its warranty rights whether or not a breach of warranty had become evident in time.

13.5 CONTRACTOR's obligations under this Section are in addition to CONTRACTOR's other express or implied warranties and other obligations under this Contract or state law, and in no way diminish any other rights that CalOptima may have against CONTRACTOR for faulty materials, equipment or work. CalOptima rejects any disclaimer by CONTRACTOR of any warranty, standard, implied or express, unless specifically agreed to in writing by both parties.

13.6 Any CalOptima property damaged by CONTRACTOR, its subcontractor(s), or by the personnel of either, will be subject to repair or replacement by CONTRACTOR at no cost to CalOptima.

14. Compensation.

14.1 Payment.

14.1.1 CalOptima agrees to pay, and CONTRACTOR agrees to accept as full consideration for the faithful performance of this Contract, the rates, charges and other payment terms identified in Exhibit B, which is attached hereto and incorporated herein by this reference.

14.1.2 CalOptima will not reimburse CONTRACTOR any expenses incurred in connection with its performance of the services, unless such reimbursement is specifically authorized in Exhibit B. Each expense reimbursement request, when authorized in Exhibit B must include receipts or other suitable documentation.

14.1.3 CONTRACTOR's requests for payments and reimbursements must comply with the requirements set forth in Exhibit B. CalOptima will not make payment for work that fails to meet the standards of performance as set forth in the Contract and Exhibit A, Scope of Work that may be reasonably expected by CalOptima. **CALOPTIMA SHALL NOT PAY ANY FEES, EXPENSES OR COSTS WHATSOEVER INCURRED BY CONTRACTOR IN RENDERING ADDITIONAL SERVICES NOT AUTHORIZED IN WRITING UNDER THIS CONTRACT.**

14.1.4 In no event shall the total compensation payable to CONTRACTOR for the services performed under this Contract exceed the maximum cumulative payment obligation, as set forth in the attached Exhibit B, without the express prior written authorization of CalOptima. CONTRACTOR shall at all times monitor its costs and expenditures for work performed under this Contract, and shall monitor its invoices, costs, and expenditures, to ensure it does not exceed the maximum cumulative payment obligation set forth herein. CONTRACTOR shall provide CalOptima with 60 days written notice if at any time during this Contract CONTRACTOR becomes aware that it may exceed the maximum cumulative payment obligation authorized under this Contract. **CONTRACTOR ACKNOWLEDGES AND AGREES THAT CALOPTIMA SHALL NOT BE LIABLE FOR ANY FEES, EXPENSES OR COMPENSATION IN EXCESS OF THE MAXIMUM CUMULATIVE PAYMENT OBLIGATION.**

14.1.5 The maximum cumulative payment obligation includes all applicable federal, state, and local taxes and duties, except sales tax, which is shown separately, if applicable. CONTRACTOR is responsible for submitting any withholding exemption forms (e.g., W-9) to CalOptima. Such forms and information should be furnished to CalOptima before payment is made. If taxes are required to be withheld on any amounts otherwise to be paid by CalOptima to CONTRACTOR due to CONTRACTOR'S failure to timely submit such forms, CalOptima will deduct such taxes from the amount otherwise owed and pay them to the appropriate taxing authority and shall have no liability for or any obligation to refund any payments withheld.

14.2 Contractor Travel Policy. CONTRACTOR is not entitled to any reimbursement for travel, meals, accommodations, or other similar expenses under this Contract.

15. Term. This Contract shall commence on June 03, 2022 and shall continue in full force and effect through June 02, 2023, unless earlier terminated as provided in this Contract.

16. Termination.

16.1 Termination without Cause. CalOptima may terminate this Contract at any time, in whole or in part, for its convenience and without cause, by giving CONTRACTOR thirty (30) days written notice hereof. Upon termination, CalOptima may pay CONTRACTOR its allowable cost incurred for services satisfactorily performed and accepted by CalOptima as of the date of termination. Thereafter, CONTRACTOR shall have no further claims against CalOptima under this Contract.

16.2 Termination for Unavailability of Funds. In recognition that CalOptima is a governmental entity, and its operations and budgets are determined on an annual basis, CalOptima shall have the right to terminate this Contract as follows:

16.2.1 CalOptima may terminate this Contract if it does not receive funding from the State of California or the federal government, as applicable, for any fiscal year.

16.2.2 In the event of Termination for Unavailability of Funds, as provided in this Section, CalOptima agrees to promptly pay CONTRACTOR all fees and other charges due and payable for services satisfactorily performed and accepted by CalOptima as of the termination date. CONTRACTOR shall not be entitled to payment for any other items, including, without limitation, lost or anticipated profit on work not performed, administrative costs, attorneys' fees, or consultants' fees.

16.2.3 In the event of Termination for Unavailability of Funds, as provided in this Section, and funds are received by CalOptima from the State of California within one-hundred twenty (120) days of the date of termination, then CalOptima shall promptly notify CONTRACTOR in writing and CalOptima shall have the right to reinstate this Contract for that period for which funds are received by CalOptima or the unexpired term of this Contract as of the date of termination, whichever period is shorter in duration. Notwithstanding the foregoing, CalOptima may only reinstate this Contract two (2) times during the Term of this Contract.

16.3 Termination for Default. Subject to a ten (10) day cure period, CalOptima may terminate this Contract for CONTRACTOR's default, or if a federal or state proceeding for the relief of debtors is undertaken by or against CONTRACTOR, or if CONTRACTOR makes an assignment for the benefit of creditors as defined in Section 6, or if CONTRACTOR breaches any term(s) or violates any provision(s) of this Contract and does not cure such breach or violation within ten (10) days after written notice thereof by CalOptima. In the event of Termination for Default, as provided by this Section, CONTRACTOR shall be liable for any and all reasonable costs incurred by CalOptima as a result of such default, including, but not limited to, reprocurement costs of the same or similar services defaulted by CONTRACTOR under this Contract.

16.4 Notwithstanding the foregoing, CalOptima may terminate this Contract immediately upon CONTRACTOR's breach of Section 3, (Insurance), Section 10, (Prohibited Interest), or Section 24, (Confidentiality).

16.5 Effect of Termination. Upon expiration or receipt of a termination notice under this Section:

16.5.1 CONTRACTOR shall promptly discontinue all services (unless the notice directs otherwise) and deliver or otherwise make available to CALOPTIMA all documents, reports, software programs and any other products, data and such other materials, equipment, and information, including but not limited to confidential information, or equipment provided by CalOptima, as may have been accumulated by CONTRACTOR in performing this Contract, whether completed or in process. If CONTRACTOR personnel were granted access to CalOptima's premises and issued a badge or access card, such badge or access card shall be returned prior to departure. Failure to return any

information or equipment, badge or access card, is considered a material breach of this Contract and CalOptima's privacy and security rules.

16.5.2 CalOptima may take over the services and may award another party a contract to complete the services under this Contract.

16.5.3 CalOptima may withhold from payment any sum that it determines to be owed to CalOptima by CONTRACTOR, or as necessary to protect CalOptima against loss due to outstanding liens or claims of former lien holders.

17. Modifications. CalOptima reserves the right to modify the Contract at any time should such modification be required by CMS or applicable law or regulation. Modifications shall be executed only by a written amendment to the Contract, signed by CalOptima and CONTRACTOR. Execution of amendments shall be contingent upon CONTRACTOR's notification to CalOptima, and CalOptima's approval, of any increase or decrease in the price of this Contract or in the time required for its performance.

18. Verification of CalOptima Costs by Government. Until the expiration of ten (10) years after the later of furnishing of any service pursuant to this Contract or completion of any audit, or longer as required by applicable regulations, CONTRACTOR will make available, upon written request of the Secretary of Health and Human Services or the Comptroller General of the United States or any of their duly authorized representatives, or the California Department of Health Care Services, or the California Department of Managed Health Care, or the Department of Justice, or the Bureau of Medical Fraud, copies of this Contract and any financial statements, books, documents, records, patient care documentation, and other records or data of CONTRACTOR that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under this Contract, or as are otherwise necessary to certify the nature and extent of costs incurred by CalOptima for such services. This provision shall also apply to any agreement between a subcontractor and an organization related to the subcontractor by control or common ownership. CONTRACTOR further agrees that regulating entities have the right to inspect, evaluate and audit any pertinent information and to facilitate the review of the items referenced herein, to make available its premises, physical facilities and equipment, records related to Medicare enrollees, and any additional relevant information that regulating entities may require. CONTRACTOR further agrees and acknowledges that this provision will be included in any and all agreements with CONTRACTOR's subcontractors.

19. Confidential Material.

19.1 During the term of this Contract, either Party may have access to confidential material or information ("Confidential Information") belonging to the other Party or the other Party's customers, vendors, or partners. "Confidential Information" shall include without limitation the disclosing Party's computer programs and codes, business plans, customer/member lists and information, financial records, partnership arrangements and licensing plans or other information, materials, records, writings or data that is marked confidential or that due to its character and nature, a reasonable person under like circumstances would treat as confidential. Confidential Information will be used only for the purposes of this Contract and related internal administrative purposes. Each Party agrees to protect the other's Confidential Information at all times and in the same manner as each protects the confidentiality of its own confidential materials, but in no event with less than a reasonable standard of care.

19.2 For the purposes of this Section 19, "Confidential Information" does not include information which: (i) is already known to the other Party at the time of disclosure; (ii) is or becomes publicly known through no wrongful act or failure of the receiving Party; (iii) is independently developed without use or benefit of the other's Confidential Information or proprietary information; (iv) is received from a third party which is not under and does not thereby breach an obligation of confidentiality; or (v) is a public record, not exempt from disclosure pursuant to California Public Records Act, Government Code Section 6250 et seq., applicable provisions of California Welfare

and Institutions Code or other state or federal laws, regardless of whether such information is marked as confidential or proprietary.

19.3 Disclosure of the Confidential Information will be restricted to the receiving Party's employees, consultants, suppliers or agents on a "need to know" basis in connection with the services performed under this Contract, who are bound by confidentiality obligations no less stringent than these prior to any disclosure. The receiving Party may disclose Confidential Information pursuant to legal, judicial, or administrative proceeding or otherwise as required by law; providing that the receiving Party shall give reasonable prior notice, if not prohibited by applicable law, to the disclosing Party and shall assist the disclosing Party, at the disclosing Party's expense, to obtain protective or other appropriate confidentiality orders, and further provided that a required disclosure of Confidential Information or proprietary information to an agency or Court does not relieve the receiving Party of its confidentiality obligations with respect to any other party.

19.4 Except as to the confidentiality of trade secrets, these confidentiality restrictions and obligations will terminate five (5) years after the expiration or termination of the Contract, unless the law requires a longer period. Upon written request of the disclosing Party, the receiving Party shall promptly return to the disclosing Party all documents, notes and other tangible materials representing the disclosing Party's Confidential Information or Proprietary Information and all copies thereof. This obligation to return materials or copies thereof does not extend to automatically generated computer backup or archival copies generated in the ordinary course of the receiving Party's information systems procedures, provided that the receiving Party shall make no further use of such copies.

19.5 For the purposes of this Section only, "Confidential Information" does not include protected health information or individually identifiable information, as defined by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and other privacy statutes or regulations. The access use and disclosure of Protected Health Information is referenced below in Section 24, and shall be governed by a Business Associate Protected Health Information Disclosure Agreement, which shall be executed by the parties if CONTRACTOR will create, receive, maintain, use, or transmit Protected Health Information in performing services under this Contract.

20. Record Ownership and Retention.

20.1 The originals of all letters, documents, reports, software programs and any other products and data prepared or generated for the purposes of this Contract shall be delivered to and become the property of CalOptima at no cost to CalOptima and in a form accessible for CalOptima's use. Copies may be made for CONTRACTOR's records but shall not be furnished to others without written authorization from CalOptima. Such deliverables shall become the sole property of CalOptima and all rights in copyright therein shall be retained by CalOptima. CalOptima's ownership of these documents includes use of reproduction or reuse of, and all incidental rights. CONTRACTOR shall provide all deliverables within a reasonable amount of time upon CalOptima's request, but in no event shall such time exceed thirty (30) calendar days unless otherwise specified by CalOptima.

20.2 CONTRACTOR hereby assigns to CalOptima all of its rights in all materials prepared by or on behalf of CalOptima under this Contract ("Works"), and this Contract shall be deemed a transfer to CalOptima of the sole and exclusive copyright of any copyrightable subject matter CONTRACTOR created in these Works. CONTRACTOR agrees to cause its agents and employees to execute any documents necessary to secure or perfect CalOptima's legal rights and worldwide ownership in such materials, including, but not limited to, documents relating to patent, trademark and copyright applications. Upon CalOptima's request, CONTRACTOR will return or transfer all property and materials, including the Works, in CONTRACTOR's possession or control belonging to CalOptima.

20.3 Notwithstanding the foregoing, CONTRACTOR's intellectual property ("CONTRACTOR IP") that preexists this Contract shall remain the sole and exclusive property of CONTRACTOR. CONTRACTOR shall not incorporate any CONTRACTOR IP into the Works that would limit CalOptima's use of the Works without CalOptima's written approval. To the extent that CONTRACTOR incorporates any CONTRACTOR IP into the Works, CONTRACTOR hereby grants to CalOptima a non-exclusive, irrevocable, perpetual, worldwide, royalty-free license to use and reproduce the CONTRACTOR IP to the extent required to fully utilize the Works.

20.4 CONTRACTOR acknowledges and agrees that, notwithstanding any provision herein to the contrary, CalOptima's Intellectual Property ("CalOptima IP") in the information, documents and other materials provided to CONTRACTOR shall remain the sole and exclusive property of CalOptima. Any information, documents or materials provided by CalOptima to CONTRACTOR pursuant to this Contract and all copies thereof (including without limitation CalOptima IP, Proprietary Information and Confidential Information, as these terms are defined in Section 19) shall upon the earlier of CalOptima's request or the expiration or termination of this Contract be returned to CalOptima.

20.5 For purposes of this Section, Intellectual Property shall mean patents, copyrights, trademarks, trade secrets, and other proprietary information.

21. Patent and Copyright Infringement. In lieu of any other warranty by CalOptima or CONTRACTOR against infringement, statutory or otherwise, it is agreed that CONTRACTOR shall indemnify, hold harmless and defend, at its expense, any suit against CalOptima based on a claim that any item furnished under this Contract, or the normal use or sale thereof, infringes on any United States letters patent, patent, trademark, copyright, or other intellectual property right, and shall pay costs and damages finally awarded in any such suit, provided that CONTRACTOR is notified in writing of the suit and given authority, information, and assistance at CONTRACTOR's expense for the defense of the suit. CONTRACTOR, at no expense to CalOptima, shall obtain for CalOptima the right to use and sell said item, or shall substitute an equivalent item acceptable to CalOptima and extend this patent indemnity thereto.

22. Names and Marks. Neither Party shall use the name, logo or other proprietary mark of the other in any press release, advertising, promotional, marketing or similar publicly disseminated material without first submitting such material to the other Party and obtaining the other Party's express written approval of the material and consent to such use.

23. Business Associate Protected Health Information Disclosure Agreement. This Contract does not require or permit CONTRACTOR to create, receive, maintain, use, or transmit Protected Health Information. As such, no Business Associate Agreement is required for this Contract.

24. Confidentiality of Member Information.

24.1 CONTRACTOR and its employees, agents, or subcontractors shall protect from unauthorized disclosure, the names and other identifying information concerning persons either receiving services pursuant to this Contract, or persons whose names or identifying information become available or are disclosed to CONTRACTOR, its employees, agents, or subcontractors as a result of services performed under this Contract, except for statistical information not identifying any such person. CONTRACTOR and its employees, agents, or subcontractors shall not use such identifying information for any purpose other than carrying out CONTRACTOR's obligations under this Contract. CONTRACTOR and its employees, agents, or subcontractors shall promptly transmit to CalOptima all requests for disclosure of such identifying information not emanating from the Member. CONTRACTOR shall not disclose, except as otherwise specifically permitted by this Contract or authorized by the Member, any such identifying information to anyone other than DHCS or CalOptima without prior written authorization from CalOptima. For purposes of this provision, identity shall include, but not be limited to, name, identifying number, symbol, or

other identifying particular assigned to the individual, such as finger or voice print or a photograph.

24.2 Names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted thereunder. For the purpose of this Contract, all information, records, data, and data elements collected and maintained for the operation of the Contract and pertaining to Members shall be protected by CONTRACTOR from unauthorized disclosure. CONTRACTOR may release Medical Records in accordance with applicable law pertaining to the release of this type of information. CONTRACTOR is not required to report requests for Medical Records made in accordance with applicable law. With respect to any identifiable information concerning a Member under this Contract that is obtained by CONTRACTOR or its subcontractors, CONTRACTOR:

24.2.1 Will not use any such information for any purpose other than carrying out the express terms of this Contract;

24.2.2 Will promptly transmit to CalOptima all requests for disclosure of such information, except requests for Medical Records in accordance with applicable law;

24.2.3 Will not disclose, except as otherwise specifically permitted by this Contract, any such information to any party other than DHCS or CalOptima without CalOptima's prior written authorization specifying that the information is releasable under Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted there under; and

24.2.4 Will, at the termination of this Contract, return all such information to CalOptima or maintain such information according to written procedures sent to the CONTRACTOR by CalOptima for this purpose.

24.3 CONTRACTOR agrees to complete a CalOptima Medi-Cal Data Access Agreement, which is attached hereto as Exhibit D and incorporated herein by this reference. All materials covered under this Medi-Cal Data Access Agreement shall be designated confidential, to the extent permitted by California law.

25. Medicare Advantage Program. Medicare Advantage Program requirements are not applicable under this Contract.

26. Time is of the Essence. Time is of the essence in performance of this Contract.

27. CalOptima Designee. The Chief Executive Officer of CalOptima, or his designee, shall have the authority to act for and exercise any of the rights of CalOptima, as set forth in this Contract, subsequent to and in accordance with the authority granted by the Board of Directors.

28. Omissions. In the event that either party hereto discovers any material omission in the provisions of this Contract which such party believes is essential to the successful performance of this Contract, the party may so inform the other party in writing, and the parties hereto shall thereafter promptly negotiate in good faith with respect to such matters for the purpose of making such reasonable adjustments, as may be necessary to perform the objectives of this Contract.

29. Choice of Law. This Contract shall be governed by and construed in accordance with all laws of the State of California. In the event any party institutes legal proceedings to enforce or interpret this Contract, venue and jurisdiction shall be in the County of Orange, California.

30. Force Majeure. When satisfactory evidence of a cause beyond a party's control is presented to the other party, and nonperformance is unforeseeable, beyond the control, and not due to the fault of the party not performing, a party shall be excused from performing its obligations under this Contract during the time and to the extent that it is prevented from performing by such cause, including, but not limited to, any incidence of fire, flood, acts of God, commandeering of material, products, plants or facilities by the federal, state or local government, or a material act or omission by the other party.

31. Notices. All notices required or permitted under this Contract and all communications regarding the interpretation of the terms of this Contract, or changes thereto, shall be in writing and shall be sent by registered or certified mail, postage prepaid, return receipt requested, or by any other overnight delivery service which delivers to the noticed destination and provides proof of delivery to the sender. All notices shall be effective when first received at the following addresses set forth below. Any party whose address changes shall notify the other party in writing.

To CONTRACTOR:	To CalOptima:
Whittingham Public Affairs Advisors	CalOptima
31441 Santa Margarita Parkway, Suite A181	505 City Parkway West
Rancho Santa Margarita, CA 92688	Orange, CA 92868
Attn: Peter Whittingham	Attention: Ryan Prest

32. Notice of Labor Disputes. Whenever CONTRACTOR has knowledge that any actual or potential labor dispute may delay this Contract, CONTRACTOR shall immediately notify and submit all relevant information to CalOptima. CONTRACTOR shall insert the substance of this entire clause in any subcontract hereunder as to which a labor dispute may delay this Contract.

33. Unavoidable Delays.

33.1 If the delivery of services under this Contract should be unavoidably delayed, CalOptima's Purchasing Department shall extend the time for completion of the Contract for the determined number of days of excusable delay. A delay is unavoidable only if the delay was not reasonably expected to occur in connection with, or during CONTRACTOR's performance, and was not caused directly or substantially by acts, omissions, negligence, or mistakes of CONTRACTOR, CONTRACTOR's subcontractors, or their agents, and was substantial and in fact caused CONTRACTOR to miss delivery dates and could not adequately have been guarded against by contractual or legal means. Delays caused by CalOptima will be sufficient justification for delay of services, and CONTRACTOR shall be allowed a day-for-day extension.

33.2 CONTRACTOR shall notify CalOptima's Purchasing Department as soon as CONTRACTOR has, or should have, knowledge that an event has occurred that will delay deliveries. Within five (5) working days, CONTRACTOR shall confirm such notice in writing, furnishing as much detail as is available.

33.3 CONTRACTOR agrees to supply, as soon as such data is available, any reasonable proof that is required by CalOptima's Purchasing Department to make a decision on any request for extension. CalOptima's Purchasing Department shall examine the request and any documents supplied by CONTRACTOR and shall determine if CONTRACTOR is entitled to an extension and the duration of such extension. CalOptima's Purchasing Department shall notify CONTRACTOR of this decision in writing. It is expressly understood and agreed that CONTRACTOR shall not be entitled to damages or compensation and shall not be reimbursed for losses on account of delays resulting from any cause under this provision.

34. No Liability of County of Orange. As required under Ordinance No. 3896 of the County of Orange, State of California, as amended, the parties hereto acknowledge and agree that the obligations of CalOptima

under this Contract are solely the obligations of CalOptima, and the County of Orange, State of California, shall have no obligation or liability therefor.

35. Attorneys' Fees. Should either party to this Contract institute any action or proceeding to enforce or interpret this Contract or any provision hereof, or for damages by reason of any alleged breach of this Contract, otherwise arising under this Contract, or for a declaration of rights hereunder, the prevailing party in any such action or proceeding shall be entitled to receive from the other party all costs and expenses, including, without limitation, reasonable attorneys' fees incurred by the prevailing party in such action or proceeding.

36. Entire Agreement. This Contract, including all exhibits and documents incorporated by reference and all Contract Documents referenced in Section 1 herein, contains the entire agreement between CONTRACTOR and CalOptima with respect to the subject matter of this Contract, and it supersedes all prior written or oral and all or contemporaneous oral agreements, representations, understandings, discussions, negotiations and commitments between CONTRACTOR and CalOptima, whether express or implied, with respect to the subject matter of this Contract.

37. Headings. The section headings used herein are for reference and convenience only and shall not enter into the interpretation hereof.

38. Waiver. No delay or failure by either party hereto to exercise any right or power accruing upon noncompliance or default by the other party with respect to any of the terms of this Contract shall impair such right or power or be construed to be a waiver thereof. A waiver by either of the parties hereto of a breach of any of the covenants, conditions or agreements to be performed by the other shall not be construed to be a waiver of any succeeding breach thereof, or of any other covenant, condition, or agreement herein contained. Any information delivered, exchanged, or otherwise provided hereunder shall be delivered, exchanged or otherwise provided in a manner that does not constitute a waiver of immunity or privilege under applicable law.

39. California Public Records Act. As a local public agency, CalOptima is subject to the California Public Records Act (California Government Code Sections 6250 et seq.) (the "Public Records Act"). CONTRACTOR hereby acknowledges that any materials, documents, data, or similar items are subject to disclosure upon public request, unless they are exempt from disclosure under the provisions of the Public Records Act. CalOptima may be required to reveal certain information believed to be proprietary or confidential by CONTRACTOR pursuant to the Public Records Act. In the event that CONTRACTOR discloses information that it believes to be proprietary or confidential to CalOptima, it shall mark such information as "Confidential," "Proprietary," or "Restricted" or other similar marking. Unless CONTRACTOR marks its materials as "Confidential," "Proprietary," or "Restricted," and also notifies CalOptima in writing that CONTRACTOR has so marked each piece of material, then CalOptima will not be responsible to take any actions to protect any CONTRACTOR's materials under the Public Records Act that are not so marked. In the event CalOptima receives a request under the Public Records Act that potentially encompasses CONTRACTOR materials that have been properly marked, CalOptima will provide CONTRACTOR with notice thereof to allow CONTRACTOR to take actions it deems appropriate to prevent disclosure of the marked material. CONTRACTOR agrees to defend, indemnify, and hold harmless CalOptima, its officers, agents, employees, members, subsidiaries, joint venture partners, and predecessors and successors in interest from and against any claim, action, proceeding, liability, loss, damage, cost, or expense, including, without limitation, attorneys' fees, and any costs awarded to the person or entity that sought the CONTRACTOR marked material, arising out of or related to CalOptima's failure to produce or provide the CONTRACTOR marked material (collectively referred to for purposes of this Section as "Public Records Act Claim(s)"). CONTRACTOR shall pay to CalOptima any expenses or charges relating to or arising from any such Public Record Act Claim(s) as they are incurred by CalOptima.

40. Audit Disclosure. Pursuant to California Government Code Section 8546.7, if this Contract is over ten thousand dollars ($10,000), it is subject to examination and audit of the State Auditor, at the request of CalOptima, or as part of any audit of CalOptima, for a period of three (3) years after final payment under

this Contract. In addition to and notwithstanding any other right of access or inspection that may be otherwise set forth in this Contract or its attachments, CONTRACTOR agrees that, during the term of this Contract and for a period of three (3) years after its termination, CalOptima shall have access to and the right to examine any directly pertinent books, documents, invoices, and records of CONTRACTOR relating to services provided under this Contract. Where another right of access or inspection in this Contract provides for a period of greater than three (3) years, nothing herein shall be construed to shorten that time period.

41. Debarment and Suspension Certification.

41.1 By signing this Contract, the CONTRACTOR agrees to comply with any and all applicable Federal suspension and debarment regulations.

41.2 By signing this Contract, the CONTRACTOR certifies to the best of its knowledge and belief, that it and its principals:

41.2.1 Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency;

41.2.2 Have not within a three-year period preceding this Contract been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

41.2.3 Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in Paragraph 41.2.2 herein;

41.2.4 Have not within a three-year period preceding this Contract had one or more public transactions (Federal, State or local) terminated for cause or default;

41.2.5 Have not and shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under Federal regulations (i.e., 48 CFR 9, subpart 9.4), debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by the State; and

41.2.6 Will include a clause entitled, "Debarment and Suspension Certification'' that essentially sets forth the provisions herein, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

41.3 If the CONTRACTOR is unable to certify to any of the statements in this certification, the CONTRACTOR shall submit an explanation to CalOptima.

41.4 The terms and definitions herein have the meanings set out in the Definitions and Coverage sections of the rules implementing Federal Executive Order 12549.

41.5 If the CONTRACTOR knowingly violates this certification, in addition to other remedies available to the Federal Government, CalOptima may terminate this Contract for cause or default.

42. Survival. The following provisions of this Contract shall survive termination or expiration of this Contract: Prohibited Interest, Warranties, Compensation, Confidentiality, Indemnification, Duty to Defend, Ownership of Records and Documents, Record Retention, Audit Disclosure, California Public Records Act, Patent and Copyright Infringement, Governing Law, and this Section.

43. Severability. If any section, subsection or provision of this Contract, or any Contract Documents incorporated into this Contract, or the application of such section, subsection or provision, is held invalid or unenforceable by any court of competent jurisdiction, the remainder of this Contract, other than that to which it is held invalid, shall not be affected thereby.

44. Third Party Beneficiaries. There are no intended third-party beneficiaries of this Contract. Nothing in this Contract shall be construed as conferring any rights on any other persons.

45. Successors and Assigns. Except as otherwise expressly provided in this Contract, this Contract will be binding on, and will inure to the benefit of, the successors and permitted assigns of the Parties to this Contract. Nothing in this Contract is intended to confer upon any Party other than the Parties hereto or their respective successors and permitted assigns any rights or obligations under or by reason of this Contract, except as expressly provided in this Contract.

46. Authority to Execute. The persons executing this Contract on behalf of the Parties warrant that they are duly authorized to execute this Contract and that by executing this Contract the Parties are formally bound.

47. Counterparts. This Contract may be executed and delivered in one or more counterparts, each of which shall be deemed an original, but all of which together will constitute one and the same instrument.

[Remainder of page left intentionally blank. Signatures on following page]

IN WITNESS WHEREOF, these Parties have, by their duly authorized representatives, executed this Contract No. 22-10953 on the day and year last shown below, retroactively agreeing that this Contract is effective as of June 03, 2022.

Whittingham Public Affairs Advisors	CalOptima
By:	By: DocuSigned by: Nancy Huang D22E3B87032946F...
Print Name: Peter Whittingham	Print Name: Nancy Huang
Title: CEO	Title: CFO, CalOptima
Date: June 21, 2022	Date: 06/23/2022
By:	By:
Print Name:	Print Name:
Title:	Title:
Date:	Date:

If CONTRACTOR is a corporation, two officer signatures or a Corporation Resolution or Corporate Seal is required

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Exhibit A

SCOPE OF WORK

Purpose
CONTRACTOR shall represent CalOptima's interests as specified below, in the City of Tustin, California, and have the responsibility of monitoring and influencing policies, building and maintaining positive and mutually beneficial relationships, and providing CalOptima with necessary advocacy services.

Services of Consultant
CONTRACTOR agrees to provide to CalOptima, as requested by CalOptima, the following advice and consulting services:

- Representing CalOptima's interests related to CalOptima's project in the City of Tustin, California (Tustin), through government affairs, strategic guidance, public relations and community outreach and engagement.
- Regularly consulting with CalOptima's leadership on CalOptima's program goals, and provide strategic and tactical recommendations at its request, as well as strategic planning and political analysis.

Performance of Duties
CONTRACTOR agents shall faithfully, industriously, and to the best of their ability, experience, and talents, perform all of the duties that may reasonably be assigned to him or her hereunder and devote such time to the performance of such duties as may be necessary, therefore.

Deliverables

- Provide a written monthly report that describes the nature and extent of the services or actions taken on behalf of CalOptima. The services or actions shall include a summary of the meetings CONTRACTOR had along with the issues discussed.

Exhibit B

PAYMENT

A. For CONTRACTOR's full and complete performance of its obligations under this Contract, CalOptima shall pay CONTRACTOR for fees and expenses in accordance with the provisions of this Exhibit and subject to the maximum cumulative payment obligations specified below.

B. CONTRACTOR shall invoice CalOptima on a monthly basis for retainer payment. The rate, as defined below, are acknowledged to include CONTRACTOR's base labor rates, expenses, overhead and profit. Work completed shall be documented in a monthly progress report prepared by CONTRACTOR, which report shall accompany each invoice submitted by CONTRACTOR. CONTRACTOR shall also furnish such other information as may be requested by CalOptima to substantiate the validity of an invoice. At its sole discretion, CalOptima may decline to make full payment for any work and direct costs until such time as CONTRACTOR has documented, to CalOptima's satisfaction, that CONTRACTOR has fully completed all work required under this Contract and CONTRACTOR's performance is accepted by CalOptima. CalOptima's payment in full for any work shall not constitute CalOptima's final acceptance of CONTRACTOR's work under this Contract.

C. CONTRACTOR shall submit to CalOptima, to the attention of Accounts Payable, accountspayable@caloptima.org, an invoice at the conclusion of every month for the Services performed during the prior thirty (30) days. Each invoice shall cite Contract No. 22-10953; specify the number of hours worked; the specific dates the hours were worked; the description of work performed; the time period covered by the invoice and the amount of payment requested; and be accompanied by a progress report. CalOptima shall remit payment within thirty (30) days of receipt and approval of each invoice.

D. Notwithstanding any provisions of this Contract to the contrary, CalOptima and CONTRACTOR mutually agree that CalOptima's maximum cumulative payment obligation hereunder for work performed and/or products received on Exhibit A of this Contract shall not exceed Seven Thousand Five Hundred Dollars ($7,500.00) per month and Ninety Thousand Dollars ($90,000.00) per year, including all amounts payable to CONTRACTOR for its direct labor and expenses, overhead costs, fixed fee, subcontracts, leases, materials, and costs arising from or due to termination of this Contract. These fees are fixed for the duration of the Contract. CONTRACTOR agrees to extend these fees to CalOptima for a period of one year after Contract termination. CalOptima shall not pay CONTRACTOR for time spent traveling.

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Exhibit B-1

Not applicable for this Contract

Exhibit C

Not applicable for this Contract

Exhibit D

MEDI-CAL DATA ACCESS AGREEMENT

As a condition of obtaining access to information concerning procedures or other data records utilized/maintained by the Department of Health Care Services and CalOptima, Whittingham Public Affairs Advisors, including any and all individual employees and agents, agrees not to divulge any information obtained in the course of completion of this Contract to any unauthorized persons.

CONTRACTOR further agrees not to publish or otherwise make public any information regarding persons receiving Medi-Cal services such that the persons who receive such services are identifiable.

CONTRACTOR further recognizes that unauthorized release of confidential information may be subject to civil and criminal sanctions pursuant to the provisions of the Welfare and Institutions Code Section 14100.2.

CONTRACTOR further agrees that this Medi-Cal Data Access Agreement shall remain in full force and effect after the termination of this Contract.

By: _____ Date: JAN 21, 2022

Print Name: PETER WHITTINGHAM

Title: CEO

Exhibit E

Not applicable for this Contract

Exhibit F

Not applicable for this Contract

Exhibit G

Not applicable for this Contract

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Exhibit H

Not applicable for this Contract

Exhibit 1

Officer, Owner, Shareholder, and Creditor Information

Contractor's Business Name: Whittingham Public Affairs Advisors

Business Entity Type: LLC
(Sole Proprietorship, Partnership, LLC, California Corporation, etc.)

Business Address: 31441 Santa Margarita Parkway, Suite A-181

City: Rancho Santa Margarita State: CA Zip: 92688

Business Phone: (949) 280-9181 Email: : peter@whittinghampaa.com

President: Peter Whittingham Contact Person: Same

Person(s) Signing Contract & Title: : Peter Whittingham

*Please provide names of owners, officers, stockholders, and creditors of Contractor's business if such interest is over 5%.

Name	Officer Title or Ownership/Creditorship %

BY SIGNING BELOW, THE UNDERSIGNED HEREBY CERTIFIES THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF HIS OR HER KNOWLEDGE AND BELIEF.

Authorized Signature

June 21, 2022
Date

Peter Whittingham, CEO
Name and Title

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Exhibit J

Not applicable for this Contract

Exhibit K

Not applicable for this Contract

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Exhibit L

Not applicable for this Contract

CalOptima Health Board Action Agenda Referral

Action To Be Taken August 3, 2023
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

6. Appointments to the CalOptima Health Whole-Child Model Family Advisory Committee

Contacts

Ladan Khamseh, Executive Director, Operations, (714) 246-8866
Yunkyung Kim, Chief Operating Officer, (714) 923-8834

Recommended Actions

The Whole-Child Model Family Advisory Committee recommends:

1. Reappointment of the following individuals to each serve two-year terms on the Whole-Child Family Advisory Committee, effective upon Board approval:
    a. Monica Maier as an Authorized Family Member Representative for a term ending June 30, 2025; and
    b. Lori Sato as an Authorized Family Member Representative for a term ending June 30, 2025.

2. New appointment of the following individuals to each serve a two-year term on the Whole-Child Model Family Advisory Committee, effective upon Board approval:
    a. Cally Johnson as an Authorized Family Member Representative for a term ending June 30, 2025;
    b. Jennifer Heavner as an Authorized Family Member Representative for a term ending June 30, 2025;
    c. Sofia Martinez as a Community Based Organization Representative for a term ending June 30, 2025; and
    d. Janis Price as a Consumer Advocate Representative for a term ending June 30, 2025

3. Reappoint Kristen Rogers an Authorized Family Member as the Committee Chair through June 30, 2024.

Background

Senate Bill 586 (SB 586) was signed into law on September 25, 2016, and authorized the establishment of the Whole-Child Model (WCM), incorporating California Children's Services (CCS)-covered services for Medi-Cal eligible children and youth into specified County-Organized Health System plans. A provision of the WCM program requires each participating health plan to establish a family advisory committee. Accordingly, the CalOptima Health Board of Directors established the Whole-Child Model Family Advisory Committee (WCM FAC) by resolution on November 2, 2017, to report and provide input and recommendations to the CalOptima Health Board relative to the WCM program.

The WCM FAC is comprised of 11 voting members, nine of whom are designated as family representatives and two of whom are designated as community seats representing the interests of children receiving CCS services. While two of the WCM FAC's 11 seats are designated as community seats, WCM FAC candidates representing the community may be considered for up to two additional

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WCM FAC seats if there are not enough family representative candidates to fill the nine designated seats.

Discussion

CalOptima Health conducted comprehensive outreach, including sending notifications to community-based organizations, conducting targeted community outreach to agencies and community-based organizations serving the various open positions, and posting recruitment materials on the CalOptima Health website as well as CalOptima Health's social media sites, such as LinkedIn and Facebook.

With the fiscal year ending on June 30, 2023, five WCM FAC seats will expire: three Authorized Family Member Representatives and two Community Based Organization/Consumer Advocate Representatives. In addition to the five expiring seats, there is one open seat for an Authorized Family Member Representative and one seat for a Consumer Advocate Representative on the committee, for a total of six seats available for appointments.

The WCM FAC Nominations Ad Hoc Subcommittee, composed of WCM FAC committee members Chair Kristen Rogers and Members Maura Byron and Erika Jewell, evaluated each of the applicants for the current openings. The WCM FAC Nominations Ad Hoc Subcommittee proposes the slate of candidates for the six vacancies and forwards the recommended slate of candidates for final consideration at the June 14, 2023 Quality Assurance Committee for appointment by the Board of Directors at its August 3, 2023 meeting.

The candidates for the open positions are as follows:

Authorized Family Member Representative

Monica Maier (Reappointment)

Monica Maier is the stepmother and main caregiver of a child who receives CCS services. Ms. Maier continues to advocate on behalf of parents and their children with CCS conditions. She has been a member of the WCM FAC since February 2020.

Lori Sato (Reappointment)

Lori Sato is the mother of a special needs child who currently receives CCS and Medi-Cal services. Ms. Sato has learned to navigate new systems to better advocate for children with special needs. She is familiar with medical therapy units for various therapies (physical and occupational) and for special equipment needs by CCS children. Ms. Sato has been inspired by other parents who are knowledgeable about the system to help CCS children get the care they need. Ms. Sato has been a member on the committee since July 2022, and she is currently serving the remainder of a term on the WCM FAC.

Cally Johnson (New Appointment)

Cally Johnson is the mother of a special needs child. Ms. Johnson has several years of experience working with the Autism Speaks foundation and as a long-term care ombudsman. Ms. Johnson has over 20 years of experience as a private tutor for children in grades K-12 with special needs. Ms. Johnson's knowledge of CCS places her in a unique perspective to assist families of children with special needs with her bilingual skills.

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Jennifer Heavener (New Appointment)
Jennifer Heavener has been navigating the Medi-Cal and CCS world for the past 20 years with her special needs child, who is a high consumer of medical services. Her experience as an advocate and caregiver gives her a unique perspective that will help other families with transition through the WCM program.

Community-Based Organization Representative

Sofia Martinez, LCSW (New Appointment)
Sofia Martinez is the Chief Executive Officer of Reimagine, a community-based organization which offers an array of specialized therapies. Ms. Martinez is a Licensed Clinical Social Worker with two decades of experience working with children and adults with developmental disabilities. Prior to becoming the Chief Executive Officer of Reimagine, Ms. Martinez led the Children's Services programs at both the Orange and Fullerton campuses. She brings her longtime management and direct experience working with children with disabilities in a community that knows her well to the WCM.

Consumer Advocate Representative

Janis Price (New Appointment)
Janis Price is a certified educator with the Orange County Department of Education serving as Coordinator of Family and Community Engagement where she works directly with families who are Medi-Cal beneficiaries. She assists families by connecting them to community outreach services. She is committed to helping every family in Orange County be empowered to know their rights and opportunities available to partner with their schools to help in their whole child's success. Her knowledge of the diverse yet detailed school system, combined with her heart for the family, offers a safe place for questions, answers, and a renewed love for schools, students, families and their communities. Ms. Price currently participates on several advisory boards to help develop comprehensive plans for prevention, homelessness and foster youth, academic success and county-wide adverse childhood experiences and equity workgroups.

Committee Chair
Kristen Rogers
Ms. Rogers is the parent of a CalOptima Health member and CCS beneficiary. She is an active volunteer at Children's Health of Orange County and has served on the WCM FAC since 2018. In March of 2019, Ms. Rogers was appointed to the state CCS Advisory Group as a representative of CalOptima Health and the WCM FAC.

Fiscal Impact
Each authorized family member representative appointed to the WCM FAC may receive a stipend of up to $50 per committee meeting attended. Funding for the stipends is a budgeted item in the CalOptima Health Fiscal Year 2023-24 Operating Budget.

Rationale for Recommendation
As stated in policy AA.1271, the WCM FAC established a Nominations Ad Hoc Subcommittee to review the potential candidates for vacancies on the committee. The WCM FAC Nominations Ad Hoc

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Subcommittee forwards the recommended candidates to the Board of Directors' Quality Assurance Committee for consideration and recommendation to the Board of Directors.

Concurrence
Whole-Child Model Family Advisory Committee Nominations Ad Hoc Subcommittee
Troy R. Szabo, Outside General Counsel, Kennaday Leavitt
Quality Assurance Committee

Attachments
None

/s/ Michael Hunn *07/27/2023*
Authorized Signature **Date**

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CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 3, 2023
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

7. Appointments to the CalOptima Health Board of Directors' Member Advisory Committee

Contacts

Yunkyung Kim, Chief Operating Officer, (714) 923-8834
Ladan Khamseh, Executive Director Operations, (714) 246-8866

Recommended Actions

The CalOptima Health Member Advisory Committee (MAC) recommends reappointment of the following individuals to serve three-year terms on the MAC, effective August 3, 2023:

a. Sandy Finestone as the Adult Beneficiaries Representative for a term ending June 30, 2026;
b. Maura Byron as the Family Support Representative for a term ending June 30, 2026;
c. Linda Adair as the Medi-Cal Beneficiaries Representative for a term ending June 30, 2026;
d. Hai Hoang as the Persons with Disabilities Representative for a term ending June 30, 2026; and
e. Meredith Chillemi as the Seniors Representative for a term ending June 30, 2026.

Background

The CalOptima Health Board of Directors (Board) established the MAC by resolution on February 14, 1995, to provide input to the Board. The MAC is comprised of fifteen voting members. Pursuant to the resolution, MAC members serve three-year terms, except for one standing seat for the representative from the County of Orange Social Services Agency. The Board is responsible for the appointment of all MAC members.

The following six MAC seat appointments expired at the end of the 2023-24 fiscal year on June 30, 2023: (i) Adult Beneficiaries, (ii) CalWORKs, (iii) Family Support, (iv) Medi-Cal Beneficiaries, (v) Persons with Disabilities, and (vi) Seniors. With the resignation of the Consumer Representative, staff is continuing the recruitment process for the Consumer Representative and the CalWORKs Representative.

Discussion

CalOptima Health conducted comprehensive outreach, including sending notifications to community-based organizations (CBOs), conducting targeted community outreach to agencies and CBOs serving the various open positions, and posting recruitment materials on the CalOptima Health website and social media sites.

The MAC Nominations Ad Hoc Subcommittee – composed of MAC Vice Chair Christine Tolbert and committee members Lee Lombardo, and Iliana Soto-Welty – evaluated each of the applicants for the impending openings and forwarded the proposed slate of candidates for the six vacancies to the MAC. At the June 8, 2023, meeting, MAC members approved the recommended slate of candidates proposed by the MAC Nominations Ad Hoc Subcommittee and requested that the proposed slate of candidates be forwarded to the Board for consideration at the August 3, 2023, meeting. Staff will continue its recruitment of the CalWORKs Representative and the Consumer Representative.

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The recommended candidates for the open positions are as follows:

Adult Beneficiaries Representative

Sandy Finestone

Sandy Finestone is the Executive Director of the Association of Cancer Patient Educators. Ms. Finestone works with individuals who have become disabled due to stage IV cancer and facilitates support groups, meets individually with patients and their families, and has created a peer support system. Ms. Finestone has been involved with the delivery of health care in the community for over 30 years, both as an advocate and as a health care provider. She has been a member of the MAC since 2013.

Family Support Representative

Maura Byron

Maura Byron is the Executive Director of the Family Support Network and is the parent of a young adult who is a current California Children's Services client. As executive director, Ms. Byron assists families of children with complex health care needs to maneuver in the system and secure services. In addition, she responds to families' questions and provides peer and emotional support. Ms. Byron also serves on CalOptima's Whole-Child Model Family Advisory Committee since 2018. She has been a member of the MAC since 2020 when she was appointed to fulfill an existing term.

Medi-Cal Beneficiaries Representative

Linda Adair Pugh

Linda Adair Pugh is retired and is a current CalOptima Medi-Cal member. Ms. Adair Pugh has lived in the Orange County area for more than 50 years. Ms. Adair Pugh currently sits on two different boards for the City of Anaheim: she serves on the Residential Advisory Board and is also a Commissioner on the Housing and Community Development Commission. Ms. Adair Pugh has served as the Medi-Cal Beneficiaries Representative on the MAC since 2021.

Persons with Disabilities Representative

Hai Hoang

Hai Hoang is currently the Chief Operating Officer at the Illumination Institute working directly with CalOptima Health's youth, disabled and adult/older adult populations. Presently, the Illumination Institute continues a parent mentoring program for children with intellectual/developmental disabilities and their families that Mr. Hoang established when he was with Boat People SOS. The Illumination Institute also works with the Garden Grove and Santa Ana school districts assisting the medical and mental health support of children. Mr. Hoang has worked with the Vietnamese community since 2009 assisting children with intellectual/developmental disabilities and their families with health care navigation. Mr. Hoang has been a life-long advocate of the persons with disabilities population of Orange County for their medical and behavioral health needs. He currently holds the MAC Persons with Disabilities seat having been appointed to fill an existing term in 2020.

Seniors Representative

Meredith Chillemi

Meredith Chillemi is the LifeSTEPS Director of Aging and Education Services where she provides direct service to CalOptima Health dual eligible older adults residing in affordable housing communities in Westminster, Brea, and San Clemente. As a lead at LifeSTEPS, she guides programs at 10 senior affordable housing apartment communities in Orange County and regularly collaborates with

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community-based adult services, senior centers, the Office on Aging, and serves on the County of Orange Senior Citizens Advisory Council Health and Nutrition Committee. Ms. Chillemi has served on the MAC since 2021and was a former member of the OneCare Connect Member Advisory Committee where she served as the Long-Term Services and Support Representative until 2022.

Fiscal Impact

Each member or family member representative appointed to the MAC may receive a stipend of up to $50 per committee meeting attended. Funding for stipends is a budgeted item under the CalOptima Health Fiscal Year 2023-24 Operating Budget, and management will include funding related to stipends in future operating budgets. There is no additional fiscal impact related to the other recommended actions.

Rationale for Recommendation

As stated in policy AA.1219a, the MAC established a Nominations Ad Hoc Subcommittee to review potential candidates for vacancies on the committee. The MAC met to discuss the Nominations Ad Hoc Subcommittee's recommended slate of candidates and concurred with the subcommittee's recommendations. The MAC forwards the recommended slate of candidates to the Board for consideration.

Concurrence

Member Advisory Committee Nominations Ad Hoc Subcommittee
Member Advisory Committee
Troy R. Szabo, Outside General Counsel, Kennaday Leavitt

Attachments

None

/s/ Michael Hunn *07/27/2023*
Authorized Signature **Date**

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CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 3, 2023
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

8. Appointments to the CalOptima Health Board of Directors' Provider Advisory Committee

Contacts

Yunkyung Kim, Chief Operating Officer, (714) 923-8834
Michael Gomez, Executive Director, Network Operations, (714) 347-3292

Recommended Actions

1. Reappoint Christy Ward as the Community Health Centers Representative for a three-year term, ending June 30, 2026.

2. Reappoint Jena Jensen as the Hospital Representative for a three-year term, ending June 30, 2026.

3. Reappoint Alpesh Amin, M.D. as the Physician Representative for a three-year term, ending June 30, 2026.

4. Reappoint Alexander Rossel as the Safety Net Representative for a three-year term, ending June 30, 2026.

Background

The CalOptima Health Board of Directors (Board) established the Provider Advisory Committee (PAC) by resolution on February 14, 1995, to provide input to the Board. The PAC is comprised of 15 voting members. Pursuant to Resolution No. 15-0806-03, PAC members serve three-year terms, except for the one standing seat, which is a representative from Orange County Health Care Agency (HCA). The CalOptima Health Board is responsible for appointing all PAC members. Four PAC seats expired at the end of the fiscal year on June 30, 2023: the Community Health Centers, Hospital, Physician and Safety Net Representatives.

Discussion

CalOptima Health conducted recruitment to ensure that there would be a diverse applicant pool from which to choose candidates. The recruitment included notification methods, such as sending outreach flyers to community-based organizations (CBOs) and targeting community outreach to agencies and CBOs serving the various open positions. Recruitment also consisted of emails to community health centers, hospitals, physicians, and safety net providers to reach all CalOptima Health providers for the open seats. CalOptima Health staff received the applications from interested candidates and submitted them to the Nominations Ad Hoc Subcommittee for review.

The Nominations Ad Hoc Subcommittee members evaluated each of the applicants. The subcommittee, consisted of Vice Chair Junie Lazo-Pearson, Ph.D., BCBA-D and PAC members Andrew Inglis, M.D., and Jacob Sweidan, M.D., FAAP, who reviewed the candidates for each of the open seats and forwarded the proposed slate of candidates to the PAC for its consideration.

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At the June 8, 2023, meeting, the PAC voted to accept the recommended slate of candidates as proposed by the Nominations Ad Hoc Subcommittee and to forward to the Board for appointment.

Information for the proposed slate of candidates is as follows:

Community Health Centers
Christy Ward
Ms. Ward is the Chief Executive Officer of Share Our Selves, a federally qualified health center (FQHC), with six FQHC sites, that serves CalOptima patients throughout Orange County. Ms. Ward serves as a board member for The Coalition of Orange County Community Health Centers and the California Primary Care Association. Ms. Ward holds a Masters in Communication and Organizational Leadership from Gonzaga University. She has served on the PAC since 2020.

Hospitals
Jena Jensen
Ms. Jensen is the Chief Government Relations Officer at CHOC Children's Hospital of Orange California. CHOC Children's has been a participant in CalOptima Health since the CalOptima Health's inception in 1993. Ms. Jensen's tenure with CHOC Children's began in 1992, when she joined the hospital as Director of Marketing and Public Relations. She currently serves as CHOC Children's central resource for legislative advocacy as well as development and maintenance of relationships with federal, state and local elected officials, government, and community and opinion leaders. Ms. Jensen currently serves as the PAC Chair.

Physician
Alpesh Amin, MD, MBA, MACP, SFHM, FACC, FRCP (Lond)
Dr. Amin is the Chair of the Department of Medicine for the University of California Irvine (UCI) and is the Founder and Executive Director, Hospitalist Program at UCI. He is a member of the American College of Physicians where he holds the title of Governor, Southern California Region II, and President, American College of Physicians, All California. Dr. Amin received his medical degree from Northwestern University and completed his residency and chief residency in internal medicine at UCI. Dr. Amin has served on the PAC since 2020.

Safety Net
Alexander Rossel
Mr. Rossel is the Chief Executive Officer of Families Together of Orange County, an FQHC in Orange County. Mr. Rossel is the current board president for the Coalition of Orange County Community Health Centers where he has developed relationships with other health agencies, health networks and other pivotal healthcare partners. He is a member of the Salvation Army Orange County Advisory committee and a member of the California Primary Care Association. He attended the Universidad Inca Garcilazo de La Vega in Lima, Peru, majoring in Accounting. Mr. Rossel has served on the PAC since 2020.

Fiscal Impact
There is no fiscal impact.

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Rationale for Recommendation

As stated in policy AA. 1219b, the PAC established a Nominations Ad Hoc Subcommittee to review potential candidates for committee vacancies. The PAC met to discuss the recommended slate of candidates and concurred with the Nomination Ad Hoc Subcommittee's recommendations. The PAC forwards the recommended slate of candidates to the Board for their consideration.

Concurrence

Provider Advisory Committee Nominations Ad Hoc
Provider Advisory Committee
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

None

/s/ Michael Hunn *07/27/2023*
Authorized Signature **Date**

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Financial Summary

May 31, 2023

Board of Directors Meeting
August 3, 2023

Nancy Huang, Chief Financial Officer

Our Mission

To serve member health with excellence and dignity, respecting the value and needs of each person.

Our Vision

By 2027, remove barriers to health care access for our members, implement same-day treatment authorizations and real-time claims payments for our providers, and annually assess members' social determinants of health.

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Financial Highlights: May 2023

May 2023					July 2022 - May 2023			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
990,186	899,892	90,294	10.0%	Member Months	10,515,639	10,019,127	496,512	5.0%
358,921,765	325,877,954	33,043,811	10.1%	Revenues	3,831,733,477	3,655,210,540	176,522,937	4.8%
319,720,941	312,456,800	(7,264,141)	(2.3%)	Medical Expenses	3,534,168,001	3,434,294,329	(99,873,672)	(2.9%)
18,169,728	19,843,184	1,673,456	8.4%	Administrative Expenses	170,003,086	200,760,841	30,757,755	15.3%
21,031,096	**(6,422,030)**	**27,453,126**	**427.5%**	**Operating Margin**	**127,562,390**	**20,155,370**	**107,407,020**	**532.9%**
				Non-Operating Income (Loss)				
7,328,445	500,000	6,828,445	1365.7%	Net Investment Income/Expense	81,408,532	5,500,000	75,908,532	1380.2%
65,924	90,835	(24,911)	(27.4%)	Net Rental Income/Expense	903,923	999,185	(95,262)	(9.5%)
(1,530,950)	-	(1,530,950)	(100.0%)	Net MCO Tax	(1,513,014)	-	(1,513,014)	(100.0%)
(871,970)	(2,077,922)	1,205,952	58.0%	Grant Expense	(24,508,333)	(17,922,076)	(6,586,257)	(36.7%)
-	-	-	0.0%	Net QAF/IGT Income/Expense	-	-	-	0.0%
30	-	30	100.0%	Other Income/Expense	135	-	135	100.0%
4,991,479	**(1,487,087)**	**6,478,566**	**435.7%**	**Total Non-Operating Income (Loss)**	**56,291,243**	**(11,422,891)**	**67,714,134**	**592.8%**
26,022,575	**(7,909,117)**	**33,931,692**	**429.0%**	**Change in Net Assets**	**183,853,633**	**8,732,479**	**175,121,154**	**2005.4%**
89.1%	95.9%	(6.8%)		Medical Loss Ratio	92.2%	94.0%	(1.7%)	
5.1%	6.1%	1.0%		Administrative Loss Ratio	4.4%	5.5%	1.1%	
5.9%	(2.0%)	7.8%		Operating Margin Ratio	3.3%	0.6%	2.8%	
100.0%	100.0%			Total Operating	100.0%	100.0%		
89.1%	95.9%	(6.8%)		*MLR (excluding Directed Payments)	91.6%	94.0%	(2.4%)	
5.1%	6.1%	1.0%		*ALR (excluding Directed Payments)	4.8%	5.5%	0.7%	

*CalOptima Health updated the category of Directed Payments per Department of Health Care Services instructions

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CalOptima Health

Consolidated Performance: May 2023 (in millions)

May 2023				July 2022 - May 2023		
Actual	Budget	Variance	Operating Income (Loss)	Actual	Budget	Variance
19.7	(4.9)	24.5	Medi-Cal	128.0	31.7	96.4
1.9	(0.0)	1.9	OCC	0.2	(3.1)	3.4
(0.4)	(1.4)	1.0	OneCare	(1.4)	(8.0)	6.6
(0.0)	(0.0)	0.0	PACE	1.5	0.1	1.4
(0.1)	(0.0)	(0.0)	MSSP	(0.8)	(0.5)	(0.3)
21.0	**(6.4)**	**27.5**	**Total Operating Income (Loss)**	**127.6**	**20.2**	**107.4**
			Non-Operating Income (Loss)			
7.3	0.5	6.8	Net Investment Income/Expense	81.4	5.5	75.9
0.1	0.1	(0.0)	Net Rental Income/Expense	0.9	1.0	(0.1)
(1.5)	0.0	(1.5)	Net Operating Tax	(1.5)	0.0	(1.5)
(0.9)	(2.1)	1.2	Grant Expense	(24.5)	(17.9)	(6.6)
0.0	0.0	0.0	Other Income	0.0	0.0	0.0
5.0	**(1.5)**	**6.5**	**Total Non-Operating Income/(Loss)**	**56.3**	**(11.4)**	**67.7**
26.0	**(7.9)**	**33.9**	**TOTAL**	**183.9**	**8.7**	**175.1**

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CalOptima Health

FY 2022-23: Management Summary

- Change in Net Assets Surplus or (Deficit)
  - Month To Date (MTD) May 2023: $26.0 million, favorable to budget $33.9 million or 429.0%
  - Year To Date (YTD) July 2022– May 2023: $183.9 million, favorable to budget $175.1 million or 2,005.4%
- Enrollment
  - MTD: 990,186 members, favorable to budget 90,294 or 10.0%
  - YTD: 10,515,639 members, favorable to budget 496,512 or 5.0%
  - Favorable enrollment primarily driven by a pause in Medi-Cal redetermination due to the extension of the COVID-19 Public Health Emergency (PHE) that ended May 11, 2023

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CalOptima Health

FY 2022-23:Management Summary (cont.)

- Revenue
  - MTD: $358.9 million, favorable to budget $33.0 million or 10.1% driven by Medi-Cal Line of Business (MC LOB):
    - $71.1 million from favorable volume and price variances primarily from updated Calendar Year (CY) 2022 premium capitation rates
    - Offset by net $45.2 million due to the COVID-19, Enhanced Care Management (ECM), and Proposition 56 risk corridor reserves
  - YTD: $3,831.7 million, favorable to budget $176.5 million or 4.8% driven by MC LOB:
    - $293.6 million of Hospital Directed Payments (DP), $135.4 million of prior period MLR accrual release, and $272.3 million primarily from favorable volume and price related variances
    - Offset by $534.4 million due to COVID-19, Proposition 56, and ECM risk corridor reserves

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CalOptima Health

FY 2022-23:Management Summary (cont.)

- Medical Expenses
  - MTD: $319.7 million, unfavorable to budget $7.3 million or 2.3% driven by MC LOB:
    - Incentive Payments expense unfavorable variance of $13.2 million primarily due to Housing and Homelessness Incentive Program (HHIP) and Shared Risk Pool
    - Provider Capitation expense unfavorable variance of $7.9 million
    - Professional Claims expense unfavorable variance of $5.1 million
    - Offset by:
      - Facilities Claims expense favorable variance of $12.9 million
      - Managed Long-Term Services and Supports (MLTSS) favorable variance of $6.4 million due to lower than budgeted utilization

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FY 2022-23:Management Summary (cont.)

- Medical Expenses
  - YTD: $3,534.2 million, unfavorable to budget $99.9 million or 2.9% driven by MC LOB:
    - Other Medical Expenses unfavorable variance of $266.3 million due to Hospital DP
    - Incentive Payments expense unfavorable variance of $46.5 million primarily due to HHIP and Shared Risk Pool
    - Offset by:
      - Provider Capitation favorable variance of $104.7 million primarily due to updated logic for Proposition 56
      - MLTSS favorable variance of $64.5 million due to lower than budgeted utilization
      - Net favorable variances totaling $55.3 million from Facilities Claims, Professional Claims, Prescription Drugs, and Medical Management due to lower than budgeted utilization

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CalOptima Health

FY 2022-23:Management Summary (cont.)

- Administrative Expenses
  - MTD: $18.2 million, favorable to budget $1.7 million or 8.4%
    - Other Non-Salary expenses favorable variance of $1.9 million
    - Offset by Salaries & Benefits expense unfavorable variance of $0.2 million
  - YTD: $170.0 million, favorable to budget $30.8 million or 15.3%
    - Other Non-Salary expenses favorable variance of $21.2 million
    - Salaries & Benefits expense favorable variance of $9.5 million

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CalOptima Health

FY 2022-23:Management Summary (cont.)

- Non-Operating Income (Loss)
  - MTD: $5.0 million, favorable to budget $6.5 million or 435.7%
    - Net Investment Income favorable variance of $6.8 million
  - YTD: $56.3 million, favorable to budget $67.7 million or 592.8%
    - Net Investment Income favorable variance of $75.9 million
    - Offset by Grant Expense unfavorable variance of $6.6 million

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CalOptima Health

FY 2022-23: Key Financial Ratios

- Medical Loss Ratio (MLR)
  - MTD: Actual 89.1% (89.1% excluding DP), Budget 95.9%
  - YTD: Actual 92.2% (91.6% excluding DP), Budget 94.0%
- Administrative Loss Ratio (ALR)
  - MTD: Actual 5.1% (5.1% excluding DP), Budget 6.1%
  - YTD: Actual 4.4% (4.8% excluding DP), Budget 5.5%
- Balance Sheet Ratios
  - Current ratio*: 1.5
  - Board-designated reserve level: 1.91
  - Net-position: $1.6 billion, including required Tangible Net Equity (TNE) of $105.9 million

*Current ratio compares current assets to current liabilities. It measures CalOptima Health's ability to pay short-term obligations

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CalOptima Health

Enrollment Summary: May 2023

May 2022					July 2022 - May 2023			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	% Variance
142,090	139,080	3,010	2.2%	SPD	1,455,510	1,428,766	26,744	1.9%
305,877	302,070	3,807	1.3%	TANF Child	3,348,728	3,353,217	(4,489)	(0.1%)
142,947	126,063	16,884	13.4%	TANF Adult	1,511,964	1,451,855	60,109	4.1%
3,192	3,511	(319)	(9.1%)	LTC	35,376	37,473	(2,097)	(5.6%)
366,361	299,970	66,391	22.1%	MCE	3,838,747	3,424,345	414,402	12.1%
11,769	11,889	(120)	(1.0%)	WCM	129,797	129,837	(40)	(0.0%)
972,236	**882,583**	**89,653**	**10.2%**	**Medi-Cal Total**	**10,320,122**	**9,825,493**	**494,629**	**5.0%**
0	**0**	**0**	**0.0%**	**OneCare Connect**	**86,185**	**87,887**	**(1,702)**	**(1.9%)**
17,515	**16,806**	**709**	**4.2%**	**OneCare**	**104,560**	**100,527**	**4,033**	**4.0%**
435	**503**	**(68)**	**(13.5%)**	**PACE**	**4,772**	**5,220**	**(448)**	**(8.6%)**
484	**568**	**(84)**	**(14.8%)**	**MSSP**	**5,208**	**6,248**	**(1,040)**	**(16.6%)**
990,186	**899,892**	**90,294**	**10.0%**	**CalOptima Total**	**10,515,639**	**10,019,127**	**496,512**	**5.0%**

*CalOptima Health Total does not include MSSP

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CalOptima Health

Consolidated Revenue & Expenses: May 2023 MTD

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	MSSP	Consolidated
MEMBER MONTHS	594,106	366,361	11,769	972,236		17,515	435	484	990,186
REVENUES									
Capitation Revenue	196,677,404	$ 99,978,366	$ 25,017,050	$ 321,672,820	$ 1,141,696	$ 31,945,488	$ 3,946,242	$ 215,519	$ 358,921,765
Total Operating Revenue	196,677,404	99,978,366	25,017,050	321,672,820	1,141,696	31,945,488	3,946,242	215,519	358,921,765
MEDICAL EXPENSES									
Provider Capitation	46,354,857	53,384,485	10,968,498	110,707,840		12,766,782			123,474,622
Facilities	27,143,274	26,829,418	2,369,559	56,342,251	(565,845)	6,143,080	1,206,124		63,125,610
Professional Claims	27,443,528	18,844,140	923,429	47,211,098	37,804	1,552,956	865,922		49,667,779
Prescription Drugs	(6,144)			(6,144)	(262,905)	8,250,382	453,906		8,435,239
MLTSS	40,568,613	5,065,077	2,076,902	47,710,592	(80,236)	81,048	(77,187)	24,284	47,658,502
Incentive Payments	8,187,961	9,505,652	107,328	17,800,941	163,006	303,237			18,267,184
Medical Management	3,081,509	2,228,454	412,309	5,722,272	(52,150)	1,187,899	1,176,285	184,382	8,218,689
Other Medical Expenses	515,997	344,206	13,114	873,316					873,316
Total Medical Expenses	153,289,594	116,201,432	16,871,140	286,362,166	(760,326)	30,285,385	3,625,050	208,667	319,720,941
Medical Loss Ratio	77.9%	116.2%	67.4%	89.0%	-66.6%	94.8%	91.9%	96.8%	89.1%
GROSS MARGIN	**43,387,811**	**(16,223,066)**	**8,145,910**	**35,310,654**	**1,902,022**	**1,660,104**	**321,192**	**6,853**	**39,200,824**
ADMINISTRATIVE EXPENSES									
Salaries & Benefits				11,063,356	29,141	892,235	162,705	89,403	12,236,839
Professional Fees				494,340	-	20,833	3,210	1,333	519,716
Purchased Services				1,500,881	1,360	171,423	169,444		1,843,108
Printing & Postage				523,807		54,395	(4,240)		573,962
Depreciation & Amortization				364,207			1,095		365,302
Other Expenses				2,218,607	5	23,042	6,509	5,083	2,253,245
Indirect Cost Allocation, Occupancy				(526,780)		884,890	13,932	5,513	377,555
Total Administrative Expenses				**15,638,418**	**30,505**	**2,046,819**	**352,654**	**101,332**	**18,169,728**
Admin Loss Ratio				4.9%	2.7%	6.4%	8.9%	47.0%	5.1%
INCOME (LOSS) FROM OPERATIONS				19,672,237	1,871,517	(386,715)	(31,463)	(94,480)	21,031,096
INVESTMENT INCOME									7,328,445
NET RENTAL INCOME									65,924
TOTAL MCO TAX				(1,530,950)					(1,530,950)
TOTAL GRANT EXPENSE				(871,970)					(871,970)
OTHER INCOME				30					30
CHANGE IN NET ASSETS				**$ 17,269,347**	**$ 1,871,517**	**$ (386,715)**	**$ (31,463)**	**$ (94,480)**	**$ 26,022,575**
BUDGETED CHANGE IN NET ASSETS				(6,952,105)	(42,805)	(1,421,828)	(35,925)	(47,289)	(7,909,117)
VARIANCE TO BUDGET - FAV (UNFAV)				$ 24,221,452	$ 1,914,322	$ 1,035,113	$ 4,462	$ (47,191)	$ 33,931,692

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CalOptima Health

Consolidated Revenue & Expenses: May 2023 YTD

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	MSSP	Consolidated
MEMBER MONTHS	6,351,578	3,838,747	129,797	10,320,122	86,185	104,560	4,772	5,208	10,515,639
REVENUES									
Capitation Revenue	1,819,045,275	$ 1,365,352,694	$ 253,754,375	$ 3,438,152,344	$ 173,886,145	$ 177,218,077	$ 40,248,377	$ 2,228,534	$ 3,831,733,477
Total Operating Revenue	1,819,045,275	1,365,352,694	253,754,375	3,438,152,344	173,886,145	177,218,077	40,248,377	2,228,534	3,831,733,477
MEDICAL EXPENSES									
Provider Capitation	435,251,839	522,648,267	94,379,878	1,052,279,984	72,095,156	69,490,318			1,193,865,458
Facilities	348,598,878	309,631,569	56,064,163	714,294,611	26,421,771	32,161,392	8,984,260		781,862,034
Professional Claims	265,469,239	165,342,103	16,064,250	446,875,592	8,774,178	7,831,824	10,415,579		473,897,173
Prescription Drugs	(3,226,768)	(2,287,072)	5,604	(5,508,236)	37,472,868	49,856,042	4,591,984		86,412,658
MLTSS	425,341,656	49,746,090	20,741,457	495,829,203	9,523,525	402,121	1,319,253	313,129	507,387,231
Incentive Payments	47,158,548	49,344,834	1,128,275	97,631,657	2,508,723	1,028,454	(120,875)		101,047,959
Medical Management	31,759,644	21,729,644	4,673,046	58,162,334	6,766,401	5,816,732	11,122,463	1,730,008	83,597,937
Other Medical Expenses	163,104,899	124,383,921	18,608,731	306,097,551					306,097,551
Total Medical Expenses	1,713,457,934	1,240,539,356	211,665,404	3,165,662,694	163,562,622	166,586,884	36,312,663	2,043,137	3,534,168,001
Medical Loss Ratio	94.2%	90.9%	83.4%	92.1%	94.1%	94.0%	90.2%	91.7%	92.2%
GROSS MARGIN	**105,587,341**	**124,813,338**	**42,088,970**	**272,489,650**	**10,323,522**	**10,631,193**	**3,935,714**	**185,397**	**297,565,476**
ADMINISTRATIVE EXPENSES									
Salaries & Benefits				103,879,351	4,276,522	4,938,740	1,529,372	852,174	115,476,158
Professional Fees				6,566,688	24,884	271,124	7,670	14,667	6,885,033
Purchased Services				11,250,406	595,858	1,075,114	460,938	5	13,382,321
Printing & Postage				3,735,100	261,432	864,504	184,283		5,045,318
Depreciation & Amortization				4,065,494			9,316		4,074,810
Other Expenses				20,837,706	10,503	40,432	114,742	66,864	21,070,247
Indirect Cost Allocation, Occupancy				(5,878,487)	4,929,832	4,803,961	153,248	60,645	4,069,199
Total Administrative Expenses				**144,456,257**	**10,099,030**	**11,993,874**	**2,459,570**	**994,355**	**170,003,086**
Admin Loss Ratio				4.2%	5.8%	6.8%	6.1%	44.6%	4.4%
INCOME (LOSS) FROM OPERATIONS				128,033,393	224,492	(1,362,680)	1,476,144	(808,958)	127,562,390
INVESTMENT INCOME									81,408,532
NET RENTAL INCOME									903,923
TOTAL MCO TAX				(1,513,014)					(1,513,014)
TOTAL GRANT EXPENSE				(24,508,333)					(24,508,333)
OTHER INCOME				135					135
CHANGE IN NET ASSETS				**$ 102,012,181**	**$ 224,492**	**$ (1,362,680)**	**$ 1,476,144**	**$ (808,958)**	**$ 183,853,633**
BUDGETED CHANGE IN NET ASSETS				13,741,234	(3,139,115)	(7,980,215)	90,290	(478,900)	8,732,479
VARIANCE TO BUDGET - FAV (UNFAV)				$ 88,270,947	$ 3,363,607	$ 6,617,535	$ 1,385,854	$ (330,058)	$ 175,121,154

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Balance Sheet: As of May 2023

ASSETS		LIABILITIES & NET POSITION	
Current Assets		**Current Liabilities**	
Operating Cash	$836,391,104	Accounts Payable	$10,212,474
Short-term Investments	1,531,409,341	Medical Claims Liability	1,686,479,305
Capitation Receivable	372,362,800	Accrued Payroll Liabilities	22,126,918
Receivables - Other	97,066,366	Deferred Revenue	19,795,272
Prepaid Expenses	18,949,539	Deferred Lease Obligations	58,447
		Capitation and Withholds	115,085,527
Total Current Assets	**2,856,179,150**	**Total Current Liabilities**	**1,853,757,943**
Capital Assets			
Furniture & Equipment	42,700,977		
Building/Leasehold Improvements	5,296,725		
Construction in Progress	7,066,731		
505 City Parkway West	52,665,722		
500 City Parkway West	22,631,500		
	130,361,655		
Less: Accumulated Depreciation	(62,717,523)	**Other Liabilities**	
Capital Assets, Net	67,644,132	GASB 96 Subscription Liabilities	-
GASB 96 Capital Assets		**Other (than pensions) Post**	
GASB 96 Subscription Assets	-	Employment Benefits Liability	22,654,785
		Net Pension Liabilities	577,854
Less: GASB 96 Accumulated Depreciation	-	Bldg 505 Development Rights	-
GASB 96 Capital Assets, Net	-		
Total Capital Assets	67,644,132		
Other Assets			
Restricted Deposit & Other	300,000	**TOTAL LIABILITIES**	**1,876,990,582**
Homeless Health Reserve	-		
Board-Designated Assets:			
Cash and Cash Equivalents	1,389,481		
Investments	576,964,131	**Deferred Inflows**	
Total Board-Designated Assets	578,353,612	Excess Earnings	686,563
		OPEB 75 Difference in Experience	4,822,000
		Change in Assumptions	1,909,305
Total Other Assets	578,653,612	OPEB Changes in Assumptions	3,389,000
		Diff in Proj vs Act	20,982,636
		Net Position	
TOTAL ASSETS	**3,502,476,894**	TNE	105,904,753
		Funds in Excess of TNE	1,497,417,648
Deferred Outflows		**TOTAL NET POSITION**	1,603,322,401
Contributions	1,931,845		
Difference in Experience	2,353,671		
Excess Earning	-		
Changes in Assumptions	2,325,077		
OPEB 75 Changes in Assumptions	2,486,000		
Pension Contributions	529,000		
TOTAL ASSETS & DEFERRED OUTFLOWS	**3,512,102,487**	**TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION**	**3,512,102,487**

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CalOptima Health

Board Designated Reserve and TNE Analysis: As of May 2023

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	235,571,951				
	Tier 1 - MetLife	233,817,793				
Board-designated Reserve		469,389,744	317,189,625	498,515,786	152,200,120	(29,126,042)
	Tier 2 - Payden & Rygel	54,603,013				
	Tier 2 - MetLife	54,360,855				
TNE Requirement		108,963,868	105,904,753	105,904,753	3,059,115	3,059,115
	Consolidated:	**578,353,612**	**423,094,377**	**604,420,539**	**155,259,235**	**(26,066,927)**
	Current reserve level	*1.91*	*1.40*	*2.00*		

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CalOptima Health

Net Assets Analysis: As of May 2023

Category	Item Description	Amount (millions)	Approved Initiative	Spend to Date	%
	Total Net Position @ 5/31/2023	**$1,603.3**			**100.0%**
Resources Assigned	Board Designated Reserve[1]	**578.4**			**36.1%**
	Capital Assets, net of depreciation	**67.6**			**4.2%**
Resources Allocated[2]	Homeless Health Initiative[3]	$21.0	$59.9	$38.9	1.3%
	Housing and Homelessness Incentive Program[4]	34.5	52.7	18.2	2.2%
	Intergovernmental Transfers (IGT)	58.7	111.7	53.0	3.7%
	Digital Transformation and Workplace Modernization	89.6	100.0	10.4	5.6%
	Mind OC Grant (Orange)	0.0	1.0	1.0	0.0%
	Outreach Strategy for CalFresh, Redetermination support, and other programs	6.9	8.0	1.1	0.4%
	Coalition of Orange County Community Health Centers Grant	40.0	50.0	10.0	2.5%
	Mind OC Grant (Irvine)	0.0	15.0	15.0	0.0%
	OneCare Member Health Rewards and Incentives	1.0	1.0	0.0	0.1%
	General Awareness Campaign	1.0	2.7	1.7	0.1%
	Member Health Needs Assessment	1.0	1.0	0.0	0.1%
	Five-Year Hospital Quality Program Beginning MY 2023	153.5	153.5	0.0	9.6%
	Medi-Cal Annual Wellness Initiative	15.0	15.0	0.0	0.9%
	Skilled Nursing Facility Access Program	10.0	10.0	0.0	0.6%
	In-Home Care Pilot Program with the UCI Family Health Center	2.0	2.0	0.0	0.1%
	National Alliance for Mental Illness Orange County Peer Support Program	4.5	5.0	0.5	0.3%
	Community Living and PACE Center in the City of Tustin	17.9	18.0	0.1	1.1%
	Stipend Program for Master of Social Works	5.0	5.0	0.0	0.3%
	Subtotal:	**$461.5**	**$611.5**	**$150.0**	**28.8%**
Resources Available for New Initiative	Unallocated/Unassigned[1]	**$495.8**			**30.9%**

[1] Total of Board Designated reserve and unallocated reserve amount can support approximately 105 days of CalOptima Health's current operations

[2] Initiatives that have been paid in full in the previous year are omitted from the list of Resource Allocated

[3] See Page 30 for Summary of Homeless Health Initiative and Allocated Funds for list of Board approved initiatives

[4] On September 1, 2022, CalOptima Health's Board of Directors approved reallocation of $40.1M from HHI to HHIP (see HHIP Summary on Page 31)

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CalOptima Health

Homeless Health Initiative and Allocated Funds: As of May 2023

Funds Allocation, approved initiatives:	Allocated Amount	Ultilized Amount	Remaining Approved Amount
Enhanced Medi-Cal Services at the Be Well OC Regional Mental Health and Wellness Campus	11,400,000	11,400,000	-
Recuperative Care	6,194,190	6,194,190	-
Medical Respite	250,000	250,000	-
Day Habilitation (County for HomeKey)	2,500,000	2,500,000	-
Clinical Field Team Start-up & Federal Qualified Health Center (FQHC)	1,600,000	1,600,000	-
CalOptima Homeless Response Team	1,681,734	1,681,734	-
Homeless Coordination at Hospitals	10,000,000	9,956,478	43,522
CalOptima Days, HCAP and FQHC Administrative Support	963,261	651,919	311,342
FQHC (Community Health Center) Expansion	21,902	21,902	-
Homeless Clinical Access Program (HCAP) and CalOptima Days	9,888,914	3,170,400	6,718,514
Vaccination Intervention and Member Incentive Strategy	400,000	54,649	345,351
Street Medicine	8,000,000	1,455,500	6,544,500
Outreach and Engagement	7,000,000	-	7,000,000
Housing and Homelessness Incentive Program (HHIP)[1]	40,100,000	-	40,100,000
Subtotal of Approved Initiatives	**$ 100,000,000**	**$ 38,936,771**	**$ 61,063,229**
Transfer of funds to HHIP[1]	(40,100,000)	-	(40,100,000)
Program Total	**$ 59,900,000**	**$ 38,936,771**	**$ 20,963,229**

Notes:

[1]On September 1, 2022, CalOptima Health's Board of Directors approved reallocation of $40.1M from HHI to HHIP.

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Housing and Homelessness Incentive Program
As of May 2023

Funds Allocation, approved initiatives:	Allocated Amount	Ultilized Amount	Remaining Approved Amount
Office of Care Coordination	2,200,000	-	2,200,000
Pulse For Good	800,000	15,000	785,000
Consultant	600,000	-	600,000
Equity Grants for Programs Serving Underrepresented Populations	3,021,311	1,461,149	1,560,162
Infrastructure Projects	5,832,314	2,785,365	3,046,949
Capital Projects	40,212,839	13,948,340	26,264,499
Total of Approved Initiatives	**$ 52,666,464** [1]	**$ 18,209,854**	**$ 34,456,610**

Notes:

[1]Total funding $52.7M: $40.1M Board approved Transfer from CalOptima Homeless Health Initiatives and $12.6M from DHCS Incentive payment

On the June 1, 2023 Board of Director's Meeting, the Board allocated an additional $44.58M to HHIP

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UNAUDITED FINANCIAL STATEMENTS

May 31, 2023

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CalOptima Health - Consolidated
Financial Highlights
For the Eleven Months Ended May 31, 2023

May 2023					July 2022 - May 2023			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
990,186	899,892	90,294	10.0%	Member Months	10,515,639	10,019,127	496,512	5.0%
358,921,765	325,877,954	33,043,811	10.1%	Revenues	3,831,733,477	3,655,210,540	176,522,937	4.8%
319,720,941	312,456,800	(7,264,141)	(2.3%)	Medical Expenses	3,534,168,001	3,434,294,329	(99,873,672)	(2.9%)
18,169,728	19,843,184	1,673,456	8.4%	Administrative Expenses	170,003,086	200,760,841	30,757,755	15.3%
21,031,096	**(6,422,030)**	**27,453,126**	**427.5%**	**Operating Margin**	**127,562,390**	**20,155,370**	**107,407,020**	**532.9%**
				Non-Operating Income (Loss)				
7,328,445	500,000	6,828,445	1365.7%	Net Investment Income/Expense	81,408,532	5,500,000	75,908,532	1380.2%
65,924	90,835	(24,911)	(27.4%)	Net Rental Income/Expense	903,923	999,185	(95,262)	(9.5%)
(1,530,950)	-	(1,530,950)	(100.0%)	Net MCO Tax	(1,513,014)	-	(1,513,014)	(100.0%)
(871,970)	(2,077,922)	1,205,952	58.0%	Grant Expense	(24,508,333)	(17,922,076)	(6,586,257)	(36.7%)
-	-	-	0.0%	Net QAF/IGT Income/Expense	-	-	-	0.0%
30	-	30	100.0%	Other Income/Expense	135	-	135	100.0%
4,991,479	**(1,487,087)**	**6,478,566**	**435.7%**	**Total Non-Operating Income (Loss)**	**56,291,243**	**(11,422,891)**	**67,714,134**	**592.8%**
26,022,575	**(7,909,117)**	**33,931,692**	**429.0%**	**Change in Net Assets**	**183,853,633**	**8,732,479**	**175,121,154**	**2005.4%**
89.1%	95.9%	(6.8%)		Medical Loss Ratio	92.2%	94.0%	(1.7%)	
5.1%	6.1%	1.0%		Administrative Loss Ratio	4.4%	5.5%	1.1%	
5.9%	(2.0%)	7.8%		Operating Margin Ratio	3.3%	0.6%	2.8%	
100.0%	100.0%			Total Operating	100.0%	100.0%		
89.1%	95.9%	(6.8%)		*MLR (excluding Directed Payments)	91.6%	94.0%	(2.3%)	
5.1%	6.1%	1.0%		*ALR (excluding Directed Payments)	4.8%	5.5%	0.7%	

*CalOptima Health updated the category of Directed Payments per Department of Health Care Services instructions

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CalOptima Health
Financial Dashboard
For the Eleven Months Ended May 31, 2023

May

Enrollment	Actual	Budget	Fav / (Unfav)	
Medi-Cal	972,236	882,583	89,653	10.2%
OneCare Connect	-	-	-	0.0%
OneCare	17,515	16,806	709	4.2%
PACE	435	503	(68)	(13.5%)
MSSP	484	568	(84)	(14.8%)
Total*	990,186	899,892	90,294	10.0%

Change in Net Assets (000)	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 17,269	$ (6,952)	24,221	348.4%
OneCare Connect	1,872	(43)	1,915	4453.5%
OneCare	(387)	(1,422)	1,035	72.8%
PACE	(31)	(36)	5	13.9%
MSSP	(94)	(47)	(47)	(100.0%)
Buildings	66	91	(25)	(27.5%)
Investment Income/Expense	7,328	500	6,828	1365.6%
Total	$ 26,023	$ (7,909)	33,932	429.0%

MLR	Actual	Budget	% Point Var
Medi-Cal	89.0%	95.9%	(6.8)
OneCare Connect	(66.6%)	0.0%	(66.6)
OneCare	94.8%	96.4%	(1.6)

Administrative Cost (000)	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 15,638	$ 17,014	$ 1,375	8.1%
OneCare Connect	31	16	(15)	(96.0%)
OneCare	2,047	2,439	392	16.1%
PACE	353	274	(79)	(28.7%)
MSSP	101	101	(0)	(0.0%)
Total	$ 18,170	$ 19,843	$ 1,673	8.4%

Total FTE's Month	Actual	Budget	Fav / (Unfav)
Medi-Cal	1,219	1,323	104
OneCare Connect	5	2	(3)
OneCare	182	222	40
PACE	102	115	13
MSSP	23	23	0
Total	1,529	1,684	155

MM per FTE	Actual	Budget	Fav / (Unfav)
Medi-Cal	798	667	(131)
OneCare Connect	-	-	-
OneCare	96	76	(21)
PACE	4	4	0
MSSP	21	25	3
Total	647	534	(113)

July 2022 - May 2023

Year To Date Enrollment	Actual	Budget	Fav / (Unfav)	
Medi-Cal	10,320,122	9,825,493	494,629	5.0%
OneCare Connect	86,185	87,887	(1,702)	(1.9%)
OneCare	104,560	100,527	4,033	4.0%
PACE	4,772	5,220	(448)	(8.6%)
MSSP	5,208	6,248	(1,040)	(16.6%)
Total*	10,515,639	10,019,127	496,512	5.0%

Change in Net Assets (000)	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 102,012	$ 13,741	88,271	642.4%
OneCare Connect	224	(3,139)	3,363	107.1%
OneCare	(1,363)	(7,980)	6,617	82.9%
PACE	1,476	90	1,386	1540.0%
MSSP	(809)	(479)	(330)	(68.9%)
Buildings	904	999	(95)	(9.5%)
Investment Income/Expense	81,409	5,500	75,909	1380.2%
Total	$ 183,853	$ 8,732	175,121	2005.5%

MLR	Actual	Budget	% Point Var
Medi-Cal	92.1%	93.8%	(1.7)
OneCare Connect	94.1%	95.2%	(1.1)
OneCare	94.0%	96.2%	(2.2)

Administrative Cost (000)	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 144,456	$ 171,555	$ 27,099	15.8%
OneCare Connect	10,099	11,169	1,070	9.6%
OneCare	11,994	14,046	2,052	14.6%
PACE	2,460	2,917	458	15.7%
MSSP	994	1,073	79	7.4%
Total	$ 170,003	$ 200,761	$ 30,758	15.3%

Total FTE's YTD	Actual	Budget	Fav / (Unfav)
Medi-Cal	12,926	14,469	1,543
OneCare Connect	1,031	1,191	159
OneCare	974	1,256	282
PACE	1,063	1,256	192
MSSP	230	253	23
Total	16,225	18,424	2,199

MM per FTE	Actual	Budget	Fav / (Unfav)
Medi-Cal	798	679	(119)
OneCare Connect	84	74	(10)
OneCare	107	80	(27)
PACE	4	4	(0)
MSSP	23	25	2
Total	648	544	(104)

Note:* Total membership does not include MSSP

CalOptima Health - Consolidated
Statement of Revenues and Expenses
For the One Month Ended May 31, 2023

	Actual		Budget		Variance	
	$	PMPM	$	PMPM	$	PMPM
MEMBER MONTHS	990,186		899,892		90,294	
REVENUE						
Medi-Cal	$ 321,672,820	$ 330.86	$ 293,337,775	$ 332.36	$ 28,335,045	$ (2)
OneCare Connect	1,141,696	-	-	-	1,141,696	-
OneCare	31,945,488	1,823.89	28,050,920	1,669.10	3,894,568	154.79
PACE	3,946,242	9,071.82	4,235,742	8,420.96	(289,500)	650.86
MSSP	215,519	445.29	253,517	446.33	(37,998)	(1.04)
Total Operating Revenue	358,921,765	362.48	325,877,954	362.13	33,043,811	0.35
MEDICAL EXPENSES						
Medi-Cal	286,362,166	294.54	281,198,380	318.61	(5,163,786)	24.07
OneCare Connect	(760,326)	-	27,242	-	787,568	-
OneCare	30,285,385	1,729.11	27,034,132	1,608.60	(3,251,253)	(120.51)
PACE	3,625,050	8,333.45	3,997,566	7,947.45	372,516	(386.00)
MSSP	208,667	431.13	199,480	351.20	(9,187)	(79.93)
Total Medical Expenses	319,720,941	322.89	312,456,800	347.22	(7,264,141)	24.33
GROSS MARGIN	39,200,824	39.59	13,421,154	14.91	25,779,670	24.68
ADMINISTRATIVE EXPENSES						
Salaries and Benefits	12,236,839	12.36	12,021,006	13.36	(215,833)	1.00
Professional Fees	519,716	0.52	1,057,569	1.18	537,853	0.66
Purchased Services	1,843,108	1.86	2,745,567	3.05	902,459	1.19
Printing & Postage	573,962	0.58	690,676	0.77	116,714	0.19
Depreciation & Amortization	365,302	0.37	525,900	0.58	160,598	0.21
Other Expenses	2,253,245	2.28	2,409,879	2.68	156,634	0.40
Indirect Cost Allocation, Occupancy	377,555	0.38	392,587	0.44	15,032	0.06
Total Administrative Expenses	18,169,728	18.35	19,843,184	22.05	1,673,456	3.70
INCOME (LOSS) FROM OPERATIONS	21,031,096	21.24	(6,422,030)	(7.14)	27,453,126	28.38
INVESTMENT INCOME						
Interest Income	11,317,314	11.43	500,000	0.56	10,817,314	10.87
Realized Gain/(Loss) on Investments	(934,869)	(0.94)	-	-	(934,869)	(0.94)
Unrealized Gain/(Loss) on Investments	(3,054,001)	(3.08)	-	-	(3,054,001)	(3.08)
Total Investment Income	7,328,445	7.40	500,000	0.56	6,828,445	6.84
NET RENTAL INCOME	65,924	0.07	90,835	0.10	(24,911)	(0.03)
TOTAL MCO TAX	(1,530,950)	(1.55)	-	-	(1,530,950)	(1.55)
TOTAL GRANT EXPENSE	(871,970)	(0.88)	(2,077,922)	(2.31)	1,205,952	1.43
OTHER INCOME	30	-	-	-	30	-
CHANGE IN NET ASSETS	**26,022,575**	**26.28**	**(7,909,117)**	**(8.79)**	**33,931,692**	**35.07**
MEDICAL LOSS RATIO	**89.1%**		**95.9%**		**(6.8%)**	
ADMINISTRATIVE LOSS RATIO	**5.1%**		**6.1%**		**1.0%**	

CalOptima Health- Consolidated
Statement of Revenues and Expenses
For the Eleven Months Ended May 31, 2023

	Actual		Budget		Variance	
	$	PMPM	$	PMPM	$	PMPM
MEMBER MONTHS	10,515,639		10,019,127		496,512	
REVENUE						
Medi-Cal	$ 3,438,152,344	$ 333.15	3,280,594,565	$ 333.89	$ 157,557,779	$ (0.74)
OneCare Connect	173,886,145	2,017.59	167,628,057	1,907.31	6,258,088	110.28
OneCare	177,218,077	1,694.89	160,611,176	1,597.69	16,606,901	97.20
PACE	40,248,377	8,434.28	43,588,055	8,350.20	(3,339,678)	84.08
MSSP	2,228,534	427.91	2,788,687	446.33	(560,153)	(18.42)
Total Operating Revenue	3,831,733,477	364.38	3,655,210,540	364.82	176,522,937	(0.44)
MEDICAL EXPENSES						
Medi-Cal	3,165,662,694	306.75	3,077,376,090	313.20	(88,286,604)	6.45
OneCare Connect	163,562,622	1,897.81	159,598,432	1,815.95	(3,964,190)	(81.86)
OneCare	166,586,884	1,593.22	154,545,114	1,537.35	(12,041,770)	(55.87)
PACE	36,312,663	7,609.53	40,580,413	7,774.03	4,267,750	164.50
MSSP	2,043,137	392.31	2,194,280	351.20	151,143	(41.11)
Total Medical Expenses	3,534,168,001	336.09	3,434,294,329	342.77	(99,873,672)	6.68
GROSS MARGIN	297,565,476	28.29	220,916,211	22.05	76,649,265	6.24
ADMINISTRATIVE EXPENSES						
Salaries and Benefits	115,476,158	10.98	125,010,805	12.48	9,534,647	1.50
Professional Fees	6,885,033	0.65	10,751,382	1.07	3,866,349	0.42
Purchased Services	13,382,321	1.27	20,824,991	2.08	7,442,670	0.81
Printing & Postage	5,045,318	0.48	6,498,903	0.65	1,453,585	0.17
Depreciation & Amortization	4,074,810	0.39	5,784,900	0.58	1,710,090	0.19
Other Expenses	21,070,247	2.00	26,748,267	2.67	5,678,020	0.67
Indirect Cost Allocation, Occupancy	4,069,199	0.39	5,141,593	0.51	1,072,394	0.12
Total Administrative Expenses	170,003,086	16.17	200,760,841	20.04	30,757,755	3.87
INCOME (LOSS) FROM OPERATIONS	127,562,390	12.13	20,155,370	2.01	107,407,020	10.12
INVESTMENT INCOME						
Interest Income	83,522,654	7.94	5,500,000	0.55	78,022,654	7.39
Realized Gain/(Loss) on Investments	(9,217,724)	(0.88)	-	0.00	(9,217,724)	(0.88)
Unrealized Gain/(Loss) on Investments	7,103,603	0.68	-	0.00	7,103,603	0.68
Total Investment Income	81,408,532	7.74	5,500,000	0.55	75,908,532	7.19
NET RENTAL INCOME	903,923	0.09	999,185	0.10	(95,262)	(0.01)
TOTAL MCO TAX	(1,513,014)	(0.14)	-	0.00	(1,513,014)	(0.14)
TOTAL GRANT EXPENSE	(24,508,333)	(2.33)	(17,922,076)	(1.79)	(6,586,257)	(0.54)
OTHER INCOME	135	0.00	-	0.00	135	0.00
CHANGE IN NET ASSETS	**183,853,633**	**17.48**	**8,732,479**	**0.87**	**175,121,154**	**16.61**
MEDICAL LOSS RATIO	**92.2%**		**94.0%**		**(1.7%)**	
ADMINISTRATIVE LOSS RATIO	**4.4%**		**5.5%**		**1.1%**	

CalOptima Health - Consolidated - Month to Date
Statement of Revenues and Expenses by LOB
For the One Month Ended May 31, 2023

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	MSSP	Consolidated
MEMBER MONTHS	594,106	366,361	11,769	972,236		17,515	435	484	990,186
REVENUES									
Capitation Revenue	196,677,404	$ 99,978,366	$ 25,017,050	$ 321,672,820	$ 1,141,696	$ 31,945,488	$ 3,946,242	$ 215,519	$ 358,921,765
Total Operating Revenue	196,677,404	99,978,366	25,017,050	321,672,820	1,141,696	31,945,488	3,946,242	215,519	358,921,765
MEDICAL EXPENSES									
Provider Capitation	46,354,857	53,384,485	10,968,498	110,707,840		12,766,782			123,474,622
Facilities	27,143,274	26,829,418	2,369,559	56,342,251	(565,845)	6,143,080	1,206,124		63,125,610
Professional Claims	27,443,528	18,844,140	923,429	47,211,098	37,804	1,552,956	865,922		49,667,779
Prescription Drugs	(6,144)			(6,144)	(262,905)	8,250,382	453,906		8,435,239
MLTSS	40,568,613	5,065,077	2,076,902	47,710,592	(80,236)	81,048	(77,187)	24,284	47,658,502
Incentive Payments	8,187,961	9,505,652	107,328	17,800,941	163,006	303,237			18,267,184
Medical Management	3,081,509	2,228,454	412,309	5,722,272	(52,150)	1,187,899	1,176,285	184,382	8,218,689
Other Medical Expenses	515,997	344,206	13,114	873,316					873,316
Total Medical Expenses	153,289,594	116,201,432	16,871,140	286,362,166	(760,326)	30,285,385	3,625,050	208,667	319,720,941
Medical Loss Ratio	77.9%	116.2%	67.4%	89.0%	-66.6%	94.8%	91.9%	96.8%	89.1%
GROSS MARGIN	**43,387,811**	**(16,223,066)**	**8,145,910**	**35,310,654**	**1,902,022**	**1,660,104**	**321,192**	**6,853**	**39,200,824**
ADMINISTRATIVE EXPENSES									
Salaries & Benefits	11,063,356	29,141	892,235	162,705	89,403	12,236,839			
Professional Fees	494,340	-	20,833	3,210	1,333	519,716			
Purchased Services	1,500,881	1,360	171,423	169,444		1,843,108			
Printing & Postage	523,807		54,395	(4,240)		573,962			
Depreciation & Amortization	364,207			1,095		365,302			
Other Expenses	2,218,607	5	23,042	6,509	5,083	2,253,245			
Indirect Cost Allocation, Occupancy	(526,780)		884,890	13,932	5,513	377,555			
Total Administrative Expenses	**15,638,418**	**30,505**	**2,046,819**	**352,654**	**101,332**	**18,169,728**			
Admin Loss Ratio	4.9%	2.7%	6.4%	8.9%	47.0%	5.1%			
INCOME (LOSS) FROM OPERATIONS	19,672,237	1,871,517	(386,715)	(31,463)	(94,480)	21,031,096			
INVESTMENT INCOME						7,328,445			
NET RENTAL INCOME						65,924			
TOTAL MCO TAX	(1,530,950)					(1,530,950)			
TOTAL GRANT EXPENSE	(871,970)					(871,970)			
OTHER INCOME	30					30			
CHANGE IN NET ASSETS	**$ 17,269,347**	**$ 1,871,517**	**$ (386,715)**	**$ (31,463)**	**$ (94,480)**	**$ 26,022,575**			
BUDGETED CHANGE IN NET ASSETS	(6,952,105)	(42,805)	(1,421,828)	(35,925)	(47,289)	(7,909,117)			
VARIANCE TO BUDGET - FAV (UNFAV)	$ 24,221,452	$ 1,914,322	$ 1,035,113	$ 4,462	$ (47,191)	$ 33,931,692			

Note:* Total membership does not include MSSP

CalOptima Health - Consolidated - Year to Date
Statement of Revenues and Expenses by LOB
For the Eleven Months Ended May 31, 2023

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	MSSP	Consolidated
MEMBER MONTHS	6,351,578	3,838,747	129,797	10,320,122	86,185	104,560	4,772	5,208	10,515,639
REVENUES									
Capitation Revenue	1,819,045,275	$ 1,365,352,694	$ 253,754,375	$ 3,438,152,344	$ 173,886,145	$ 177,218,077	$ 40,248,377	$ 2,228,534	$ 3,831,733,477
Total Operating Revenue	1,819,045,275	1,365,352,694	253,754,375	3,438,152,344	173,886,145	177,218,077	40,248,377	2,228,534	3,831,733,477
MEDICAL EXPENSES									
Provider Capitation	435,251,839	522,648,267	94,379,878	1,052,279,984	72,095,156	69,490,318			1,193,865,458
Facilities	348,598,878	309,631,569	56,064,163	714,294,611	26,421,771	32,161,392	8,984,260		781,862,034
Professional Claims	265,469,239	165,342,103	16,064,250	446,875,592	8,774,178	7,831,824	10,415,579		473,897,173
Prescription Drugs	(3,226,768)	(2,287,072)	5,604	(5,508,236)	37,472,868	49,856,042	4,591,984		86,412,658
MLTSS	425,341,656	49,746,090	20,741,457	495,829,203	9,523,525	402,121	1,319,253	313,129	507,387,231
Incentive Payments	47,158,548	49,344,834	1,128,275	97,631,657	2,508,723	1,028,454	(120,875)		101,047,959
Medical Management	31,759,644	21,729,644	4,673,046	58,162,334	6,766,401	5,816,732	11,122,463	1,730,008	83,597,937
Other Medical Expenses	163,104,899	124,383,921	18,608,731	306,097,551					306,097,551
Total Medical Expenses	1,713,457,934	1,240,539,356	211,665,404	3,165,662,694	163,562,622	166,586,884	36,312,663	2,043,137	3,534,168,001
Medical Loss Ratio	94.2%	90.9%	83.4%	92.1%	94.1%	94.0%	90.2%	91.7%	92.2%
GROSS MARGIN	**105,587,341**	**124,813,338**	**42,088,970**	**272,489,650**	**10,323,522**	**10,631,193**	**3,935,714**	**185,397**	**297,565,476**
ADMINISTRATIVE EXPENSES									
Salaries & Benefits	103,879,351	4,276,522	4,938,740	1,529,372	852,174				115,476,158
Professional Fees	6,566,688	24,884	271,124	7,670	14,667				6,885,033
Purchased Services	11,250,406	595,858	1,075,114	460,938	5				13,382,321
Printing & Postage	3,735,100	261,432	864,504	184,283					5,045,318
Depreciation & Amortization	4,065,494			9,316					4,074,810
Other Expenses	20,837,706	10,503	40,432	114,742	66,864				21,070,247
Indirect Cost Allocation, Occupancy	(5,878,487)	4,929,832	4,803,961	153,248	60,645				4,069,199
Total Administrative Expenses	**144,456,257**	**10,099,030**	**11,993,874**	**2,459,570**	**994,355**				**170,003,086**
Admin Loss Ratio	4.2%	5.8%	6.8%	6.1%	44.6%				4.4%
INCOME (LOSS) FROM OPERATIONS	128,033,393	224,492	(1,362,680)	1,476,144	(808,958)				127,562,390
INVESTMENT INCOME									81,408,532
NET RENTAL INCOME									903,923
TOTAL MCO TAX	(1,513,014)								(1,513,014)
TOTAL GRANT EXPENSE	(24,508,333)								(24,508,333)
OTHER INCOME	135								135
CHANGE IN NET ASSETS	**$ 102,012,181**	**$ 224,492**	**$ (1,362,680)**	**$ 1,476,144**	**$ (808,958)**				**$ 183,853,633**
BUDGETED CHANGE IN NET ASSETS	13,741,234	(3,139,115)	(7,980,215)	90,290	(478,900)				8,732,479
VARIANCE TO BUDGET - FAV (UNFAV)	$ 88,270,947	$ 3,363,607	$ 6,617,535	$ 1,385,854	$ (330,058)				$ 175,121,154

Note:* Total membership does not include MSSP

CalOptima Health

May 31, 2023 Unaudited Financial Statements

MONTHLY RESULTS:

- Change in Net Assets is $26.0 million, $33.9 million favorable to budget
- Operating surplus is $21.0 million, with a surplus in non-operating income of $5.0 million

YEAR TO DATE RESULTS:

- Change in Net Assets is $183.9 million, $175.1 million favorable to budget
- Operating surplus is $127.6 million, with a surplus in non-operating income of $56.3 million

Change in Net Assets by Line of Business (LOB) ($ millions):

May 2023				July 2022 - May 2023		
Actual	Budget	Variance	Operating Income (Loss)	Actual	Budget	Variance
19.7	(4.9)	24.5	Medi-Cal	128.0	31.7	96.4
1.9	(0.0)	1.9	OCC	0.2	(3.1)	3.4
(0.4)	(1.4)	1.0	OneCare	(1.4)	(8.0)	6.6
(0.0)	(0.0)	0.0	PACE	1.5	0.1	1.4
(0.1)	(0.0)	(0.0)	MSSP	(0.8)	(0.5)	(0.3)
21.0	**(6.4)**	**27.5**	**Total Operating Income (Loss)**	**127.6**	**20.2**	**107.4**
			Non-Operating Income (Loss)			
7.3	0.5	6.8	Net Investment Income/Expense	81.4	5.5	75.9
0.1	0.1	(0.0)	Net Rental Income/Expense	0.9	1.0	(0.1)
(1.5)	0.0	(1.5)	Net Operating Tax	(1.5)	0.0	(1.5)
(0.9)	(2.1)	1.2	Grant Expense	(24.5)	(17.9)	(6.6)
0.0	0.0	0.0	Other Income	0.0	0.0	0.0
5.0	**(1.5)**	**6.5**	**Total Non-Operating Income/(Loss)**	**56.3**	**(11.4)**	**67.7**
26.0	**(7.9)**	**33.9**	**TOTAL**	**183.9**	**8.7**	**175.1**

CalOptima Health - Consolidated
Enrollment Summary
For the Eleven Months Ended May 31, 2023

May 2022					July 2022 - May 2023			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	% Variance
142,090	139,080	3,010	2.2%	SPD	1,455,510	1,428,766	26,744	1.9%
305,877	302,070	3,807	1.3%	TANF Child	3,348,728	3,353,217	(4,489)	(0.1%)
142,947	126,063	16,884	13.4%	TANF Adult	1,511,964	1,451,855	60,109	4.1%
3,192	3,511	(319)	(9.1%)	LTC	35,376	37,473	(2,097)	(5.6%)
366,361	299,970	66,391	22.1%	MCE	3,838,747	3,424,345	414,402	12.1%
11,769	11,889	(120)	(1.0%)	WCM	129,797	129,837	(40)	(0.0%)
972,236	**882,583**	**89,653**	**10.2%**	**Medi-Cal Total**	**10,320,122**	**9,825,493**	**494,629**	**5.0%**
0	**0**	**0**	**0.0%**	**OneCare Connect**	**86,185**	**87,887**	**(1,702)**	**(1.9%)**
17,515	**16,806**	**709**	**4.2%**	**OneCare**	**104,560**	**100,527**	**4,033**	**4.0%**
435	**503**	**(68)**	**(13.5%)**	**PACE**	**4,772**	**5,220**	**(448)**	**(8.6%)**
484	**568**	**(84)**	**(14.8%)**	**MSSP**	**5,208**	**6,248**	**(1,040)**	**(16.6%)**
990,186	**899,892**	**90,294**	**10.0%**	**CalOptima Total**	**10,515,639**	**10,019,127**	**496,512**	**5.0%**
				Enrollment (by Network)				
271,473	202,684	68,789	33.9%	HMO	2,714,677	2,289,952	424,725	18.5%
193,647	233,505	(39,858)	(17.1%)	PHC	2,296,087	2,608,832	(312,745)	(12.0%)
237,012	214,263	22,749	10.6%	Shared Risk Group	2,531,659	2,412,869	118,790	4.9%
270,104	232,131	37,973	16.4%	Fee for Service	2,777,699	2,513,840	263,859	10.5%
972,236	**882,583**	**89,653**	**10.2%**	**Medi-Cal Total**	**10,320,122**	**9,825,493**	**494,629**	**5.0%**
0	**0**	**0**	**0.0%**	**OneCare Connect**	**86,185**	**87,887**	**(1,702)**	**(1.9%)**
17,515	**16,806**	**709**	**4.2%**	**OneCare**	**104,560**	**100,527**	**4,033**	**4.0%**
435	**503**	**(68)**	**(13.5%)**	**PACE**	**4,772**	**5,220**	**(448)**	**(8.6%)**
484	**568**	**(84)**	**(14.8%)**	**MSSP**	**5,208**	**6,248**	**(1,040)**	**(16.6%)**
990,186	**899,892**	**90,294**	**10.0%**	**CalOptima Total**	**10,515,639**	**10,019,127**	**496,512**	**5.0%**

Note:* Total membership does not include MSSP

CalOptima Health
Enrollment Trend by Network
Fiscal Year 2023

	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	YTD Actual	YTD Budget	Variance
HMOs															
SPD	11,237	11,250	11,290	11,288	14,002	14,044	14,044	14,090	14,108	14,091	14,118		143,562	120,976	22,586
TANF Child	58,966	58,892	58,837	58,847	69,892	69,736	69,972	70,036	70,162	70,142	70,154		725,636	648,224	77,412
TANF Adult	38,926	38,983	39,331	39,640	48,530	48,844	49,255	49,567	49,999	50,561	50,926		504,562	450,002	54,560
LTC	1	2	2	1				1		3	1		11		11
MCE	99,022	99,788	100,301	101,292	127,939	128,438	129,823	131,179	131,973	133,319	134,134		1,317,208	1,047,388	269,820
WCM	2,034	2,020	2,021	2,050	2,272	2,268	2,242	2,285	2,234	2,132	2,140		23,698	23,362	336
Total	**210,186**	**210,935**	**211,782**	**213,118**	**262,635**	**263,330**	**265,336**	**267,158**	**268,476**	**270,248**	**271,473**		**2,714,677**	**2,289,952**	**424,725**
PHCs															
SPD	7,040	7,022	7,037	7,029	4,408	4,387	4,435	4,356	4,476	4,436	4,450		59,076	76,948	(17,872)
TANF Child	158,385	158,345	158,767	159,067	148,298	148,419	148,820	149,257	149,182	149,847	149,599		1,677,986	1,748,623	(70,637)
TANF Adult	16,704	16,780	16,830	16,855	8,478	8,499	8,550	8,590	8,640	8,718	8,830		127,474	188,596	(61,122)
LTC		1	1	3		2							7		7
MCE	47,505	47,574	47,748	48,051	22,411	22,545	22,920	23,161	23,297	23,504	23,665		352,381	514,648	(162,267)
WCM	7,366	7,472	7,340	7,301	7,096	7,142	7,175	7,108	7,043	7,017	7,103		79,163	80,017	(854)
Total	**237,000**	**237,194**	**237,723**	**238,306**	**190,691**	**190,994**	**191,900**	**192,472**	**192,638**	**193,522**	**193,647**		**2,296,087**	**2,608,832**	**(312,745)**
Shared Risk Groups															
SPD	10,824	10,928	10,995	10,954	11,023	11,046	11,181	11,053	11,123	11,105	11,075		121,307	112,123	9,184
TANF Child	57,419	57,075	56,762	56,460	56,201	55,828	55,913	55,869	55,922	55,824	55,613		618,886	659,017	(40,131)
TANF Adult	40,518	40,260	40,370	40,566	40,961	41,218	41,636	42,055	42,377	43,108	43,416		456,485	439,474	17,011
LTC	2	1	3	6	2				1	1	1		17		17
MCE	114,819	115,585	116,539	117,839	118,935	119,808	121,272	122,217	123,296	124,524	125,603		1,320,437	1,186,920	133,517
WCM	1,360	1,341	1,332	1,369	1,325	1,303	1,294	1,317	1,310	1,272	1,304		14,527	15,335	(808)
Total	**224,942**	**225,190**	**226,001**	**227,194**	**228,447**	**229,203**	**231,296**	**232,511**	**234,029**	**235,834**	**237,012**		**2,531,659**	**2,412,869**	**118,790**
Fee for Service (Dual)															
SPD	82,253	82,742	82,935	83,572	84,174	83,819	98,278	98,465	98,630	98,988	99,157		993,013	993,361	(348)
TANF Child	1	1	1	1	1	1	1	1	1	1	1		11		11
TANF Adult	1,675	1,712	1,743	1,742	1,767	1,776	2,271	2,318	2,310	2,360	2,366		22,040	22,035	5
LTC	2,894	2,874	2,845	2,879	2,929	2,915	2,943	2,745	2,683	2,870	2,845		31,422	33,782	(2,360)
MCE	6,480	6,749	7,030	7,314	7,498	7,795	8,014	8,269	8,589	8,853	9,217		85,808	58,785	27,023
WCM	20	18	24	17	16	18	14	16	16	16	22		197	168	29
Total	**93,323**	**94,096**	**94,578**	**95,525**	**96,385**	**96,324**	**111,521**	**111,814**	**112,229**	**113,088**	**113,608**		**1,132,491**	**1,108,131**	**24,360**
Fee for Service (Non-Dual - Total)															
SPD	11,984	12,003	16,296	8,528	12,224	12,480	15,537	10,292	13,086	12,832	13,290		138,552	125,358	13,194
TANF Child	28,613	28,702	29,350	29,540	30,022	28,970	30,017	30,313	29,679	30,493	30,510		326,209	297,353	28,856
TANF Adult	32,830	33,442	37,388	38,818	35,106	35,368	37,021	39,824	36,971	37,226	37,409		401,403	351,748	49,655
LTC	360	364	366	345	344	346	367	366	357	359	345		3,919	3,691	228
MCE	63,450	64,657	66,876	67,538	69,063	69,002	71,735	72,881	71,606	72,363	73,742		762,913	616,604	146,309
WCM	1,096	1,094	1,049	1,080	1,036	1,069	1,094	1,147	1,166	1,181	1,200		12,212	10,955	1,257
Total	**138,333**	**140,262**	**151,325**	**145,849**	**147,795**	**147,235**	**155,771**	**154,823**	**152,865**	**154,454**	**156,496**		**1,645,208**	**1,405,709**	**239,499**
Grand Totals															
SPD	123,338	123,945	128,553	121,371	125,831	125,776	143,475	138,256	141,423	141,452	142,090		1,455,510	1,428,766	26,744
TANF Child	303,384	303,015	303,717	303,915	304,414	302,954	304,723	305,476	304,946	306,307	305,877		3,348,728	3,353,217	(4,489)
TANF Adult	130,653	131,177	135,662	137,621	134,842	135,705	138,733	142,354	140,297	141,973	142,947		1,511,964	1,451,855	60,109
LTC	3,257	3,242	3,217	3,234	3,275	3,263	3,310	3,112	3,041	3,233	3,192		35,376	37,473	(2,097)
MCE	331,276	334,353	338,494	342,034	345,846	347,588	353,764	357,707	358,761	362,563	366,361		3,838,747	3,424,345	414,402
WCM	11,876	11,945	11,766	11,817	11,745	11,800	11,819	11,873	11,769	11,618	11,769		129,797	129,837	(40)
Total MediCal MM	**903,784**	**907,677**	**921,409**	**919,992**	**925,953**	**927,086**	**955,824**	**958,778**	**960,237**	**967,146**	**972,236**		**10,320,122**	**9,825,493**	**494,629**
OneCare Connect	**14,203**	**14,771**	**14,405**	**14,198**	**14,197**	**14,385**	**26**						**86,185**	**87,887**	**(1,702)**
OneCare	**2,764**	**2,874**	**2,905**	**2,964**	**3,015**	**3,067**	**17,293**	**17,342**	**17,415**	**17,406**	**17,515**		**104,560**	**100,527**	**4,033**
PACE	**435**	**434**	**437**	**430**	**433**	**437**	**428**	**432**	**437**	**434**	**435**		**4,772**	**5,220**	**(448)**
MSSP	**466**	**470**	**478**	**478**	**476**	**471**	**467**	**472**	**473**	**473**	**484**		**5,208**	**6,248**	**(1,040)**
Grand Total	**921,186**	**925,756**	**939,156**	**937,584**	**943,598**	**944,975**	**973,571**	**976,552**	**978,089**	**984,986**	**990,186**		**10,515,639**	**10,019,127**	**496,512**

Note:* Total membership does not include MSSP

ENROLLMENT:

Overall, May enrollment was 990,186

- Favorable to budget 90,294 or 10.0%
- Increased 5,200 or 0.5% from Prior Month (PM) (April 2023)
- Increased 78,759 or 8.6% from Prior Year (PY) (May 2022)

Medi-Cal enrollment was 972,236

- Favorable to budget 89,653 or 10.2% driven by Department of Health Care Services (DHCS) pause of Medi-Cal redetermination due to the extension of the Public Health Emergency (PHE), which expired on May 11, 2023
  - Medi-Cal Expansion (MCE) favorable 66,391
  - Temporary Assistance for Needy Families (TANF) favorable 20,691
  - Seniors and Persons with Disabilities (SPD) favorable 3,010
  - Long-Term Care (LTC) unfavorable 319
  - Whole Child Model (WCM) unfavorable 120
- Increased 5,090 from PM

OneCare enrollment was 17,515

- Favorable to budget 709 or 4.2%
- Increased 109 from PM

PACE enrollment was 435

- Unfavorable to budget 68 or 13.5%
- Increased 1 from PM

MSSP enrollment was 484

- Unfavorable to budget 84 or 14.8%
- Increased 11 from PM

OneCare Connect enrollment was 0 due to transition of OneCare Connect (OCC) members to OneCare (OC), effective January 1, 2023

CalOptima Health
Medi-Cal
Statement of Revenues and Expenses
For the Eleven Months Ending May 31, 2023

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
972,236	**882,583**	**89,653**	**10.2%**	**Member Months**	**10,320,122**	**9,825,493**	**494,629**	**5.0%**
				Revenues				
321,672,820	293,337,775	28,335,045	9.7%	Medi-Cal Capitation Revenue	3,438,152,344	3,280,594,565	157,557,779	4.8%
321,672,820	**293,337,775**	**28,335,045**	**9.7%**	**Total Operating Revenue**	**3,438,152,344**	**3,280,594,565**	**157,557,779**	**4.8%**
				Medical Expenses				
110,707,840	102,803,931	(7,903,909)	(7.7%)	Provider Capitation	1,052,279,984	1,156,975,086	104,695,102	9.0%
56,342,251	69,234,835	12,892,584	18.6%	Facilities Claims	714,294,611	746,883,467	32,588,856	4.4%
47,211,098	42,083,020	(5,128,078)	(12.2%)	Professional Claims	446,875,592	448,447,636	1,572,044	0.4%
47,710,592	54,097,512	6,386,920	11.8%	MLTSS	495,829,203	560,358,559	64,529,356	11.5%
(6,144)		6,144	100.0%	Prescription Drugs	(5,508,236)		5,508,236	100.0%
17,800,941	4,581,384	(13,219,557)	(288.5%)	Incentive Payments	97,631,657	51,141,304	(46,490,353)	(90.9%)
5,722,272	6,823,626	1,101,354	16.1%	Medical Management	58,162,334	73,755,247	15,592,913	21.1%
873,316	1,574,072	700,756	44.5%	Other Medical Expenses	306,097,551	39,814,791	(266,282,760)	(668.8%)
286,362,166	**281,198,380**	**(5,163,786)**	**(1.8%)**	**Total Medical Expenses**	**3,165,662,694**	**3,077,376,090**	**(88,286,604)**	**(2.9%)**
35,310,654	**12,139,395**	**23,171,259**	**190.9%**	**Gross Margin**	**272,489,650**	**203,218,475**	**69,271,175**	**34.1%**
				Administrative Expenses				
11,063,356	10,656,819	(406,537)	(3.8%)	Salaries, Wages & Employee Benefits	103,879,351	110,490,060	6,610,709	6.0%
494,340	1,005,239	510,899	50.8%	Professional Fees	6,566,688	10,222,769	3,656,081	35.8%
1,500,881	2,284,413	783,532	34.3%	Purchased Services	11,250,406	17,488,899	6,238,493	35.7%
523,807	487,740	(36,067)	(7.4%)	Printing & Postage	3,735,100	4,718,174	983,074	20.8%
364,207	525,000	160,793	30.6%	Depreciation & Amortization	4,065,494	5,775,000	1,709,506	29.6%
2,218,607	2,380,027	161,420	6.8%	Other Operating Expenses	20,837,706	26,442,523	5,604,817	21.2%
(526,780)	(325,660)	201,120	61.8%	Indirect Cost Allocation, Occupancy	(5,878,487)	(3,582,260)	2,296,227	64.1%
15,638,418	**17,013,578**	**1,375,160**	**8.1%**	**Total Administrative Expenses**	**144,456,257**	**171,555,165**	**27,098,908**	**15.8%**
				Non-Operating Income (Loss)				
(1,530,950)	-	(1,530,950)	(100.0%)	Net Operating Tax	(1,513,014)	-	(1,513,014)	(100.0%)
(871,970)	(2,077,922)	1,205,952	58.0%	Grant Expense	(24,508,333)	(17,922,076)	(6,586,257)	(36.7%)
30		30	100.0%	Other Income	135		135	100.0%
(2,402,890)	**(2,077,922)**	**(324,968)**	**(15.6%)**	**Total Non-Operating Income (Loss)**	**(26,021,212)**	**(17,922,076)**	**(8,099,136)**	**(45.2%)**
17,269,347	**(6,952,105)**	**24,221,452**	**348.4%**	**Change in Net Assets**	**102,012,181**	**13,741,234**	**88,270,947**	**642.4%**
89.0%	***95.9%***	***(6.8%)***		***Medical Loss Ratio***	***92.1%***	***93.8%***	***(1.7%)***	
4.9%	***5.8%***	***0.9%***		***Admin Loss Ratio***	***4.2%***	***5.2%***	***1.0%***	

MEDI-CAL INCOME STATEMENT– MAY MONTH:

REVENUES of $321.7 million are favorable to budget $28.3 million driven by:

- Favorable volume related variance of $29.8 million
- Unfavorable price related variance of $1.5 million
  - $42.2 million due to COVID-19, Proposition 56 and Enhanced Care Management (ECM) ri orri or r r
  - $11.2 million due to prior period recoupment from the DHCS for MCE
  - Offset by:
    - $52.4 million driven primarily by updated Calendar Year (CY) 2022 premium capitation rates from DHCS

MEDICAL EXPENSES of $286.4 million are unfavorable to budget $5.2 million driven by:

- Unfavorable volume related variance of $28.6 million to in r nro nt rin t
- Favorable price related variance of $23.4 million
  - Facilities Claims expense favorable variance of $19.9 million due to low utilization
  - Managed Long-Term Services and Supports (MLTSS) expense favorable variance of $11.9 million due to lower than budgeted utilization
  - Provider Capitation expense favorable variance of $2.5 million
  - Medical Management expense favorable variance of $1.8 million
  - Offset by:
    - Incentive Payments expense unfavorable variance of $12.8 million due primarily to Housing and Homelessness Incentive Program (HHIP) and Shared Risk Pool

ADMINISTRATIVE EXPENSES of $15.6 million are favorable to budget $1.4 million driven by:

- Other Non-Salary expense favorable to budget $1.8 million
- Salaries & Benefit expense unfavorable to budget $0.4 million

CHANGE IN NET ASSETS is $17.3 million, favorable to budget $24.2 million

CalOptima Health
OneCare
Statement of Revenues and Expenses
For the Eleven Months Ending May 31, 2023

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
17,515	**16,806**	**709**	**4.2%**	**Member Months**	**104,560**	**100,527**	**4,033**	**4.0%**
				Revenues				
23,400,093	21,224,912	2,175,181	10.2%	Medicare Part C Revenue	128,715,297	119,883,193	8,832,104	7.4%
8,545,395	6,826,008	1,719,387	25.2%	Medicare Part D Revenue	48,502,780	40,727,983	7,774,797	19.1%
31,945,488	**28,050,920**	**3,894,568**	**13.9%**	**Total Operating Revenue**	**177,218,077**	**160,611,176**	**16,606,901**	**10.3%**
				Medical Expenses				
12,766,782	10,886,729	(1,880,053)	(17.3%)	Provider Capitation	69,490,318	59,583,251	(9,907,067)	(16.6%)
6,143,080	4,782,769	(1,360,311)	(28.4%)	Inpatient	32,161,392	30,816,301	(1,345,091)	(4.4%)
1,552,956	1,150,030	(402,926)	(35.0%)	Ancillary	7,831,824	6,176,155	(1,655,669)	(26.8%)
81,048	70,754	(10,294)	(14.5%)	MLTSS	402,121	356,158	(45,963)	(12.9%)
8,250,382	8,111,212	(139,170)	(1.7%)	Prescription Drugs	49,856,042	46,416,194	(3,439,848)	(7.4%)
303,237	579,680	276,443	47.7%	Incentive Payments	1,028,454	3,467,698	2,439,244	70.3%
1,187,899	1,452,958	265,059	18.2%	Medical Management	5,816,732	7,729,357	1,912,625	
30,285,385	**27,034,132**	**(3,251,253)**	**(12.0%)**	**Total Medical Expenses**	**166,586,884**	**154,545,114**	**(12,041,770)**	**(7.8%)**
1,660,104	**1,016,788**	**643,316**	**63.3%**	**Gross Margin**	**10,631,193**	**6,066,062**	**4,565,131**	**75.3%**
				Administrative Expenses				
892,235	1,078,941	186,706	17.3%	Salaries, Wages & Employee Benefits	4,938,740	6,076,324	1,137,584	18.7%
20,833	40,583	19,750	48.7%	Professional Fees	271,124	344,413	73,289	21.3%
171,423	392,542	221,119	56.3%	Purchased Services	1,075,114	2,093,118	1,018,004	48.6%
54,395	202,268	147,873	73.1%	Printing & Postage	864,504	1,247,192	382,688	30.7%
23,042	25,992	2,950	11.3%	Other Operating Expenses	40,432	108,460	68,028	62.7%
884,890	698,290	(186,600)	(26.7%)	Indirect Cost Allocation, Occupancy	4,803,961	4,176,770	(627,191)	(15.0%)
2,046,819	**2,438,616**	**391,797**	**16.1%**	**Total Administrative Expenses**	**11,993,874**	**14,046,277**	**2,052,403**	**14.6%**
(386,715)	**(1,421,828)**	**1,035,113**	**72.8%**	**Change in Net Assets**	**(1,362,680)**	**(7,980,215)**	**6,617,535**	**82.9%**
94.8%	***96.4%***	***(1.6%)***		***Medical Loss Ratio***	***94.0%***	***96.2%***	***(2.2%)***	
6.4%	***8.7%***	***2.3%***		***Admin Loss Ratio***	***6.8%***	***8.7%***	***2.0%***	

ONECARE INCOME STATEMENT– MAY MONTH:

REVENUES of $31.9 million are favorable to budget $3.9 million driven by:

- Favorable volume related variance of $1.2 million
- Favorable price related variance of $2.7 million

MEDICAL EXPENSES of $30.3 million are unfavorable to budget $3.3 million driven by:

- Unfavorable volume related variance of $1.1 million
- Unfavorable price related variance of $2.1 million
  - Provider Capitation expense unfavorable variance of $1.4 million
  - Facilities Inpatient expense unfavorable variance of $1.3 million
  - Ancillary expense unfavorable variance of $0.4 million
  - Offset by:
    - All other expenses net favorable variance of $0.8 million

ADMINISTRATIVE EXPENSES of $2.0 million are favorable to budget $0.45 million driven by:

- Other Non-Salary expense favorable to budget $0.2 million
- Salaries & Benefit expense favorable to budget $0.2 million

CHANGE IN NET ASSETS is ($0.4) million, favorable to budget $1.0 million

CalOptima Health
OneCare Connect - Total
Statement of Revenue and Expenses
For the Eleven Months Ending May 31, 2023

Month					Year to Date				
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
-	-	-	0.0%	**Member Months**	**86,185**	**87,887**	**(1,702)**	**(1.9%)**
				Revenues				
1,376,348	-	1,376,348	100.0%	Medi-Cal Revenue	17,527,477	16,971,109	556,368	3.3%
-	-	-	0.0%	Medicare Part C Revenue	121,331,695	117,560,580	3,771,115	3.2%
(234,652)	-	(234,652)	(100.0%)	Medicare Part D Revenue	35,026,972	33,096,368	1,930,604	5.8%
1,141,696	**-**	**1,141,696**	**100.0%**	**Total Operating Revenue**	**173,886,145**	**167,628,057**	**6,258,088**	**3.7%**
				Medical Expenses				
		-	0.0%	Provider Capitation	72,095,156	69,401,413	(2,693,743)	(3.9%)
(565,845)		565,845	100.0%	Facilities Claims	26,421,771	24,684,406	(1,737,365)	(7.0%)
37,804		(37,804)	(100.0%)	Ancillary	8,774,178	7,214,705	(1,559,473)	(21.6%)
(80,236)		80,236	100.0%	MLTSS	9,523,525	8,924,314	(599,211)	(6.7%)
(262,905)		262,905	100.0%	Prescription Drugs	37,472,868	38,194,494	721,626	1.9%
163,006		(163,006)	(100.0%)	Incentive Payments	2,508,723	3,304,554	795,831	24.1%
(52,150)	27,242	79,392	291.4%	Medical Management	6,766,401	7,874,546	1,108,145	14.1%
(760,326)	**27,242**	**787,568**	**2891.0%**	**Total Medical Expenses**	**163,562,622**	**159,598,432**	**(3,964,190)**	**(2.5%)**
1,902,022	**(27,242)**	**1,929,264**	**7081.9%**	**Gross Margin**	**10,323,522**	**8,029,625**	**2,293,897**	**28.6%**
				Administrative Expenses				
29,141	15,563	(13,578)	(87.2%)	Salaries, Wages & Employee Benefits	4,276,522	5,611,355	1,334,833	23.8%
-		-	0.0%	Professional Fees	24,884	124,998	100,114	80.1%
1,360	9,666	8,306	85.9%	Purchased Services	595,858	731,965	136,107	18.6%
	(9,666)	(9,666)	100.0%	Printing & Postage	261,432	330,761	69,329	21.0%
5		(5)	(100.0%)	Other Operating Expenses	10,503	36,561	26,058	71.3%
		-	0.0%	Indirect Cost Allocation, Occupancy	4,929,832	4,333,100	(596,732)	(13.8%)
30,505	**15,563**	**(14,942)**	**(96.0%)**	**Total Administrative Expenses**	**10,099,030**	**11,168,740**	**1,069,710**	**9.6%**
1,871,517	**(42,805)**	**1,914,322**	**4472.2%**	**Change in Net Assets**	**224,492**	**(3,139,115)**	**3,363,607**	**107.2%**
(66.6%)	***0.0%***	***(66.6%)***		***Medical Loss Ratio***	***94.1%***	***95.2%***	***(1.1%)***	
2.7%	***0.0%***	***(2.7%)***		***Admin Loss Ratio***	***5.8%***	***6.7%***	***0.9%***	

CalOptima Health
PACE
Statement of Revenues and Expenses
For the Eleven Months Ending May 31, 2023

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
435	**503**	**(68)**	**(13.5%)**	**Member Months**	**4,772**	**5,220**	**(448)**	**(8.6%)**
				Revenues				
2,905,005	3,238,988	(333,983)	(10.3%)	Medi-Cal Capitation Revenue	30,869,916	33,356,786	(2,486,870)	(7.5%)
783,358	782,449	909	0.1%	Medicare Part C Revenue	7,018,205	8,008,865	(990,660)	(12.4%)
257,880	214,305	43,575	20.3%	Medicare Part D Revenue	2,360,256	2,222,404	137,852	6.2%
3,946,242	**4,235,742**	**(289,500)**	**(6.8%)**	**Total Operating Revenue**	**40,248,377**	**43,588,055**	**(3,339,678)**	**(7.7%)**
				Medical Expenses				
1,176,285	1,178,825	2,540	0.2%	Medical Management	11,122,463	12,400,279	1,277,816	10.3%
1,206,124	1,034,917	(171,207)	(16.5%)	Facilities Claims	8,984,260	10,357,000	1,372,740	13.3%
640,957	1,041,317	400,360	38.4%	Professional Claims	8,282,620	10,414,983	2,132,364	20.5%
453,906	449,138	(4,768)	(1.1%)	Prescription Drugs	4,591,984	4,451,355	(140,629)	(3.2%)
(77,187)	78,546	155,733	198.3%	MLTSS	1,319,253	770,679	(548,574)	(71.2%)
224,965	208,419	(16,546)	(7.9%)	Patient Transportation	2,132,959	2,120,842	(12,117)	(0.6%)
	6,404	6,404	100.0%	Incentive Payments	(120,875)	65,275	186,150	285.2%
3,625,050	**3,997,566**	**372,516**	**9.3%**	**Total Medical Expenses**	**36,312,663**	**40,580,413**	**4,267,750**	**10.5%**
321,192	**238,176**	**83,016**	**34.9%**	**Gross Margin**	**3,935,714**	**3,007,642**	**928,072**	**30.9%**
				Administrative Expenses				
162,705	185,393	22,688	12.2%	Salaries, Wages & Employee Benefits	1,529,372	1,947,123	417,751	21.5%
3,210	10,413	7,203	69.2%	Professional Fees	7,670	44,536	36,866	82.8%
169,444	58,946	(110,498)	(187.5%)	Purchased Services	460,938	511,009	50,071	9.8%
(4,240)	10,334	14,574	141.0%	Printing & Postage	184,283	202,776	18,493	9.1%
1,095	900	(195)	(21.6%)	Depreciation & Amortization	9,316	9,900	584	5.9%
6,509	(5,292)	(11,801)	(223.0%)	Other Operating Expenses	114,742	60,075	(54,667)	(91.0%)
13,932	13,407	(525)	(3.9%)	Indirect Cost Allocation, Occupancy	153,248	141,933	(11,315)	(8.0%)
352,654	**274,101**	**(78,553)**	**(28.7%)**	**Total Administrative Expenses**	**2,459,570**	**2,917,352**	**457,782**	**15.7%**
				Non-Operating Income (Loss)				
(31,463)	**(35,925)**	**4,462**	**12.4%**	**Change in Net Assets**	**1,476,144**	**90,290**	**1,385,854**	**1534.9%**
91.9%	***94.4%***	***(2.5%)***		***Medical Loss Ratio***	***90.2%***	***93.1%***	***(2.9%)***	
8.9%	***6.5%***	***(2.5%)***		***Admin Loss Ratio***	***6.1%***	***6.7%***	***0.6%***	

Back to Agenda

CalOptima Health
Multipurpose Senior Services Program
Statement of Revenues and Expenses
For the Eleven Months Ending May 31, 2023

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
484	**568**	**(84)**	**(14.8%)**	**Member Months**	**5,208**	**6,248**	**(1,040)**	**(16.6%)**
				Revenues				
215,519	253,517	(37,998)	(15.0%)	Revenue	2,228,534	2,788,687	(560,153)	(20.1%)
215,519	**253,517**	**(37,998)**	**(15.0%)**	**Total Operating Revenue**	**2,228,534**	**2,788,687**	**(560,153)**	**(20.1%)**
				Medical Expenses				
184,382	166,522	17,860	10.7%	Medical Management	1,730,008	1,831,742	(101,734)	(5.6%)
24,284	32,958	(8,674)	(26.3%)	Waiver Services	313,129	362,538	(49,409)	(13.6%)
208,667	**199,480**	**(9,187)**	**(4.6%)**	**Total Program Expenses**	**2,043,137**	**2,194,280**	**151,143**	**6.9%**
6,853	**54,037**	**(47,184)**	**(87.3%)**	**Gross Margin**	**185,397**	**594,407**	**(409,010)**	**(68.8%)**
				Administrative Expenses				
89,403	84,290	(5,113)	(6.1%)	Salaries, Wages & Employee Benefits	852,174	885,943	33,769	3.8%
1,333	1,334	1	0.1%	Professional Fees	14,667	14,666	(1)	(0.0%)
5,083	9,152	4,069	44.5%	Other Operating Expenses	66,864	100,648	33,784	33.6%
5,513	6,550	1,037	15.8%	Indirect Cost Allocation, Occupancy	60,645	72,050	11,405	15.8%
101,332	**101,326**	**(6)**	**(0.0%)**	**Total Administrative Expenses**	**994,350**	**1,073,307**	**78,957**	**7.4%**
(94,480)	**(47,289)**	**(47,191)**	**(99.8%)**	**Change in Net Assets**	**(808,953)**	**(478,900)**	**(330,053)**	**(68.9%)**
96.8%	***78.7%***	***18.1%***		***Medical Loss Ratio***	***91.7%***	***78.7%***	***13.0%***	
47.0%	***40.0%***	***(7.0%)***		***Admin Loss Ratio***	***44.6%***	***38.5%***	***(6.1%)***	

CalOptima Health
Building 505 - City Parkway
Statement of Revenues and Expenses
For the Eleven Months Ending May 31, 2023

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
-	-	-	0.0%	Rental Income	-	-	-	0.0%
-	-	-	**0.0%**	**Total Operating Revenue**	-	-	-	**0.0%**
				Administrative Expenses				
43,913	55,650	11,737	21.1%	Purchased Services	467,120	612,150	145,030	23.7%
174,199	224,250	50,051	22.3%	Depreciation & Amortization	1,932,137	2,466,750	534,613	21.7%
15,258	22,500	7,242	32.2%	Insurance Expense	233,392	247,500	14,108	5.7%
148,081	138,755	(9,326)	(6.7%)	Repair & Maintenance	1,392,771	1,526,305	133,534	8.7%
46,037	48,405	2,368	4.9%	Other Operating Expenses	628,537	532,455	(96,082)	(18.0%)
(427,489)	(489,560)	(62,071)	(12.7%)	Indirect Cost Allocation, Occupancy	(4,653,958)	(5,385,160)	(731,202)	(13.6%)
-	-	-	**0.0%**	**Total Administrative Expenses**	-	-	-	**0.0%**
-	-	-	**0.0%**	**Change in Net Assets**	-	-	-	**0.0%**

CalOptima Health
Building 500 - City Parkway
Statement of Revenues and Expenses
For the Eleven Months Ending May 31, 2023

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
183,865	172,500	11,365	6.6%	Rental Income	2,012,008	1,897,500	114,508	6.0%
183,865	**172,500**	**11,365**	**6.6%**	**Total Operating Revenue**	**2,012,008**	**1,897,500**	**114,508**	**6.0%**
				Administrative Expenses				
		-	0.0%	Professional Fees			-	0.0%
16,687	13,333	(3,354)	(25.2%)	Purchased Services	139,414	146,663	7,249	4.9%
34,573		(34,573)	(100.0%)	Depreciation & amortization	380,302		(380,302)	(100.0%)
15,001	2,733	(12,268)	(448.9%)	Insurance Expense	15,001	30,063	15,062	50.1%
38,023	25,666	(12,357)	(48.1%)	Repair & Maintenance	364,613	282,326	(82,287)	(29.1%)
13,658	39,933	26,275	65.8%	Other Operating Expense	208,754	439,263	230,509	52.5%
		-		Indirect Allocation, Occupancy			-	0.0%
117,941	**81,665**	**(36,276)**	**(44.4%)**	**Total Administrative Expenses**	**1,108,085**	**898,315**	**(209,770)**	**(23.4%)**
65,924	**90,835**	**(24,911)**	**(27.4%)**	**Change in Net Assets**	**903,923**	**999,185**	**(95,262)**	**(9.5%)**

OTHER INCOME STATEMENTS – MAY MONTH:

ONECARE CONNECT INCOME STATEMENT

CHANGE IN NET ASSETS is $1.9 million, favorable to budget $1.9 million

PACE INCOME STATEMENT

CHANGE IN NET ASSETS is ($31,463), favorable to budget $4,462

MSSP INCOME STATEMENT

CHANGE IN NET ASSETS is ($94,480), unfavorable to budget $47,191

BUILDING 500 INCOME STATEMENT

CHANGE IN NET ASSETS is $65,924, unfavorable to budget $24,911

- Net of $0.2 million in rental income and $0.1 million in expenses

INVESTMENT INCOME

- Favorable variance of $6.8 million primarily from $10.8 million of interest income offset by $4.0 million realized and unrealized loss on investments

CalOptima Health
Balance Sheet
May 31, 2023

ASSETS		LIABILITIES & NET POSITION	
Current Assets		**Current Liabilities**	
Operating Cash	$836,391,104	Accounts Payable	$10,212,474
Short-term Investments	1,531,409,341	Medical Claims Liability	1,686,479,305
Capitation Receivable	372,362,800	Accrued Payroll Liabilities	22,126,918
Receivables - Other	97,066,366	Deferred Revenue	19,795,272
Prepaid Expenses	18,949,539	Deferred Lease Obligations	58,447
		Capitation and Withholds	115,085,527
Total Current Assets	**2,856,179,150**	**Total Current Liabilities**	**1,853,757,943**
Capital Assets			
Furniture & Equipment	42,700,977		
Building/Leasehold Improvements	5,296,725		
Construction in Progress	7,066,731		
505 City Parkway West	52,665,722		
500 City Parkway West	22,631,500		
	130,361,655		
Less: Accumulated Depreciation	(62,717,523)	**Other Liabilities**	
Capital Assets, Net	67,644,132	GASB 96 Subscription Liabilities	-
GASB 96 Capital Assets		Other (than pensions) Post	
GASB 96 Subscription Assets	-	Employment Benefits Liability	22,654,785
		Net Pension Liabilities	577,854
Less: GASB 96 Accumulated Depreciation	-	Bldg 505 Development Rights	-
GASB 96 Capital Assets, Net	-		
Total Capital Assets	67,644,132		
Other Assets			
Restricted Deposit & Other	300,000	**TOTAL LIABILITIES**	**1,876,990,582**
Homeless Health Reserve	-		
Board-Designated Assets:			
Cash and Cash Equivalents	1,389,481		
Investments	576,964,131	**Deferred Inflows**	
Total Board-Designated Assets	578,353,612	Excess Earnings	686,563
		OPEB 75 Difference in Experience	4,822,000
		Change in Assumptions	1,909,305
Total Other Assets	578,653,612	OPEB Changes in Assumptions	3,389,000
		Diff in Proj vs Act	20,982,636
		Net Position	
TOTAL ASSETS	**3,502,476,894**	TNE	105,904,753
		Funds in Excess of TNE	1,497,417,648
Deferred Outflows		**TOTAL NET POSITION**	1,603,322,401
Contributions	1,931,845		
Difference in Experience	2,353,671		
Excess Earning	-		
Changes in Assumptions	2,325,077		
OPEB 75 Changes in Assumptions	2,486,000		
Pension Contributions	529,000		
TOTAL ASSETS & DEFERRED OUTFLOWS	**3,512,102,487**	**TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION**	**3,512,102,487**

CalOptima Health
Board Designated Reserve and TNE Analysis
as of May 31, 2023

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	235,571,951				
	Tier 1 - MetLife	233,817,793				
Board-designated Reserve		469,389,744	317,189,625	498,515,786	152,200,120	(29,126,042)
	Tier 2 - Payden & Rygel	54,603,013				
	Tier 2 - MetLife	54,360,855				
TNE Requirement		108,963,868	105,904,753	105,904,753	3,059,115	3,059,115
	Consolidated:	**578,353,612**	**423,094,377**	**604,420,539**	**155,259,235**	**(26,066,927)**
	Current reserve level	*1.91*	*1.40*	*2.00*		

CalOptima Health
Statement of Cash Flows
May 31, 2023

	Month Ended	Year-To-Date
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets	26,022,575	183,853,633
Adjustments to reconcile change in net assets to net cash provided by operating activities		
Depreciation & Amortization	574,074	6,387,250
Changes in assets and liabilities:		
Prepaid expenses and other	1,788,853	3,642,715
Catastrophic reserves		
Capitation receivable	(1,212,305)	7,435,420
Medical claims liability	(12,600,379)	408,463,956
Deferred revenue	11,989,381	11,691,228
Payable to health networks	14,289,606	(78,129,102)
Accounts payable	998,256	(42,104,414)
Accrued payroll	2,873,319	3,036,164
Other accrued liabilities	6,143	(33,725)
Net cash provided by/(used in) operating activities	44,729,523	504,243,125
GASB 68 CalPERS Adjustments	-	-
CASH FLOWS FROM CAPITAL AND RELATED FINANCING ACTIVITIES:		
Net Asset transfer from Foundation	-	-
Net cash provided by (used in) in capital and related financing activities	-	-
CASH FLOWS FROM INVESTING ACTIVITIES		
Change in Investments	(27,025,909)	(516,948,838)
Change in Property and Equipment	(1,078,635)	(7,167,346)
Change in Restricted Deposit & Other	-	51
Change in Board designated reserves	1,556,332	(7,861,972)
Change in Homeless Health Reserve	-	40,636,739
Net cash provided by/(used in) investing activities	(26,548,213)	(491,341,366)
NET INCREASE/(DECREASE) IN CASH & CASH EQUIVALENTS	18,181,311	12,901,759
CASH AND CASH EQUIVALENTS, beginning of period	$818,209,793	823,489,344
CASH AND CASH EQUIVALENTS, end of period	**836,391,104**	**836,391,104**

BALANCE SHEET – MAY MONTH:

ASSETS of $3.5 billion increased $43.6 million from April or 1.3%

- Operating Cash and Short-term Investments net increase of $45.2 million due to the timing of the $30.0 million base capitation receipt from the Centers for Medicare & Medicaid Services (CMS) and due to the receipt of a state final rate settlement of $12.5 million for the Student Behavioral Health Incentive Program (SBHIP)

LIABILITIES of $1.9 billion increased $17.6 million from April or 0.9%

- Capitation and Withholds increased $14.3 million primarily due to timing of capitation payments from CMS
- Deferred Revenue increased $12.0 million due to timing of capitation payments from CMS
- Claims Liabilities decreased $12.6 million due to timing of claim payments

NET ASSETS of $1.6 billion, increased $26.0 million from April or 1.6%

CalOptima Health - Consolidated
Net Assets Analysis
For the Eleven Months Ended May 31, 2023

Category	Item Description	Amount (millions)	Approved Initiative	Spend to Date	%
	Total Net Position @ 5/31/2023	**$1,603.3**			**100.0%**
Resources Assigned	Board Designated Reserve[1]	**578.4**			**36.1%**
	Capital Assets, net of depreciation	**67.6**			**4.2%**
Resources Allocated[2]	Homeless Health Initiative[3]	$21.0	$59.9	$38.9	1.3%
	Housing and Homelessness Incentive Program[4]	34.5	52.7	18.2	2.2%
	Intergovernmental Transfers (IGT)	58.7	111.7	53.0	3.7%
	Digital Transformation and Workplace Modernization	89.6	100.0	10.4	5.6%
	Mind OC Grant (Orange)	0.0	1.0	1.0	0.0%
	Outreach Strategy for CalFresh, Redetermination support, and other programs	6.9	8.0	1.1	0.4%
	Coalition of Orange County Community Health Centers Grant	40.0	50.0	10.0	2.5%
	Mind OC Grant (Irvine)	0.0	15.0	15.0	0.0%
	OneCare Member Health Rewards and Incentives	1.0	1.0	0.0	0.1%
	General Awareness Campaign	1.0	2.7	1.7	0.1%
	Member Health Needs Assessment	1.0	1.0	0.0	0.1%
	Five-Year Hospital Quality Program Beginning MY 2023	153.5	153.5	0.0	9.6%
	Medi-Cal Annual Wellness Initiative	15.0	15.0	0.0	0.9%
	Skilled Nursing Facility Access Program	10.0	10.0	0.0	0.6%
	In-Home Care Pilot Program with the UCI Family Health Center	2.0	2.0	0.0	0.1%
	National Alliance for Mental Illness Orange County Peer Support Program	4.5	5.0	0.5	0.3%
	Community Living and PACE Center in the City of Tustin	17.9	18.0	0.1	1.1%
	Stipend Program for Master of Social Works	5.0	5.0	0.0	0.3%
	Subtotal:	**$461.5**	**$611.5**	**$150.0**	**28.8%**
Resources Available for New Initiatives	Unallocated/Unassigned[1]	**$495.8**			**30.9%**

[1] Total of Board Designated reserve and unallocated reserve amount can support approximately 10 days of CalOptima Health's current operations

[2]Initiatives that have been paid in full in the previous year are omitted from the list of Resource Allocated

[3] See Page 30 for Summary of Homeless Health Initiative and Allocated Funds for list of Board approved initiatives

[4] On September 1, 2022, CalOptima Health's Board of Directors approved reallocation of $40.1M from HHI to HHIP (see HHIP Summary on Page 31)

CalOptima Health
Key Financial Indicators
As of May 2023

Income Statement

Item Name	Month-to-Date (May 2023) Actual	Budget	Variance	%		FY 2023 Year-to-Date (May 2023) Actual	Budget	Variance	%	
Member Months	990,186	899,892	90,294	10.0%		10,515,639	10,019,127	496,512	5.0%	
*Operating Revenue **	358,921,765	325,877,954	33,043,811	10.1%		3,831,733,477	3,655,210,540	176,522,937	4.8%	
*Medical Expenses **	319,720,941	312,456,800	(7,264,141)	(2.3%)		3,534,168,001	3,434,294,329	(99,873,672)	(2.9%)	
General and Administrative Expense	18,169,728	19,843,184	1,673,456	8.4%		170,003,086	200,760,841	30,757,755	15.3%	
Non-Operating Income/(Loss)	4,991,479	(1,487,087)	6,478,566	435.7%		56,291,243	(11,422,891)	67,714,134	592.8%	
Summary of Income & Expenses	26,022,575	(7,909,117)	33,931,692	429.0%		183,853,633	8,732,479	175,121,154	2,005.4%	

Ratios

Medical Loss Ratio (MLR)	Actual	Budget	Variance		Actual	Budget	Variance	
Consolidated	89.1%	95.9%	(6.8%)		92.2%	94.0%	(1.7%)	

Administrative Loss Ratio (ALR)	Actual	Budget	Variance		Actual	Budget	Variance	
Consolidated	5.1%	6.1%	1.0%		4.4%	5.5%	1.1%	

Key:

> 0%	
> -20%, < 0%	
< -20%	

Investment

Investment Balance (excluding CCE)	Current Month	Prior Month	Change	%
@5/31/2023	2,096,689,310	2,074,740,140	21,949,170	1.1%

Unallocated/Unassigned Reserve Balance	Current Month @ May 2023	Fiscal Year Ending June 2022	Change	%
Consolidated	495,787,074	448,294,548	47,492,526	10.6%
*Days Cash On Hand***	105			

*$293M of Directed Payments (DP) are included in YTD revenue and $291M of DP are included in YTD expenses.
**Total of Board Designated reserve and unallocated reserve amount can support approximatley 105 days of CalOptima Health's current operations.

CalOptima Health
Digital Transformation Strategy ($100 million total reserve)
Funding Balance Tracking Summary
For the Eleven Months Ending May 31, 2023

	FY 2022-23 Month-to-Date				FY 2022-23 Year-to-Date			
	Actual Spend	**Approved Budget**	**Variance $**	**Variance %**	**Actual Spend**	**Approved Budget**	**Variance $**	**Variance %**
Capital Assets (Cost, Information Only):								
Total Capital Assets	**609,523**	**166,666**	**(442,857)**	**-265.7%**	**5,014,764**	**36,679,332**	**31,664,568**	**86.3%**
Operating Expenses:								
Salaries, Wages & Benefits	625,318	541,962	(83,356)	-15.4%	2,845,305	4,769,294	1,923,989	40.3%
Professional Fees	-	186,041	186,041	100.0%	118,650	2,046,451	1,927,801	94.2%
Purchased Services	-	50,833	50,833	100.0%	-	259,163	259,163	100.0%
Depreciation Expenses	-	-	-	0.0%	-	-	-	0.0%
Other Expenses	744,559	274,365	(470,194)	-171.4%	2,471,051	3,018,015	546,964	18.1%
Total Operating Expenses	**1,369,877**	**1,053,201**	**(316,676)**	**-30.1%**	**5,435,006**	**10,092,923**	**4,657,917**	**46.2%**

Funding Balance Tracking:	**Actual Spend**	**Approved Budget**
Beginning Funding Balance	100,000,000	100,000,000
Less:		
FY2022-23	10,449,770	47,973,113
FY2023-24		
FY2024-25		
Ending Funding Balance	**89,550,230**	**52,026,887**

Summary of Homeless Health Initiatives (HHI) and Allocated Funds
As of May 31, 2023

Funds Allocation, approved initiatives:	Allocated Amount	Ultilized Amount	Remaining Approved Amount
Enhanced Medi-Cal Services at the Be Well OC Regional Mental Health and Wellness Campus	11,400,000	11,400,000	-
Recuperative Care	6,194,190	6,194,190	-
Medical Respite	250,000	250,000	-
Day Habilitation (County for HomeKey)	2,500,000	2,500,000	-
Clinical Field Team Start-up & Federal Qualified Health Center (FQHC)	1,600,000	1,600,000	-
CalOptima Homeless Response Team	1,681,734	1,681,734	-
Homeless Coordination at Hospitals	10,000,000	9,956,478	43,522
CalOptima Days, HCAP and FQHC Administrative Support	963,261	651,919	311,342
FQHC (Community Health Center) Expansion	21,902	21,902	-
Homeless Clinical Access Program (HCAP) and CalOptima Days	9,888,914	3,170,400	6,718,514
Vaccination Intervention and Member Incentive Strategy	400,000	54,649	345,351
Street Medicine	8,000,000	1,455,500	6,544,500
Outreach and Engagement	7,000,000	-	7,000,000
Housing and Homelessness Incentive Program (HHIP)[1]	40,100,000	-	40,100,000
Subtotal of Approved Initiatives	**$ 100,000,000**	**$ 38,936,771**	**$ 61,063,229**
Transfer of funds to HHIP[1]	(40,100,000)	-	(40,100,000)
Program Total	**$ 59,900,000**	**$ 38,936,771**	**$ 20,963,229**

Notes:

[1]On September 1, 2022, CalOptima Health's Board of Directors approved reallocation of $40.1M from HHI to HHIP.

Summary of Housing and Homelessness Incentive Program (HHIP) and Allocated Funds
As of May 31, 2023

Funds Allocation, approved initiatives:	Allocated Amount	Ultilized Amount	Remaining Approved Amount
Office of Care Coordination	2,200,000	-	2,200,000
Pulse For Good	800,000	15,000	785,000
Consultant	600,000	-	600,000
Equity Grants for Programs Serving Underrepresented Populations	3,021,311	1,461,149	1,560,162
Infrastructure Projects	5,832,314	2,785,365	3,046,949
Capital Projects	40,212,839	13,948,340	26,264,499
Total of Approved Initiatives	**$ 52,666,464** [1]	**$ 18,209,854**	**$ 34,456,610**

Notes:

[1]Total funding $52.7M: $40.1M Board approved Transfer from CalOptima Homeless Health Initiatives and $12.6M from DHCS Incentive payment

On the June 1, 2023 Board of Director's Meeting, the Board allocated an additional $44.58M to HHIP

CalOptima Health
Budget Allocation Changes
Reporting Changes for May 2023

Transfer Month	Line of Business	From	To	Amount	Expense Description	Fiscal Year
August	Medi-Cal	Health Reward Incentive Fulfillment	Health Reward Incentive Fulfillment	$75,000	To reallocate funds from Purchased Services – Health Reward Incentive Fulfillment to Incentive Budget for PHM Health Rewards	2022-23
October	Medi-Cal	Quality Improvements - Professional Fees - Consultants for NCQA Accreditation	Quality Improvements - Subscriptions - CAQH Application Subscription - Credentialing Database	$75,000	To reallocate funds from Professional Fees – Consultants for NCQA Accreditation to Subscriptions – CAQH Application Subscription – Credentialing Database to provide additional funding for expanding scope of services	2022-23
November	OneCare	Customer Service - Member Communication	Cultural & Linguistic Services - Purchased Services	$75,000	To reallocate funds from OC Customer Service – Member Communication to OC Cultural & Linguistic Services – Purchased Services to provide additional funding for translation of documents due to OCC/OC transition	2022-23
November	Medi-Cal	Human Resources - Cert/Cont. Education	Human Resources - Training & Seminars	$10,000	To reallocate funds from HR Onsite Computer Classes to Training & Seminars, HR Staff Development (for the CPS Academy classes)	2022-23
November	Medi-Cal	Population Health Management - Professional Fees	Case management - Training & Seminars	$27,000	To reallocate funds from Population Health Management – Purchased Services to Case Management – Training & Seminars to provide funding for WPATH training	2022-23
December	Medi-Cal	Quality Improvements - Subscriptions	Quality Improvements - Purchased Services	$75,000	To reallocate funds from Subscriptions – CAQH Application Subscription – Credentialing Database to Purchased Services to provide funding for additional credentialing services with a new vendor	2022-23
December	Medi-Cal	Communications - Purchased Services	Communications - Public Activities	$10,000	To reallocate funds from Purchased Services to Public Activities to provide funding for additional Medi-Cal Campaigns Support	2022-23
December	Medi-Cal	Population Health Management - Purchased Services	Quality Improvements - Purchased Services	$24,950	To reallocate funds from Population Health Management – Purchased Services to Quality Improvement – Purchased Services to provide additional funding for CVO credentialing services	2022-23
December	PACE	Capital: Interior Light Improvement	Capital: Additional Furniture, Fixtures and Equipment	$35,000	To reallocate funds from Interior Light Improvement to Additional Furniture Fixtures	2022-23
January	Medi-Cal	Facilities - Comp Supply/Minor Equipment	Facilities - R&M Building	$70,000	To reallocate funds from Facilities Comp Supply/Minor Equipment to Facilities R&M Building to cover any remaining purchases that will be incurred in FY23.	2022-23
January	OCC	Sales & Marketing - Printing & Postage	Cultural & Linguistic Services - Purchased Services	$18,000	To reallocate funds from Sales & Marketing Printing Postage & Customer Service Postage to Cultural Linguistic Purchased OCC-803 (C&L translations/interpreter services) needed an additional $58K to pay outstanding invoices.	2022-23
January	OCC	Customer Service - Postage	Cultural & Linguistic Services - Purchased Services	$40,000	To reallocate funds from Sales & Marketing Printing Postage & Customer Service Postage to Cultural Linguistic Purchased OCC-803 (C&L translations/interpreter services) needed an additional $58K to pay outstanding invoices.	2022-23
January	OC	Sales & Marketing - Purchased Services General	Cultural & Linguistic Services - Purchased Services	$50,000	To reallocate funds from Sales & Marketing - Purchased Services to Cultural & Linguistic - Purchased Services for translations/interpreter services.	2022-23
January	Medi-Cal	Medical Management - Food Services	Medical Management - Professional Dues	$12,000	To reallocate funds from Medical Management Food Services to Medical Management Professional Dues to pay for Orange County Medical Association dues for the Medical Directors.	2022-23
February	Medi-Cal	Capital: Building Security Projects	Capital: Office Suite Renovation & Improvements	$150,000	To reallocate funds from Facilities Building Security Projects to Facilities Office Suite Renovation for Improvements for 8th Floor HR renovation, 9th Floor Office renovation, 9th Floor hallway renovation and Directory signage.	2022-23
February	Medi-Cal	Facilities - Comp Supply/Minor Equipment	Facilities - R&M Building	$70,000	To reallocate funds from Facilities Comp Supply/Minor Equipment to Facilities R&M Building to cover any remaining purchases that will be incurred in FY23.	2022-23
February	Medi-Cal	Capital: Building Security Projects	Capital: Electric Car Charging Station	$30,000	To reallocate funds from Facilities Building Security Projects to Facilities Electric Car Charging Station.	2022-23
February	Medi-Cal	Renaming Capital : Touchless Faucet	Capital - 9th Floor Improvement	$183,000	To re-name and re-purpose to meet new fire code requirements for fire exiting on the 9th floor.	2022-23
February	OC	Sales & Marketing - Purchased Services General	Financial Analysis - Professional Fees	$30,000	To reallocate funds from Sales & Marketing Purchased Services to Financial Analysis Professional Fees for OneCare VBID Model.	2022-23
February	PACE	PACE Center Support - Repair & Maintenance	PACE Administrative - Professional Fees	$50,000	To reallocate funds from PACE Center Support Repair & Maintenance to PACE Administrative Professional Fees for anticipated PACE audit.	2022-23
March	OC	Sales & Marketing - Purchased Services General	IS Application Management - Purchased Services	$80,000	To reallocate funds from Sales & Marketing Purchased Services to IS Application Management Purchased Services to support WIPRO/Infocrossing testing of Edifecs files.	2022-23
March	Medi-Cal	Population Health Mgmt. - Purchased Services General	Quality Analytics - Purchased Services General	$200,000	To reallocate funds from Population Health Management Purchased Services to Quality Analytics Purchased Services for 5 Star Rating Medicare Member Engagement.	2022-23
March	OC	Sales & Marketing - Purchased Services General	Sales & Marketing - Public Activities	$35,000	To reallocate funds from Sales & Marketing Purchased Services to Sales & Marketing Public Activities for OneCare branded promotional items.	2022-23
March	Medi-Cal	Government Affairs - Training & Seminars	Government Affairs - Professional Fees	$10,000	To reallocate funds from Government Affairs Training & Seminars to Government Affairs Professional Fees due to funding shortfall for the short-term Government Affairs consulting contract with Strategies 360.	2022-23
March	Medi-Cal	IS - Application Mgmt. - Maintenance HW/SW	Human Resources - Professional Fees	$100,000	To reallocate funds from IS Application Management - Maintenance HW/SW to Human Resources Professional Fees for Recruiting Services.	2022-23
March	Medi-Cal	Capital: Migrate Data Warehouse/Analytics to the Cloud	Capital: DTS Planning and Executive Support - Cloud Migration Strategy Professional Services	$235,000	To reallocate funds for the shortfall of the DTS Cloud Migration Strategy Professional Services.	2022-23
March	Medi-Cal	Capital: Migrate Data Warehouse/Analytics to the Cloud	Capital: DTS Planning and Executive Support - Vital Group Redlines for Agent Portal	$220,000	To reallocate funds for the shortfall of the DTS Cloud Migration Strategy Professional Services.	2022-23
April	Medi-Cal	Budget & Vendor Mgmt - Training & Seminars	Budget & Vendor Mgmt - Subscriptions	$7,000	To reallocate funds from Budget & Vendor Mgmt Training and Seminars to Budget & Vendor Mgmt Subscriptions to cover the expense of Dun & Bradstreet.	2022-23
April	Medi-Cal	Capital: Facilities Road Warning Light Crosswalk	Capital: Facilities Electric Car Charging Station	$50,000	To reallocate funds from Facilities Road Warning Light (Crosswalk) to Facilities Electric Car Charging Station.	2022-23
April	Medi-Cal	Capital: Facilities IDF Room HVAC Replacement	Capital: Facilities Office Suite Renovations	$40,000	To reallocate funds from Facilities IDF Room HVAC Replacement to Facilities Office Suite Renovations due to additional office space.	2022-23
April	Medi-Cal	Capital: Facilities - Freight Elevator	Capital: Parking Lot Improvement	$42,000	To reallocate funds from Facilities Freight Elevator to Parking Lot Improvement.	2022-23

This report summarizes budget transfers between general ledger classes that are greater than $10,000 and less than $250,000.
This is the result of Board Resolution No. 12-0301-01 which permits the CEO to make budget allocation changes within certain parameters.

Financial Summary

Preliminary Unaudited Financials

June 30, 2023

Board of Directors Meeting

August 3, 2023

Nancy Huang, Chief Financial Officer

Our Mission

To serve member health with excellence and dignity, respecting the value and needs of each person.

Our Vision

By 2027, remove barriers to health care access for our members, implement same-day treatment authorizations and real-time claims payments for our providers, and annually assess members' social determinants of health.

Back to Agenda

Financial Highlights: June 2023

June 2023					July 2022 - June 2023			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
988,716	895,152	93,564	10.5%	Member Months	11,504,355	10,914,279	590,076	5.4%
415,187,148	346,955,671	68,231,477	19.7%	Revenues	4,246,920,626	4,002,166,211	244,754,415	6.1%
323,485,290	328,823,483	5,338,193	1.6%	Medical Expenses	3,857,653,291	3,763,117,812	(94,535,479)	(2.5%)
22,883,247	19,465,376	(3,417,871)	(17.6%)	Administrative Expenses	192,886,333	220,226,217	27,339,884	12.4%
68,818,612	**(1,333,188)**	**70,151,800**	**5262.0%**	**Operating Margin**	**196,381,001**	**18,822,182**	**177,558,819**	**943.3%**
				Non-Operating Income (Loss)				
8,980,251	500,000	8,480,251	1696.1%	Net Investment Income/Expense	90,388,783	6,000,000	84,388,783	1406.5%
83,122	90,815	(7,693)	(8.5%)	Net Rental Income/Expense	987,045	1,090,000	(102,955)	(9.4%)
(907,562)	-	(907,562)	(100.0%)	Net MCO Tax	(2,420,576)	-	(2,420,576)	(100.0%)
(871,970)	(12,077,924)	11,205,954	92.8%	Grant Expense	(25,380,303)	(30,000,000)	4,619,697	15.4%
-	-	-	0.0%	Net QAF/IGT Income/Expense	-	-	-	0.0%
97	-	97	100.0%	Other Income/Expense	232	-	232	100.0%
7,283,939	**(11,487,109)**	**18,771,048**	**163.4%**	**Total Non-Operating Income (Loss)**	**63,575,182**	**(22,910,000)**	**86,485,182**	**377.5%**
76,102,551	**(12,820,297)**	**88,922,848**	**693.6%**	**Change in Net Assets**	**259,956,184**	**(4,087,818)**	**264,044,002**	**6459.3%**
77.9%	94.8%	(16.9%)		Medical Loss Ratio	90.8%	94.0%	(3.2%)	
5.5%	5.6%	0.1%		Administrative Loss Ratio	4.5%	5.5%	1.0%	
16.6%	(0.4%)	17.0%		Operating Margin Ratio	4.6%	0.5%	4.2%	
100.0%	100.0%			Total Operating	100.0%	100.0%		
77.9%	94.8%	(16.9%)		*MLR (excluding Directed Payments)	90.2%	94.0%	(3.9%)	
5.5%	5.6%	0.1%		*ALR (excluding Directed Payments)	4.9%	5.5%	0.6%	

*CalOptima Health updated the category of Directed Payments per Department of Health Care Services instructions

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CalOptima Health

Consolidated Performance: June 2023 (in millions)

June 2023				July 2022 - June 2023		
Actual	Budget	Variance	Operating Income (Loss)	Actual	Budget	Variance
69.5	(0.3)	69.8	Medi-Cal	197.5	31.4	166.1
1.7	(0.0)	1.7	OCC	1.9	(3.2)	5.1
(2.9)	(1.0)	(1.9)	OneCare	(4.3)	(9.0)	4.7
0.7	0.1	0.6	PACE	2.1	0.2	2.0
(0.1)	(0.0)	(0.0)	MSSP	(0.9)	(0.5)	(0.4)
68.8	**(1.3)**	**70.2**	**Total Operating Income (Loss)**	**196.4**	**18.8**	**177.6**
			Non-Operating Income (Loss)			
9.0	0.5	8.5	Net Investment Income/Expense	90.4	6.0	84.4
0.1	0.1	(0.0)	Net Rental Income/Expense	1.0	1.1	(0.1)
(0.9)	0.0	(0.9)	Net Operating Tax	(2.4)	0.0	(2.4)
(0.9)	(12.1)	11.2	Grant Expense	(25.4)	(30.0)	4.6
0.0	0.0	0.0	Other Income	0.0	0.0	0.0
7.3	**(11.5)**	**18.8**	**Total Non-Operating Income/(Loss)**	**63.6**	**(22.9)**	**86.5**
76.1	**(12.8)**	**88.9**	**TOTAL**	**260.0**	**(4.1)**	**264.0**

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CalOptima Health

FY 2022-23: Management Summary

- Change in Net Assets Surplus or (Deficit)
  - Month To Date (MTD) June 2023: $76.1 million, favorable to budget $88.9 million or 693.6%
  - Year To Date (YTD) July 2022– June 2023: $260.0 million, favorable to budget $264.0 million or 6,459.3%
- Enrollment
  - MTD: 988,716 members, favorable to budget 93,564 or 10.5%
  - YTD: 11,504,355 members, favorable to budget 590,076 or 5.4%
  - Favorable enrollment primarily driven by a pause in Medi-Cal redetermination due to the extension of the COVID-19 Public Health Emergency (PHE) that ended May 11, 2023

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CalOptima Health

FY 2022-23:Management Summary (cont.)

- Revenue
  - MTD: $415.2 million, favorable to budget $68.2 million or 19.7% driven by Medi-Cal Line of Business (MC LOB):
    - $40.4 million from favorable volume and price variances
    - $34.5 million from Department of Health Care Services (DHCS) In-Home Supportive Services (IHSS) reconciliation
    - $22.3 million from DHCS Housing and Homelessness Incentive Program (HHIP)
    - Offset by net $32.4 million due to the COVID-19, Enhanced Care Management (ECM), and Proposition 56 risk corridor reserves
  - YTD: $4,246.9 million, favorable to budget $244.8 million or 6.1% driven by MC LOB:
    - $312.7 million from favorable volume and price variances, $293.6 million of Hospital Directed Payments (DP), $135.4 million of prior period Medical Loss Ratio (MLR) accrual release, and $35.0 million from HHIP
    - Offset by $566.8 million due to COVID-19, Proposition 56, and ECM risk corridor reserves

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CalOptima Health

FY 2022-23:Management Summary (cont.)

- Medical Expenses
  - MTD: $323.5 million, favorable to budget $5.3 million or 1.6% driven by MC LOB:
    - Other Medical expense favorable variance of $24.5 million due primarily to the recategorization of CalAIM Incentive Payment Program (IPP) in Incentive Payments
    - Managed Long-Term Services and Supports (MLTSS) favorable variance of $11.3 million due to lower than budgeted utilization
    - Facilities Claims expense favorable variance of $4.3 million
    - Offset by:
      - Incentive Payments expense unfavorable variance of $13.7 million primarily due to HHIP
      - Professional Claims expense unfavorable variance of $13.1 million due to increased utilization in CalAIM Community Support services

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CalOptima Health

FY 2022-23:Management Summary (cont.)

- Medical Expenses
  - YTD: $3,857.7 million, unfavorable to budget $94.5 million or 2.5% driven by MC LOB:
    - Other Medical Expenses unfavorable variance of $241.8 million due primarily to Hospital DP
    - Incentive Payments expense unfavorable variance of $60.2 million primarily due to HHIP and Shared Risk Pool
    - Professional Claims expense unfavorable variance of $11.5 million
    - Offset by:
      - Provider Capitation favorable variance of $104.0 million primarily due to updated logic for Proposition 56
      - MLTSS favorable variance of $75.8 million due to lower than budgeted utilization
      - Net favorable variances totaling $57.5 million from Facilities Claims, Prescription Drugs, and Medical Management due to lower than budgeted utilization

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CalOptima Health

FY 2022-23:Management Summary (cont.)

- Administrative Expenses
  - MTD: $22.9 million, unfavorable to budget $3.4 million or 17.6% due primarily to updates to Pension and Other Post-Employment Benefits (OPEB) liabilities in accordance with the Government Accounting Standards Board (GASB)
    - Salaries & Benefits expense unfavorable variance of $1.9 million
    - Other Non-Salary expenses unfavorable variance of $1.5 million
  - YTD: $192.9 million, favorable to budget $27.3 million or 12.4%
    - Other Non-Salary expenses favorable variance of $19.7 million
    - Salaries & Benefits expense favorable variance of $7.6 million

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CalOptima Health

FY 2022-23:Management Summary (cont.)

- Non-Operating Income (Loss)
  - MTD: $7.3 million, favorable to budget $18.8 million or 163.4%
    - Grant Expense favorable variance of $11.2 million
    - Net Investment Income favorable variance of $8.5 million
  - YTD: $63.6 million, favorable to budget $86.5 million or 377.5%
    - Net Investment Income favorable variance of $84.4 million
    - Grant Expense favorable variance of $4.6 million

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FY 2022-23: Key Financial Ratios

- Medical Loss Ratio (MLR)
  - MTD: Actual 77.9% (77.9% excluding DP), Budget 94.8%
  - YTD: Actual 90.8% (90.2% excluding DP), Budget 94.0%
- Administrative Loss Ratio (ALR)
  - MTD: Actual 5.5% (5.5% excluding DP), Budget 5.6%
  - YTD: Actual 4.5% (4.9% excluding DP), Budget 5.5%
- Balance Sheet Ratios
  - Current ratio*: 1.6
  - Board-designated reserve level: 1.79
  - Net-position: $1.7 billion, including required Tangible Net Equity (TNE) of $107.8 million

*Current ratio compares current assets to current liabilities. It measures CalOptima Health's ability to pay short-term obligations

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CalOptima Health

Enrollment Summary: June 2023

June 2023					July 2022 - June 2023			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	% Variance
181,230	139,356	41,874	30.0%	SPD	1,636,740	1,568,122	68,618	4.4%
300,038	301,477	(1,439)	(0.5%)	TANF Child	3,648,766	3,654,694	(5,928)	(0.2%)
134,844	124,730	10,114	8.1%	TANF Adult	1,646,808	1,576,585	70,223	4.5%
852	3,525	(2,673)	(75.8%)	LTC	36,228	40,998	(4,770)	(11.6%)
347,169	296,910	50,259	16.9%	MCE	4,185,916	3,721,255	464,661	12.5%
6,457	11,910	(5,453)	(45.8%)	WCM	136,254	141,747	(5,493)	(3.9%)
970,590	**877,908**	**92,682**	**10.6%**	**Medi-Cal Total**	**11,290,712**	**10,703,401**	**587,311**	**5.5%**
		0	**0.0%**	**OneCare Connect**	**86,185**	**87,887**	**(1,702)**	**(1.9%)**
17,687	**16,736**	**951**	**5.7%**	**OneCare**	**122,247**	**117,263**	**4,984**	**4.3%**
439	**508**	**(69)**	**(13.6%)**	**PACE**	**5,211**	**5,728**	**(517)**	**(9.0%)**
498	**568**	**(70)**	**(12.3%)**	**MSSP**	**5,706**	**6,816**	**(1,110)**	**(16.3%)**
988,716	**895,152**	**93,564**	**10.5%**	**CalOptima Total**	**11,504,355**	**10,914,279**	**590,076**	**5.4%**

*CalOptima Health Total does not include MSSP

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CalOptima Health

Consolidated Revenue & Expenses: June 2023 MTD

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	MSSP	Consolidated
MEMBER MONTHS	616,964	347,169	6,457	970,590		17,687	439	498	988,716
REVENUES									
Capitation Revenue	237,039,819	$ 128,249,268	$ 10,514,068	$ 375,803,155	$ (1,737,339)	$ 37,135,796	$ 3,759,112	$ 226,425	$ 415,187,148
Total Operating Revenue	237,039,819	128,249,268	10,514,068	375,803,155	(1,737,339)	37,135,796	3,759,112	226,425	415,187,148
MEDICAL EXPENSES									
Provider Capitation	44,794,541	52,477,987	5,669,902	102,942,430	(822)	16,161,505			119,103,113
Facilities	31,796,398	27,091,782	3,635,581	62,523,761	(113,209)	7,169,259	214,297		69,794,108
Professional Claims	31,917,792	20,487,103	1,994,553	54,399,449	11,566	1,836,963	963,059		57,211,037
Prescription Drugs	(5,634)			(5,634)	(1,954,660)	8,890,609	537,741		7,468,057
MLTSS	34,899,473	4,681,784	1,593,943	41,175,199	(2,611)	81,440	(38,416)	29,741	41,245,353
Incentive Payments	9,847,444	8,271,671	169,208	18,288,324	58,286	690,099			19,036,708
Medical Management	4,652,275	2,558,720	(46,127)	7,164,868	(1,435,528)	2,992,172	1,144,594	184,676	10,050,782
Other Medical Expenses	(336,079)	(73,878)	(13,912)	(423,868)					(423,868)
Total Medical Expenses	157,566,211	115,495,169	13,003,148	286,064,529	(3,436,978)	37,822,047	2,821,275	214,417	323,485,290
Medical Loss Ratio	66.5%	90.1%	123.7%	76.1%	197.8%	101.8%	75.1%	94.7%	77.9%
GROSS MARGIN	**79,473,608**	**12,754,099**	**(2,489,081)**	**89,738,626**	**1,699,638**	**(686,250)**	**937,837**	**12,007**	**91,701,858**
ADMINISTRATIVE EXPENSES									
Salaries & Benefits				12,436,453	20,466	870,209	149,084	84,809	13,561,021
Professional Fees				924,983	(13,075)	41,957		1,333	955,198
Purchased Services				1,768,244		337,939	62,770	22	2,168,975
Printing & Postage				288,085		89,051	21,979		399,116
Depreciation & Amortization				438,887			1,072		439,959
Other Expenses				4,967,736	(1)	31,478	17,811	6,504	5,023,528
Indirect Cost Allocation, Occupancy				(567,145)		877,451	17,008	8,137	335,451
Total Administrative Expenses				**20,257,242**	**7,390**	**2,248,085**	**269,725**	**100,804**	**22,883,247**
Admin Loss Ratio				5.4%	-0.4%	6.1%	7.2%	44.5%	5.5%
INCOME (LOSS) FROM OPERATIONS				69,481,384	1,692,248	(2,934,335)	668,112	(88,797)	68,818,612
INVESTMENT INCOME									8,980,251
NET RENTAL INCOME									83,122
TOTAL MCO TAX				(907,562)					(907,562)
TOTAL GRANT EXPENSE				(871,970)					(871,970)
OTHER INCOME				97					97
CHANGE IN NET ASSETS				**$ 67,701,949**	**$ 1,692,248**	**$ (2,934,335)**	**$ 668,112**	**$ (88,797)**	**$ 76,102,551**
BUDGETED CHANGE IN NET ASSETS				(12,367,481)	(42,321)	(1,037,047)	80,340	(44,603)	(12,820,297)
VARIANCE TO BUDGET - FAV (UNFAV)				$ 80,069,430	$ 1,734,569	$ (1,897,288)	$ 587,772	$ (44,194)	$ 88,922,848

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CalOptima Health

Consolidated Revenue & Expenses: June 2023 YTD

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	MSSP	Consolidated
MEMBER MONTHS	6,968,542	4,185,916	136,254	11,290,712	86,185	122,247	5,211	5,706	11,504,355
REVENUES									
Capitation Revenue	2,056,085,094	$ 1,493,601,963	$ 264,268,442	$ 3,813,955,499	$ 172,148,805	$ 214,353,873	$ 44,007,489	$ 2,454,959	$ 4,246,920,626
Total Operating Revenue	2,056,085,094	1,493,601,963	264,268,442	3,813,955,499	172,148,805	214,353,873	44,007,489	2,454,959	4,246,920,626
MEDICAL EXPENSES									
Provider Capitation	480,046,380	575,126,254	100,049,780	1,155,222,414	72,094,334	85,651,823			1,312,968,571
Facilities	380,395,276	336,723,351	59,699,744	776,818,371	26,308,563	39,330,651	9,198,557		851,656,142
Professional Claims	297,387,031	185,829,206	18,058,804	501,275,041	8,785,745	9,668,787	11,378,637		531,108,210
Prescription Drugs	(3,232,402)	(2,287,072)	5,604	(5,513,869)	35,518,208	58,746,651	5,129,725		93,880,715
MLTSS	460,241,129	54,427,873	22,335,400	537,004,402	9,520,914	483,561	1,280,837	342,870	548,632,585
Incentive Payments	57,005,992	57,616,506	1,297,483	115,919,981	2,567,009	1,718,553	(120,875)		120,084,667
Medical Management	36,411,919	24,288,364	4,626,919	65,327,202	5,330,873	8,808,904	12,267,056	1,914,684	93,648,719
Other Medical Expenses	162,768,820	124,310,043	18,594,819	305,673,683					305,673,683
Total Medical Expenses	1,871,024,145	1,356,034,525	224,668,553	3,451,727,223	160,125,645	204,408,930	39,133,938	2,257,555	3,857,653,291
Medical Loss Ratio	91.0%	90.8%	85.0%	90.5%	93.0%	95.4%	88.9%	92.0%	90.8%
GROSS MARGIN	**185,060,949**	**137,567,437**	**39,599,890**	**362,228,276**	**12,023,160**	**9,944,943**	**4,873,551**	**197,404**	**389,267,335**
ADMINISTRATIVE EXPENSES									
Salaries & Benefits				116,315,804	4,296,988	5,808,949	1,678,456	936,983	129,037,179
Professional Fees				7,491,671	11,809	313,081	7,670	16,000	7,840,231
Purchased Services				13,018,650	595,858	1,413,053	523,708	27	15,551,296
Printing & Postage				4,023,185	261,432	953,556	206,262		5,444,434
Depreciation & Amortization				4,504,381			10,389		4,514,769
Other Expenses				25,805,442	10,502	71,910	132,553	73,368	26,093,774
Indirect Cost Allocation, Occupancy				(6,445,632)	4,929,832	5,681,411	170,256	68,782	4,404,650
Total Administrative Expenses				**164,713,499**	**10,106,420**	**14,241,959**	**2,729,295**	**1,095,159**	**192,886,333**
Admin Loss Ratio				4.3%	5.9%	6.6%	6.2%	44.6%	4.5%
INCOME (LOSS) FROM OPERATIONS				197,514,777	1,916,740	(4,297,015)	2,144,256	(897,755)	196,381,001
INVESTMENT INCOME									90,388,783
NET RENTAL INCOME									987,045
TOTAL MCO TAX				(2,420,576)					(2,420,576)
TOTAL GRANT EXPENSE				(25,380,303)					(25,380,303)
OTHER INCOME				232					232
CHANGE IN NET ASSETS				**$ 169,714,130**	**$ 1,916,740**	**$ (4,297,015)**	**$ 2,144,256**	**$ (897,755)**	**$ 259,956,184**
BUDGETED CHANGE IN NET ASSETS				1,373,753	(3,181,436)	(9,017,262)	170,630	(523,503)	(4,087,818)
VARIANCE TO BUDGET - FAV (UNFAV)				$ 168,340,377	$ 5,098,176	$ 4,720,247	$ 1,973,626	$ (374,252)	$ 264,044,002

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CalOptima Health

Balance Sheet: As of June 2023

ASSETS		LIABILITIES & NET POSITION	
Current Assets		**Current Liabilities**	
Operating Cash	$765,622,444	Accounts Payable	$15,006,508
Short-term Investments	1,676,736,064	Medical Claims Liability	1,635,571,979
Capitation Receivable	380,839,599	Accrued Payroll Liabilities	17,378,874
Receivables - Other	93,084,099	Deferred Revenue	63,442,911
Prepaid Expenses	15,210,703	Deferred Lease Obligations	55,308
		Capitation and Withholds	120,901,347
Total Current Assets	**2,931,492,908**	**Total Current Liabilities**	**1,852,356,927**
Capital Assets			
Furniture & Equipment	45,292,383		
Building/Leasehold Improvements	5,296,725		
Construction in Progress	3,027,022		
505 City Parkway West	53,164,315		
500 City Parkway West	22,631,500		
	129,411,945		
Less: Accumulated Depreciation	(63,239,022)	**Other Liabilities**	
Capital Assets, Net	66,172,922	GASB 96 Subscription Liabilities	16,107,717
GASB 96 Capital Assets		**Other (than pensions) Post**	
GASB 96 Subscription Assets	21,732,875	Employment Benefits Liability	18,975,000
		Net Pension Liabilities	40,465,145
Less: GASB 96 Accumulated Amoritzation	(3,714,493)	Bldg 505 Development Rights	-
GASB 96 Capital Assets, Net	18,018,382		
Total Capital Assets	**84,191,304**		
Other Assets			
Restricted Deposit & Other	300,000	**TOTAL LIABILITIES**	**1,927,904,789**
Homeless Health Reserve	-		
Board-Designated Assets:			
Cash and Cash Equivalents	1,940,210		
Investments	574,611,484	**Deferred Inflows**	
Total Board-Designated Assets	576,551,694	GASB 68 - PERS - Difference in Experience	2,185,361
		GASB 68 - PERS - Changes in Assumptions	1,202,155
		GASB 68 - PERS - Differnece in Earnings	-
Total Other Assets	576,851,694	GASB 75 - OPEB - Changes in Assumptions	4,921,000
		GASB 75 - OPEB - Difference in Experience	2,867,000
		Net Position	
TOTAL ASSETS	**3,592,535,906**	TNE	107,787,389
		Funds in Excess of TNE	1,571,637,563
Deferred Outflows		**TOTAL NET POSITION**	1,679,424,952
GASB 68 - PERS - Contirbutions	2,375,580		
GASB 68 - PERS - Difference in Experience	1,547,292		
GASB 68 - PERS - Excess Earnings	-		
GASB 68 - PERS - Changes in Assumptions	7,732,138		
GASB 68 - PERS - Differnece in Earnings	12,718,340		
GASB 75 - OPEB - Contributions	528,000		
GASB 75 - OPEB - Changes in Assumptions	1,068,000		
TOTAL ASSETS & DEFERRED OUTFLOWS	**3,618,505,256**	**TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION**	**3,618,505,256**

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CalOptima Health

Board Designated Reserve and TNE Analysis: As of June 2023

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	234,960,591				
	Tier 1 - MetLife	233,211,082				
Board-designated Reserve		468,171,673	344,338,512	538,106,755	123,833,161	(69,935,083)
	Tier 2 - Payden & Rygel	54,321,782				
	Tier 2 - MetLife	54,058,239				
TNE Requirement		108,380,021	107,787,389	107,787,389	592,632	592,632
	Consolidated:	**576,551,694**	**452,125,901**	**645,894,144**	**124,425,793**	**(69,342,451)**
	Current reserve level	*1.79*	*1.40*	*2.00*		

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CalOptima Health

Net Assets Analysis: As of June 2023

Category	Item Description	Amount (millions)	Approved Initiative	Spend to Date	%
	Total Net Position @ 6/30/2023	**$1,679.4**			**100.0%**
Resources Assigned	Board Designated Reserve[1]	**576.6**			**34.3%**
	Capital Assetss, net of Depreciation[2]	**84.2**			**5.0%**
Resources Allocated[3]	Homeless Health Initiative[4]	$21.0	$59.9	$38.9	1.2%
	Housing and Homelessness Incentive Program[5]	69.7	97.2	27.5	4.2%
	Intergovernmental Transfers (IGT)	58.9	111.7	52.8	3.5%
	Digital Transformation and Workplace Modernization	88.0	100.0	12.0	5.2%
	Mind OC Grant (Orange)	0.0	1.0	1.0	0.0%
	Outreach Strategy for CalFresh, Redetermination support, and other programs	6.9	8.0	1.1	0.4%
	Coalition of Orange County Community Health Centers Grant	40.0	50.0	10.0	2.4%
	Mind OC Grant (Irvine)	0.0	15.0	15.0	0.0%
	OneCare Member Health Rewards and Incentives	1.0	1.0	0.0	0.1%
	General Awareness Campaign	1.0	2.7	1.7	0.1%
	Member Health Needs Assessment	1.0	1.0	0.0	0.1%
	Five-Year Hospital Quality Program Beginning MY 2023	153.0	153.5	0.5	9.1%
	Medi-Cal Annual Wellness Initiative	14.8	15.0	0.2	0.9%
	Skilled Nursing Facility Access Program	10.0	10.0	0.0	0.6%
	In-Home Care Pilot Program with the UCI Family Health Center	1.5	2.0	0.5	0.1%
	National Alliance for Mental Illness Orange County Peer Support Program	4.5	5.0	0.5	0.3%
	Community Living and PACE Center in the City of Tustin	17.9	18.0	0.1	1.1%
	Stipend Program for Master of Social Works	5.0	5.0	0.0	0.3%
	Wellness & Prevention Program	2.7	2.7	0.0	0.2%
	CalOptima Health Provider Workforce Development Fund	50.0	50.0	0.0	3.0%
	Post-Pandemic Supplemental	107.5	107.5	0.0	6.4%
	Subtotal:	**$654.4**	**$816.2**	**$161.8**	**39.0%**
Resources Available for New Initiative	Unallocated/Unassigned[1]	**$364.2**			**21.7%**

[1] Total of Board Designated reserve and unallocated reserve amount can support approximately 91 days of CalOptima Health's current operations

[2] Increase due to the adoption of GASB 96 Subscription-Based Information Technology Arrangements

[3] Initiatives that have been paid in full in the previous year are omitted from the list of Resource Allocated

[4] See Page 30 for Summary of Homeless Health Initiative and Allocated Funds for list of Board approved initiatives

[5] On September 1, 2022, CalOptima Health's Board of Directors approved reallocation of $40.1M from HHI to HHIP (see HHIP Summary on Page 31)

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CalOptima Health

Homeless Health Initiative and Allocated Funds: As of June 2023

Funds Allocation, approved initiatives:	Allocated Amount	Utilized Amount	Remaining Approved Amount
Enhanced Medi-Cal Services at the Be Well OC Regional Mental Health and Wellness Campus	11,400,000	11,400,000	-
Recuperative Care	6,194,190	6,194,190	-
Medical Respite	250,000	250,000	-
Day Habilitation (County for HomeKey)	2,500,000	2,500,000	-
Clinical Field Team Start-up & Federal Qualified Health Center (FQHC)	1,600,000	1,600,000	-
CalOptima Homeless Response Team	1,681,734	1,681,734	-
Homeless Coordination at Hospitals	10,000,000	9,956,478	43,522
CalOptima Days, HCAP and FQHC Administrative Support	963,261	662,709	300,552
FQHC (Community Health Center) Expansion	21,902	21,902	-
Homeless Clinical Access Program (HCAP) and CalOptima Days	9,888,914	3,170,400	6,718,514
Vaccination Intervention and Member Incentive Strategy	400,000	54,649	345,351
Street Medicine	8,000,000	1,455,500	6,544,500
Outreach and Engagement	7,000,000	-	7,000,000
Housing and Homelessness Incentive Program (HHIP)[1]	40,100,000	-	40,100,000
Subtotal of Approved Initiatives	**$ 100,000,000**	**$ 38,947,561**	**$ 61,052,439**
Transfer of funds to HHIP[1]	(40,100,000)	-	(40,100,000)
Program Total	**$ 59,900,000**	**$ 38,947,561**	**$ 20,952,439**

Notes:

[1]On September 1, 2022, CalOptima Health's Board of Directors approved reallocation of $40.1M from HHI to HHIP.

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CalOptima Health

Housing and Homelessness Incentive Program
As of June 2023

Funds Allocation, approved initiatives:	Allocated Amount	Utilized Amount	Remaining Approved Amount
Office of Care Coordination	2,200,000	2,200,000	-
Pulse For Good	800,000	15,000	785,000
Consultant	600,000	-	600,000
Equity Grants for Programs Serving Underrepresented Populations	4,021,311	1,461,149	2,560,162
Infrastructure Projects	5,832,314	2,785,365	3,046,949
Capital Projects	73,247,369	21,000,000	52,247,369
System Change Projects	10,180,000	-	10,180,000
Non-Profit Healthcare Academy	354,530	-	354,530
Total of Approved Initiatives	**$ 97,235,524** [1]	**$ 27,461,514**	**$ 69,774,010**

Notes:

[1]Total funding $97.2M: $40.1M Board approved Transfer from CalOptima Homeless Health Initiatives, $22.3M from CalOptima Existing Reserve and $34.8M from DHCS HHIP Incentive payment

On the June 1, 2023 Board of Director's Meeting, the Board allocated an additional $44.6M to HHIP

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UNAUDITED FINANCIAL STATEMENTS

June 30, 2023

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CalOptima Health - Consolidated
Financial Highlights
For the Twelve Months Ended June 30, 2023

June 2023					July 2022 - June 2023			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
988,716	895,152	93,564	10.5%	Member Months	11,504,355	10,914,279	590,076	5.4%
415,187,148	346,955,671	68,231,477	19.7%	Revenues	4,246,920,626	4,002,166,211	244,754,415	6.1%
323,485,290	328,823,483	5,338,193	1.6%	Medical Expenses	3,857,653,291	3,763,117,812	(94,535,479)	(2.5%)
22,883,247	19,465,376	(3,417,871)	(17.6%)	Administrative Expenses	192,886,333	220,226,217	27,339,884	12.4%
68,818,612	**(1,333,188)**	**70,151,800**	**5262.0%**	**Operating Margin**	**196,381,001**	**18,822,182**	**177,558,819**	**943.3%**
				Non-Operating Income (Loss)				
8,980,251	500,000	8,480,251	1696.1%	Net Investment Income/Expense	90,388,783	6,000,000	84,388,783	1406.5%
83,122	90,815	(7,693)	(8.5%)	Net Rental Income/Expense	987,045	1,090,000	(102,955)	(9.4%)
(907,562)	-	(907,562)	(100.0%)	Net MCO Tax	(2,420,576)	-	(2,420,576)	(100.0%)
(871,970)	(12,077,924)	11,205,954	92.8%	Grant Expense	(25,380,303)	(30,000,000)	4,619,697	15.4%
-	-	-	0.0%	Net QAF/IGT Income/Expense	-	-	-	0.0%
97	-	97	100.0%	Other Income/Expense	232	-	232	100.0%
7,283,939	**(11,487,109)**	**18,771,048**	**163.4%**	**Total Non-Operating Income (Loss)**	**63,575,182**	**(22,910,000)**	**86,485,182**	**377.5%**
76,102,551	**(12,820,297)**	**88,922,848**	**693.6%**	**Change in Net Assets**	**259,956,184**	**(4,087,818)**	**264,044,002**	**6459.3%**
77.9%	94.8%	(16.9%)		Medical Loss Ratio	90.8%	94.0%	(3.2%)	
5.5%	5.6%	0.1%		Administrative Loss Ratio	4.5%	5.5%	1.0%	
16.6%	(0.4%)	17.0%		Operating Margin Ratio	4.6%	0.5%	4.2%	
100.0%	100.0%			Total Operating	100.0%	100.0%		
77.9%	94.8%	(16.9%)		*MLR (excluding Directed Payments)	90.2%	94.0%	(3.9%)	
5.5%	5.6%	0.1%		*ALR (excluding Directed Payments)	4.9%	5.5%	0.6%	

*CalOptima Health updated the category of Directed Payments per Department of Health Care Services instructions

CalOptima Health
Financial Dashboard
For the Twelve Months Ended June 30, 2023

JUNE

Enrollment	Actual	Budget	Fav / (Unfav)	
Medi-Cal	970,590	877,908	92,682	10.6%
OneCare Connect	-	-	-	0.0%
OneCare	17,687	16,736	951	5.7%
PACE	439	508	(69)	(13.6%)
MSSP	498	568	(70)	(12.3%)
Total*	988,716	895,152	93,564	10.5%

Change in Net Assets (000)	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 67,702	$ (12,367)	80,069	647.4%
OneCare Connect	1,692	(42)	1,734	4128.6%
OneCare	(2,934)	(1,037)	(1,897)	(182.9%)
PACE	668	80	588	735.0%
MSSP	(89)	(45)	(44)	(97.8%)
Buildings	83	91	(8)	(8.8%)
Investment Income/Expense	8,980	500	8,480	1696.0%
Total	$ 76,102	$ (12,820)	88,922	693.6%

MLR	Actual	Budget	% Point Var
Medi-Cal	76.1%	94.8%	(18.7)
OneCare Connect	197.8%	0.0%	197.8
OneCare	101.8%	95.1%	6.8

Administrative Cost (000)	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 20,257	$ 16,680	$ (3,577)	(21.4%)
OneCare Connect	7	15	8	51.0%
OneCare	2,248	2,404	156	6.5%
PACE	270	268	(2)	(0.6%)
MSSP	101	99	(2)	(2.2%)
Total	$ 22,883	$ 19,465	$ (3,418)	(17.6%)

Total FTE's Month	Actual	Budget	Fav / (Unfav)
Medi-Cal	1,231	1,323	91
OneCare Connect	2	2	(0)
OneCare	182	222	40
PACE	104	115	11
MSSP	23	23	0
Total	1,543	1,684	142

MM per FTE	Actual	Budget	Fav / (Unfav)
Medi-Cal	788	664	(124)
OneCare Connect	-	-	-
OneCare	97	75	(22)
PACE	4	4	0
MSSP	22	25	3
Total	641	531	(109)

JULY 2022 - JUNE 2023

Year To Date Enrollment	Actual	Budget	Fav / (Unfav)	
Medi-Cal	11,290,712	10,703,401	587,311	5.5%
OneCare Connect	86,185	87,887	(1,702)	(1.9%)
OneCare	122,247	117,263	4,984	4.3%
PACE	5,211	5,728	(517)	(9.0%)
MSSP	5,706	6,816	(1,110)	(16.3%)
Total*	11,504,355	10,914,279	590,076	5.4%

Change in Net Assets (000)	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 169,714	$ 1,374	168,340	12251.8%
OneCare Connect	1,917	(3,181)	5,098	160.3%
OneCare	(4,297)	(9,017)	4,720	52.3%
PACE	2,144	171	1,973	1153.8%
MSSP	(898)	(524)	(374)	(71.4%)
Buildings	987	1,090	(103)	(9.4%)
Investment Income/Expense	90,389	6,000	84,389	1406.5%
Total	$ 259,956	$ (4,087)	264,043	6460.6%

MLR	Actual	Budget	% Point Var
Medi-Cal	90.5%	93.9%	(3.4)
OneCare Connect	93.0%	95.2%	(2.2)
OneCare	95.4%	96.1%	(0.7)

Administrative Cost (000)	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 164,713	$ 188,235	$ 23,522	12.5%
OneCare Connect	10,106	11,184	1,077	9.6%
OneCare	14,242	16,450	2,208	13.4%
PACE	2,729	3,185	456	14.3%
MSSP	1,095	1,172	77	6.6%
Total	$ 192,886	$ 220,226	$ 27,340	12.4%

Total FTE's YTD	Actual	Budget	Fav / (Unfav)
Medi-Cal	14,157	15,792	1,634
OneCare Connect	1,034	1,193	159
OneCare	1,156	1,478	322
PACE	1,167	1,370	203
MSSP	253	276	23
Total	17,768	20,108	2,340

MM per FTE	Actual	Budget	Fav / (Unfav)
Medi-Cal	798	678	(120)
OneCare Connect	83	74	(10)
OneCare	106	79	(26)
PACE	4	4	(0)
MSSP	23	25	2
Total	647	543	(105)

Note:* Total membership does not include MSSP

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CalOptima Health - Consolidated
Statement of Revenues and Expenses
For the One Month Ended June 30, 2023

	Actual		Budget		Variance	
	$	PMPM	$	PMPM	$	PMPM
MEMBER MONTHS	988,716		895,152		93,564	
REVENUE						
Medi-Cal	$ 375,803,155	$ 387.19	$ 314,565,191	$ 358.31	$ 61,237,964	$ 28.88
OneCare Connect	(1,737,339)	-	-	-	(1,737,339)	-
OneCare	37,135,796	2,099.61	27,873,795	1,665.50	9,262,001	434.11
PACE	3,759,112	8,562.90	4,263,163	8,392.05	(504,051)	170.85
MSSP	226,425	454.67	253,522	446.34	(27,097)	8.33
Total Operating Revenue	415,187,148	419.93	346,955,671	387.59	68,231,477	32.34
MEDICAL EXPENSES						
Medi-Cal	286,064,529	294.73	298,174,911	339.64	12,110,382	44.91
OneCare Connect	(3,436,978)	-	27,249	-	3,464,227	-
OneCare	37,822,047	2,138.41	26,507,133	1,583.84	(11,314,914)	(554.57)
PACE	2,821,275	6,426.59	3,914,707	7,706.12	1,093,432	1,279.53
MSSP	214,417	430.56	199,483	351.20	(14,934)	(79.36)
Total Medical Expenses	323,485,290	327.18	328,823,483	367.34	5,338,193	40.16
GROSS MARGIN	91,701,858	92.75	18,132,188	20.25	73,569,670	72.50
ADMINISTRATIVE EXPENSES						
Salaries and Benefits	13,561,021	13.72	11,645,972	13.01	(1,915,049)	(0.71)
Professional Fees	955,198	0.97	957,597	1.07	2,399	0.10
Purchased Services	2,168,975	2.19	2,745,587	3.07	576,612	0.88
Printing & Postage	399,116	0.40	690,663	0.77	291,547	0.37
Depreciation & Amortization	439,959	0.44	525,900	0.59	85,941	0.15
Other Expenses	5,023,528	5.08	2,509,842	2.80	(2,513,686)	(2.28)
Indirect Cost Allocation, Occupancy	335,451	0.34	389,815	0.44	54,364	0.10
Total Administrative Expenses	22,883,247	23.14	19,465,376	21.75	(3,417,871)	(1.39)
INCOME (LOSS) FROM OPERATIONS	68,818,612	69.60	(1,333,188)	(1.49)	70,151,800	71.09
INVESTMENT INCOME						
Interest Income	11,441,793	11.57	500,000	0.56	10,941,793	11.01
Realized Gain/(Loss) on Investments	(275,978)	(0.28)	-	-	(275,978)	(0.28)
Unrealized Gain/(Loss) on Investments	(2,185,564)	(2.21)	-	-	(2,185,564)	(2.21)
Total Investment Income	8,980,251	9.08	500,000	0.56	8,480,251	8.52
NET RENTAL INCOME	83,122	0.08	90,815	0.10	(7,693)	(0.02)
TOTAL MCO TAX	(907,562)	(0.92)	-	-	(907,562)	(0.92)
TOTAL GRANT EXPENSE	(871,970)	(0.88)	(12,077,924)	(13.49)	11,205,954	12.61
OTHER INCOME	97	-	-	-	97	-
CHANGE IN NET ASSETS	**76,102,551**	**76.97**	**(12,820,297)**	**(14.32)**	**88,922,848**	**91.29**
MEDICAL LOSS RATIO	**77.9%**		**94.8%**		**(16.9%)**	
ADMINISTRATIVE LOSS RATIO	**5.5%**		**5.6%**		**0.1%**	

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CalOptima Health- Consolidated
Statement of Revenues and Expenses
For the Twelve Months Ended June 30, 2023

	Actual		Budget		Variance	
	$	PMPM	$	PMPM	$	PMPM
MEMBER MONTHS	11,504,355		10,914,279		590,076	
REVENUE						
Medi-Cal	$ 3,813,955,499	$ 337.80	3,595,159,756	$ 335.89	$ 218,795,743	$ 1.91
OneCare Connect	172,148,805	1,997.43	167,628,057	1,907.31	4,520,748	90.12
OneCare	214,353,873	1,753.45	188,484,971	1,607.37	25,868,902	146.08
PACE	44,007,489	8,445.11	47,851,218	8,353.91	(3,843,729)	91.20
MSSP	2,454,959	430.24	3,042,209	446.33	(587,250)	(16.09)
Total Operating Revenue	4,246,920,626	369.16	4,002,166,211	366.69	244,754,415	2.47
MEDICAL EXPENSES						
Medi-Cal	3,451,727,223	305.71	3,375,551,001	315.37	(76,176,222)	9.66
OneCare Connect	160,125,645	1,857.93	159,625,681	1,816.26	(499,964)	(41.67)
OneCare	204,408,930	1,672.10	181,052,247	1,543.98	(23,356,683)	(128.12)
PACE	39,133,938	7,509.87	44,495,120	7,768.00	5,361,182	258.13
MSSP	2,257,555	395.65	2,393,763	351.20	136,208	(44.45)
Total Medical Expenses	3,857,653,291	335.32	3,763,117,812	344.79	(94,535,479)	9.47
GROSS MARGIN	389,267,335	33.84	239,048,399	21.90	150,218,936	11.94
ADMINISTRATIVE EXPENSES						
Salaries and Benefits	129,037,179	11.22	136,656,777	12.52	7,619,598	1.30
Professional Fees	7,840,231	0.68	11,708,979	1.07	3,868,748	0.39
Purchased Services	15,551,296	1.35	23,570,578	2.16	8,019,283	0.81
Printing & Postage	5,444,434	0.47	7,189,566	0.66	1,745,132	0.19
Depreciation & Amortization	4,514,769	0.39	6,310,800	0.58	1,796,031	0.19
Other Expenses	26,093,774	2.27	29,258,109	2.68	3,164,335	0.41
Indirect Cost Allocation, Occupancy	4,404,650	0.38	5,531,408	0.51	1,126,758	0.13
Total Administrative Expenses	192,886,333	16.77	220,226,217	20.18	27,339,884	3.41
INCOME (LOSS) FROM OPERATIONS	196,381,001	17.07	18,822,182	1.72	177,558,819	15.35
INVESTMENT INCOME						
Interest Income	94,964,447	8.25	6,000,000	0.55	88,964,447	7.70
Realized Gain/(Loss) on Investments	(9,493,702)	(0.83)	-	0.00	(9,493,702)	(0.83)
Unrealized Gain/(Loss) on Investments	4,918,038	0.43	-	0.00	4,918,038	0.43
Total Investment Income	90,388,783	7.86	6,000,000	0.55	84,388,783	7.31
NET RENTAL INCOME	987,045	0.09	1,090,000	0.10	(102,955)	(0.01)
TOTAL MCO TAX	(2,420,576)	(0.21)	-	0.00	(2,420,576)	(0.21)
TOTAL GRANT EXPENSE	(25,380,303)	(2.21)	(30,000,000)	(2.75)	4,619,697	0.54
OTHER INCOME	232	0.00	-	0.00	232	0.00
CHANGE IN NET ASSETS	**259,956,184**	**22.60**	**(4,087,818)**	**(0.37)**	**264,044,002**	**22.97**
MEDICAL LOSS RATIO	**90.8%**		**94.0%**		**(3.2%)**	
ADMINISTRATIVE LOSS RATIO	**4.5%**		**5.5%**		**1.0%**	

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CalOptima Health - Consolidated - Month to Date
Statement of Revenues and Expenses by LOB
For the One Month Ended June 30, 2023

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	MSSP	Consolidated
MEMBER MONTHS	616,964	347,169	6,457	970,590		17,687	439	498	988,716
REVENUES									
Capitation Revenue	237,039,819	$ 128,249,268	$ 10,514,068	$ 375,803,155	$ (1,737,339)	$ 37,135,796	$ 3,759,112	$ 226,425	$ 415,187,148
Total Operating Revenue	237,039,819	128,249,268	10,514,068	375,803,155	(1,737,339)	37,135,796	3,759,112	226,425	415,187,148
MEDICAL EXPENSES									
Provider Capitation	44,794,541	52,477,987	5,669,902	102,942,430	(822)	16,161,505			119,103,113
Facilities	31,796,398	27,091,782	3,635,581	62,523,761	(113,209)	7,169,259	214,297		69,794,108
Professional Claims	31,917,792	20,487,103	1,994,553	54,399,449	11,566	1,836,963	963,059		57,211,037
Prescription Drugs	(5,634)			(5,634)	(1,954,660)	8,890,609	537,741		7,468,057
MLTSS	34,899,473	4,681,784	1,593,943	41,175,199	(2,611)	81,440	(38,416)	29,741	41,245,353
Incentive Payments	9,847,444	8,271,671	169,208	18,288,324	58,286	690,099			19,036,708
Medical Management	4,652,275	2,558,720	(46,127)	7,164,868	(1,435,528)	2,992,172	1,144,594	184,676	10,050,782
Other Medical Expenses	(336,079)	(73,878)	(13,912)	(423,868)					(423,868)
Total Medical Expenses	157,566,211	115,495,169	13,003,148	286,064,529	(3,436,978)	37,822,047	2,821,275	214,417	323,485,290
Medical Loss Ratio	66.5%	90.1%	123.7%	76.1%	197.8%	101.8%	75.1%	94.7%	77.9%
GROSS MARGIN	**79,473,608**	**12,754,099**	**(2,489,081)**	**89,738,626**	**1,699,638**	**(686,250)**	**937,837**	**12,007**	**91,701,858**
ADMINISTRATIVE EXPENSES									
Salaries & Benefits				12,436,453	20,466	870,209	149,084	84,809	13,561,021
Professional Fees				924,983	(13,075)	41,957		1,333	955,198
Purchased Services				1,768,244		337,939	62,770	22	2,168,975
Printing & Postage				288,085		89,051	21,979		399,116
Depreciation & Amortization				438,887			1,072		439,959
Other Expenses				4,967,736	(1)	31,478	17,811	6,504	5,023,528
Indirect Cost Allocation, Occupancy				(567,145)		877,451	17,008	8,137	335,451
Total Administrative Expenses				**20,257,242**	**7,390**	**2,248,085**	**269,725**	**100,804**	**22,883,247**
Admin Loss Ratio				5.4%	-0.4%	6.1%	7.2%	44.5%	5.5%
INCOME (LOSS) FROM OPERATIONS				69,481,384	1,692,248	(2,934,335)	668,112	(88,797)	68,818,612
INVESTMENT INCOME									8,980,251
NET RENTAL INCOME									83,122
TOTAL MCO TAX				(907,562)					(907,562)
TOTAL GRANT EXPENSE				(871,970)					(871,970)
OTHER INCOME				97					97
CHANGE IN NET ASSETS				**$ 67,701,949**	**$ 1,692,248**	**$ (2,934,335)**	**$ 668,112**	**$ (88,797)**	**$ 76,102,551**
BUDGETED CHANGE IN NET ASSETS				(12,367,481)	(42,321)	(1,037,047)	80,340	(44,603)	(12,820,297)
VARIANCE TO BUDGET - FAV (UNFAV)				$ 80,069,430	$ 1,734,569	$ (1,897,288)	$ 587,772	$ (44,194)	$ 88,922,848

Note:* Total membership does not include MSSP

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CalOptima Health - Consolidated - Year to Date
Statement of Revenues and Expenses by LOB
For the Twelve Months Ended June 30, 2023

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	MSSP	Consolidated
MEMBER MONTHS	6,968,542	4,185,916	136,254	11,290,712	86,185	122,247	5,211	5,706	11,504,355
REVENUES									
Capitation Revenue	2,056,085,094	$ 1,493,601,963	$ 264,268,442	$ 3,813,955,499	$ 172,148,805	$ 214,353,873	$ 44,007,489	$ 2,454,959	$ 4,246,920,626
Total Operating Revenue	2,056,085,094	1,493,601,963	264,268,442	3,813,955,499	172,148,805	214,353,873	44,007,489	2,454,959	4,246,920,626
MEDICAL EXPENSES									
Provider Capitation	480,046,380	575,126,254	100,049,780	1,155,222,414	72,094,334	85,651,823			1,312,968,571
Facilities	380,395,276	336,723,351	59,699,744	776,818,371	26,308,563	39,330,651	9,198,557		851,656,142
Professional Claims	297,387,031	185,829,206	18,058,804	501,275,041	8,785,745	9,668,787	11,378,637		531,108,210
Prescription Drugs	(3,232,402)	(2,287,072)	5,604	(5,513,869)	35,518,208	58,746,651	5,129,725		93,880,715
MLTSS	460,241,129	54,427,873	22,335,400	537,004,402	9,520,914	483,561	1,280,837	342,870	548,632,585
Incentive Payments	57,005,992	57,616,506	1,297,483	115,919,981	2,567,009	1,718,553	(120,875)		120,084,667
Medical Management	36,411,919	24,288,364	4,626,919	65,327,202	5,330,873	8,808,904	12,267,056	1,914,684	93,648,719
Other Medical Expenses	162,768,820	124,310,043	18,594,819	305,673,683					305,673,683
Total Medical Expenses	1,871,024,145	1,356,034,525	224,668,553	3,451,727,223	160,125,645	204,408,930	39,133,938	2,257,555	3,857,653,291
Medical Loss Ratio	91.0%	90.8%	85.0%	90.5%	93.0%	95.4%	88.9%	92.0%	90.8%
GROSS MARGIN	**185,060,949**	**137,567,437**	**39,599,890**	**362,228,276**	**12,023,160**	**9,944,943**	**4,873,551**	**197,404**	**389,267,335**
ADMINISTRATIVE EXPENSES									
Salaries & Benefits				116,315,804	4,296,988	5,808,949	1,678,456	936,983	129,037,179
Professional Fees				7,491,671	11,809	313,081	7,670	16,000	7,840,231
Purchased Services				13,018,650	595,858	1,413,053	523,708	27	15,551,296
Printing & Postage				4,023,185	261,432	953,556	206,262		5,444,434
Depreciation & Amortization				4,504,381			10,389		4,514,769
Other Expenses				25,805,442	10,502	71,910	132,553	73,368	26,093,774
Indirect Cost Allocation, Occupancy				(6,445,632)	4,929,832	5,681,411	170,256	68,782	4,404,650
Total Administrative Expenses				**164,713,499**	**10,106,420**	**14,241,959**	**2,729,295**	**1,095,159**	**192,886,333**
Admin Loss Ratio				4.3%	5.9%	6.6%	6.2%	44.6%	4.5%
INCOME (LOSS) FROM OPERATIONS				197,514,777	1,916,740	(4,297,015)	2,144,256	(897,755)	196,381,001
INVESTMENT INCOME									90,388,783
NET RENTAL INCOME									987,045
TOTAL MCO TAX				(2,420,576)					(2,420,576)
TOTAL GRANT EXPENSE				(25,380,303)					(25,380,303)
OTHER INCOME				232					232
CHANGE IN NET ASSETS				**$ 169,714,130**	**$ 1,916,740**	**$ (4,297,015)**	**$ 2,144,256**	**$ (897,755)**	**$ 259,956,184**
BUDGETED CHANGE IN NET ASSETS				1,373,753	(3,181,436)	(9,017,262)	170,630	(523,503)	(4,087,818)
VARIANCE TO BUDGET - FAV (UNFAV)				$ 168,340,377	$ 5,098,176	$ 4,720,247	$ 1,973,626	$ (374,252)	$ 264,044,002

Note:* Total membership does not include MSSP

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CalOptima Health

Unaudited Financial Statements as of June 30, 2023

MONTHLY RESULTS:

- Change in Net Assets is $76.1 million, $88.9 million favorable to budget
- Operating surplus is $68.8 million, with a surplus in non-operating income of $7.3 million

YEAR TO DATE RESULTS:

- Change in Net Assets is $260.0 million, $264.0 million favorable to budget
- Operating surplus is $196.4 million, with a surplus in non-operating income of $63.6 million

Change in Net Assets by Line of Business (LOB) ($ millions):

June 2023				July 2022 - June 2023		
Actual	**Budget**	**Variance**	**Operating Income (Loss)**	**Actual**	**Budget**	**Variance**
69.5	(0.3)	69.8	Medi-Cal	197.5	31.4	166.1
1.7	(0.0)	1.7	OCC	1.9	(3.2)	5.1
(2.9)	(1.0)	(1.9)	OneCare	(4.3)	(9.0)	4.7
0.7	0.1	0.6	PACE	2.1	0.2	2.0
(0.1)	(0.0)	(0.0)	MSSP	(0.9)	(0.5)	(0.4)
68.8	**(1.3)**	**70.2**	**Total Operating Income (Loss)**	**196.4**	**18.8**	**177.6**
			Non-Operating Income (Loss)			
9.0	0.5	8.5	Net Investment Income/Expense	90.4	6.0	84.4
0.1	0.1	(0.0)	Net Rental Income/Expense	1.0	1.1	(0.1)
(0.9)	0.0	(0.9)	Net Operating Tax	(2.4)	0.0	(2.4)
(0.9)	(12.1)	11.2	Grant Expense	(25.4)	(30.0)	4.6
0.0	0.0	0.0	Other Income	0.0	0.0	0.0
7.3	**(11.5)**	**18.8**	**Total Non-Operating Income/(Loss)**	**63.6**	**(22.9)**	**86.5**
76.1	**(12.8)**	**88.9**	**TOTAL**	**260.0**	**(4.1)**	**264.0**

CalOptima Health - Consolidated
Enrollment Summary
For the Twelve Months Ended June 30, 2023

June 2023					Year-to-Date			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	% Variance
181,230	139,356	41,874	30.0%	SPD	1,636,740	1,568,122	68,618	4.4%
300,038	301,477	(1,439)	(0.5%)	TANF Child	3,648,766	3,654,694	(5,928)	(0.2%)
134,844	124,730	10,114	8.1%	TANF Adult	1,646,808	1,576,585	70,223	4.5%
852	3,525	(2,673)	(75.8%)	LTC	36,228	40,998	(4,770)	(11.6%)
347,169	296,910	50,259	16.9%	MCE	4,185,916	3,721,255	464,661	12.5%
6,457	11,910	(5,453)	(45.8%)	WCM	136,254	141,747	(5,493)	(3.9%)
970,590	**877,908**	**92,682**	**10.6%**	**Medi-Cal Total**	**11,290,712**	**10,703,401**	**587,311**	**5.5%**
		0	**0.0%**	**OneCare Connect**	**86,185**	**87,887**	**(1,702)**	**(1.9%)**
17,687	**16,736**	**951**	**5.7%**	**OneCare**	**122,247**	**117,263**	**4,984**	**4.3%**
439	**508**	**(69)**	**(13.6%)**	**PACE**	**5,211**	**5,728**	**(517)**	**(9.0%)**
498	**568**	**(70)**	**(12.3%)**	**MSSP**	**5,706**	**6,816**	**(1,110)**	**(16.3%)**
988,716	**895,152**	**93,564**	**10.5%**	**CalOptima Total**	**11,504,355**	**10,914,279**	**590,076**	**5.4%**
				Enrollment (by Network)				
302,007	201,496	100,511	49.9%	HMO	3,016,684	2,491,448	525,236	21.1%
225,890	232,716	(6,826)	(2.9%)	PHC	2,521,977	2,841,548	(319,571)	(11.2%)
310,718	213,177	97,541	45.8%	Shared Risk Group	2,842,377	2,626,046	216,331	8.2%
131,975	230,519	(98,544)	(42.7%)	Fee for Service	2,909,674	2,744,359	165,315	6.0%
970,590	**877,908**	**92,682**	**10.6%**	**Medi-Cal Total**	**11,290,712**	**10,703,401**	**587,311**	**5.5%**
0	**0**	**0**	**0.0%**	**OneCare Connect**	**86,185**	**87,887**	**(1,702)**	**(1.9%)**
17,687	**16,736**	**951**	**5.7%**	**OneCare**	**122,247**	**117,263**	**4,984**	**4.3%**
439	**508**	**(69)**	**(13.6%)**	**PACE**	**5,211**	**5,728**	**(517)**	**(9.0%)**
498	**568**	**(70)**	**(12.3%)**	**MSSP**	**5,706**	**6,816**	**(1,110)**	**(16.3%)**
988,716	**895,152**	**93,564**	**10.5%**	**CalOptima Total**	**11,504,355**	**10,914,279**	**590,076**	**5.4%**

Note:* Total membership does not include MSSP

CalOptima Health
Enrollment Trend by Network
Fiscal Year 2023

	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	YTD Actual	YTD Budget	Variance
HMOs															
SPD	11,237	11,250	11,290	11,288	14,002	14,044	14,044	14,090	14,108	14,091	14,118	21,440	165,002	132,049	32,953
TANF Child	58,966	58,892	58,837	58,847	69,892	69,736	69,972	70,036	70,162	70,142	70,154	75,358	800,994	705,935	95,059
TANF Adult	38,926	38,983	39,331	39,640	48,530	48,844	49,255	49,567	49,999	50,561	50,926	55,849	560,411	488,674	71,737
LTC	1	2	2	1				1		3	1	15	26		26
MCE	99,022	99,788	100,301	101,292	127,939	128,438	129,823	131,179	131,973	133,319	134,134	148,644	1,465,852	1,139,286	326,566
WCM	2,034	2,020	2,021	2,050	2,272	2,268	2,242	2,285	2,234	2,132	2,140	701	24,399	25,504	(1,105)
Total	**210,186**	**210,935**	**211,782**	**213,118**	**262,635**	**263,330**	**265,336**	**267,158**	**268,476**	**270,248**	**271,473**	**302,007**	**3,016,684**	**2,491,448**	**525,236**
PHCs															
SPD	7,040	7,022	7,037	7,029	4,408	4,387	4,435	4,356	4,476	4,436	4,450	10,976	70,052	83,944	(13,892)
TANF Child	158,385	158,345	158,767	159,067	148,298	148,419	148,820	149,257	149,182	149,847	149,599	167,946	1,845,932	1,905,720	(59,788)
TANF Adult	16,704	16,780	16,830	16,855	8,478	8,499	8,550	8,590	8,640	8,718	8,830	8,901	136,375	204,470	(68,095)
LTC		1	1	3		2						10	17		17
MCE	47,505	47,574	47,748	48,051	22,411	22,545	22,920	23,161	23,297	23,504	23,665	32,885	385,266	560,064	(174,798)
WCM	7,366	7,472	7,340	7,301	7,096	7,142	7,175	7,108	7,043	7,017	7,103	5,172	84,335	87,350	(3,015)
Total	**237,000**	**237,194**	**237,723**	**238,306**	**190,691**	**190,994**	**191,900**	**192,472**	**192,638**	**193,522**	**193,647**	**225,890**	**2,521,977**	**2,841,548**	**(319,571)**
Shared Risk Groups															
SPD	10,824	10,928	10,995	10,954	11,023	11,046	11,181	11,053	11,123	11,105	11,075	20,189	141,496	122,318	19,178
TANF Child	57,419	57,075	56,762	56,460	56,201	55,828	55,913	55,869	55,922	55,824	55,613	69,143	688,029	719,499	(31,470)
TANF Adult	40,518	40,260	40,370	40,566	40,961	41,218	41,636	42,055	42,377	43,108	43,416	55,556	512,041	477,263	34,778
LTC	2	1	3	6	2				1	1	1	25	42		42
MCE	114,819	115,585	116,539	117,839	118,935	119,808	121,272	122,217	123,296	124,524	125,603	164,909	1,485,346	1,290,232	195,114
WCM	1,360	1,341	1,332	1,369	1,325	1,303	1,294	1,317	1,310	1,272	1,304	896	15,423	16,734	(1,311)
Total	**224,942**	**225,190**	**226,001**	**227,194**	**228,447**	**229,203**	**231,296**	**232,511**	**234,029**	**235,834**	**237,012**	**310,718**	**2,842,377**	**2,626,046**	**216,331**
Fee for Service (Dual)															
SPD	82,253	82,742	82,935	83,572	84,174	83,819	98,278	98,465	98,630	98,988	99,157	111,569	1,104,582	1,092,719	11,863
TANF Child	1	1	1	1	1	1	1	1	1	1	1	(35)	(24)		(24)
TANF Adult	1,675	1,712	1,743	1,742	1,767	1,776	2,271	2,318	2,310	2,360	2,366	3,020	25,060	24,210	850
LTC	2,894	2,874	2,845	2,879	2,929	2,915	2,943	2,745	2,683	2,870	2,845	578	32,000	36,961	(4,961)
MCE	6,480	6,749	7,030	7,314	7,498	7,795	8,014	8,269	8,589	8,853	9,217	(3,540)	82,268	62,858	19,410
WCM	20	18	24	17	16	18	14	16	16	16	22	11	208	184	24
Total	**93,323**	**94,096**	**94,578**	**95,525**	**96,385**	**96,324**	**111,521**	**111,814**	**112,229**	**113,088**	**113,608**	**111,603**	**1,244,094**	**1,216,932**	**27,162**
Fee for Service (Non-Dual - Total)															
SPD	11,984	12,003	16,296	8,528	12,224	12,480	15,537	10,292	13,086	12,832	13,290	17,056	155,608	137,092	18,516
TANF Child	28,613	28,702	29,350	29,540	30,022	28,970	30,017	30,313	29,679	30,493	30,510	(12,374)	313,835	323,540	(9,705)
TANF Adult	32,830	33,442	37,388	38,818	35,106	35,368	37,021	39,824	36,971	37,226	37,409	11,518	412,921	381,968	30,953
LTC	360	364	366	345	344	346	367	366	357	359	345	224	4,143	4,037	106
MCE	63,450	64,657	66,876	67,538	69,063	69,002	71,735	72,881	71,606	72,363	73,742	4,271	767,184	668,815	98,369
WCM	1,096	1,094	1,049	1,080	1,036	1,069	1,094	1,147	1,166	1,181	1,200	(323)	11,889	11,975	(86)
Total	**138,333**	**140,262**	**151,325**	**145,849**	**147,795**	**147,235**	**155,771**	**154,823**	**152,865**	**154,454**	**156,496**	**20,372**	**1,665,580**	**1,527,427**	**138,153**
Grand Totals															
SPD	123,338	123,945	128,553	121,371	125,831	125,776	143,475	138,256	141,423	141,452	142,090	181,230	1,636,740	1,568,122	68,618
TANF Child	303,384	303,015	303,717	303,915	304,414	302,954	304,723	305,476	304,946	306,307	305,877	300,038	3,648,766	3,654,694	(5,928)
TANF Adult	130,653	131,177	135,662	137,621	134,842	135,705	138,733	142,354	140,297	141,973	142,947	134,844	1,646,808	1,576,585	70,223
LTC	3,257	3,242	3,217	3,234	3,275	3,263	3,310	3,112	3,041	3,233	3,192	852	36,228	40,998	(4,770)
MCE	331,276	334,353	338,494	342,034	345,846	347,588	353,764	357,707	358,761	362,563	366,361	347,169	4,185,916	3,721,255	464,661
WCM	11,876	11,945	11,766	11,817	11,745	11,800	11,819	11,873	11,769	11,618	11,769	6,457	136,254	141,747	(5,493)
Total MediCal MM	**903,784**	**907,677**	**921,409**	**919,992**	**925,953**	**927,086**	**955,824**	**958,778**	**960,237**	**967,146**	**972,236**	**970,590**	**11,290,712**	**10,703,401**	**587,311**
OneCare Connect	**14,203**	**14,771**	**14,405**	**14,198**	**14,197**	**14,385**	**26**						**86,185**	**87,887**	**(1,702)**
OneCare	**2,764**	**2,874**	**2,905**	**2,964**	**3,015**	**3,067**	**17,293**	**17,342**	**17,415**	**17,406**	**17,515**	**17,687**	**122,247**	**117,263**	**4,984**
PACE	**435**	**434**	**437**	**430**	**433**	**437**	**428**	**432**	**437**	**434**	**435**	**439**	**5,211**	**5,728**	**(517)**
MSSP	**466**	**470**	**478**	**478**	**476**	**471**	**467**	**472**	**473**	**473**	**484**	**498**	**5,706**	**6,816**	**(1,110)**
Grand Total	**921,186**	**925,756**	**939,156**	**937,584**	**943,598**	**944,975**	**973,571**	**976,552**	**978,089**	**984,986**	**990,186**	**988,716**	**11,504,355**	**10,914,279**	**590,076**

Note:* Total membership does not include MSSP

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ENROLLMENT:

Overall, June enrollment was 988,716

- Favorable to budget 93,564 or 10.5%
- Decreased 1,470 or 0.1% from Prior Month (PM) (May 2023)
- Increased 74,070 or 8.1% from Prior Year (PY) (June 2022)

Medi-Cal enrollment was 970,590

- Favorable to budget 92,682 or 10.6% driven by Department of Health Care Services (DHCS) pause of Medi-Cal redetermination due to the extension of the Public Health Emergency (PHE), which expired on May 11, 2023
  - Medi-Cal Expansion (MCE) favorable 50,259
  - Seniors and Persons with Disabilities (SPD) favorable 41,874
  - Temporary Assistance for Needy Families (TANF) favorable 8,675
  - Whole Child Model (WCM) unfavorable 5,453
  - Long-Term Care (LTC) unfavorable 2,673
- Decreased 1,646 from PM

OneCare enrollment was 17,687

- Favorable to budget 951 or 5.7%
- Increased 172 from PM

PACE enrollment was 439

- Unfavorable to budget 69 or 13.6%
- Increased 4 from PM

MSSP enrollment was 498

- Unfavorable to budget 70 or 12.3%
- Increased 14 from PM

OneCare Connect enrollment was 0 due to transition of OneCare Connect (OCC) members to OneCare (OC), effective January 1, 2023

CalOptima Health
Medi-Cal
Statement of Revenues and Expenses
For the Twelve Months Ended June 30, 2023

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
970,590	**877,908**	**92,682**	**10.6%**	**Member Months**	**11,290,712**	**10,703,401**	**587,311**	**5.5%**
				Revenues				
375,803,155	314,565,191	61,237,964	19.5%	Medi-Cal Capitation Revenue	3,813,955,499	3,595,159,756	218,795,743	6.1%
375,803,155	**314,565,191**	**61,237,964**	**19.5%**	**Total Operating Revenue**	**3,813,955,499**	**3,595,159,756**	**218,795,743**	**6.1%**
				Medical Expenses				
102,942,430	102,290,784	(651,646)	(0.6%)	Provider Capitation	1,155,222,414	1,259,265,870	104,043,456	8.3%
62,523,761	66,850,033	4,326,272	6.5%	Facilities Claims	776,818,371	813,733,500	36,915,129	4.5%
54,399,449	41,324,702	(13,074,747)	(31.6%)	Professional Claims	501,275,041	489,772,338	(11,502,703)	(2.3%)
41,175,199	52,435,670	11,260,471	21.5%	MLTSS	537,004,402	612,794,229	75,789,827	12.4%
(5,634)	-	5,634	100.0%	Prescription Drugs	(5,513,869)	-	5,513,869	100.0%
18,288,324	4,566,769	(13,721,555)	(300.5%)	Incentive Payments	115,919,981	55,708,073	(60,211,908)	(108.1%)
7,164,868	6,632,875	(531,993)	(8.0%)	Medical Management	65,327,202	80,388,122	15,060,920	18.7%
(423,868)	24,074,078	24,497,946	101.8%	Other Medical Expenses	305,673,683	63,888,869	(241,784,814)	(378.4%)
286,064,529	**298,174,911**	**12,110,382**	**4.1%**	**Total Medical Expenses**	**3,451,727,223**	**3,375,551,001**	**(76,176,222)**	**(2.3%)**
89,738,626	**16,390,280**	**73,348,346**	**447.5%**	**Gross Margin**	**362,228,276**	**219,608,755**	**142,619,521**	**64.9%**
				Administrative Expenses				
12,436,453	10,323,057	(2,113,396)	(20.5%)	Salaries, Wages & Employee Benefits	116,315,804	120,813,117	4,497,313	3.7%
924,983	905,262	(19,721)	(2.2%)	Professional Fees	7,491,671	11,128,031	3,636,360	32.7%
1,768,244	2,284,426	516,182	22.6%	Purchased Services	13,018,650	19,773,325	6,754,675	34.2%
288,085	487,743	199,658	40.9%	Printing & Postage	4,023,185	5,205,917	1,182,732	22.7%
438,887	525,000	86,114	16.4%	Depreciation & Amortization	4,504,381	6,300,000	1,795,619	28.5%
4,967,736	2,480,011	(2,487,725)	(100.3%)	Other Operating Expenses	25,805,442	28,922,534	3,117,092	10.8%
(567,145)	(325,662)	241,483	74.2%	Indirect Cost Allocation, Occupancy	(6,445,632)	(3,907,922)	2,537,710	64.9%
20,257,242	**16,679,837**	**(3,577,405)**	**(21.4%)**	**Total Administrative Expenses**	**164,713,499**	**188,235,002**	**23,521,503**	**12.5%**
				Non-Operating Income (Loss)				
(907,562)	-	(907,562)	(100.0%)	Net Operating Tax	(2,420,576)	-	(2,420,576)	(100.0%)
(871,970)	(12,077,924)	11,205,954	92.8%	Grant Expense	(25,380,303)	(30,000,000)	4,619,697	15.4%
-	-	-	0.0%	Net QAF & IGT Income/Expense	-	-	-	0.0%
97	-	97	100.0%	Other Income	232	-	232	100.0%
(1,779,435)	**(12,077,924)**	**10,298,489**	**85.3%**	**Total Non-Operating Income (Loss)**	**(27,800,646)**	**(30,000,000)**	**2,199,354**	**7.3%**
67,701,949	**(12,367,481)**	**80,069,430**	**647.4%**	**Change in Net Assets**	**169,714,130**	**1,373,753**	**168,340,377**	**12254.0%**
76.1%	***94.8%***	***(18.7%)***		***Medical Loss Ratio***	***90.5%***	***93.9%***	***(3.4%)***	
5.4%	***5.3%***	***(0.1%)***		***Admin Loss Ratio***	***4.3%***	***5.2%***	***0.9%***	

MEDI-CAL INCOME STATEMENT– JUNE MONTH:

REVENUES of $375.8 million are favorable to budget $61.2 million driven by:

- Favorable volume related variance of $33.2 million
- Favorable price related variance of $28.0 million
  - $34.5 million due to completion of In-Home Supportive Services (IHSS) reconciliation with DHCS
  - $22.3 million from DHCS' Housing and Homelessness Incentive Program (HHIP)
  - $5.9 million from favorable premium capitation rates
  - Offset by:
    - $23.4 million due to prior period updates to the COVID-19 risk corridor
    - $9.0 million from Proposition 56 and Enhanced Care Management (ECM) risk corridor

MEDICAL EXPENSES of $286.1 million are favorable to budget $12.1 million driven by:

- Unfavorable volume related variance of $31.5 million
- Favorable price related variance of $43.6 million
  - Other Medical Expenses favorable variance of $27.0 million due primarily to a recategorization of CalAIM Incentive Payment Program (IPP) expenses in Incentive Payments
  - Managed Long-Term Services and Supports (MLTSS) expense favorable variance of $16.8 million due to lower than budgeted utilization
  - Facilities Claims expense favorable variance of $11.4 million due to low utilization
  - Provider Capitation expense favorable variance of $10.1 million due to Proposition 56
  - Medical Management expense favorable variance of $0.2 million
  - Offset by:
    - Incentive Payments expense unfavorable variance of $13.2 million due primarily to HHIP
    - Professional Claims expense unfavorable variance of $8.7 million due primarily to increased utilization in CalAIM Community Support services

ADMINISTRATIVE EXPENSES of $20.3 million are unfavorable to budget $3.6 million driven by:

- Salaries & Benefit expense unfavorable to budget $2.1 million due primarily to changes in CalOptima Health's Total Other Post-Employment Benefits (OPEB) and Pension liabilities.
- Other Non-Salary expense unfavorable to budget $1.5 million

CHANGE IN NET ASSETS is $67.7 million, favorable to budget $80.1 million

CalOptima Health
OneCare
Statement of Revenues and Expenses
For the Twelve Months Ended June 30, 2023

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
17,687	**16,736**	**951**	**5.7%**	**Member Months**	**122,247**	**117,263**	**4,984**	**4.3%**
				Revenues				
27,977,788	21,085,422	6,892,366	32.7%	Medicare Part C Revenue	156,693,085	140,968,615	15,724,470	11.2%
9,158,008	6,788,373	2,369,635	34.9%	Medicare Part D Revenue	57,660,788	47,516,356	10,144,432	21.3%
37,135,796	**27,873,795**	**9,262,001**	**33.2%**	**Total Operating Revenue**	**214,353,873**	**188,484,971**	**25,868,902**	**13.7%**
				Medical Expenses				
16,161,505	10,827,666	(5,333,839)	(49.3%)	Provider Capitation	85,651,823	70,410,917	(15,240,906)	(21.6%)
7,169,259	4,608,707	(2,560,552)	(55.6%)	Inpatient	39,330,651	35,425,008	(3,905,643)	(11.0%)
1,836,963	1,113,098	(723,865)	(65.0%)	Ancillary	9,668,787	7,289,253	(2,379,534)	(32.6%)
81,440	70,465	(10,975)	(15.6%)	MLTSS	483,561	426,623	(56,938)	(13.3%)
8,890,609	7,841,275	(1,049,334)	(13.4%)	Prescription Drugs	58,746,651	54,257,469	(4,489,182)	(8.3%)
690,099	636,187	(53,912)	(8.5%)	Incentive Payments	1,718,553	4,103,885	2,385,332	58.1%
2,992,172	1,409,735	(1,582,437)	(112.3%)	Medical Management	8,808,904	9,139,092	330,188	3.6%
37,822,047	**26,507,133**	**(11,314,914)**	**(42.7%)**	**Total Medical Expenses**	**204,408,930**	**181,052,247**	**(23,356,683)**	**(12.9%)**
(686,250)	**1,366,662**	**(2,052,912)**	**(150.2%)**	**Gross Margin**	**9,944,943**	**7,432,724**	**2,512,219**	**33.8%**
				Administrative Expenses				
870,209	1,046,919	176,710	16.9%	Salaries, Wages & Employee Benefits	5,808,949	7,123,243	1,314,294	18.5%
41,957	40,587	(1,370)	(3.4%)	Professional Fees	313,081	385,000	71,919	18.7%
337,939	392,544	54,605	13.9%	Purchased Services	1,413,053	2,485,662	1,072,609	43.2%
89,051	202,256	113,205	56.0%	Printing & Postage	953,556	1,449,448	495,892	34.2%
31,478	25,973	(5,505)	(21.2%)	Other Operating Expenses	71,910	134,433	62,523	46.5%
877,451	695,430	(182,021)	(26.2%)	Indirect Cost Allocation, Occupancy	5,681,411	4,872,200	(809,211)	(16.6%)
2,248,085	**2,403,709**	**155,624**	**6.5%**	**Total Administrative Expenses**	**14,241,959**	**16,449,986**	**2,208,027**	**13.4%**
(2,934,335)	**(1,037,047)**	**(1,897,288)**	**(183.0%)**	**Change in Net Assets**	**(4,297,015)**	**(9,017,262)**	**4,720,247**	**52.3%**
101.8%	***95.1%***	***6.8%***		***Medical Loss Ratio***	***95.4%***	***96.1%***	***(0.7%)***	
6.1%	***8.6%***	***2.6%***		***Admin Loss Ratio***	***6.6%***	***8.7%***	***2.1%***	

ONECARE INCOME STATEMENT– JUNE MONTH:

REVENUES of $37.1 million are favorable to budget $9.3 million driven by:

- Favorable volume related variance of $1.6 million
- Favorable price related variance of $7.7 million due to the Centers for Medicare and Medicaid Services' 2023 Hierarchical Condition Category (HCC) reconciliation

MEDICAL EXPENSES of $37.8 million are unfavorable to budget $11.3 million driven by:

- Unfavorable volume related variance of $1.5 million
- Unfavorable price related variance of $9.8 million
  - Provider Capitation expense unfavorable variance of $4.7 million due primarily to the Centers for Medicare and Medicaid Services (CMS) 2023 HCC reconciliation
  - Facilities Inpatient expense unfavorable variance of $2.3 million
  - Medical Management expense unfavorable variance of $1.5 million due an increase to the claims settlement liability from the transition of OCC members to OC on January 1, 2023.
  - Ancillary expense unfavorable variance of $0.7 million
  - All other expenses unfavorable variance of $0.6 million

ADMINISTRATIVE EXPENSES of $2.2 million are favorable to budget $0.2 million driven by:

- Salaries & Benefit expense favorable to budget $0.2 million
- Other Non-Salary expense unfavorable to budget $21,086

CHANGE IN NET ASSETS is ($2.9) million, unfavorable to budget $1.9 million

CalOptima Health
OneCare Connect - Total
Statement of Revenue and Expenses
For the Twelve Months Ended June 30, 2023

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
-	-	-	0.0%	**Member Months**	**86,185**	**87,887**	**(1,702)**	**(1.9%)**
				Revenues				
3,256	-	3,256	100.0%	Medi-Cal Revenue	17,530,733	16,971,109	559,624	3.3%
-	-	-	0.0%	Medicare Part C Revenue	121,331,695	117,560,580	3,771,115	3.2%
(1,740,595)	-	(1,740,595)	(100.0%)	Medicare Part D Revenue	33,286,377	33,096,368	190,009	0.6%
(1,737,339)	**-**	**(1,737,339)**	**(100.0%)**	**Total Operating Revenue**	**172,148,805**	**167,628,057**	**4,520,748**	**2.7%**
				Medical Expenses				
(822)	-	822	100.0%	Provider Capitation	72,094,334	69,401,413	(2,692,921)	(3.9%)
(113,209)	-	113,209	100.0%	Facilities Claims	26,308,563	24,684,406	(1,624,157)	(6.6%)
11,566	-	(11,566)	(100.0%)	Ancillary	8,785,745	7,214,705	(1,571,040)	(21.8%)
(2,611)	-	2,611	100.0%	MLTSS	9,520,914	8,924,314	(596,600)	(6.7%)
(1,954,660)	-	1,954,660	100.0%	Prescription Drugs	35,518,208	38,194,494	2,676,286	7.0%
58,286	-	(58,286)	(100.0%)	Incentive Payments	2,567,009	3,304,554	737,545	22.3%
(1,435,528)	27,249	1,462,777	5368.2%	Medical Management	5,330,873	7,901,795	2,570,922	32.5%
(3,436,978)	**27,249**	**3,464,227**	**12713.2%**	**Total Medical Expenses**	**160,125,645**	**159,625,681**	**(499,964)**	**(0.3%)**
1,699,638	**(27,249)**	**1,726,887**	**6337.4%**	**Gross Margin**	**12,023,160**	**8,002,376**	**4,020,784**	**50.2%**
				Administrative Expenses				
20,466	15,072	(5,394)	(35.8%)	Salaries, Wages & Employee Benefits	4,296,988	5,626,427	1,329,439	23.6%
(13,075)	-	13,075	100.0%	Professional Fees	11,809	124,998	113,189	90.6%
-	9,670	9,670	100.0%	Purchased Services	595,858	741,635	145,777	19.7%
-	(9,670)	(9,670)	100.0%	Printing & Postage	261,432	321,091	59,659	18.6%
(1)	-	1	100.0%	Other Operating Expenses	10,502	36,561	26,059	71.3%
-	-	-	0.0%	Indirect Cost Allocation, Occupancy	4,929,832	4,333,100	(596,732)	(13.8%)
7,390	**15,072**	**7,682**	**51.0%**	**Total Administrative Expenses**	**10,106,420**	**11,183,812**	**1,077,392**	**9.6%**
1,692,248	**(42,321)**	**1,734,569**	**4098.6%**	**Change in Net Assets**	**1,916,740**	**(3,181,436)**	**5,098,176**	**160.2%**
197.8%	***0.0%***	***197.8%***		***Medical Loss Ratio***	***93.0%***	***95.2%***	***(2.2%)***	
(0.4%)	***0.0%***	***0.4%***		***Admin Loss Ratio***	***5.9%***	***6.7%***	***0.8%***	

CalOptima Health
PACE
Statement of Revenues and Expenses
For the Twelve Months Ended June 30, 2023

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
439	**508**	(69)	(13.6%)	**Member Months**	**5,211**	**5,728**	**(517)**	**(9.0%)**
				Revenues				
2,866,640	3,272,773	(406,133)	(12.4%)	Medi-Cal Capitation Revenue	33,736,556	36,629,559	(2,893,003)	(7.9%)
692,066	774,324	(82,258)	(10.6%)	Medicare Part C Revenue	7,710,272	8,783,189	(1,072,917)	(12.2%)
200,406	216,066	(15,660)	(7.2%)	Medicare Part D Revenue	2,560,661	2,438,470	122,191	5.0%
3,759,112	**4,263,163**	**(504,051)**	**(11.8%)**	**Total Operating Revenue**	**44,007,489**	**47,851,218**	**(3,843,729)**	**(8.0%)**
				Medical Expenses				
1,144,594	1,149,428	4,834	0.4%	Medical Management	12,267,056	13,549,707	1,282,651	9.5%
214,297	1,015,244	800,947	78.9%	Facilities Claims	9,198,557	11,372,244	2,173,687	19.1%
694,534	1,021,723	327,189	32.0%	Professional Claims	8,977,154	11,436,706	2,459,552	21.5%
537,741	441,514	(96,227)	(21.8%)	Prescription Drugs	5,129,725	4,892,869	(236,856)	(4.8%)
(38,416)	76,766	115,182	150.0%	MLTSS	1,280,837	847,445	(433,392)	(51.1%)
268,525	203,773	(64,752)	(31.8%)	Patient Transportation	2,401,484	2,324,615	(76,869)	(3.3%)
-	6,259	6,259	100.0%	Incentive Payments	(120,875)	71,534	192,409	269.0%
2,821,275	**3,914,707**	**1,093,432**	**27.9%**	**Total Medical Expenses**	**39,133,938**	**44,495,120**	**5,361,182**	**12.0%**
937,837	**348,456**	**589,381**	**169.1%**	**Gross Margin**	**4,873,551**	**3,356,098**	**1,517,453**	**45.2%**
				Administrative Expenses				
149,084	179,318	30,234	16.9%	Salaries, Wages & Employee Benefits	1,678,456	2,126,441	447,985	21.1%
-	10,414	10,414	100.0%	Professional Fees	7,670	54,950	47,280	86.0%
62,770	58,947	(3,823)	(6.5%)	Purchased Services	523,708	569,956	46,248	8.1%
21,979	10,334	(11,645)	(112.7%)	Printing & Postage	206,262	213,110	6,848	3.2%
1,072	900	(172)	(19.2%)	Depreciation & Amortization	10,389	10,800	411	3.8%
17,811	(5,294)	(23,105)	(436.4%)	Other Operating Expenses	132,553	54,781	(77,772)	(142.0%)
17,008	13,497	(3,511)	(26.0%)	Indirect Cost Allocation, Occupancy	170,256	155,430	(14,826)	(9.5%)
269,725	**268,116**	**(1,609)**	**(0.6%)**	**Total Administrative Expenses**	**2,729,295**	**3,185,468**	**456,173**	**14.3%**
668,112	**80,340**	**587,772**	**731.6%**	**Change in Net Assets**	**2,144,256**	**170,630**	**1,973,626**	**1156.7%**
75.1%	***91.8%***	***(16.8%)***		***Medical Loss Ratio***	***88.9%***	***93.0%***	***(4.1%)***	
7.2%	***6.3%***	***(0.9%)***		***Admin Loss Ratio***	***6.2%***	***6.7%***	***0.5%***	

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CalOptima Health
Multipurpose Senior Services Program
Statement of Revenues and Expenses
For the Twelve Months Ended June 30, 2023

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
498	**568**	**(70)**	**(12.3%)**	**Member Months**	**5,706**	**6,816**	**(1,110)**	**(16.3%)**
				Revenues				
226,425	253,522	(27,097)	(10.7%)	Revenue	2,454,959	3,042,209	(587,250)	(19.3%)
226,425	**253,522**	**(27,097)**	**(10.7%)**	**Total Operating Revenue**	**2,454,959**	**3,042,209**	**(587,250)**	**(19.3%)**
				Medical Expenses				
184,676	166,521	(18,155)	(10.9%)	Medical Management	1,914,684	1,998,263	83,579	4.2%
29,741	32,962	3,221	9.8%	Waiver Services	342,870	395,500	52,630	13.3%
184,676	166,521	(18,155)	(10.9%)	Total Medical Management	1,914,684	1,998,263	83,579	4.2%
29,741	32,962	3,221	9.8%	Total Waiver Services	342,870	395,500	52,630	13.3%
214,417	**199,483**	**(14,934)**	**(7.5%)**	**Total Program Expenses**	**2,257,555**	**2,393,763**	**136,208**	**5.7%**
12,007	**54,039**	**(42,032)**	**(77.8%)**	**Gross Margin**	**197,404**	**648,446**	**(451,042)**	**(69.6%)**
				Administrative Expenses				
84,809	81,606	(3,203)	(3.9%)	Salaries, Wages & Employee Benefits	936,983	967,549	30,566	3.2%
1,333	1,334	1	0.0%	Professional Fees	16,000	16,000	-	0.0%
22	-	(22)	(100.0%)	Purchased Services	27	-	(27)	(100.0%)
6,504	9,152	2,648	28.9%	Other Operating Expenses	73,368	109,800	36,432	33.2%
8,137	6,550	(1,587)	(24.2%)	Indirect Cost Allocation, Occupancy	68,782	78,600	9,818	12.5%
100,804	**98,642**	**(2,162)**	**(2.2%)**	**Total Administrative Expenses**	**1,095,159**	**1,171,949**	**76,790**	**6.6%**
(88,797)	**(44,603)**	**(44,194)**	**(99.1%)**	**Change in Net Assets**	**(897,755)**	**(523,503)**	**(374,252)**	**(71.5%)**
94.7%	***78.7%***	***16.0%***		***Medical Loss Ratio***	***92.0%***	***78.7%***	***13.3%***	
44.5%	***38.9%***	***(5.6%)***		***Admin Loss Ratio***	***44.6%***	***38.5%***	***(6.1%)***	

CalOptima Health
Building 505 - City Parkway
Statement of Revenues and Expenses
For the Twelve Months Ended June 30, 2023

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
-	-	-	0.0%	Rental Income	-	-	-	0.0%
-	-	-	**0.0%**	**Total Operating Revenue**	-	-	-	**0.0%**
				Administrative Expenses				
42,603	55,650	13,047	23.4%	Purchased Services	509,723	667,800	158,077	23.7%
174,199	224,250	50,051	22.3%	Depreciation & Amortization	2,106,337	2,691,000	584,663	21.7%
22,758	22,500	(258)	(1.1%)	Insurance Expense	256,150	270,000	13,850	5.1%
94,889	138,755	43,866	31.6%	Repair & Maintenance	1,487,660	1,665,060	177,400	10.7%
55,344	48,405	(6,939)	(14.3%)	Other Operating Expenses	683,881	580,860	(103,021)	(17.7%)
(389,793)	(489,560)	(99,767)	(20.4%)	Indirect Cost Allocation, Occupancy	(5,043,751)	(5,874,720)	(830,969)	(14.1%)
-	-	-	**0.0%**	**Total Administrative Expenses**	-	-	-	**0.0%**
-	-	-	**0.0%**	**Change in Net Assets**	-	-	-	**0.0%**

CalOptima Health
Building 500 - City Parkway
Statement of Revenues and Expenses
For the Twelve Months Ended June 30, 2023

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
181,333	172,500	8,833	5.1%	Rental Income	2,193,341	2,070,000	123,341	6.0%
181,333	**172,500**	**8,833**	**5.1%**	**Total Operating Revenue**	**2,193,341**	**2,070,000**	**123,341**	**6.0%**
				Administrative Expenses				
-	-	-	0.0%	Professional Fees	-	-	-	0.0%
13,392	13,337	(55)	(0.4%)	Purchased Services	152,806	160,000	7,194	4.5%
34,573	-	(34,573)	(100.0%)	Depreciation & Amortization	414,875	-	(414,875)	(100.0%)
7,500	2,737	(4,763)	(174.0%)	Insurance Expense	22,501	32,800	10,299	31.4%
27,535	25,674	(1,861)	(7.2%)	Repair & Maintenance	392,148	308,000	(84,148)	(27.3%)
15,211	39,937	24,726	61.9%	Other Operating Expenses	223,965	479,200	255,235	53.3%
-	-	-	0.0%	Indirect Cost Allocation, Occupancy	-	-	-	0.0%
98,211	**81,685**	**(16,526)**	**(20.2%)**	**Total Administrative Expenses**	**1,206,295**	**980,000**	**(226,295)**	**(23.1%)**
83,122	**90,815**	**(7,693)**	**(8.5%)**	**Change in Net Assets**	**987,045**	**1,090,000**	**(102,955)**	**(9.4%)**

OTHER INCOME STATEMENTS – JUNE MONTH:

ONECARE CONNECT INCOME STATEMENT

CHANGE IN NET ASSETS is $1.7 million, favorable to budget $1.7 million due primarily to a decrease to the claims settlement liability as OneCare Connect members transitioned to OneCare effective January 1, 2023 and prior period Pharmacy rebates

PACE INCOME STATEMENT

CHANGE IN NET ASSETS is $0.7 million favorable to budget $0.6 million

MSSP INCOME STATEMENT

CHANGE IN NET ASSETS is ($88,797), unfavorable to budget $44,194

BUILDING 500 INCOME STATEMENT

CHANGE IN NET ASSETS is $83,122, unfavorable to budget $7,693

- Net of $0.2 million in rental income and $0.1 million in expenses

INVESTMENT INCOME

- Favorable variance of $8.5 million due to $10.9 million of interest income offset by $2.5 million realized and unrealized loss on investments

CalOptima Health
Balance Sheet
June 30, 2023

ASSETS		**LIABILITIES & NET POSITION**	
Current Assets		Current Liabilities	
Operating Cash	$765,622,444	Accounts Payable	$15,006,508
Short-term Investments	1,676,736,064	Medical Claims Liability	1,635,571,979
Capitation Receivable	380,839,599	Accrued Payroll Liabilities	17,378,874
Receivables - Other	93,084,099	Deferred Revenue	63,442,911
Prepaid Expenses	15,210,703	Deferred Lease Obligations	55,308
		Capitation and Withholds	120,901,347
Total Current Assets	**2,931,492,908**	**Total Current Liabilities**	**1,852,356,927**
Capital Assets			
Furniture & Equipment	45,292,383		
Building/Leasehold Improvements	5,296,725		
Construction in Progress	3,027,022		
505 City Parkway West	53,164,315		
500 City Parkway West	22,631,500		
	129,411,945		
Less: Accumulated Depreciation	(63,239,022)	Other Liabilities	
Capital Assets, Net	66,172,922	GASB 96 Subscription Liabilities	16,107,717
GASB 96 Capital Assets		Other (than pensions) Post	
GASB 96 Subscription Assets	21,732,875	Employment Benefits Liability	18,975,000
		Net Pension Liabilities	40,465,145
Less: GASB 96 Accumulated Amoritzation	(3,714,493)	Bldg 505 Development Rights	-
GASB 96 Capital Assets, Net	18,018,382		
Total Capital Assets	**84,191,304**		
Other Assets			
Restricted Deposit & Other	300,000	**TOTAL LIABILITIES**	**1,927,904,789**
Homeless Health Reserve	-		
Board-Designated Assets:			
Cash and Cash Equivalents	1,940,210		
Investments	574,611,484	Deferred Inflows	
Total Board-Designated Assets	576,551,694	GASB 68 - PERS - Difference in Experience	2,185,361
		GASB 68 - PERS - Changes in Assumptions	1,202,155
		GASB 68 - PERS - Differnece in Earnings	-
Total Other Assets	576,851,694	GASB 75 - OPEB - Changes in Assumptions	4,921,000
		GASB 75 - OPEB - Difference in Experience	2,867,000
		Net Position	
TOTAL ASSETS	**3,592,535,906**	TNE	107,787,389
		Funds in Excess of TNE	1,571,637,563
Deferred Outflows		**TOTAL NET POSITION**	1,679,424,952
GASB 68 - PERS - Contirbutions	2,375,580		
GASB 68 - PERS - Difference in Experience	1,547,292		
GASB 68 - PERS - Excess Earnings	-		
GASB 68 - PERS - Changes in Assumptions	7,732,138		
GASB 68 - PERS - Differnece in Earnings	12,718,340		
GASB 75 - OPEB - Contributions	528,000		
GASB 75 - OPEB - Changes in Assumptions	1,068,000		
TOTAL ASSETS & DEFERRED OUTFLOWS	**3,618,505,256**	**TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION**	**3,618,505,256**

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CalOptima Health
Board Designated Reserve and TNE Analysis
as of June 30 2023

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	234,960,591				
	Tier 1 - MetLife	233,211,082				
Board-designated Reserve		468,171,673	344,338,512	538,106,755	123,833,161	(69,935,083)
	Tier 2 - Payden & Rygel	54,321,782				
	Tier 2 - MetLife	54,058,239				
TNE Requirement		108,380,021	107,787,389	107,787,389	592,632	592,632
	Consolidated:	**576,551,694**	**452,125,901**	**645,894,144**	**124,425,793**	**(69,342,451)**
	Current reserve level	*1.79*	*1.40*	*2.00*		

CalOptima Health
Statement of Cash Flows
June 30, 2023

	Month Ended	Year-To-Date
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets	76,102,551	259,956,184
Adjustments to reconcile change in net assets		
to net cash provided by operating activities		
Depreciation & Amortization	648,731	7,035,981
Changes in assets and liabilities:		
Prepaid expenses and other	3,738,837	7,381,552
Catastrophic reserves		
Capitation receivable	(4,494,533)	2,940,887
Medical claims liability	(50,907,326)	357,556,630
Deferred revenue	43,647,639	55,338,867
Payable to health networks	5,815,821	(72,313,281)
Accounts payable	4,794,034	(37,310,380)
Accrued payroll	31,459,462	34,495,626
Other accrued liabilities	16,104,577	16,070,853
Net cash provided by/(used in) operating activities	126,909,792	631,152,918
GASB 68 and GASB 75 Adjustments	(36,957,745)	(36,957,745)
CASH FLOWS FROM CAPITAL AND RELATED FINANCING ACTIVITIES:		
Net Asset transfer from Foundation	-	-
Net cash provided by (used in) in capital and related financing activities	-	-
CASH FLOWS FROM INVESTING ACTIVITIES		
Change in Investments	(145,326,723)	(662,275,561)
Change in Property and Equipment	(17,195,904)	(24,363,250)
Change in Restricted Deposit & Other	-	51
Change in Board designated reserves	1,801,919	(6,060,053)
Change in Homeless Health Reserve	-	40,636,739
Net cash provided by/(used in) investing activities	(160,720,708)	(652,062,074)
NET INCREASE/(DECREASE) IN CASH & CASH EQUIVALENTS	(70,768,660)	(57,866,901)
CASH AND CASH EQUIVALENTS, beginning of period	$836,391,104	823,489,344
CASH AND CASH EQUIVALENTS, end of period	**765,622,444**	**765,622,444**

BALANCE SHEET– JUNE MONTH:

ASSETS of $3.6 billion increased $106.4 million from May or 3.0%

- Operating Cash and Short-term Investments net increase of $74.6 million due to the timing of the $30.0 million base capitation receipt from CMS and the receipt of supplemental state funding for HHIP, and IHSS reconciliation
- Capital Assets increased $16.5 million due to the required adoption and recording of Government Accounting Standards Board (GASB) Statement No. 96 for Subscription Based Information Technology Assets (SBITA)
- Deferred Outflows increased $16.3 million due to adjustments to Net Pension Liabilities in accordance with GASB 68

LIABILITIES of $1.9 billion increased $50.9 million from May or 2.7%

- Deferred Revenue increased $43.6 million due to timing of capitation payments from CMS
- GASB 96 liabilities increased $16.1 million due to the required adoption and recording of Subscription Based Information
- Net Pension Liabilities increased $39.9 million due to adjustments in accordance with GASB 68
- Medical Claims Liabilities decreased $50.9 million due to IHSS reconciliation and timing of claim payments

NET ASSETS of $1.7 billion, increased $76.1 million from May or 4.7%

CalOptima Health - Consolidated
Net Assets Analysis
For the Twelve Months Ended June 30, 2023

Category	Item Description	Amount (millions)	Approved Initiative	Spend to Date	%
	Total Net Position @ 6/30/2023	**$1,679.4**			**100.0%**
Resources Assigned	Board Designated Reserve[1]	**576.6**			**34.3%**
	Capital Assetss, net of Depreciation[2]	**84.2**			**5.0%**
Resources Allocated[3]	Homeless Health Initiative[4]	$21.0	$59.9	$38.9	1.2%
	Housing and Homelessness Incentive Program[5]	69.7	97.2	27.5	4.2%
	Intergovernmental Transfers (IGT)	58.9	111.7	52.8	3.5%
	Digital Transformation and Workplace Modernization	88.0	100.0	12.0	5.2%
	Mind OC Grant (Orange)	0.0	1.0	1.0	0.0%
	Outreach Strategy for CalFresh, Redetermination support, and other programs	6.9	8.0	1.1	0.4%
	Coalition of Orange County Community Health Centers Grant	40.0	50.0	10.0	2.4%
	Mind OC Grant (Irvine)	0.0	15.0	15.0	0.0%
	OneCare Member Health Rewards and Incentives	1.0	1.0	0.0	0.1%
	General Awareness Campaign	1.0	2.7	1.7	0.1%
	Member Health Needs Assessment	1.0	1.0	0.0	0.1%
	Five-Year Hospital Quality Program Beginning MY 2023	153.0	153.5	0.5	9.1%
	Medi-Cal Annual Wellness Initiative	14.8	15.0	0.2	0.9%
	Skilled Nursing Facility Access Program	10.0	10.0	0.0	0.6%
	In-Home Care Pilot Program with the UCI Family Health Center	1.5	2.0	0.5	0.1%
	National Alliance for Mental Illness Orange County Peer Support Program	4.5	5.0	0.5	0.3%
	Community Living and PACE Center in the City of Tustin	17.9	18.0	0.1	1.1%
	Stipend Program for Master of Social Works	5.0	5.0	0.0	0.3%
	Wellness & Prevention Program	2.7	2.7	0.0	0.2%
	CalOptima Health Provider Workforce Development Fund	50.0	50.0	0.0	3.0%
	Post-Pandemic Supplemental	107.5	107.5	0.0	6.4%
	Subtotal:	**$654.4**	**$816.2**	**$161.8**	**39.0%**
Resources Available for New Initiatives	Unallocated/Unassigned[1]	**$364.2**			**21.7%**

[1] Total of Board Designated reserve and unallocated reserve amount can support approximately 91 days of CalOptima Health's current operations
[2] Increase due to the adoption of GASB 96 Subscription-Based Information Technology Arrangements
[3] Initiatives that have been paid in full in the previous year are omitted from the list of Resource Allocated
[4] See Page 30 for Summary of Homeless Health Initiative and Allocated Funds for list of Board approved initiatives
[5] On September 1, 2022, CalOptima Health's Board of Directors approved reallocation of $40.1M from HHI to HHIP (see HHIP Summary on Page 31)

CalOptima Health
Key Financial Indicators
As of June 2023

	Item Name	Month-to-Date (Jun 2023)					FY 2023 Year-to-Date (Jun 2023)				
		Actual	Budget	Variance	%		Actual	Budget	Variance	%	
Income Statement	*Member Months*	988,716	895,152	93,564	10.5%		11,504,355	10,914,279	590,076	5.4%	
	*Operating Revenue **	415,187,148	346,955,671	68,231,477	19.7%		4,246,920,626	4,002,166,211	244,754,415	6.1%	
	*Medical Expenses **	323,485,290	328,823,483	5,338,193	1.6%		3,857,653,291	3,763,117,812	(94,535,479)	(2.5%)	
	General and Administrative Expense	22,883,247	19,465,376	(3,417,871)	(17.6%)		192,886,333	220,226,217	27,339,884	12.4%	
	Non-Operating Income/(Loss)	7,283,939	(1,487,109)	8,771,048	589.8%		63,575,182	(12,910,000)	76,485,182	592.4%	
	Summary of Income & Expenses	76,102,551	(2,820,297)	78,922,848	2,798.4%		259,956,184	5,912,182	254,044,002	4,297.0%	
Ratios	**Medical Loss Ratio (MLR)**	**Actual**	**Budget**	**Variance**			**Actual**	**Budget**	**Variance**		
	Consolidated	77.9%	94.8%	(16.9%)			90.8%	94.0%	(3.2%)		
	Administrative Loss Ratio (ALR)	**Actual**	**Budget**	**Variance**			**Actual**	**Budget**	**Variance**		
	Consolidated	5.5%	5.6%	0.1%			4.5%	5.5%	1.0%		

Key:

> 0%	
> -20%, < 0%	
< -20%	

Investment	Investment Balance (excluding CCE)	Current Month	Prior Month	Change	%
	@6/30/2023	2,235,945,330	2,096,689,310	139,256,020	6.6%

Unallocated/Unassigned Reserve Balance	Current Month @ June 2023	Fiscal Year Ending June 2022	Change	%
Consolidated	364,234,549	448,294,548	84,059,999	(28.1%)
*Days Cash On Hand***	91			

*$293M of Directed Payments (DP) are included in YTD revenue and $291M of DP are included in YTD expenses.
**Total of Board Designated reserve and unallocated reserve amount can support approximatley 91 days of CalOptima Health's current operations.

CalOptima Health
Digital Transformation Strategy ($100 million total reserve)
Funding Balance Tracking Summary
For the Twelve Months Ended June 30, 2023

	FY 2022-23 Month-to-Date				FY 2022-23 Year-to-Date			
	Actual Spend	**Approved Budget**	**Variance $**	**Variance %**	**Actual Spend**	**Approved Budget**	**Variance $**	**Variance %**
Capital Assets (Cost, Information Only):								
Total Capital Assets	**(1,416,713)**	**166,668**	**1,583,381**	**950.0%**	**3,598,051**	**36,846,000**	**33,247,949**	**90.2%**
Operating Expenses:								
Salaries, Wages & Benefits	573,271	522,939	(50,332)	-9.6%	3,418,577	5,292,233	1,873,656	35.4%
Professional Fees	147,543	86,049	(61,494)	-71.5%	266,193	2,132,500	1,866,307	87.5%
Purchased Services	-	50,837	50,837	100.0%	-	310,000	310,000	100.0%
Depreciation Expenses	-	-	-	0.0%	-	-	-	0.0%
Other Expenses	2,225,191	374,365	(1,850,826)	-494.4%	4,696,242	3,392,380	(1,303,862)	-38.4%
Total Operating Expenses	**2,946,005**	**1,034,190**	**(1,911,815)**	**-184.9%**	**8,381,011**	**11,127,113**	**2,746,102**	**24.7%**

Funding Balance Tracking:	**Actual Spend**	**Approved Budget**
Beginning Funding Balance	100,000,000	100,000,000
Less:		
FY2022-23	11,979,061	47,973,113
FY2023-24		
FY2024-25		
Ending Funding Balance	**88,020,939**	**52,026,887**

Summary of Homeless Health Initiatives (HHI) and Allocated Funds
As of June 30, 2023

Funds Allocation, approved initiatives:	Allocated Amount	Utilized Amount	Remaining Approved Amount
Enhanced Medi-Cal Services at the Be Well OC Regional Mental Health and Wellness Campus	11,400,000	11,400,000	-
Recuperative Care	6,194,190	6,194,190	-
Medical Respite	250,000	250,000	-
Day Habilitation (County for HomeKey)	2,500,000	2,500,000	-
Clinical Field Team Start-up & Federal Qualified Health Center (FQHC)	1,600,000	1,600,000	-
CalOptima Homeless Response Team	1,681,734	1,681,734	-
Homeless Coordination at Hospitals	10,000,000	9,956,478	43,522
CalOptima Days, HCAP and FQHC Administrative Support	963,261	662,709	300,552
FQHC (Community Health Center) Expansion	21,902	21,902	-
Homeless Clinical Access Program (HCAP) and CalOptima Days	9,888,914	3,170,400	6,718,514
Vaccination Intervention and Member Incentive Strategy	400,000	54,649	345,351
Street Medicine	8,000,000	1,455,500	6,544,500
Outreach and Engagement	7,000,000	-	7,000,000
Housing and Homelessness Incentive Program (HHIP)[1]	40,100,000	-	40,100,000
Subtotal of Approved Initiatives	**$ 100,000,000**	**$ 38,947,561**	**$ 61,052,439**
Transfer of funds to HHIP[1]	(40,100,000)	-	(40,100,000)
Program Total	**$ 59,900,000**	**$ 38,947,561**	**$ 20,952,439**

Notes:

[1]On September 1, 2022, CalOptima Health's Board of Directors approved reallocation of $40.1M from HHI to HHIP.

Summary of Housing and Homelessness Incentive Program (HHIP) and Allocated Funds
As of June 30, 2023

Funds Allocation, approved initiatives:	Allocated Amount	Utilized Amount	Remaining Approved Amount
Office of Care Coordination	2,200,000	2,200,000	-
Pulse For Good	800,000	15,000	785,000
Consultant	600,000	-	600,000
Equity Grants for Programs Serving Underrepresented Populations	4,021,311	1,461,149	2,560,162
Infrastructure Projects	5,832,314	2,785,365	3,046,949
Capital Projects	73,247,369	21,000,000	52,247,369
System Change Projects	10,180,000	-	10,180,000
Non-Profit Healthcare Academy	354,530	-	354,530
Total of Approved Initiatives	**$ 97,235,524** [1]	**$ 27,461,514**	**$ 69,774,010**

Notes:

[1]Total funding $97.2M: $40.1M Board approved Transfer from CalOptima Homeless Health Initiatives, $22.3M from CalOptima Existing Reserve and $34.8M from DHCS HHIP Incentive payment

On the June 1, 2023 Board of Director's Meeting, the Board allocated an additional $44.6M to HHIP

CalOptima Health
Budget Allocation Changes
Reporting Changes for June 2023

Transfer Month	Line of Business	From	To	Amount	Expense Description	Fiscal Year
August	Medi-Cal	Health Reward Incentive Fulfillment	Health Reward Incentive Fulfillment	$75,000	To reallocate funds from Purchased Services – Health Reward Incentive Fulfillment to Incentive Budget for PHM Health Rewards	2022-23
October	Medi-Cal	Quality Improvements - Professional Fees - Consultants for NCQA Accreditation	Quality Improvements - Subscriptions - CAQH Application Subscription - Credentialing Database	$75,000	To reallocate funds from Professional Fees – Consultants for NCQA Accreditation to Subscriptions – CAQH Application Subscription – Credentialing Database to provide additional funding for expanding scope of services	2022-23
November	OneCare	Customer Service - Member Communication	Cultural & Linguistic Services - Purchased Services	$75,000	To reallocate funds from OC Customer Service – Member Communication to OC Cultural & Linguistic Services – Purchased Services to provide additional funding for translation of documents due to OCC/OC transition	2022-23
November	Medi-Cal	Human Resources - Cert/Cont. Education	Human Resources - Training & Seminars	$10,000	To reallocate funds from HR Onsite Computer Classes to Training & Seminars, HR Staff Development (for the CPS Academy classes)	2022-23
November	Medi-Cal	Population Health Management - Professional Fees	Case management - Training & Seminars	$27,000	To reallocate funds from Population Health Management – Purchased Services to Case Management – Training & Seminars to provide funding for WPATH training	2022-23
December	Medi-Cal	Quality Improvements - Subscriptions	Quality Improvements - Purchased Services	$75,000	To reallocate funds from Subscriptions – CAQH Application Subscription – Credentialing Database to Purchased Services to provide funding for additional credentialing services with a new vendor	2022-23
December	Medi-Cal	Communications - Purchased Services	Communications - Public Activities	$10,000	To reallocate funds from Purchased Services to Public Activities to provide funding for additional Medi-Cal Campaigns Support	2022-23
December	Medi-Cal	Population Health Management - Purchased Services	Quality Improvements - Purchased Services	$24,950	To reallocate funds from Population Health Management – Purchased Services to Quality Improvement – Purchased Services to provide additional funding for CVO credentialing services	2022-23
December	PACE	Capital: Interior Light Improvement	Capital: Additional Furniture, Fixtures and Equipment	$35,000	To reallocate funds from Interior Light Improvement to Additional Furniture Fixtures	2022-23
January	Medi-Cal	Facilities - Comp Supply/Minor Equipment	Facilities - R&M Building	$70,000	To reallocate funds from Facilities Comp Supply/Minor Equipment to Facilities R&M Building to cover any remaining purchases that will be incurred in FY23.	2022-23
January	OCC	Sales & Marketing - Printing & Postage	Cultural & Linguistic Services - Purchased Services	$18,000	To reallocate funds from Sales & Marketing Printing Postage & Customer Service Postage to Cultural Linguistic Purchased OCC-803 (C&L translations/interpreter services) needed an additional $58K to pay outstanding invoices.	2022-23
January	OCC	Customer Service - Postage	Cultural & Linguistic Services - Purchased Services	$40,000	To reallocate funds from Sales & Marketing Printing Postage & Customer Service Postage to Cultural Linguistic Purchased OCC-803 (C&L translations/interpreter services) needed an additional $58K to pay outstanding invoices.	2022-23
January	OC	Sales & Marketing - Purchased Services General	Cultural & Linguistic Services - Purchased Services	$50,000	To reallocate funds from Sales & Marketing - Purchased Services to Cultural & Linguistic - Purchased Services for translations/interpreter services.	2022-23
January	Medi-Cal	Medical Management - Food Services	Medical Management - Professional Dues	$12,000	To reallocate funds from Medical Management Food Services to Medical Management Professional Dues to pay for Orange County Medical Association dues for the Medical Directors.	2022-23
February	Medi-Cal	Capital: Building Security Projects	Capital: Office Suite Renovation & Improvements	$150,000	To reallocate funds from Facilities Building Security Projects to Facilities Office Suite Renovation for Improvements for 8th Floor HR renovation, 9th Floor Office renovation, 9th Floor hallway renovation and Directory signage.	2022-23
February	Medi-Cal	Facilities - Comp Supply/Minor Equipment	Facilities - R&M Building	$70,000	To reallocate funds from Facilities Comp Supply/Minor Equipment to Facilities R&M Building to cover any remaining purchases that will be incurred in FY23.	2022-23
February	Medi-Cal	Capital: Building Security Projects	Capital: Electric Car Charging Station	$30,000	To reallocate funds from Facilities Building Security Projects to Facilities Electric Car Charging Station.	2022-23
February	Medi-Cal	Renaming Capital : Touchless Faucet	Capital - 9th Floor Improvement	$183,000	To re-name and re-purpose to meet new fire code requirements for fire exiting on the 9th floor.	2022-23
February	OC	Sales & Marketing - Purchased Services General	Financial Analysis - Professional Fees	$30,000	To reallocate funds from Sales & Marketing Purchased Services to Financial Analysis Professional Fees for OneCare VBID Model.	2022-23
February	PACE	PACE Center Support - Repair & Maintenance	PACE Administrative - Professional Fees	$50,000	To reallocate funds from PACE Center Support Repair & Maintenance to PACE Administrative Professional Fees for anticipated PACE audit.	2022-23
March	OC	Sales & Marketing - Purchased Services General	IS Application Management - Purchased Services	$80,000	To reallocate funds from Sales & Marketing Purchased Services to IS Application Management Purchased Services to support WIPRO/Infocrossing testing of Edifecs files.	2022-23
March	Medi-Cal	Population Health Mgmt. - Purchased Services General	Quality Analytics - Purchased Services General	$200,000	To reallocate funds from Population Health Management Purchased Services to Quality Analytics Purchased Services for 5 Star Rating Medicare Member Engagement.	2022-23
March	OC	Sales & Marketing - Purchased Services General	Sales & Marketing - Public Activities	$35,000	To reallocate funds from Sales & Marketing Purchased Services to Sales & Marketing Public Activities for OneCare branded promotional items.	2022-23
March	Medi-Cal	Government Affairs - Training & Seminars	Government Affairs - Professional Fees	$10,000	To reallocate funds from Government Affairs Training & Seminars to Government Affairs Professional Fees due to funding shortfall for the short-term Government Affairs consulting contract with Strategies 360.	2022-23
March	Medi-Cal	IS - Application Mgmt. - Maintenance HW/SW	Human Resources - Professional Fees	$100,000	To reallocate funds from IS Application Management - Maintenance HW/SW to Human Resources Professional Fees for Recruiting Services.	2022-23
March	Medi-Cal	Capital: Migrate Data Warehouse/Analytics to the Cloud	Capital: DTS Planning and Executive Support - Cloud Migration Strategy Professional Services	$235,000	To reallocate funds for the shortfall of the DTS Cloud Migration Strategy Professional Services.	2022-23
March	Medi-Cal	Capital: Migrate Data Warehouse/Analytics to the Cloud	Capital: DTS Planning and Executive Support - Vital Group Redlines for Agent Portal	$220,000	To reallocate funds for the shortfall of the DTS Cloud Migration Strategy Professional Services.	2022-23
April	Medi-Cal	Capital: Facilities Road Warning Light Crosswalk	Capital: Facilities Electric Car Charging Station	$50,000	To reallocate funds from Facilities Road Warning Light (Crosswalk) to Facilities Electric Car Charging Station.	2022-23
April	Medi-Cal	Capital: Facilities IDF Room HVAC Replacement	Capital: Facilities Office Suite Renovations	$40,000	To reallocate funds from Facilities IDF Room HVAC Replacement to Facilities Office Suite Renovations due to additional office space.	2022-23
April	Medi-Cal	Capital: Facilities - Freight Elevator	Capital: Parking Lot Improvement	$42,000	To reallocate funds from Facilities Freight Elevator to Parking Lot Improvement.	2022-23
June	OC	Customer Service - Postage	Customer Service - Communication	$60,000	To reallocate funds from Customer Service - OC Postage to Customer Service - OC Printing to replenished PO to pay off outstanding invoices.	2022-23
June	Medi-Cal	Facilities - Capital Office Suite Renovation & Improvements	Facilities - Capital 9th Floor Improvement	$42,847	To reallocate funds from Office Suite Renovation & Improvements to 9th Floor Improvement for rebuilding two corridors on the 9th floor requirement from the Fire Department.	2022-23
June	Medi-Cal	Capital : I&O - Test Environment, I&O - Virtual Private Network Upgrade	Capital - I&O - Data Protection & Recovery Operations SW Solution	$82,000	To reallocate funds from I&O – Test Environment & I&O Virtual Private Network Upgrade to I&O – Data Protection & Recovery Operations SW Solution, need additional funds due to Final RFP contract.	2022-23
June	Medi-Cal	Capital: I&O - Internet Bandwidth	Capital: I&O - Cybersecurity Asset Mgt SW Solution	$32,000	To reallocate funds from I&O – Internet Bandwidth to I&O – Cybersecurity Asset Mgt SW Solution, need additional funds due to Final RFP contract.	2022-23
June	Medi-Cal	Human Resources - Purchased Services - Executive Coaching	Human Resources - Purchased Services - Employment Screening	$45,000	To reallocate funds from Purchased Services Executive Coaching to Purchased Services Accurate Employment Screening for Post Employment background checks.	2022-23
June	Medi-Cal	Claims Administration - Purch Svcs - General - Varis	Claims Administration - Purch Svcs - General - Cotiviti	$200,000	To reallocate funds from Claims Administration Purchased Services – Varis to Claims Administration Purchased Services – Cotiviti to pay for the remaining of FY23 invoices.	2022-23
June	Medi-Cal	IS - Infrastructure - Consulting/Professional Fees	IS - Infrastructure - Subscriptions, Fees & Dues	$100,000	To reallocate funds from Infrastructure – Professional Fees to Infrastructure – Subscriptions; need additional funds to pay for Azure Cloud Costs Invoices.	2022-23

This report summarizes budget transfers between general ledger classes that are greater than $10,000 and less than $250,000.
This is the result of Board Resolution No. 12-0301-01 which permits the CEO to make budget allocation changes within certain parameters.

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Board of Directors Meeting
August 3, 2023

Monthly Compliance Report

The purpose of this report is to provide compliance updates to CalOptima Health's Board of Directors including, but not limited to, updates on internal and health network monitoring and audits conducted by CalOptima Health'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 (OC)/ PACE

- **2023 DHCS PACE Audit *(applicable to PACE)*:**

  - On February 22, 2023, CalOptima Health was formally engaged by DHCS for the PACE Program Audit.
    - The Audit was conducted from April 10, 2023, through April 21, 2023, with the onsite review from April 11, 2023, through April 13, 2023.
    - Exit conference was conducted on April 21, 2023.
  - Audit Findings Report was provided on April 28, 2023, with findings noted in the following areas:
    - Employee Requirements
    - Employee Records
    - Nutrition Services – Food Storage
    - Nutrition Services – Food Sanitation
    - Service Delivery – Provision of Services
    - Medical Records
    - Participant Assessment
  - There was a total of 8 findings.
    - 5 CAPs have been accepted by DHCS
    - 3 CAPs require further information to DHCS on July 14, 2023.
- Remediation action is underway for all findings.

- **2021 Centers for Medicare & Medicaid Services (CMS) Program Audit/Independent Validation Audit (IVA)/2023 Revalidation Audit *(applicable to OC and OCC)*:**

  - This audit is being conducted to validate that an issue identified in the 2021 CMS Routine Program Audit of CalOptima Health has been successfully remediated. Special Needs Plan – Model of Care (SNP-MOC) #5.41
    - Validation to be conducted by independent validation auditor July 20, 2023.
    - Final report to CMS due August 9, 2023.

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- **2023 Medicare Part C and Part D Data Validation Audit (MDVA) *(applicable to OC)*:**

  - CMS requires Sponsors to participate in a yearly independent review to validate data reported to CMS per the Medicare Part C and Part D Reporting Requirements.
  - CalOptima Health is required to contract with an independent auditor approved by CMS.
  - On June 27, 2023, the independent validation auditor finalized the 2023 Medicare Data Validation Audit scores in HPMS. Below is a summary of the scores. A Closing Conference with auditor will be scheduled in July.

  OneCare – H5433

Part C Reporting Measures	Final Score
Grievances	100%
Organization Determinations & Reconsiderations	100%
SNP Care Management	100%
	Average Part C Score: **100%**

Part D Reporting Measures	Final Score
Grievances	100%
Coverage Determinations and Redeterminations	100%
Improving Drug Utilization Review Controls	100%
Medication Therapy Management Program	100%
	Average Part D Score: **100%**

2. Medi-Cal

- **2024 Managed Care Plan (MCP) Operational Readiness Contract:**

  Update:

  As of May 1, 2023:
  - **193 deliverables have been submitted** for 2024 MCP operational readiness.
  - **183 items have received approval** at this point.
    - Remaining deliverables are awaiting a response from the Department of Health Care Services (DHCS) or under review by CalOptima Health as part of an additional information request made by DHCS.

  On-track for all remaining deliverables.

  Background – FYI Only

  Throughout CY 2022 and CY 2023, MCPs, including CalOptima Health will be required to submit a series of contract readiness deliverables to DHCS for review and approval. Staff will implement the broad operational changes and contractual requirements outlined in the Operational Readiness agreement to ensure compliance with all requirements by January 1, 2024, contract effective date.

- **2023 DHCS Routine Medical Audit:**

Update: On 7/5/23, CalOptima Health received the draft findings report for the 2023 DHCS Medical Audit. DHCS' draft findings report identified **two (2) findings**; this is an improvement from the 2022 DHCS Medical Audit which resulted in nine (9) total findings.

Below is a summary of the draft findings and identified next steps:

- Category breakdown and findings are as follows:
  - Category 1 Utilization Management (UM) – **No Findings**
  - Category 2 Case Management and Coordination of Care – **2 Findings**
  - Category 3 Access and Availability of Care – **No Findings**
  - Category 4 Members' Rights – **No Findings**
  - Category 5 Quality Management – **No Findings**
  - Category 6 Administrative and Organizational Capacity – **No Findings**

The summary of the draft findings in Category 2 are as follows:

- **2.1.1 Provision of Initial Health Assessment (IHA)**
  DHCS Finding #1: The Plan did not ensure that an IHA was performed by the member's primary care providers, perinatal care providers, and non-physician mid-level practitioners.
  - DHCS Recommendation: Revise and implement policies and procedures to ensure compliance and the provision of the Plan's contracted PCPs to perform IHA to new members.
- **2.2.1 - Performance of Pediatric Risk Stratification Process (PRSP)**
  DHCS Finding #2: The Plan did not ensure that members who did not have medical utilization data, claims processing data history, or other assessments or survey information available for PRSP were automatically categorized as high risk until further assessment data was gathered to make an additional risk determination.
  - DHCS Recommendation: Revise and implement policies and procedures to ensure compliance with PRSP performance to WCM members.

- **NEXT STEPS**
  Dates are subject to change based on DHCS timeline.
  - **Exit Conference**: CalOptima Health will have an exit conference with DHCS on Wednesday, July 12, 2023.
  - **Comment/Rebuttal Period**: Upon completion of the exit conference, CalOptima Health will have fifteen (15) calendar days to provide comments or dispute the content of the draft report, if necessary.
  - **Final Report & CAP**: DHCS is expected to finalize its report and formally request a Corrective Action Plan (CAP) from CalOptima Health in August 2023.
  - **CAP Response**: Medi-Cal Regulatory Affairs and Compliance (RAC) anticipates that CalOptima Health will have thirty (30) calendar days from date of receipt, to respond to the CAP request.
    - ***CalOptima Health staff notes that mitigation and resolution efforts are underway as is documentation of corrective action, in anticipation of a formal corrective action request***.

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Background – FYI Only

***Annual (routine) Audit**:*

- Scope included:
  - Utilization management
  - Case management and coordination of care
  - Availability and accessibility
  - Member rights
  - Quality management
  - Administrative and organizational capacity
- Staff interviews concluded; audit remains open
  - Interviews were conducted February 27 through March 3, 2023
  - DHCS hosted a soft exit on March 2, 2023
  - No preliminary findings will be shared with the Plan
  - All findings will be noted in the draft findings report which they hope to provide within three months (~June 2023)

Although DHCS did not identify observations, RAC will proactively begin outreach and engagement to ensure mitigation and resolution to areas of opportunity identified during the audit prep and interviews are remediated.

Focused Audit:

- Scope included:
  - Transportation
  - Behavioral Health
- Staff interviews were conducted February 27 through March 8, 2023.
- No soft exit.
- Once DHCS concludes its focused audit reviews of all MCPs, a report is anticipated to be released by Q2 2024. More information to follow as DHCS finalizes and communicates next steps.

- **2021 DHCS Medical Audit:**

Update: June CAP update was submitted to DHCS timely. CalOptima Health is awaiting feedback or status update based on submissions.

Background – FYI Only

On December 22, 2022, CalOptima Health submitted its formal corrective action plan (CAP) to DHCS. CalOptima Health must provide **monthly updates** on findings with future milestones. These monthly updates will continue until all milestones have been reached and/or DHCS determines the CAP is closed.

B. Regulatory Notices of Non-Compliance

- Call Center Monitoring - Timeliness Study - Quarter 1 2023
  - On June 28, 2023, CalOptima Health received a Notice of Non-Compliance for Contract H5433 (OneCare) for failure to meet call center timeliness requirements.
  - The Timeliness Study measures the average hold times and disconnect percentage rates for Part C and Part D current beneficiary customer service phone lines and pharmacy technical help desk phone lines.
  - CalOptima Health did not meet the requirement that it limit the disconnect rate of all incoming calls to no higher than 5 percent.
    - Part C Disconnect Percentage Rate: 7.14%
    - Part D Disconnect Percentage Rate: 7.14%
  - This issue was identified internally in January 2023. Customer Service (CS) implemented corrective actions at that time to remediate this issue. Based on the monthly Key Performance Indicator (KPI) for this metric, CS has been meeting the 5% benchmark February through June 2023 with the months March through June achieving a disconnect rate significantly below 2%.

C. Updates on Internal and Health Network Monitoring and Audits

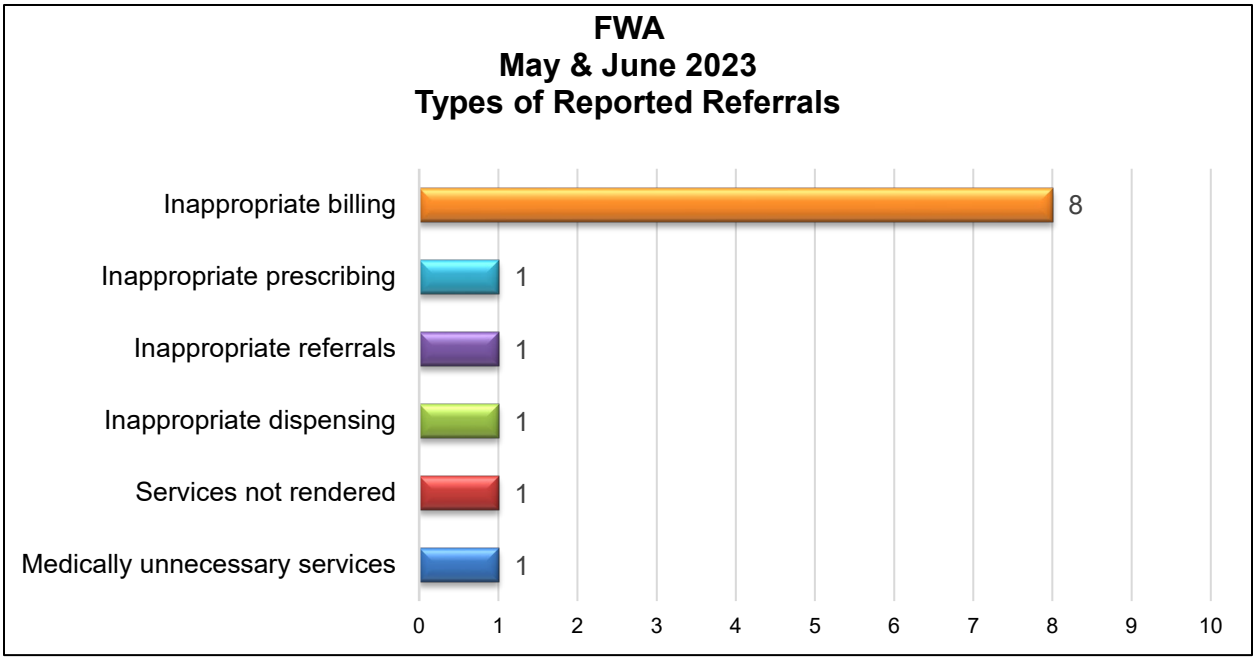
- **Health Network Audits:**

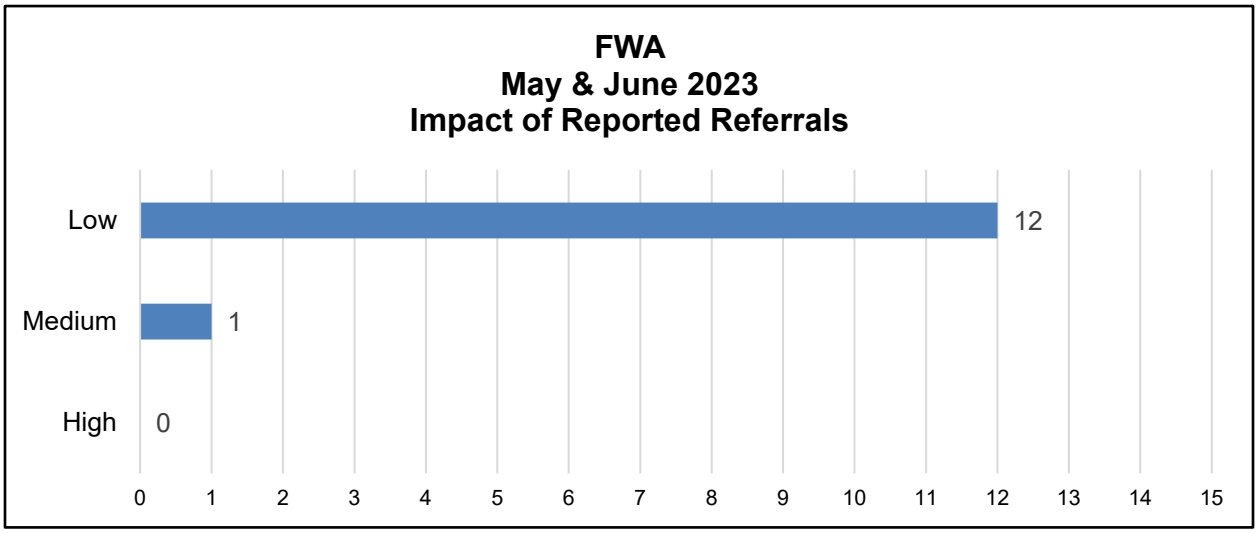
  - CalOptima Health's Delegation Oversight (DO) department completed annual audits on the following delegated health networks to assess their capabilities and performance with delegated activities:

    - Kaiser Foundation Health Plan, Inc. April 1, 2022, to January 31, 2023

  - Audit tools and elements were derived from accrediting, regulatory and CalOptima Health contractual standards. For areas that scored below the 100% threshold, DO issued a corrective action plan (CAP) request and is actively working with each health network to remediate findings.
  - The audit included review of specific P&Ps and sample files.
  - A number of areas were identified as opportunities to improve processes and timeliness of notifications to achieve 100% compliance.
  - Kaiser Foundation Health Plan, Inc. has submitted Corrective Action Plans for all findings and is in the process of implementing the corrective actions.
  - CalOptima Health will validate the effectiveness of corrective actions once implementation is complete.

D. Fraud, Waste & Abuse (FWA) Investigations (May and June 2023)

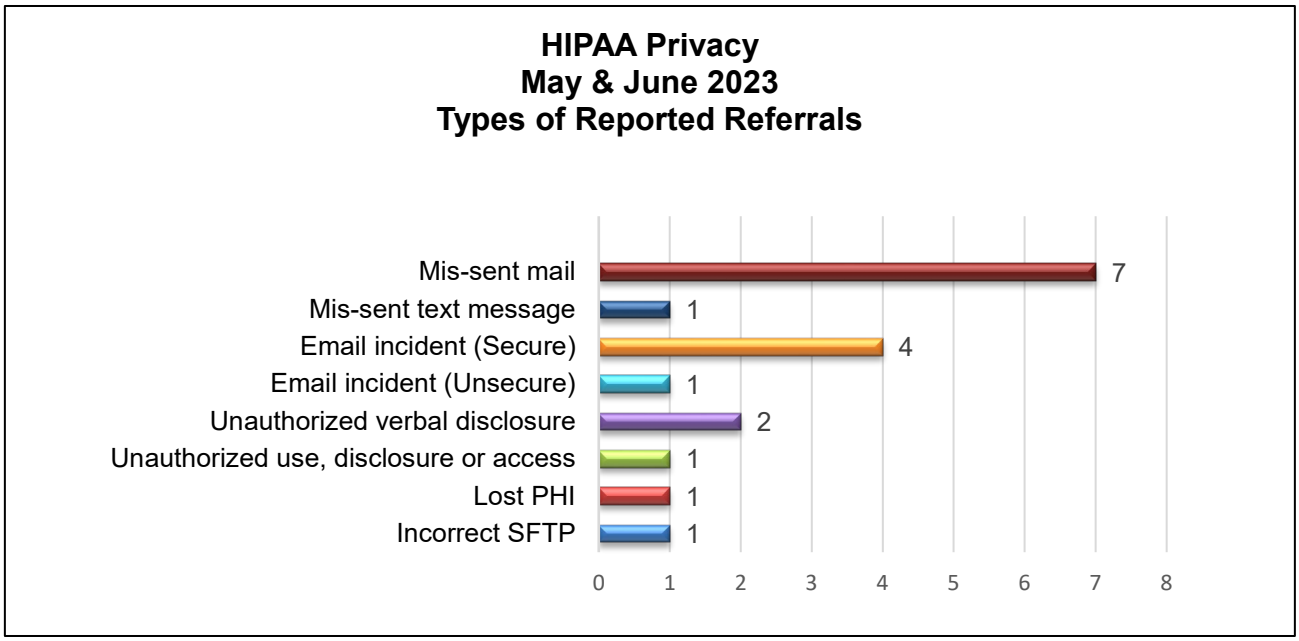


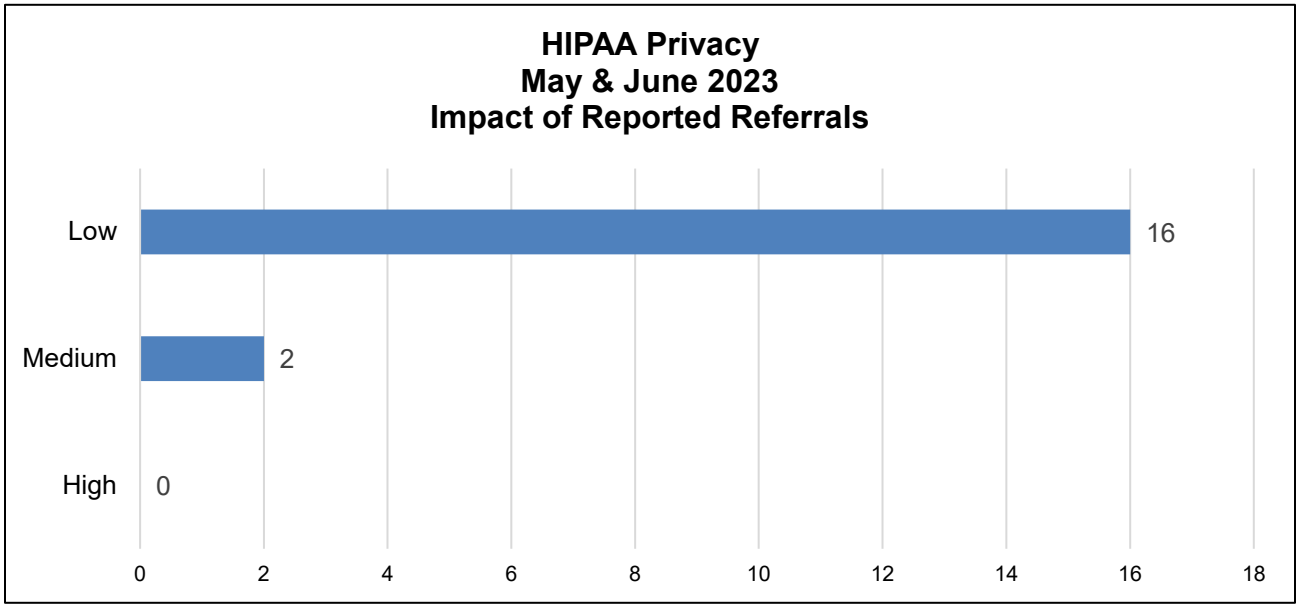


Total Number of New Cases Referred to DHCS (State)	13
Total Number of New Cases Referred to DHCS and CMS*	9
Total Number of Referrals (Subjects) Reported to Regulatory Agencies	**13**

* Any potential FWA *with impact to Medicare* is reported to CMS within 30 days of the start of an investigation.

E. Privacy Update: (May and June 2023)





PRIVACY STATISTICS

Total Number of Referrals Reported to DHCS (State)	18
Total Number of Referrals / Breaches Reported to DHCS and Office for Civil Rights (OCR)	0

POTOMAC PARTNERS DC

STRATEGIC HEALTH CARE

MEMORANDUM

July 14, 2023

To: CalOptima Health

From: Potomac Partners DC & Strategic Health Care

Re: July Board of Directors Report

FISCAL YEAR 2024 APPROPRIATIONS

Last month, the House Appropriations Committee approved the Fiscal Year 2024 (FY24) Subcommittee allocations. These allocations, known as the "302(b) numbers," set the topline spending limits for each of the 12 appropriations subcommittees. This year, the House allocations are significantly lower than last year's spending. Bills that will feature a cut of over 25 percent to their subcommittee allocations are the Agriculture, Commerce-Justice-Science, Financial Services, Interior-Environment, Labor-HHS-Education, State-Foreign Operations, and Transportation-HUD. The subcommittee spending caps are lower than the caps set in the debt limit deal passed in Spring. The full allocations are available here.

The Senate Appropriations Committee has released and is marking up their appropriations bills, but the Labor-HHS-Education bill has still not been released. In a joint statement, Chairwoman Murray (D-WA) and Ranking Member Collins (R-ME) said they would be moving forward bipartisanly. They also said they would be using all the spending authority set by the debt limit bill and that they would not seek spending reductions like the House.

HOUSE WAYS AND MEANS COMMITTEE APPROVES HEALTH BILLS

Legislation approved by the House Ways and Means Committee would allow small businesses to reimburse employees for buying qualified health insurance, increase flexibility for coverage of health care services for workers, give pre-deductible coverage for certain chronic conditions, and reduce paperwork and reporting requirements. Additionally, the Committee passed a bill to permanently allow high-deductible health plans to cover telehealth before customers hit their deductibles, with five Democrats joining Republicans in a 30-12 vote to advance the bill to the House Floor. This bill, H.R. 1843 – *Telehealth Expansion Act of 2023*, is sponsored by Rep. Michelle Steel (R-CA) and is awaiting a floor vote in the House. The full hearing is available here.

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Medicare Advantage

Identical letters from the House and Senate are urging the Centers for Medicare & Medicaid Services (CMS) to swiftly finalize rules that would modernize Medicare Advantage prior authorization regulations with changes made to the proposal. Specifically, Congress would like for the agency to expand the rule by "(1) establishing a mechanism for real-time electronic prior authorization (e-PA) decisions for routinely approved items and services; (2) requiring that plans respond to PA requests within 24 hours for urgently needed care; and (3) requiring detailed transparency metrics." The House letter is available here, and the Senate letter is available here.

New Medicaid and Children's Health Insurance Program (CHIP) Flexibilities

The U.S. Department of Health and Human Services (HHS) has introduced new flexibilities to aid the continuation of Medicaid and Children's Health Insurance Program (CHIP) coverage as states resume renewals. New flexibilities include:

- Allowing managed care plans to assist people with Medicaid with completing their renewal forms, including completing certain parts of the renewal forms on their behalf.
- Allowing states to delay an administrative termination for one month while the state conducts additional targeted outreach. This will give people more time to be reminded to fill out and return their renewal forms.
- Allowing pharmacies and community-based organizations to facilitate reinstatement of coverage for those who were recently disenrolled for procedural reasons based on presumptive eligibility criteria.

A press release with additional information is available here. A letter from Secretary Becerra to U.S. governors is available here. This letter and these actions from HHS come after a report stated that nearly half a million people have been disenrolled from Medicaid so far, according to an analysis by Kaiser Family Foundation (KFF). States that were early adopters of dropping beneficiaries from the Medicaid rolls following the public health emergency (PHE) have already disenrolled almost 500,000 people, with nearly 250,000 in Florida alone. So far, 11 states have begun the process; however, not all are reporting the numbers just yet, so KFF warns that the numbers could increase rapidly soon. More data is available here.

COVID-19 Vaccines

On Thursday, July 13, HHS Secretary Becerra sent a letter to COVID-19 vaccine manufacturers to ensure that manufacturers are preparing to offer ample supplies of updated doses in 2023 and 2024. This letter also asks manufacturers to ensure that payment systems, regulatory submissions, and supplies can meet demand during the fall transition period. This letter was sent simultaneously

with two announcements on COVID-19 vaccine payment models and deployment campaigns, summarized below. The full letter is available here.

On Thursday, July 13, CMS Administrator Brooks-LaSure sent a letter to Medicare Plans, Private Insurance Plans, and State Medicaid and Chip Programs regarding COVID-19 vaccine payments. The letter reminds health plans that "By law, any Food and Drug Administration (FDA)-approved or authorized COVID-19 vaccine is covered under Medicare Part B. Medicare is also required by law to cover COVID-19 vaccinations without cost-sharing. Medicare Advantage plans are required to cover the same benefits covered by Medicare Parts A and B." The American Rescue Plan Act (ARPA) requires states to cover COVID-19 vaccines and their administration for all CHIP beneficiaries and most Medicaid beneficiaries until September 30, 2024. Afterward, state expenditures on vaccines and vaccine administration services will be matched at the applicable state federal medical assistance percentage (FMAP). The full letter is available here.

For the uninsured or underinsured, the Centers for Disease Control and Prevention (CDC) is launching a new program called the "Bridge Access Program." Starting this fall, this program will target an estimated 25-30 million uninsured adults. CDC has published its intent to modify existing Increasing Community Access to Testing (ICATT) program contracts with those select pharmacy partners with proven capacity to reach and vaccinate millions of adults. The program is intended to be temporary, lasting only until December 2024.

ADMINISTRATION ACTIONS ON 'JUNK PLANS'

In a three-part plan, the Biden Administration has announced proposed regulations to strengthen efforts against short-term health plans, surprise medical bills, and medical debt. The Consumer Financial Protection Bureau (CFPB), the Treasury Department, the Labor Department, and HHS are coordinating proposed rules, guidance documents, and requests for information. In coordination with Treasury and Labor, HHS released a proposed rule to limit the scope of short-term health plans and modify the conditions for hospital indemnity or other fixed indemnity insurance plans. HHS also released new guidance requiring transparency on facility fees for uninsured and self-pay under the good faith estimates. Finally, the CFPB, Treasury Department, and HHS released a Request for Information (RFI) looking for information on high-cost specialty financial products, such as medical credit cards and installment loans aimed at covering high-cost health care procedures. A White House Factsheet is available here, along with the HHS announcement here, and CMS factsheets here and here. Congressional Republicans were quick to condemn the plan, particularly the proposed rule to overturn short-term plans. House Ways and Means Chairman Smith (R-MO) said the rule "ignores the fact that short-term, limited-duration insurance coverage is used by 1.5 million Americans."

HHS Proposed Rule to Protect LGBTQI+ Rights

The proposed HHS Grants Rule, if finalized, would seek to clarify and reaffirm the prohibition on discrimination on the basis of sexual orientation and gender identity in federal statutes administered by HHS, consistent with the Supreme Court's decision in *Bostock v. Clayton County*, 140 S. Ct. 1731 (2020). The proposed rule would confirm non-discrimination protections in HHS programs, including Head Start, as well as services and grants that provide aid to refugees, assistance to people experiencing homelessness, substance abuse treatment and prevention, community mental health services, maternal and child health services, and community services. The proposed HHS Grants Rule also includes a provision that ensures that those with religious objections may seek an exemption from (or modification of) program requirements. The full proposed rule is available here. Public comments will be accepted until September 11, 2023.

FDA Approves First Nonprescription Daily Oral Contraceptive

For the first time, the FDA has approved a daily oral contraceptive for over-the-counter use. Opill is a 0.075 mg oral norgestrel tablet that has been in use as a prescription drug since 1973. The full press release is available here.

EDELSTEIN GILBERT ROBSON & SMITH LLC

Donald B. Gilbert Michael R. Robson Trent E. Smith Jason D. Ikerd Associate Bridget E. McGowan Associate

July 20, 2023

CalOptima Health
LEGISLATIVE UPDATE
Edelstein Gilbert Robson & Smith LLC

General Update

We are now well over halfway done with the first year of a two-year session. The Legislature recently wrapped up with the second policy committee deadline by which bills were required to pass out of policy committees in the second house by July 14. The Legislature is now adjourned for summer recess until August 14.

When it returns, the Legislature must meet the fiscal committee deadline on September 1, when all fiscal bills must pass out of the Appropriations Committee in the second house in order to keep moving. After that, the Legislature will have two weeks to pass the remaining bills off the floor in the second house and, in many cases, the floor of the house of origin for concurrence before session adjourns on September 14.

On June 30, Assemblymember Robert Rivas from Hollister was sworn in as Speaker of the Assembly. He also announced his new leadership team, which includes Assemblymember Cecilia Aguiar-Curry as Speaker Pro Tempore and Assemblymember Isaac Bryan as Majority Leader. As a result of these three Assemblymembers taking on new roles, a handful of committee Chairs changed as well. However, it is not anticipated that there will be a large-scale shake-up of Chair positions this year despite the leadership transition.

Budget Update

The Legislature and Governor reached a final budget agreement in late June, after a series of negotiations that were drawn out over disagreement on the Governor's proposed infrastructure package. The most contentious item was the inclusion of language that would have expedited the Delta Tunnels project, which was ultimately removed in the final agreement.

Thereafter, the Legislature passed a series of budget bills and budget trailer bills, with the Governor signing the package on July 10. This included the Managed Care Organization (MCO) Tax, which will provide $19.4 billion in funding to balance the budget and support the Medi-Cal program and Medi-Cal Provider Payment Reserve Fund through December 2026. The funds for the Medi-Cal Provider Payment Reserve Fund will be used for rate increases, support for distressed and rural hospitals, and medical education programs.

Legislation of Interest

AB 271 (Quirk-Silva) - Homeless Death Review Committee. This bill would allow counties to establish a homeless death review committee to gather information to identify the root causes of death of homeless individuals as well as determine strategies to improve the coordination of services for this population.

This bill passed out of the Senate and is pending a concurrence vote in the Assembly.

CalOptima Health supports this bill.

AB 1230 (Valencia) - Special Needs Plans. This measure directs the Department of Health Care Services to offer contracts to health care service plans for Highly Integrated Dual Eligible Special Needs Plans (HIDE-SNPs) and Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs) to provide care to dual eligible beneficiaries. Most County Organized Health Systems (COHS) have expressed concerns with this bill because it circumvents COHS authority to exclusively contract with providers in their services areas. This bill is a two-year bill.

SB 598 (Skinner) - Prior Authorization. This bill would prohibit insurance plans from requiring contracted physicians and other health professionals to receive prior authorization for any covered services if the plan approved or would have approved no less than 90% of prior authorization requests in the last one-year contract period. Amendments accepted in May encourage providers and plans towards a 2018 agreement to improve prior authorization.

The commercial health plans and the Local Health Plans of California (LHPC) are opposing SB 598. This bill is pending a hearing in the Assembly Appropriations Committee.

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2023–24 Legislative Tracking Matrix

Bill Number Author	Bill Summary	Bill Status	Position/Notes
Behavioral Health			
S. 923 Bennet (CO)	**Better Mental Health Care for Americans Act:** Would require parity for mental health services in Medicaid, Medicare Advantage (MA) and Medicare Part D. Would also enhance Medicaid and Medicare payments for integrating mental health and substance use disorder services with physical care. Finally, would create a 54-month Medicaid demonstration project to increase state funding for enhanced access to mental health services for children. In addition, would require MA plans to verify and update provider directories at least every 90 days and remove a non-participating provider within two business days of notification. ***Potential CalOptima Health Impact**:* Increased access to behavioral health services for CalOptima Health members; increased funding for contracted providers; increased staff oversight of OneCare provider directory.	**03/22/2023** Introduced; referred to Senate Finance Committee	CalOptima Health: Watch
S. 1378 Cortez Masto (NV)	**Connecting Our Medical Providers with Links to Expand Tailored and Effective (COMPLETE) Care Act:** Would improve access to timely, effective mental health care in the primary care setting by increasing Medicare payments to providers for implementing integrated care models. ***Potential CalOptima Health Impact**:* Increased resources and access to behavioral health services for CalOptima Health OneCare members; increased funding for contracted providers.	**04/27/2023** Introduced; referred to Senate Finance Committee	CalOptima Health: Watch
SB 363 Eggman	**Behavioral Health Facilities Database:** No later than January 1, 2026, would require the California Department of Health Care Services (DHCS) to develop a real-time, internet-based database to display information about beds in certain facilities, including chemical dependency recovery hospitals, acute psychiatric hospitals and mental health rehabilitation centers, to identify the availability of inpatient and residential mental health or substance use disorder treatment. ***Potential CalOptima Health Impact:*** Increased resources and access to behavioral health services for CalOptima Health Medi-Cal members.	**06/13/2023** Passed Assembly Health Committee; referred to Assembly Appropriations Committee **05/24/2023** Passed Senate floor; referred to Assembly	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 492 Pellerin	**Reproductive and Behavioral Health Integration Pilot Programs:** Would provide grants, incentive payments or other financial support to Medi-Cal managed care plans (MCPs) to partner with providers for the development and implementation of behavioral health integration pilot programs to improve access to services. Partnering providers must be enrolled in the Family Planning, Access, Care, and Treatment (Family PACT) program and provide reproductive health services. ***Potential CalOptima Health Impact:*** Increased funding and access to reproductive and behavioral health services.	**06/14/2023** Referred to Senate Health Committee **05/31/2023** Passed Assembly floor	CalOptima Health: Watch
AB 512 Waldron	**Behavioral Health Facilities Database:** Would require the California Health and Human Services Agency (CalHHS) to create a committee to study how to develop a real-time, internet-based system, usable by hospitals, clinics, law enforcement, paramedics and emergency medical technicians, and other health care providers to display information about available beds in inpatient psychiatric facilities, crisis stabilization units, residential community mental health facilities and residential alcoholism or substance abuse treatment facilities in order to identify available facilities for the temporary treatment of individuals experiencing a mental health or substance use disorder crisis. ***Potential CalOptima Health Impact:*** Increased efficiency and timeliness of facility referrals; decreased visits to the emergency department.	**03/14/2023** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch
AB 940 Villapudua	**Eating Disorder Treatment**: Would expand the approved facilities for inpatient treatment of eating disorders to include psychiatric health facilities. ***Potential CalOptima Health Impact:*** Increased access to treatment for eating disorders.	**04/11/2023** Assembly Health Committee hearing canceled by author	CalOptima Health: Watch
AB 1316 Irwin	**Psychiatric Emergency Medical Conditions**: Would require the Medi-Cal program to cover emergency services and care necessary to treat an emergency medical condition, including screening examinations necessary to determine the presence or absence of an emergency medical condition. ***Potential CalOptima Health Impact:*** Increased scope of behavioral health services for CalOptima Health Medi-Cal members.	**04/10/2023** Assembly Health Committee hearing canceled by author	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 1470 Quirk-Silva	**Behavioral Health Services: Documentation Standards:** Would require DHCS to standardize data elements relating to documentation requirements, including medically necessary criteria and develop standard forms containing information necessary to properly adjudicate claims. No later than July 1, 2025, regional personnel training on documentation should be completed along with the exclusive use of the standard forms. ***Potential CalOptima Health Impact:*** New data requirements; additional training for CalOptima Health behavioral health staff on new documentation.	**06/28/2023** Passed Senate Health Committee; referred to Senate Appropriations Committee **06/01/2023** Passed Assembly floor	CalOptima Health: Watch
Budget			
SB 101 Skinner **AB 102** Ting	**Budget Act of 2023:** Makes appropriations for the government of the State of California for Fiscal Year (FY) 2023–24. Total spending is $310.8 billion, of which $226 billion is from the General Fund. ***Potential CalOptima Health Impact:*** Impacts are discussed in the enclosed FY 2023–24 Enacted State Budget Analysis.	**7/10/2023** Signed into law	CalOptima Health: Watch
AB 118 Committee on Budget	**Health Trailer Bill:** Consolidates and enacts certain budget trailer bill language containing the policy changes needed to implement health-related expenditures in the FY 2023-24 state budget. ***Potential CalOptima Health Impact:*** Impacts are discussed in the enclosed FY 2023–24 Enacted State Budget Analysis.	**07/10/2023** Signed into law	CalOptima Health: Watch
AB 119 Committee on Budget	**Managed Care Organization (MCO) Provider Tax Trailer Bill:** Renews the MCO provider tax, retroactively effective April 1, 2023, through December 31, 2026, and restructures the tax tiers and amounts. Also creates the Managed Care Enrollment Fund to fund Medi-Cal programs. ***Potential CalOptima Health Impact:*** Impacts are discussed in the enclosed FY 2023–24 Enacted State Budget Analysis.	**06/29/2023** Signed into law	CalOptima Health: Watch
California Advancing and Innovating Medi-Cal (CalAIM)			
AB 586 Calderon	**Community Support: Climate Change or Environmental Remediation Devices:** Would add "climate change remediation" as a Community Support option, defined as the coverage and installation of devices to address health-related complications, barriers or other factors linked to extreme weather or other climate events, including air conditioners, heaters, air filters and generators. ***Potential CalOptima Health Impact:*** New services available for CalOptima Health Medi-Cal members to address social determinants of health (SDOH).	**04/11/2023** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 1338 Petrie-Norris	**Community Support: Fitness**: Would add fitness, physical activity, or recreational sports programs, activities, or memberships as a Community Support option. ***Potential CalOptima Health Impact:*** New services available for CalOptima Health Medi-Cal members to address SDOH.	**04/18/2023** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch
Covered Benefits			
SB 257 Portantino	**Mammography:** Beginning January 1, 2025, would require health plans to cover, without cost sharing, screening mammography and medically necessary diagnostic breast imaging, including following an abnormal mammography result and for individuals with a risk factor associated with breast cancer. ***Potential CalOptima Health Impact:*** Expanded covered benefit for CalOptima Health Medi-Cal members.	**06/27/2023** Passed Assembly Health Committee; referred to Assembly Appropriations Committee **05/26/2023** Passed Senate floor	CalOptima Health: Watch CAHP: Oppose
SB 324 Limón	**Endometriosis:** Would add any clinically indicated treatment for endometriosis as a covered benefit without prior authorization or other utilization review. ***Potential CalOptima Health Impact:*** Expanded covered benefit for CalOptima Health Medi-Cal members.	**06/27/2023** Passed Assembly Health Committee; referred to Assembly Appropriations Committee **05/24/2023** Passed Senate floor	CalOptima Health: Watch CAHP: Oppose
SB 339 Wiener	**Human Immunodeficiency Virtus (HIV) Preexposure Prophylaxis (PrEP) and Postexposure Prophylaxis (PEP):** Would require the Medi-Cal program to cover PrEP and PEP furnished by a pharmacist for up to a 90-day course. ***Potential CalOptima Health Impact:*** Expanded Medi-Cal Rx benefit for CalOptima Health Medi-Cal members.	**07/11/2023** Passed Assembly Business and Professions Committee; referred to Assembly Appropriations Committee **05/22/2023** Passed Senate floor	CalOptima Health: Watch CAHP: Oppose Unless Amended
SB 496 Limón	**Biomarker Testing:** No later than July 1, 2024, would add biomarker testing, including whole genome sequencing, as a covered Medi-Cal benefit for the purposes of diagnosis, treatment, appropriate management or ongoing monitoring of a disease or condition to guide treatment decisions, if the test is supported by medical and scientific evidence, as prescribed. ***Potential CalOptima Health Impact:*** Expanded covered benefit for CalOptima Health Medi-Cal members.	**07/11/2023** Passed Assembly Health Committee; referred to Assembly Appropriations Committee **05/24/2023** Passed Senate floor	CalOptima Health: Watch CAHP: Oppose Unless Amended

Bill Number Author	Bill Summary	Bill Status	Position/Notes
SB 694 Eggman	**Self-Measured Blood Pressure (SMBP) Devices and Services**: Would add SMBP devices and related services as covered Medi-Cal benefits for the treatment of high blood pressure. ***Potential CalOptima Health Impact:*** New covered benefits for CalOptima Health Medi-Cal members.	**06/20/2023** Passed Assembly Health Committee; referred to Assembly Appropriations Committee **05/25/2023** Passed Senate floor	CalOptima Health: Watch CalPACE: Support
AB 47 Boerner Horvath	**Pelvic Floor Physical Therapy**: Beginning January 1, 2024, would require health plans to provide coverage for pelvic floor physical therapy after pregnancy. ***Potential CalOptima Health Impact:*** New covered benefit for CalOptima Health Medi-Cal members.	**04/20/2023** Assembly Health Committee hearing canceled by author	CalOptima Health: Watch CAHP: Oppose
AB 365 Aguiar-Curry	**Continuous Glucose Monitors (CGMs):** Would add CGMs and related supplies as a covered Medi-Cal benefit, subject to utilization controls based on clinical practice guidelines. Would also authorize DHCS to require a manufacturer of CGMs to enter into a rebate agreement with DHCS. ***Potential CalOptima Health Impact:*** New covered benefits for CalOptima Health Medi-Cal members.	**06/28/2023** Passed Senate Health Committee; referred to Senate Appropriations Committee **05/31/2023** Passed Assembly floor	CalOptima Health: Watch CalPACE: Support
AB 425 Alvarez	**Pharmacogenomics Advancing Total Health for All Act:** Would add pharmacogenomic testing as a covered Medi-Cal benefit, defined as laboratory genetic testing to identify how an individual's genetics may impact the efficacy, toxicity and safety of medications. ***Potential CalOptima Health Impact:*** New covered benefit for CalOptima Health Medi-Cal members.	**06/29/2023** Passed Senate Health Committee; referred to Senate Appropriations Committee **05/31/2023** Passed Assembly floor	CalOptima Health: Watch
AB 608 Schiavo	**Perinatal Services**: Would require DHCS to cover additional perinatal assessments, individualized care plans and other services during the one-year postpartum Medi-Cal eligibility period at least proportional to those available during pregnancy and the initial 60-day postpartum period. DHCS would be required to collaborate with the California Department of Public Health (CDPH) and stakeholders to determine the specific levels of additional coverage. Would also allow perinatal services to be rendered by a nonlicensed perinatal health worker in a beneficiary's home or other community setting away from a medical site. Lastly, would allow such workers to be supervised by a community-based organization or local health jurisdiction. ***Potential CalOptima Health Impact:*** Expanded covered benefit and associated provider network for CalOptima Health Medi-Cal members.	**07/11/2023** Passed Senate Governmental Organizational Committee; referred to Senate Appropriations Committee **05/31/2023** Passed Assembly floor	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 620 Connolly	**Digestive and Metabolic Disorders:** Beginning January 1, 2024, would require health plans to expand coverage for the testing and treatment of phenylketonuria (PKU) to include other digestive and inherited metabolic disorders. Coverage would include the formulas and special food products that are part of a prescribed diet. ***Potential CalOptima Health Impact:*** Expanded covered benefit for CalOptima Health Medi-Cal members.	**06/29/2023** Passed Senate Health Committee; referred to Senate Appropriations Committee **05/31/2023** Passed Assembly floor	CalOptima Health: Watch CAHP: Oppose
AB 847 Rivas, L.	**Pediatric Palliative Care Services**: Would extend Medi-Cal coverage for palliative care and hospice services after 21 years of age until 26 years of age for individuals who were previously determined eligible prior to 21 years of age. Would require Medi-Cal MCPs to be liable for payment of out-of-county services if unavailable in county of residence. ***Potential CalOptima Health Impact:*** Expanded covered benefit for certain CalOptima Health Medi-Cal members; increased costs for out-of-county services.	**07/06/2023** Passed Senate Health Committee; referred to Senate Appropriations Committee **05/30/2023** Passed Assembly floor	CalOptima Health: Watch
AB 907 Lowenthal	**PANDAS and PANS**: Beginning January 1, 2024, would require a health plan to provide coverage for prophylaxis, diagnosis and treatment of Pediatric Autoimmune Neuropsychiatric Disorder Associated with Streptococcal Infections (PANDAS) and Pediatric Acute-onset Neuropsychiatric Syndrome (PANS) prescribed or ordered by a provider. ***Potential CalOptima Health Impact:*** New covered benefit for pediatric CalOptima Health Medi-Cal members.	**06/28/2023** Passed Senate Health Committee; referred to Senate Appropriations Committee **05/31/2023** Passed Assembly floor	CalOptima Health: Watch CAHP: Oppose
AB 1036 Bryan	**Emergency Medical Transportation:** Would require a physician to certify upon patient arrival at an emergency room via emergency medical transportation whether an emergency medical condition existed and required emergency medical transportation. If certified, would require a health plan to provide coverage for emergency medical transportation. ***Potential CalOptima Health Impact:*** Increased CalOptima Health costs for reimbursement of emergency transportation services.	**04/18/2023** Assembly Health Committee hearing canceled by author	CalOptima Health: Watch
AB 1060 Ortega	**Naloxone Hydrochloride:** Would add prescription and non-prescription naloxone hydrochloride or another drug approved by the U.S. Food and Drug Administration as a covered benefit under the Medi-Cal program for the complete or partial reversal of an opioid overdose. ***Potential CalOptima Health Impact:*** New Medi-Cal Rx benefit for CalOptima Health Medi-Cal members.	**06/28/2023** Passed Senate Health Committee; referred to Senate Appropriations Committee **05/25/2023** Passed Assembly floor	CalOptima Health: Watch CAHP: Oppose Unless Amended

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 1085 Maienschein	**Housing Support Services**: Would require DHCS, if the state has sufficient network capacity, to add housing support services as a covered Medi-Cal benefit for individuals experiencing or at risk of homelessness, consistent with the following Community Supports offered through CalAIM: • Housing Transition Navigation Services • Housing Deposits • Housing Tenancy and Sustaining Services ***Potential CalOptima Health Impact:*** Formalization of certain Community Support services as covered benefits for eligible CalOptima Health Medi-Cal members.	**06/14/2023** Passed Sente Health Committee; referred to Senate Appropriations Committee **05/30/2023** Passed Assembly floor	CalOptima Health: Watch CalPACE: Support
AB 1644 Bonta	**Medically Supportive Food**: Would add medically supportive food and nutrition intervention plans as covered Medi-Cal benefits, when determined to be medically necessary to a patient's medical condition by a provider or plan. The benefit would be based in part on the following Community Support offered through CalAIM: Medically Tailored Meals. ***Potential CalOptima Health Impact:*** Formalization and expansion of certain Community Support services as covered benefits for eligible CalOptima Health Medi-Cal members.	**04/25/2023** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch
Medi-Cal Eligibility and Enrollment			
S. 423 Van Hollen (MD) **H.R. 1113** Bera (CA)	**Easy Enrollment in Health Care Act:** To streamline and increase enrollment into public health insurance programs, would allow taxpayers to request their federal income tax returns include a determination of eligibility for Medicaid, the Children's Health Insurance Program (CHIP) or advance premium tax credits to purchase insurance through a health plan exchange. Taxpayers could also consent to be automatically enrolled into any such program or plan if they were subject to a zero net premium. Would also make individuals eligible for Medicaid or CHIP based on a prior finding of eligibility for the Temporary Assistance for Needy Families program or the Supplemental Nutrition Assistance Program. ***Potential CalOptima Health Impact*:** Expanded eligibility standards and procedures for enrollment of CalOptima Health members.	**02/14/2023** Introduced; referred to committees	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 1481 Boerner Horvath	**Medi-Cal Presumptive Eligibility for Pregnancy**: Would expand presumptive eligibility for pregnant women to all pregnant people, renaming the program "Presumptive Eligibility for Pregnant People" (PE4PP). Would make a presumptively eligible pregnant person eligible for all covered Medi-Cal benefits, except for inpatient services and institutional long-term care. If an application for full-scope Medi-Cal benefits is submitted within 60 days of a PE4PP determination, PE4PP coverage would be effective until the Medi-Cal application is approved or denied. ***Potential CalOptima Health Impact:*** Improved Medi-Cal enrollment process and timelier access to covered benefits for eligible pregnant individuals.	**07/13/2023** Passed Senate Health Committee; referred to Senate Appropriations Committee **05/25/2023** Passed Assembly floor	CalOptima Health: Watch
AB 1608 Patterson	**Regional Center Clients:** Would exempt from mandatory Medi-Cal MCP enrollment any dual-eligible and non-dual-eligible Medi-Cal beneficiaries who receive services from a regional center and use the Medi-Cal fee-for-service (FFS) delivery system as secondary form of health coverage. ***Potential CalOptima Health Impact:*** Decreased number of CalOptima Health members.	**03/27/2023** Amended and re-referred to Assembly Health Committee	CalOptima Health: Watch
Medi-Cal Operations and Administration			
H.R.2811 Arrington (TX)	**Limit, Save, Grow Act of 2023:** Would require Medicaid beneficiaries ages 19–55 without dependents to work, complete community service and/or participate in a work training program for at least 80 hours per month for at least three months per year. Exemptions would be provided for those who are pregnant, physically or mentally unfit for employment, complying with work requirements under a different federal program, participating in a drug or alcohol treatment program, or enrolled in school at least half-time. The U.S. Department of Health and Human Services estimates that 294,981 Medi-Cal beneficiaries in Orange County would be subject to the proposed work requirements without an exemption. ***Potential CalOptima Health Impact:*** Disenrollment of certain CalOptima Health Medi-Cal members, especially those who experience homelessness, who are not exempted from work requirements.	**04/26/2023** Passed House floor; referred to Senate Budget Committee	CalOptima Health: Concerns ACAP: Oppose

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 557 Hart	**Brown Act Flexibilities:** Would permanently extend current Brown Act teleconferencing flexibilities — when a declared state of emergency is in effect — beyond January 1, 2024. Would also extend the period for a legislative body to make findings related to a continuing state of emergency from every 30 days to every 45 days. ***Potential CalOptima Health Impact:*** Extended teleconferencing flexibilities for Board and advisory committee meetings.	**06/27/2023** Passed Senate Judiciary Committee; referred to Senate floor **05/15/2023** Passed Assembly floor	CalOptima Health: Watch
AB 719 Boerner Horvath	**Public Transit Contracts**: Would require Medi-Cal managed care plans to contract with public paratransit operators for nonmedical transportation (NMT) and nonemergency medical transportation (NEMT) services. Would require reimbursement to be based on the Medi-Cal FFS rates for those services. ***Potential CalOptima Health Impact:*** Execution of additional NMT and NEMT contracts; increased transportation options for CalOptima Health Medi-Cal members.	**07/05/2023** Passed Senate Health Committee; referred to Senate Appropriations Committee **05/30/2023** Passed Assembly floor	CalOptima Health: Watch CAHP: Oppose LHPC: Oppose
AB 1202 Lackey	**Pediatric Time and Distance Standards:** Would require DHCS to report to the Legislature the results of an analysis to identify the number and geographic distribution of Medi-Cal providers needed to ensure compliance with time and distances standards for pediatric primary care. ***Potential CalOptima Health Impact:*** Increased network analysis and reporting to DHCS.	**07/12/2023** Passed Senate Health Committee; refereed to Senate Appropriations Committee **05/31/2023** Passed Assembly	CalOptima Health: Watch
AB 1690 Kalra	**Universal Health Care Coverage**: States the intent of the Legislature to guarantee accessible, affordable, equitable and high-quality health care for all Californians through a comprehensive universal single-payer health care program. ***Potential CalOptima Health Impact:*** Unknown but potentially significant impacts to the Medi-Cal program and CalOptima Health care delivery, financing and administration.	**02/17/2023** Introduced	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
Older Adult Services			
S. 1002 Cassidy (LA)	**No Unreasonable Payments, Coding, or Diagnoses for the Elderly (No UPCODE) Act:** Would modify the MA risk adjustment model to prevent overpayment to MA plans, as follows: • Utilization of two years instead of one of diagnostic data • Exclusion of outdated diagnoses solely included on health risk assessments • Coding adjustment to account for other payment differences between MA and Medicare FFS ***Potential CalOptima Health Impact:*** Decreased reimbursement rates from the Centers for Medicare and Medicaid Services (CMS) for CalOptima Health OneCare members.	**03/28/2023** Introduced; referred to Senate Finance Committee	CalOptima Health: Watch
S. 1703 Carper (DE) **H.R. 3549** Wenstrup (OH)	**Program of All-Inclusive Care for the Elderly (PACE) Part D Choice Act of 2023:** Would allow a Medicare-only PACE participant to opt out of drug coverage provided by the PACE program and instead enroll in a standalone Medicare Part D prescription drug plan that results in equal or lesser out-of-pocket costs. PACE programs would be required to educate their participants about this option. ***Potential CalOptima Health Impact:*** Increased enrollment into CalOptima Health PACE by Medicare-only beneficiaries due to decreased out-of-pocket costs.	**05/18/2023** Introduced; referred to committees	CalOptima Health: Watch NPA: Support
SB 311 Eggman	**Medicare Part A Buy-In:** No later than January 1, 2024, would require DHCS to submit a Medicaid state plan amendment to enter into a Medicare Part A buy-in agreement with CMS. This would allow DHCS to automatically enroll individuals with a Part A premium into Part A on their behalf. ***Potential CalOptima Health Impact:*** Simplified Medicare enrollment and increased financial stability for dual-eligible CalOptima Health members with Part A premium requirements.	**06/13/2023** Passed Assembly Health Committee; referred to Assembly Appropriations Committee **05/25/2023** Passed Senate floor	CalOptima Health: Watch LHPC: Support CalPACE: Support
AB 1022 Mathis	**PACE Rates and Assessments**: Would require PACE capitation rates to also reflect the frailty level and risk associated with participants. In addition, would expand a PACE organization's authority to use video telehealth to conduct all assessments. ***Potential CalOptima Health Impact:*** Increased capitation rates for CalOptima Health PACE participants; expanded use of video telehealth assessments.	**03/02/2023** Referred to Assembly Health Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 1223 Hoover	**PACE Audits:** Would require DHCS to perform program audits of PACE organizations and to develop and maintain standards, rules and auditing protocols, including related to data collection, technical assistance, formal decisions and enforcement of non-compliance. ***Potential CalOptima Health Impact:*** Modified audit protocols for CalOptima Health PACE.	**03/13/2023** Amended and re-referred to Assembly Health Committee	CalOptima Health: Watch
AB 1230 Valencia	**Special Needs Plans (SNPs)**: No later than January 1, 2025, would require DHCS to offer contracts to health plans for Highly Integrated Dual Eligible Special Needs Plans (HIDE-SNPs) and Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs) to provide care to dual eligible beneficiaries. ***Potential CalOptima Health Impact:*** Increased number of SNPs in Orange County; decreased number of CalOptima Health OneCare members.	**04/20/2023** Assembly Health Committee hearing canceled by author	CalOptima Health: Watch LHPC: Oppose
Providers			
H.R. 497 Duncan (SC)	**Freedom for Health Care Workers Act:** would repeal the rule issued by CMS on November 5, 2021, that requires health care providers participating in the Medicare and Medicaid programs to ensure staff are fully vaccinated against COVID-19**.** ***Potential CalOptima Health Impact:*** Elimination of COVID-19 vaccination mandate for CalOptima Health PACE staff and contracted providers.	**01/31/2023** Passed House floor; referred to Senate Finance Committee	CalOptima Health: Watch
SB 598 Skinner	**Prior Authorization "Gold Carding"**: Beginning January 1, 2025, would prohibit a health plan from requiring a contracted provider to obtain a prior authorization for any services if the plan approved or would have approved no less than 90% of the prior authorization requests submitted by the provider in the most recent one-year contracted period. ***Potential CalOptima Health Impact:*** Implementation of new utilization management (UM) procedures to assess provider approval rates; decreased number of prior authorizations.	**07/11/2023** Passed Assembly Health Committee; referred to Assembly Appropriations Committee **05/25/2023** Passed Senate floor	CalOptima Health: Watch CAHP: Oppose LHPC: Oppose
SB 819 Eggman	**Medi-Cal Mobile Health Care Site Enrollment:** Would exempt intermittent or mobile health care sites from enrolling in Medi-Cal as a separate provider if operated by a government-operated primary care clinic that is exempt from licensure by CDPH. ***Potential CalOptima Health Impact:*** Expansion of intermittent and mobile health care sites; increased access to care for CalOptima Health members.	**07/12/2023** Passed Assembly Health Committee; referred to Assembly Appropriations Committee **05/04/2023** Passed Senate floor	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 236 Holden	**Provider Directory Audits:** Would require health plans to annually audit and delete inaccurate listings from its provider directories. Would also require a provider directory to be 60% accurate by January 1, 2024, with increasing percentage accuracy each year until the directories are 95% accurate by January 1, 2027. In addition, plans would be subject to penalties for failure to meet the prescribed benchmarks and for each inaccurate listing in its directories. Finally, beginning July 1, 2024, would require plans to delete a provider from its directory if a plan has not reimbursed the provider in the prior year. ***Potential CalOptima Health Impact:*** Increased oversight of CalOptima Health provider directory; increased coordination with contracted providers; increased penalty payments to DHCS.	**03/14/2023** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch LHPC: Oppose CAHP: Oppose
AB 564 Villapudua	**Medi-Cal Claim Signatures**: Would allow Medi-Cal providers to submit electronic signatures for claims and remittance forms. ***Potential CalOptima Health Impact:*** Reduced administrative burden for CalOptima Health contracted providers.	**06/14/2023** Referred to Senate Health Committee **05/31/2023** Passed Assembly floor	CalOptima Health: Watch
AB 815 Wood	**Provider Credentialing**: Would require CalHHS to create a provider credentialing board that certifies entities to credential providers in lieu of a health plan's credentialing process, effective July 1, 2025. Would require a health plan to accept a credential from such entities without imposing additional criteria and to pay a fee to such entities based on the number of contracted providers credentialed. Health plans could use their own credentialing processes for any providers who are not credentialed by certified entities. ***Potential CalOptima Health Impact***: Reduced credentialing application workload for CalOptima Health staff; reduced quality oversight of contracted providers.	**06/07/2023** Referred to Senate Health Committee **05/30/2023** Passed Assembly floor	CalOptima Health: Watch CAHP: Concerns LHPC: Oppose Unless Amended
AB 904 Calderon	**Doula Access**: Beginning January 1, 2025, would require a health plan to develop a maternal and infant health equity program that addresses racial health disparities in maternal and infant health outcomes through the use of doulas. ***Potential CalOptima Health Impact:*** Increased access to prenatal care for eligible CalOptima Health Medi-Cal members; additional provider contracting and credentialing, additional staff time for program management.	**06/21/2023** Passed Senate Health Committee; referred to Senate Appropriations Committee **05/30/2023** Passed Assembly floor	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 931 Irwin	**Physical Therapy Prior Authorization**: Beginning January 1, 2025, would prohibit health plans from requiring prior authorization for the initial 12 treatment visits for a new episode of care for physical therapy. ***Potential CalOptima Health Impact:*** Modified UM procedures for a covered Medi-Cal benefit.	**06/14/2023** Passed Senate Health Committee; referred to Senate Appropriations Committee **05/01/2023** Passed Assembly floor	CalOptima Health: Watch CAHP: Oppose
AB 1122 Bains	**Medi-Cal Provider Applications:** Would allow providers to submit an alternative type of primary, authoritative source documentation as proof of information required on a Medi-Cal enrollment application. Would also authorize providers to submit applications up to 30 days before having an established place of business. ***Potential CalOptima Health Impact:*** Streamlined Medi-Cal provider enrollment process; increased number of CalOptima Health contracted providers.	**07/05/2023** Passed Senate Health Committee; referred to Senate Appropriations Committee **05/25/2023** Passed Assembly floor	CalOptima Health: Watch
AB 1241 Weber	**Medi-Cal Telehealth Access:** Would require Medi-Cal telehealth providers to maintain and follow protocols to either offer in-person services or arrange a referral to in-person services. However, this would not require a provider to schedule an appointment with a different provider on behalf of a patient. ***Potential CalOptima Health Impact:*** Continued flexibility to access in-person, video and audio-only health care services for CalOptima Health Medi-Cal members.	**06/07/2023** Passed Senate Health Committee; referred to Senate Appropriations Committee **04/27/2023** Passed Assembly floor	CalOptima Health: Watch
AB 1288 Reyes	**Medication-Assisted Treatment Prior Authorization**: Would prohibit health plans from requiring prior authorization for a naloxone product, buprenorphine product, methadone or long-acting injectable naltrexone for detoxification or maintenance treatment of a substance use disorder, when prescribed according to generally accepted national professional guidelines. ***Potential CalOptima Health Impact:*** Modified UM procedures for a covered Medi-Cal benefit.	**07/12/2023** Passed Senate Health Committee; referred to Senate Appropriations Committee **05/18/2023** Passed Assembly floor	CalOptima Health: Watch CAHP: Oppose
Rates & Financing			
S. 570 Cardin (MD) **H.R. 1342** Barragan (CA)	**Medicaid Dental Benefit Act of 2023:** Would require state Medicaid programs to cover dental and oral health services for adults. Would also increase the Federal Medical Assistance Percentage (FMAP) (i.e., federal matching rate) for such services. CMS would be required to develop oral health quality and equity measures and conduct outreach relating to dental and oral health coverage. ***Potential CalOptima Health Impact:*** Increased payments to CalOptima Health and contracted providers; additional quality metrics.	**02/28/2023** Introduced; referred to committees	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 485 McMorris (WA)	**Protecting Health Care for All Patients Act of 2023:** Would prohibit all federally funded health care programs from using quality-adjusted life years (i.e., measures that discount the value of a life based on disability) to determine coverage and payment determinations for treatments and prescription drugs. ***Potential CalOptima Health Impact:*** Modified authorization limits for certain CalOptima Health members.	**03/24/2023** Passed by House Energy and Commerce Committee; referred to House floor	CalOptima Health: Watch
SB 282 Eggman	**Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) Same-Day Visits**: Would authorize reimbursement for a maximum of two separate visits that take place on the same day at a single FQHC or RHC site, whether through a face-to-face or telehealth-based encounter (e.g., a medical visit and dental visit on the same day). In addition, would add a licensed acupuncturist within those health care professionals covered under the definition of a "visit." ***Potential CalOptima Health Impact:*** Timelier access to services at CalOptima Health's contracted FQHCs.	**07/12/2023** Passed Assembly Health Committee; referred to Assembly Appropriations Committee **05/25/2023** Passed Senate floor	CalOptima Health: Watch LHPC: Support
SB 340 Eggman	**Eyeglasses Reimbursement**: Would authorize a provider to purchase eyeglasses from a private entity instead of from the Prison Industry Authority for the purpose of Medi-Cal reimbursement for covered optometric services. ***Potential CalOptima Health Impact:*** Timelier access to prescription eyeglasses for CalOptima Health Medi-Cal members.	**06/15/2023** Referred to Assembly Health Committee and Assembly Public Safety Committee **05/25/2023** Passed Senate floor	CalOptima Health: Watch
SB 870 Caballero	**MCO Tax:** Would renew the MCO tax on health plans, which expired on January 1, 2023, to an unspecified future date. Would also modify the tax rates to unspecified percentages that are based on the Medi-Cal membership of the health plan. ***Potential CalOptima Health Impact:*** Increased tax liability on CalOptima Health.	**04/26/2023** Passed Senate Health Committee; referred to Senate Appropriations Committee	CalOptima Health: Watch
AB 55 Rodriguez	**Ground Ambulance Transportation**: Effective January 1, 2024, would require Medi-Cal MCPs to implement a value-based purchasing model that increases reimbursement to ground ambulance transportation providers who meet certain workforce standards. ***Potential CalOptima Health Impact:*** Increased financial stability for CalOptima Health's contracted transportation providers; increased costs for CalOptima Health.	**04/25/2023** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 488 Nguyen, S.	**Vision Loss:** Would modify the Skilled Nursing Facility (SNF) Workforce and Quality Incentive Program measures and milestones to include program access, staff training and capital improvement measures aimed at addressing the needs of SNF residents with vision loss. ***Potential CalOptima Health Impact:*** Modified payments to CalOptima Health contracted SNFs; increased data collection, tracking and reporting requirements; improved quality of life for certain members with vision loss.	**03/27/2023** Assembly Health Committee hearing canceled by author	CalOptima Health: Watch
AB 576 Weber	**Abortion Reimbursement**: Would require DHCS to fully reimburse Medi-Cal providers for providing medication to terminate a pregnancy that aligns with clinical guidelines, evidence-based research and provider discretion. ***Potential CalOptima Health Impact:*** Increased financial stability for eligible CalOptima Health contracted providers.	**06/28/2023** Passed Senate Health Committee; referred to Senate Appropriations Committee **05/31/2023** Passed Assembly floor	CalOptima Health: Watch
AB 1549 Carrillo	**FQHC and RHC Rates:** Would require that DHCS's per-visit rates to FQHCs and RHCs account for costs that are reasonable and related to the provision of covered services, the intensity of activities taking place in an average visit, the length or duration of a visit and the number of activities provided during a visit. ***Potential CalOptima Health Impact:*** Increased financial stability of CalOptima Health's contracted FQHCs.	**04/25/2023** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch
AB 1698 Wood	**Medi-Cal Funding**: States the intent of the Legislature to enact future legislation to increase overall funding and reimbursement for the Medi-Cal program. ***Potential CalOptima Health Impact***: Increased financial stability for CalOptima Health and its contracted providers.	**02/17/2023** Introduced	CalOptima Health: Watch
Social Determinants of Health			
H.R. 1066 Blunt Rochester (DE)	**Collecting and Analyzing Resources Integral and Necessary for Guidance (CARING) for Social Determinants Act of 2023:** Would require CMS to update guidance at least once every three years to help states address SDOH under Medicaid and CHIP. ***Potential CalOptima Health Impact:*** Increased opportunities for CalOptima Health to address SDOH.	**02/17/2023** Introduced; referred to House Energy and Commerce Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 3746 McHenry	**Fiscal Responsibility Act (FRA) of 2023:** Suspends the $31 trillion debt limit until January 1, 2025, and includes additional policies to cap discretionary spending limits and modify work reporting requirements for certain safety net programs. Most notably, modifies work requirements for the Supplemental Nutrition Assistance Program (SNAP). Specifically, through October 1, 2030, raises the age SNAP recipients subject to work requirements from 49 to 55 years old but also creates new exemptions that waive SNAP work requirements for veterans, individuals experiencing homelessness and young adults ages 18–24 years old who are aging out of the foster care system. ***Potential CalOptima Health Impact:*** Increased number of CalOptima Health members eligible for CalFresh.	**06/03/2023** Signed into law	CalOptima Health: Watch
AB 85 Weber	**SDOH Screenings:** Would add SDOH screenings as a covered Medi-Cal benefit. Would also require health plans to provide primary care providers with adequate access to community health workers, social workers and peer support specialists. Would also FQHCs and RHCs to be reimbursed for these services at the Med-Cal FFS rate. ***Potential CalOptima Health Impact:*** New covered benefits for CalOptima Health Medi-Cal members.	**06/28/2023** Passed Senate Health Committee; referred to Senate Appropriations Committee **05/25/2023** Passed Assembly floor	CalOptima Health: Watch CAHP: Oppose
AB 257 Hoover	**Encampment Restrictions:** Would prohibit a person from sitting, lying, sleeping or placing personal property in any street, sidewalk or other public property within 500 feet of a school, daycare center, park or library. ***Potential CalOptima Health Impact:*** Increased outreach and support services for unsheltered CalOptima Health Medi-Cal members.	**03/07/2023** Failed passage in Assembly Public Safety Committee	CalOptima Health: Watch
AB 271 Quirk-Silva	**Homeless Death Review Committee:** Would authorize counties to establish a homeless death review committee for the purpose of gathering information to identify the root causes of the deaths of homeless individuals and to determine strategies to improve coordination of services for the homeless population. ***Potential CalOptima Health Impact:*** Increased coordination and data review between the County of Orange and CalOptima Health.	**07/13/2023** Passed Senate floor; re-referred to Assembly floor for concurrence **03/06/2023** Passed Assembly floor	**03/02/2023** CalOptima Health: Support

Information in this document is subject to change as bills proceed through the legislative process.

ACAP: Association for Community Affiliated Plans
CAHP: California Association of Health Plans
CalPACE: California PACE Association
LHPC: Local Health Plans of California
NPA: National PACE Association

Last Updated: July 21, 2023

2023 Federal Legislative Dates

January 3	118th Congress, 1st Session convenes
July 31–September 4	Summer recess for Senate
July 31–September 11	Summer recess for House
December 15	1st Session adjourns

Source: Floor Calendars, United States Congress: https://www.congress.gov/calendars-and-schedules

2023 State Legislative Dates

January 4	Legislature reconvenes
January 10	Proposed budget must be submitted by Governor
February 17	Last day for legislation to be introduced
March 30–April 10	Spring recess
April 28	Last day for policy committees to hear and report to fiscal committees any fiscal bills introduced in that house
May 5	Last day for policy committees to hear and report to the Floor any non-fiscal bills introduced in that house
May 19	Last day for fiscal committees to hear and report to the Floor any bills introduced in that house
May 30–June 2	Floor session only
June 2	Last day for each house to pass bills introduced in that house
June 15	Budget bill must be passed by midnight
July 14	Last day for policy committees to hear and report bills in their second house to fiscal committees or the Floor
July 14–August 14	Summer recess
September 1	Last day for fiscal committees to report bills in their second house to the Floor
September 5–14	Floor session only
September 8	Last day to amend bills on the Floor
September 14	Last day for each house to pass bills; final recess begins upon adjournment
October 14	Last day for Governor to sign or veto bills passed by the Legislature

Source: 2023 State Legislative Deadlines, California State Assembly: http://assembly.ca.gov/legislativedeadlines

About CalOptima Health

CalOptima Health is a county organized health system that administers health insurance programs for low-income children, adults, seniors and people with disabilities. As Orange County's community health plan, our mission is to serve member health with excellence and dignity, respecting the value and needs of each person. We provide coverage through three major programs: Medi-Cal, OneCare (HMO D-SNP) and the Program of All-Inclusive Care for the Elderly (PACE).

FY 2023–24 Enacted State Budget Analysis

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Background

On January 10, 2023, Gov. Gavin Newsom released the Fiscal Year (FY) 2023–24 Proposed State Budget, effective July 1, 2023. The proposed budget's total spending of $297 billion ($223.6 billion General Fund [GF]) reflected an estimated $22.5 billion deficit and a 9.8% decrease in overall spending compared to the FY 2022–23 Enacted Budget.

On May 12, Gov. Newsom released the FY 2023–24 Revised Budget Proposal, also known as the May Revise, with total funding at $306 billion, including $224 billion GF. As tax revenues continued to decline, the projected budget deficit increased by $9.3 billion compared to January Proposed Budget — totaling a $31.5 billion deficit. Nevertheless, the governor continued to present a balanced budget — largely without program cuts — through spending delays, shifts to funding sources, pullbacks of unused expenditures, new revenue sources, borrowing and limited reserve withdrawal.

To meet the constitutionally obligated deadline to pass a balanced budget, on June 15, the State Senate and State Assembly both passed Senate Bill (SB) 101, a placeholder budget representing the Legislature's joint counterproposal to the May Revise. Once a final budget agreement deal was reached between the governor and legislative leaders, the governor signed into law the placeholder state budget (SB 101) on June 27 and the final, agreed-upon budget revisions (Assembly Bill [AB] 102) on July 10. In addition to the budget, the governor also signed the Managed Care Organization (MCO) Tax Trailer Bill (AB 119) on June 29 and the consolidated Health Trailer Bill (AB 118) on July 10, which contain the policy changes needed to implement health-related budget expenditures. Together, these bills represent the FY 2023–24 Enacted Budget.

Overview

As the second largest budget in California history, the FY 2023–24 Enacted Budget sits at $310.8 billion, including nearly $226 billion GF spending, which attempts to close the gap on a $32 billion deficit while safeguarding $37.8 billion in reserve funds. This represents a 4.4% decrease in GF spending compared to the FY 2022–23 Enacted Budget ($234.4 billion GF). To achieve a balanced budget this FY, certain commitments will be delayed or added to the FY 2024–25 budget as a future investment.

The enacted budget estimates Medi-Cal spending of $151.2 billion ($37.6 billion GF), an 11.7% total increase (21.7% GF increase) from FY 2022–23, despite the fact that average Medi-Cal caseload in FY 2023–24 is expected to decrease by 7.2% to 14.2 million beneficiaries

as redeterminations resume following the end of the COVID-19 public health emergency (PHE). Total COVID-19-specific impacts on the Medi-Cal budget impacts are projected to decline overall, but GF costs are predicted to increase due to the phase-out of federal relief funding related to the PHE.

Managed Care Organization (MCO) Provider Tax

With renewed commitments to Medi-Cal spending, the enacted budget retroactively implements a new MCO Provider Tax, effective April 1, 2023, through December 31, 2026. Over the period of the tax, a total of $19.4 billion in net benefits will be generated — with $8.3 billion allocated for GF offsets to support a balanced budget and the remaining $11.1 billion for historic new investments in the Medi-Cal program, including targeted increases to Medi-Cal rates, access and provider participation.

In facilitating the $11.1 billion allocation, the new Medi-Cal Provider Payment Reserve Fund will support investments in Medi-Cal that maintain and expand programs by increasing quality of health care delivery and reducing barriers to care. These funds will preserve eligibility and benefit expansions in the Medi-Cal program, strengthen the program's participation, especially in underserved areas and in primary and preventive care, and maximize opportunities to draw additional federal matching funds to the Medi-Cal program. While a detailed plan for most investments will be submitted as part of the FY 2024–25 budget next year, specific limited investments beginning in FY 2023–24 can be found below:

Rate Increases in the Medi-Cal Program: No sooner than January 1, 2024, reimbursement rates for primary care services (including nurse practitioners and physician assistants), maternity care (including obstetric and doula services), and certain outpatient non-specialty mental health services will increase to at least 87.5% of Medicare rates. This is an adjustment to base rates that takes into account current Proposition 56 supplemental payments and the elimination of AB 97 rate reductions for these services. Estimated costs to increase provider rates are $237.4 million ($98.2 million Medi-Cal Provider Payment Reserve Fund) in FY 2023–24 and $580.5 million ($240.1 million Medi-Cal Provider Payment Reserve Fund) annually thereafter.

Distressed Hospital Loan Program: $300 million is allocated to support not-for-profit and public hospitals facing closure or facilitating the reopening of a hospital. The Department of Health Care Access and Information (HCAI) and California Health Facilities Financing Authority will provide one-time interest-free cashflow loans of up to $150 million from the Medi-Cal Provider Payment Reserve Fund in FY 2023–24 and up to $150 million from the GF in the previous FY 2022–23 to distressed hospitals in need.

Small and Rural Hospital Relief Program: $52.2 million will support rural hospitals to meet compliance standards with the State's seismic mandate with $50 million one-time from the Medi-Cal Provider Payment Reserve and $2.2 million from the Small and Rural Hospital Relief Fund for assessment and construction.

Graduate Medical Education Program: In an effort to increase the number of primary and specialty care physicians in the state — based on demonstrated workforce needs and priorities — $75 million will be expended for the University of California to expand graduate medical education programs and annually thereafter.

Behavioral Health

The state budget continues to address gaps through renewed commitments to modernize current programs in the mental health continuum. The enacted budget includes $40 million ($20 million Mental Health Services Fund; $20 million federal funds) to continue reforming the behavioral health system. As part of the final budget agreement, DHCS will work to implement the governor's proposal to modernize the Mental Health Services Act as well as authorize a general obligation bond to fund the following:

- Unlocked community behavioral health residential settings
- Permanent supportive housing for people experiencing or at risk of homelessness who have behavioral health conditions
- Housing for veterans experiencing or at risk of homelessness who have behavioral health conditions

988 Suicide and Crisis Program: $13.2 million in special funds and federal funds will support a five-year implementation plan for a comprehensive 988 system. Under the health trailer bill language, prior authorization will no longer be required for behavioral health crisis stabilization services and care but authorizes prior authorization for medically necessary mental health or substance use disorder services following stabilization from a behavioral health crisis provided through the 988 system. Additionally, a plan that provides behavioral health crisis services and is contacted by a 988 center or mobile crisis team must authorize post-stabilization care or arrange for prompt transfer of care to another provider within 30 minutes

of initial contact.

Children and Youth Behavioral Health Initiative (CYBHI) Fee Schedule Third Party Administrator (TPA): As part of the CYBHI mandate, an established statewide all-payer fee schedule will reimburse school-linked behavioral health providers who deliver services to students at or near a school-site. $10 million from the Mental Health Services Fund will be expended in support of the statewide infrastructure that will consolidate provider management operations to include credentialing, quality assurance, billing and claims.

CalHOPE: The CalHOPE program is a vital element of the statewide crisis support system. $69.5 million total funding will assist in continuing operations, including media messaging to destigmatize stress and anxiety as well as CalHOPE web services, warm line and partnership opportunities with up to 30 community-based organizations and over 400 peer crisis counselors.

CalFresh

CalFresh — California's implementation of the federal Supplemental Nutrition Assistance Program (SNAP) — sees $35 million in funding for the California Nutrition Incentive Program, which helps members purchase healthy food from farmers' markets. The Legislature also included a line item for $16.8 million in one-time funding to extend the sunset dates for a CalFresh fruit and vegetable pilot EBT program Market Match. For every benefit dollar spent, participants receive an additional dollar to spend on fruits and vegetables at a market within set parameters. The deal also includes $915,000 to trial monthly minimum CalFresh benefit increase from $23 to $50.

California Advancing and Innovating Medi-Cal (CalAIM)

Transitional Rent: DHCS successfully sought an amendment to the CalAIM Transitional Rent Waiver with a commitment of $17.9 million ($6.3 million GF) for an additional community support that may be offered by Medi-Cal MCPs. Under the DHCS budget, the new "Transitional Rent" community support would allow the provision of up to six months of rent or temporary housing to eligible individuals experiencing homelessness or at risk of homelessness and transitioning out of institutional levels of care, a correctional facility, or the foster care system.

Relatedly, the budget also includes an additional $40 million GF for the Provider Access and Transforming Health (PATH) initiative to assist providers with implementing community supports and enhanced care management (ECM) through CalAIM in clinics.

Justice Involved: CalAIM receives a commitment of $9.9 million total funding ($3.8 million GF) in FY 2023–24 for pre-release services, with an additional $225 million estimated subsidy through the PATH program to support correctional agencies in collaborating with county social services department planning and implementation of pre-release Medi-Cal enrollment services.

Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT): Formerly referred to as the California Behavioral Health Community-Based Continuum (CalBH-CBC) Demonstration, BH-CONNECT receives $6.1 billion total ($306.2 million GF; $87.5 million Mental Health Services Fund; $2.1 billion Medi-Cal County Behavioral Health Fund; $3.6 billion federal funds) over a span of five years for DHCS and the California Department of Social Services (DSS) to implement this CalAIM program as soon as January 1, 2024. BH-CONNECT includes statewide and county opt-in components, including rent and temporary housing for up to six months for certain high-needs beneficiaries as well a behavioral health workforce initiative to expand provider capacity and services. DHCS will also seek federal approval of a Medicaid Section 1115 demonstration waiver to expand behavioral health services for Medi-Cal members living with serious mental illness and serious emotional disturbance.

As part of CalAIM Behavioral Health Payment Reform, the budget also provides $250 million GF one-time to support the non-federal share of behavioral health-related services. These funds will help mitigate a significant cash flow concern for counties as they transition from cost-based reimbursement to a fee schedule.

Community Assistance, Recovery and Empowerment (CARE) Act

With a renewed pledge to serve California's most severely impaired population who often struggle with homelessness or incarceration without treatment, the CARE Act receives funding of $52.3 million GF in FY 2023–24, $121 million GF in FY 2024-25 and $151.5 million GF in FY 2025–26 to support ongoing county behavioral health department costs. The CARE Act facilitates delivery of mental health and substance use disorder services to individuals with schizophrenia spectrum or other psychotic disorders who lack medical decision-making competences. The program would connect a person in crisis with a court-ordered

care plan for up to 24 months as a diversion from homelessness, incarcerations, or conservatorship.

Medi-Cal Eligibility

Enrollment Navigators: In addition to the $60 million appropriated in FY 2022–23, $10 million from the GF will be invested into the Health Enrollment Navigators Project (AB 74) over four years. The project aims to promote outreach, enrollment and retention activities in vulnerable populations through partnerships with counties and community-based organizations. Target populations of priority include but are not limited to persons with mental health disorder needs, persons with disabilities, older adults, unhoused individuals, young people of color, immigrants and families of mixed immigration status.

Medi-Cal Expansion to Undocumented Individual: The enacted budget maintains $1.4 billion ($1.2 billion GF) in FY 2023–24 and $3.4 billion ($3.1 billion GF) at full operation, inclusive of In-Home Supportive Services (IHSS) costs, to expand full-scope Medi-Cal eligibility to all income-eligible adults ages 26–49, regardless of immigration status, on January 1, 2024.

Newborn Hospital Gateway: The Newborn Hospital Gateway system provides presumptive eligibility determinations through an electronic process for families to enroll a deemed eligible newborn into the Medi-Cal program from hospitals that elected to participate in the program. Effective July 1, 2024, all qualified Medi-Cal providers participating in presumptive eligibility programs must utilize the Newborn Hospital Gateway system via the Children's Presumptive Eligibility Program portal to report a Medi-Cal-eligible newborn born in their facilities within 72 hours after birth or one business day after discharge.

Whole Child Model (WCM): As part of the budget, WCM will be extended to 15 additional counties no sooner than January 1, 2025. Currently implemented in 21 counties, WCM integrates children's specialty care services provided in the California Children's Services (CCS) program into Medi-Cal managed care plans (MCPs). WCM is already implemented in Orange County. The budget also requires a Medi-Cal MCP participating in WCM to ensure that a CCS-eligible child has a primary point of contact that will be responsible for the child's care coordination and support the referral pathways in non-WCM counties.

Miscellaneous

The enacted budget includes several other adjustments and provisions that potentially impact CalOptima Health:

- **COVID-19 Response:** a one-time funding of $126.6 million will continue ongoing efforts to protect the state's public health against COVID-19 – including maintenance of reporting systems, lab management and CalCONNECT — for oversight case and outbreak investigation.
- **Hepatitis C Virus Equity:** $10 million one-time GF spending, spanning over five years, to expand Hepatitis C Virus services — including outreach, linkage and testing — among high priority populations including young people who use drugs, indigenous communities and those experiencing homelessness.
- **Medi-Cal Rx Naloxone Access Initiative:** a one-time $30 million Opioid Settlements Fund expenditure to support the creation or procurement of a lower cost generic version of naloxone nasal product.
- **Medi-Cal Rx Reproductive Health Costs:** a one-time $2 million GF reappropriation and permissive use of funds for reproductive health care – including statutory changes to provide flexibility for the Medi-Cal Rx program to acquire various pharmaceutical drugs — Mifepristone or Misoprostol — to address urgent and emerging reproductive health needs.
- **Public Health Workforce:** upholds $97.5 million GF over four years for various public health workforce training and development programs.
- **Reproductive Waiver:** $200 million total funds to implement the Reproductive Health Services 1115 demonstration waiver that will support access to family planning and related services for Medi-Cal members as well as support sustainability and system transformation for California's reproductive health safety net.

Next Steps

State agencies will begin implementing the policies included in the enacted budget. Staff will continue to monitor these polices and provide updates regarding issues that have a significant impact to CalOptima Health. In addition, the Legislature will continue to advance policy bills through the legislative process.

Bills with funding allocated in the enacted budget are more likely to be passed and signed into law. The Legislature has until September 14 to pass legislation, and Gov. Newsom has until October 14 to either sign or veto that legislation.

About CalOptima Health

CalOptima Health, a county organized health system (COHS), is the single plan providing guaranteed access to Medi-Cal for all eligible individuals in Orange County and is responsible for almost all medical acute services, including custodial long-term care. CalOptima Health is governed by a locally appointed Board of Directors, which represents the diverse interests that impact Medi-Cal.

If you have any questions, please contact GA@caloptima.org.

CalOptima Health Community Outreach Summary — July and August 2023

Background

CalOptima Health is committed to serving the community by sharing information with current and potential members and strengthening relationships with community partners. To this end, our team attends community coalitions, collaborative meetings and advisory groups as well as supports our community partners' public activities. Participation includes providing Medi-Cal educational materials and, if criteria are met, financial support and/or CalOptima Health-branded items.

CalOptima Health's participation in public activities promotes:

- Member interaction/enrollment in a CalOptima Health program
- Community awareness of CalOptima Health
- Partnerships that increase positive visibility and relationships with community organizations

Community Outreach Highlight

With the new school year approaching, it is important to ensure that CalOptima Health families and students in Orange County are ready to return to the classroom. To deliver critical school readiness resources, CalOptima Health is hosting an inaugural back-to-school member celebration and community resource fair event on Saturday, August 26, from 9 a.m.–1 p.m. at St. Anthony Claret Church in Anaheim. The event will offer health services, including vision and dental screenings, sports physicals, and haircuts by appointment. In addition, there will be food, diaper and bike helmet distributions, community resources, fun family-friendly activities, cultural performances, entertainment, and more.

Summary of Public Activities

As of July 18, CalOptima Health plans to participate in, organize or convene 68 public activities in July and August. In July, there were 33 public activities, including 14 virtual community/collaborative meetings, six community-based presentations, 12 community events and one Health Network Forum. In August there will be 35 public activities, including 18 virtual community/collaborative meetings, six community-based presentations, nine community events, one Health Network Forum and one Cafecito meeting. A summary of the agency's participation in community events throughout Orange County is attached.

Endorsements

CalOptima Health provided zero endorsements since the last reporting period (e.g., letters of support, program/public activity events with support or use of name/logo). Endorsement requests must meet the requirements of CalOptima Health's Policy AA.1214: Guidelines for Endorsements by CalOptima Health, for Letters of Support and Use of CalOptima Health's Name and Logo. More information about policy requirements can be found at: https://www.caloptima.org/en/About/CommunityRelations/CommunityOutreach.aspx.

For additional information or questions, contact CalOptima Health Community Relations Director Tiffany Kaaiakamanu at 657-235-6872 or tkaaiakamanu@caloptima.org.

Attachment to the August 3, 2023 CalOptima Health Outreach Summary

Community events hosted by CalOptima Health and community partners in July and August 2023:

July 2023

July 1, 10 a.m.–Noon, Park Awareness and Resource Fair, hosted by Santa Ana Early Learning Initiative

Delhi Center, 505 E. Central Ave., Santa Ana

- At least one staff member attended (in-person).
- Health/resource fair, open to the public

July 6, 4:30–6 p.m., Anaheim Mobile Family Resource Center (FRC), hosted by Neighborhood Human Services

1627 W. Catalpa Drive, Anaheim

- At least one staff member attended (in-person).
- Health/resource fair, open to the public

July 7, 9:30–10:30 a.m., CalOptima Health Medi-Cal Overview in English

Equus Workforce Solutions, Virtual

- At least one staff member presented.
- Community-based organization presentation, open to members/community

July 11, 11 a.m.–Noon, CalOptima Health Medi-Cal Overview in English

Church World Service, 7441 Lincoln Way, Garden Grove

- At least one staff member attended (in-person).
- Community-based organization presentation, open to members/community

July 13, 4:30–6 p.m., Anaheim Mobile FRC, hosted by Neighborhood Human Services

Alameda/Brownwood/Catalina, Anaheim

- At least one staff member attended (in-person).
- Health/resource fair, open to the public

July 15, Noon–4 p.m., Carnival for Kids, hosted by Illumination Foundation

St. Anthony Claret Catholic Church, 1450 E. La Palma Ave., Anaheim

- At least one staff member attended (in-person).
- Sponsorship fee: $1,000; included resource table at event, being featured in e-blast and recognition on social media
- Health/resource fair, open to the public

CalOptima Health-hosted | CalFresh Outreach (e.g., colleges, food banks) | Community Presentation | Exhibitor/Attendee

July 18, 8:30–10 a.m., CalOptima Health Medi-Cal Overview in Spanish
Boys and Girls Club, 950 W. Highland St., Santa Ana

- At least one staff member presented (in-person).
- Community-based organization presentation, open to members/community

July 19, 3–4 p.m., CalOptima Health Medi-Cal Overview in English
High School Equivalency (HSE) Academy, Virtual

- At least one staff member presented.
- Community-based organization presentation, open to members/community

July 19, 8–10 a.m., Safety Day, hosted by the City of Westminster
St. Anthony Claret Catholic Church, 1450 E. La Palma Ave., Anaheim

- At least two staff members attended (in-person).
- Health/resource fair, open to the public

July 20, 9–10 a.m., CalOptima Health Medi-Cal Overview in English
Stanton Library, 7850 Katella Ave., Stanton

- At least one staff member presented (in-person).
- Community-based organization presentation, open to members/community

July 20,10 a.m.–Noon, CalOptima Health Medi-Cal Overview in English
Virtual

- At least one staff member presented.
- Community-based organization presentation, open to members/community

July 24–25, 8 a.m.–Noon, Katella High School Registration Day, hosted by Katella High School
2200 E. Wagner Ave., Anaheim

- At least one staff member attended (in-person).
- Health/resource fair, open to the public

July 27, 5–7:30 p.m., Buena Clinton Lucha Libre Family Night, hosted by Buena Clinton Youth and Family Center
12661 Sunswept Ave., Garden Grove

- At least one staff member attended (in-person).
- Health/resource fair, open to the public

July 29, 8 a.m.–Noon, Back to School Outreach Fair, hosted by Collaborative to Assist McKinney Vento and Motel Families
Gilbert High School, 1800 W. Ball Rd., Anaheim

- At least two staff members attended (in-person).
- Sponsorship fee: $2,000; included resource table at event, space for a banner and display of logo on event flyer
- Health/resource fair, open to the public

CalOptima Health-hosted CalFresh Outreach (e.g., colleges, food banks) Community Presentation
Exhibitor/Attendee

July 29, 10 a.m.–2 p.m., Supervisor Sarmiento and CalOptima Health Community Resource Fair

Ponderosa Park & Family Resource Center, 320 E. Orangewood, Anaheim

- At least fifty staff members attended (in-person).
- Health/resource fair, open to the public

July 30, 1–4 p.m., Food Distribution and Enrollment Event, hosted by CalAssist and Frances Nguyen and Associates

Westminster City Hall, 8200 Westminster Blvd., Westminster

- At least one staff member attended (in-person).
- Health/resource fair, open to the public

August 2023

August 1, 5–8 p.m., National Night Out, hosted by Garden Grove Police Department

Garden Grove Police Department, 11301 Acacia Pkwy., Garden Grove

- At least two staff members to attend (in-person).
- Health/resource fair, open to the public

August 1, 9 a.m.–4 p.m., Unforgettable Conference, hosted by Moving Forward

750 The City Drive South, Suite 130, Orange

- At least two staff members to attend (in-person).
- Health/resource fair, open to the public

August 2, 3–7 p.m., Back to School Family Fair, hosted by Boys & Girls Club of Garden Grove

KiwanisLand Park, 9840 Larson Ave., Garden Grove

- At least one staff member to attend (in-person).
- Health/resource fair, open to the public

August 3, 9–10 a.m., CalOptima Health Medi-Cal Overview in English

US Vets, 1231 Warner Ave., Tustin

- At least one staff member to attend (in-person).
- Community-based organization presentation, open to members/community

August 5, 9 a.m.–1 p.m., Newport-Mesa Unified School District (NMUSD) Family Resource Fair, hosted by NMUSD and Hoag

IKEA-Costa Mesa, 1475 S. Coast Dr., Costa Mesa

- At least one staff member to attend (in-person).
- Health/resource fair, open to the public

CalOptima Health-hosted CalFresh Outreach (e.g., colleges, food banks) Community Presentation Exhibitor/Attendee

August 8, 9–10 a.m., CalOptima Health Medi-Cal Overview in English
Garden Grove Main Library, 11200 Stanford Ave., Garden Grove

- At least one staff member to attend (in-person).
- Community-based organization presentation, open to members/community

August 10, 1–2 p.m., CalOptima Health Medi-Cal Overview in Spanish
Garden Grove Main Library, 11200 Stanford Ave., Garden Grove

- At least one staff member to attend (in-person).
- Community-based organization presentation, open to members/community

August 10, 4:30–6 p.m., Anaheim Mobile FRC, hosted by Neighborhood Human Services
Athena/Sunburst, Anaheim

- At least one staff member to attend (in-person).
- Health/resource fair, open to the public

August 12, 9 a.m.–1 p.m., Super Senior Saturday, hosted by City of Buena Park
Buena Park Senior Center, 8150 Knott Ave., Buena Park

- At least one staff member to attend (in-person).
- Exhibitor Fee: $150
- Health/resource fair, open to the public

August 17, 10:45–11:45 a.m., CalOptima Health Medi-Cal Overview in English
Brea Senior Center, 500 Sievers Ave., Brea

- At least one staff member to present (in-person).
- Community-based organization presentation, open to members/community

August 17, 4:30–6 p.m., Anaheim Mobile FRC, hosted by Neighborhood Human Services
Cabot St., Anaheim

- At least one staff member to attend (in-person).
- Health/resource fair, open to the public

August 18, 8–11:30 a.m., Senior Resource Fair, hosted by Office of Young Kim
Orange Senior Center, 170 S. Olive St., Orange

- At least one staff member to attend (in-person).
- Health/resource fair, open to the public

August 23, 10–11 a.m., CalOptima Health Medi-Cal Overview in English
Fullerton Community Center, 340 W. Commonwealth Ave., Fullerton

- At least one staff member to present (in-person).
- Community-based organization presentation, open to members/community

CalOptima Health-hosted | CalFresh Outreach (e.g., colleges, food banks) | Community Presentation | Exhibitor/Attendee

August 25, 8–11:30 a.m., Annual Southern California Alzheimer's Disease Research Conference, hosted by UCI Institute for Memory Impairments and Neurological Disorders (MIND)

Orange Senior Center, 170 S. Olive St., Orange

- At least one staff member to attend (in-person).
- Sponsorship fee: $1,000; includes resource table at event, placement of logo and website link on event website, signage during event break.
- Health/resource fair, open to the public

August 29, 9–10:30 a.m., Cafecito Meeting

Virtual

- At least nine staff members to attend.
- Steering committee meeting, open to collaborative members

August 30, 10–11 a.m., CalOptima Health Medi-Cal Overview in English

Laura's House, Virtual

- At least one staff member to attend (in-person).
- Community-based organization presentation, open to members/community

These sponsorship request(s) and community event(s) met the requirements of CalOptima Health Policy AA.1223: Participation in Community Events Involving External Entities. More information about policy requirements can be found at:
https://www.caloptima.org/en/About/CommunityRelations/CommunityOutreach.aspx

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 3, 2023
Regular Meeting of the CalOptima Health Board of Directors

Report Item
10. Extend the Terms of the Current Chair and Vice Chair of the Board of Directors until the September 2023 Board Meeting

Contact
Michael Hunn, Chief Executive Officer, (657) 900-1481

Recommended Action
Extend the Terms of the Current Chair and Vice Chair of the Board of Directors (Board) until the September 2023 Board Meeting.

Background/Discussion
In accordance with Article VIII, Section 8.1 of CalOptima Health'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, shall preside at all meetings of the Board, and shall appoint all members of the Ad Hoc Committees, as well as the chair of the Ad Hoc Committees and all Committees other than the Member and Provider Advisory Committees. The Chair shall perform all duties incident to the office and such other duties as may be prescribed by the Board from time to time.

Section 8.2 of the CalOptima Health Bylaws states that the Board shall elect one of its Directors to serve as Vice Chair at an organizational meeting. The Vice Chair shall perform the duties of the Chair if the Chair is absent from the meeting or is otherwise unable to act.

The Chair and Vice Chair terms shall commence on the first day of the month after the organizational meeting at which they are elected to their respective positions.

The Board typically holds its organizational meeting in June and conducts its annual election of officers at that time. Due to the absence of several Board members at the June 2023 meeting, the election was delayed until the August Board meeting. Due to anticipated absences at the August 2023 Board meeting staff recommends that the Board consider extending the terms of the current Chair and Vice Chair until the September 2023 Board meeting.

Fiscal Impact
There is no fiscal impact.

Rationale for Recommendation
The recommended actions are in accordance with Article VIII of the CalOptima Health Bylaws.

Concurrence
Troy R. Szabo, Outside General Counsel, Kennaday Leavitt

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Attachments
None

/s/ Michael Hunn *07/27/2023*
Authorized Signature **Date**

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CalOptima Health Board Action Agenda Referral

Action To Be Taken August 3, 2023
Regular Meeting of the CalOptima Health Board of Directors

Report Item
11. Authorize Naloxone Distribution Event for CalOptima Health Members

Contacts
Michael Hunn, Chief Executive Officer (657) 900-1481
Dr. Richard Pitts, Chief Medical Officer (714) 246-8491

Recommended Actions
1. Authorize CalOptima Health to host an event to distribute naloxone to members;
2. Authorize the allocation and expenditure of up to $15 million from existing reserves to fund the purchase of naloxone doses for members, and to organize, promote and execute the event and distribution of unused doses;
3. Authorize the Chief Executive Officer to engage partners and execute contracts to implement the event; and
4. Make a finding that such expenditures are for a public purpose and in furtherance of CalOptima Health's mission and purpose.

Background
In 2017, the United States declared the opioid epidemic a public health emergency. According to County of Orange Health Care Agency, the rate of death from opioid overdose nearly tripled from 2017 to 2021.

Naloxone (common brands include Narcan and Evzio) is a life-saving medication that can reverse an overdose from opioids – including heroin, fentanyl, and prescription opioid medications – when given in time. According to the Centers for Disease Control and Prevention (CDC), naloxone can restore normal breathing within 2-3 minutes in a person whose breath has slowed, or even stopped, because of an opioid overdose. Since naloxone does not cause harm to an individual who is not overdosing on drugs, the CDC recommends using it for potential overdose situations. In March 2023, the U.S. Food and Drug Administration approved the first naloxone product over the counter without a prescription, increasing access to this life-saving medication. Naloxone can now serve as a first aid response like the availability of automated external defibrillators (AEDs) for cardiac arrest or epinephrine (EpiPen®) for life-threatening allergic reactions.

Discussion
CalOptima Health staff requests approval to develop and host a naloxone distribution event for CalOptima Health members. Staff proposes to partner with community leaders, elected officials, providers and county officials to purchase and distribute up to 250,000 doses of this life-saving medication. Staff conducted exploratory conversations with various stakeholders and identified a consensus on need and broad support for CalOptima Health to act. Staff propose an event within the following parameters:

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What:	Single-day event to distribute 8mL naloxone
When:	Late summer or early fall 2023
Where:	Large, well-known, and accessible parking lot in Orange County
Who:	CalOptima Health will purchase the doses and work with community partners (*e.g.*, providers, pharmacies, county) to distribute the doses to CalOptima Health members. CalOptima Health will ensure that all requirements related to prescriptions and distribution of medications are met.
How:	Members will drive through the event and receive naloxone doses. Households of more than 1 member may receive up to 2 doses. Households of only 1 member may receive 1 dose. Members must show proof of CalOptima Health enrollment to receive the naloxone. CalOptima Health will provide any undistributed doses to community clinics for continued used and distribution to members after the event.

Staff estimate the total cost of the event at no more than $15 million. This estimate is based on the following:

- $14 million for 250,000 doses of naloxone.
- $1 million for transport, storage, security, event staff, promotion and a public health awareness campaign.

Fiscal Impact
The recommended actions related to this event are separate from the normal operating budget process. An appropriation of up to $15 million from existing reserves will fund the purchase of naloxone for members and the one-time distribution event.

Rationale for Recommendation
The recommended action will increase access to naloxone for members and will save lives.

Concurrence
Troy R. Szabo, Outside General Counsel, Kennaday Leavitt

Attachment
N/A

/s/ Michael Hunn *07/27/2023*
Authorized Signature **Date**

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CalOptima Health Board Action Agenda Referral

Action To Be Taken August 3, 2023
Regular Meeting of the CalOptima Health Board of Directors

Report Item

12. Approve Actions Related to the Housing and Homelessness Incentive Program for the Nonprofit Healthcare Academy

Contacts

Kelly Bruno Nelson, Executive Director, Medi-Cal and CalAIM, (657) 550-4741
Yunkyung Kim, Chief Operating Officer, (714) 923-8834

Recommended Actions

1. Authorize the Chief Executive Officer to execute a one (1)-year contract with Consilience Group, LLC, effective September 1, 2023, with a one (1) year renewal option at CalOptima Health's discretion to provide Nonprofit Healthcare Academy technical services.
2. Authorize CalOptima Health staff to conduct a notice of funding opportunity (NOFO) process related to the Nonprofit Healthcare Academy, administer grant agreements and release award payments to up to 20 selected community-based organizations in an amount up to $5,000 per grantee.

Background

The Department of Health Care Services (DHCS) established the Housing and Homelessness Incentive Program (HHIP) to be implemented from January 1, 2022, to December 31, 2023. HHIP is a voluntary program that aims to improve health outcomes and access to whole person care services by addressing housing insecurity and instability as a social determinant of health for the Medi-Cal population. CalOptima Health has been eligible to receive up to $83,755,557 in incentive payments over a two-year period. The HHIP incentive payments are based on Medi-Cal managed care plan performance and demonstrated progress in tackling housing and homelessness needs.

In January 2023, CalOptima Health staff initiated the first HHIP NOFO that included an equity grants priority geared toward smaller, grassroots, community-based organizations (CBOs) in an effort to help build their capacity to serve populations experiencing health disparities. In soliciting and reviewing these proposals, it was evident there was an opportunity to further support these organizations by providing technical assistance around how they could partner with the healthcare sector, position their organizations as potential service providers, and craft effective proposals that convey those concepts.

In response to this need, CalOptima Health staff sought and received the Board of Directors' (Board) approval in June 2023 to allocate $10.53 million in HHIP funding to HHIP Priority 4, Innovation and Implementation of Strategic Interventions, including $350,000 for the Nonprofit Healthcare Academy. The academy is set to include a series of learning experiences, skill-building sessions, and the opportunity to receive technical assistance to prepare these organizations for contracted partnership with CalOptima Health and more broadly, the healthcare sector. In May 2023, CalOptima Health staff administered a request for proposal (RFP) to identify a vendor to design and facilitate the Nonprofit Healthcare Academy.

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Discussion

Contract to Provide Nonprofit Healthcare Academy Technical Assistance

In selecting the recommended vendor, an RFP for organizations to provide healthcare workshop services was issued by CalOptima Health on May 11, 2023, and a total of three proposals were received. An evaluation committee comprised of staff from Operations Management and Vendor Management departments reviewed and scored the proposals. The highest scoring respondent was interviewed by the evaluation committee. The following table provides a summary of the final proposal scores:

Company Name	Proposal Score
Consilience Group LLC	4.19
Institute for Healthcare Improvement	3.58
Wellness and Equity Alliance	2.96

Staff requests that the Board authorize the execution of a contract with Consilience Group, LLC to administer the Nonprofit Healthcare Academy.

Notice of Funding Opportunity to Community-Based Organizations

Staff requests authorization to conduct a NOFO to identify and onboard up to 20 grassroots, nonprofit organizations who are interested in participating in the Nonprofit Healthcare Academy. Should more than 20 applications meet the eligibility criteria, staff will make a request to the Board to provide additional support for this project to offer a second round of the academy in 2024. This NOFO process is not meant to be competitive, but rather to engage as many grassroots CBOs as possible.

Eligibility criteria for interested CBOs will include grassroots non-profit organizations with operating budgets of $5 million or less. CalOptima Health staff will identify CalAIM populations of focus or community supports contracted provider needs that will drive additional eligibility criteria. Organizations that are Black, Indigenous or People of Color (BIPOC)-led will be prioritized for the initial round of participation. Organizations selected to participate that complete all sessions will be provided with a $5,000 stipend for their time and effort.

Fiscal Impact

The recommended actions have no additional fiscal impact. A previous Board action on June 1, 2023, allocated up to $350,000 in HHIP funding to the Nonprofit Healthcare Academy under Priority 4, System Change projects. This allocation will fund:

- Up to $250,000 to execute a contract with Consilience Group, LLC to provide Nonprofit Healthcare Academy technical services; and
- Up to $100,000 to award grants in an amount up to $5,000 to up to 20 CBO grantees.

Rationale for Recommendation

Funding these programs and projects will aid CalOptima Health in meeting HHIP measures while also strengthen the CBOs. Staff will bring additional recommendations to the Board for review and approval in the future.

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Concurrence
Troy R. Szabo, Outside General Counsel, Kennaday Leavitt

Attachments
1. Entities Covered by this Recommended Action

Board Actions

Board Meeting Dates	Action	Term	Not to Exceed Amount
6/1/2023	Approve Actions Related to the Housing and Homelessness Incentive Program	-	$350,000

/s/ Michael Hunn *07/27/2023*
Authorized Signature **Date**

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Attachment to the August 3, 2023 Board of Directors Meeting – Agenda Item 12

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Consilience Group, LLC	2157 Madison Ave.	Memphis	TN	38104

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Continued to a future meeting due to lack of a quorum

CalOptima Health Board Action Agenda Referral

Action To Be Taken August 3, 2023
Regular Meeting of the CalOptima Health Board of Directors

Report Item

13. Ratify the Temporary, Short-Term Supplemental Medi-Cal Payment Increase for Contracted Fee-for-Service Physicians, Except Physicians Employed by UCI Health or the University of California, Irvine, to Support Expenses for Services Provided to Members during the Transition out of the Public Health Emergency

Contacts

Yunkyung Kim, Chief Operating Officer (714) 923-8834
Michael Gomez, Executive Director, Network Operations (714) 347-3262

Recommended Actions

1. Ratify a temporary, short-term supplemental Medi-Cal rate increases of up to 7.5% for contracted fee-for-service physicians, except physicians employed by UCI Health or the University of California, Irvine, for the period of July 1, 2023, through August 31, 2024;
2. Ratify contract amendments and policies and procedures that implement these temporary, short-term public health emergency transition supplemental Medi-Cal rate increases; and
3. Ratify unbudgeted expenditures from existing reserves in an amount up to $10.2 million to support the public health emergency transition supplemental payment program for all contracted fee-for-service physicians.

Background

On January 31, 2020, the Secretary of Health and Human Services declared a public health emergency (PHE) under section 319, of the Public Health Service Act (42 U.S.C. 247d) in response to a novel coronavirus known as SARS-CoV-2 (COVID-19). On March 13, 2020, the President of the United States declared a national emergency based on the spread of this coronavirus. On January 30, 2023, the White House announced that the federal PHE would end on May 11, 2023. Furthermore, the fiscal year (FY) 2023 federal budget ended the continuous Medicaid coverage that had been in place during the PHE after March 31, 2023, triggering the commencement of Medi-Cal redetermination activities on April 1, 2023.

Throughout these past three years, CalOptima Health's Board of Directors (Board) took actions to protect the health and safety of providers and members and to ensure continued access to health care for members, including authorizing supplemental payments to providers for services related to COVID-19. On February 2, 2023, the Board authorized up to $6 million to support redetermination efforts for members and members' communities. The transition out of the PHE after three years and the member redetermination process will place additional strains on the provider delivery system.

Discussion

CalOptima Health staff requests that the Board ratify the temporary, short-term supplemental rate increases to contracted fee-for-service physicians, except physicians employed by UCI Health or the University of California, Irvine, to support the delivery systems' transition out of the PHE and the

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impacts of Medi-Cal redetermination. Staff propose to build upon the methodology the Board previously approved for COVID-19 supplemental payments.

Staff propose to designate the period of July 1, 2023, through August 31, 2024, as the transition period. This period is based on the first month of impact for Medi-Cal redetermination disenrollments. During this period, staff propose to provide a 7.5% increase from contracted rates in effect each month to physicians contracted with CalOptima Health for services provided to CalOptima Health Medi-Cal members enrolled in the CalOptima Health Community Network and CalOptima Direct. Medically necessary covered services provided on dates of service July 1, 2023, through August 31, 2024, would qualify for the temporary rate increase.

The following services are excluded from the short-term supplemental Medi-Cal payment increase:

- Pharmacy and non-pharmacy administered drugs (carved-out under Medi-Cal Rx);
- Long-term care services;
- Durable medical equipment, orthotics, prosthetics and other medical devices;
- Crossover claims;
- Other supplemental or directed payments, such as Proposition 56;
- Cost of administrative services providers; and
- Claims paid by letter of agreement.

Staff will monitor utilization and select quality metrics for access and quality care across the delivery system to monitor the impact of these funds during the transition period.

Fiscal Impact

The recommended actions will be funded by CalOptima Health reserves. An appropriation of up to $10.2 million in undesignated reserves will fund actions for all contracted fee-for-service physicians for the fourteen (14)-month period of July 1, 2023, through August 31, 2024.

Rationale for Recommendation

A temporary, short-term supplemental Medi-Cal payment program will support CalOptima Health's delivery system to ensure continuous access to care for members throughout the PHE transition period.

Concurrence

Troy R. Szabo, Outside General Counsel, Kennaday Leavitt

Attachment

N/A

/s/ Michael Hunn *07/27/2023*
Authorized Signature **Date**

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Continued to a future meeting due to lack of a quorum

CalOptima Health Board Action Agenda Referral

Action To Be Taken August 3, 2023
Regular Meeting of the CalOptima Health Board of Directors

Report Item

14. Ratify a Temporary, Short-Term Supplemental Medi-Cal Payment Increase for Contracted Fee-for-Service Physicians Employed by UCI Health or the University of California, Irvine to Support Expenses for Services Provided to Members during the Transition out of the Public Health Emergency

Contacts

Yunkyung Kim, Chief Operating Officer (714) 923-8834
Michael Gomez, Executive Director, Network Operations (714) 347-3262

Recommended Actions

1. Ratify the temporary, short-term supplemental Medi-Cal rate increases of up to 7.5% for contracted fee-for-service physicians employed by UCI Health or the University of California, Irvine for the period of July 1, 2023, through August 31, 2024; and
2. Ratify contract amendments and policies and procedures to implement these temporary, short-term public health emergency transition supplemental Medi-Cal rate increases.

Background

On January 31, 2020, the Secretary of Health and Human Services declared a public health emergency (PHE) under section 319, of the Public Health Service Act (42 U.S.C. 247d) in response to a novel coronavirus known as SARS-CoV-2 (COVID-19). On March 13, 2020, the President of the United States declared a national emergency based on the spread of this coronavirus. On January 30, 2023, the White House announced that the federal PHE would end on May 11, 2023. Furthermore, the fiscal year (FY) 2023 federal budget ended the continuous Medicaid coverage that had been in place during the PHE after March 31, 2023, triggering the commencement of Medi-Cal redetermination activities on April 1, 2023.

Throughout these past three years, CalOptima Health's Board of Directors (Board) took actions to protect the health and safety of providers and members and to ensure continued access to health care for members, including authorizing supplemental payments to providers for services related to COVID-19. On February 2, 2023, the Board authorized up to $6 million to support redetermination efforts for members and members' communities. The transition out of the PHE after three years and the member redetermination process will place additional strains on the provider delivery system.

Discussion

CalOptima Health staff requests that the Board ratify the implementation of temporary, short-term supplemental rate increases to contracted fee-for-service physicians employed by UCI Health or the University of California, Irvine, to support the delivery systems' transition out of the PHE and the impacts of Medi-Cal redetermination. Staff propose to build upon the methodology the Board previously approved for COVID-19 supplemental payments.

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Staff propose to designate the period of July 1, 2023, through August 31, 2024, as the transition period. This period is based on the first month of impact for Medi-Cal redetermination disenrollments. During this period, staff propose to provide a 7.5% increase from contracted rates in effect each month to physicians contracted with CalOptima Health for services provided to CalOptima Health Medi-Cal members enrolled in the CalOptima Health Community Network and CalOptima Direct. Medically necessary covered services provided on dates of service July 1, 2023, through August 31, 2024, would qualify for the temporary rate increase.

The following services are excluded from the short-term supplemental Medi-Cal payment increase:

- Pharmacy and non-pharmacy administered drugs (carved-out under Medi-Cal Rx);
- Long-term care services;
- Durable medical equipment, orthotics, prosthetics and other medical devices;
- Crossover claims;
- Other supplemental or directed payments, such as Proposition 56;
- Cost of administrative services providers; and
- Claims paid by letter of agreement.

Staff will monitor utilization and select quality metrics for access and quality care across the delivery system to monitor the impact of these funds during the transition period.

Fiscal Impact

The recommended actions will be funded by CalOptima Health reserves and are ratified through separate Board action. An appropriation of up to $10.2 million in undesignated reserves will fund actions for all contracted fee-for-service physicians for the fourteen (14)-month period of July 1, 2023, through August 31, 2024.

Rationale for Recommendation

A temporary, short-term supplemental Medi-Cal payment program will support CalOptima Health's delivery system to ensure continuous access to care for members throughout the PHE transition period.

Concurrence

Troy R. Szabo, Outside General Counsel, Kennaday Leavitt

Attachment

N/A

/s/ Michael Hunn *07/27/2023*
Authorized Signature **Date**

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CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 3, 2023
Regular Meeting of the CalOptima Health Board of Directors

Report Item

15. Authorize Contract with a Non-Medical Transportation and a Non-Emergency Medical Transportation Vendor Effective January 1, 2024

Contacts

Yunkyung Kim, Chief Operating Officer, (714) 923-8834
Ladan Khamseh, Executive Director, Operations, (714) 246-8866

Recommended Actions

Authorize the Chief Executive Officer to:

1. Execute a contract with ModivCare Solutions, LLC (ModivCare) to serve as CalOptima Health's Non-Medical Transportation (NMT) and Non-Emergency Medical Transportation (NEMT) vendor for OneCare and Medi-Cal members. The contract is to be effective April 1, 2024, for a three (3) year term with two (2) additional one-year extension options, each exercisable at CalOptima Health's sole discretion.
2. Extend the current contract with Medical Transportation Management Inc. (MTM) for 90 days to provide NMT services for OneCare and Medi-Cal members. Contract to be effective January 1, 2024, through March 31, 2024.

Background

On June 29, 2017, the California Department of Health care Services (DHCS) released All Plan Letter (APL) 17-010 (superseded by APL 21-008 released on May 18, 2022) providing managed care plans (MCP), including CalOptima Health, with guidance for NMT and NEMT services. The APL specifies that MCPs are expected to provide NMT and NEMT services for all Medi-Cal members. These services include round trip transportation for medically necessary covered and carved-out Medi-Cal services. NMT services may be provided by passenger car, taxicab, or any other form of public or private conveyance as well as mileage reimbursement under certain conditions. NEMT services are prescribed in writing by a provider for the purposes of enabling a member to obtain medically necessary covered services or pharmacy prescriptions authorized by Medi-Cal Rx. NEMT services include ambulance, wheelchair van, litter van, and air transportation.

Discussion

CalOptima Health issued a request for proposal (RFP) in August 2022, which included a scope of work and the CalOptima Health contract. Five vendors participated in the RFP, and their responses were reviewed by CalOptima Health's evaluation team, consisting of representatives from the following departments: Customer Service, Medical Management, Utilization Management, Contracting, Finance, Claims Administration, Regulatory Affairs and Compliance, Privacy, and Information Technology Services. The selected vendor will be obligated to coordinate the NMT and NEMT transportation needs of all OneCare and Medi-Cal members. As such, the RFP responders were evaluated based on experience and footprint in Orange County for NMT and NEMT services, ability to manage

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administrative services, which includes eligibility verification, reporting, technical capabilities, interpreter services, claims administration and adequacy of vehicles. In addition, the five vendors that responded underwent an interview process conducted by the evaluation team and were assessed based on their presentations and qualifications.

The criteria used by the evaluation team included:

- Knowledge of the industry and experience.
- Call center member support and scheduling.
- Ability to assign medically necessary trips using the lowest cost mode and flexibility with those options.
- Driver communication, training, and flexibility.
- Network fleet.
- Tracking and reporting of rides.
- Technological capabilities as well as low tech process as needed.
- Grievances, and fraud, waste and abuse.
- Pricing and claims submission.

The evaluation team's final weighted scoring for the top two RFP responders is as follows:

Vendor	Score
Medical Transportation Management Inc.	20.26
ModivCare Solutions, LLC	19.80

The scores and pricing were close between the top two vendors. Although the incumbent, MTM, scored slightly higher, the evaluation team recommends selecting ModivCare as the NMT and NEMT vendor for the following reasons:

- ModivCare demonstrated the ability to perform both NMT and NEMT services immediately. The incumbent did not provide sufficient evidence of a fully functioning NEMT program. The evaluation team determined the importance of readily available and functioning NEMT outweighed the slightly lower score, and that ModivCare would be the best option for providing NMT and NEMT through one vendor.
- ModivCare has a larger driver fleet size.
- ModivCare has driver incentive programs in place to promote better customer service.

Based on standard procurement processes and in conjunction with CalOptima Health Policy GA.5002: Purchasing, the evaluation team identified ModivCare as the vendor that best meets CalOptima Health members' need for a safe, reliable, experienced, regulatorily compliant, and cost-effective transportation vendor. Accordingly, staff recommends contracting with ModivCare for an initial three (3) year term with the option to extend the contract for two (2) additional one-year terms.

To ensure sufficient time is allocated for readiness assessment, implementation activities, and multiple priority projects for January 1, 2024, staff recommends extending the current contract with MTM from

January 1, 2024 through no later than March 31, 2024. This provides internal and external stakeholders sufficient time to complete the necessary implementation activities.

Fiscal Impact

The recommended actions to extend the current contract with MTM under the same terms and conditions for the period of January 1, 2024, through March 31, 2024, and execute a new contract with ModivCare effective April 1, 2024, has no additional fiscal impact to the CalOptima Health Fiscal Year 2023-24 Operating Budget approved by the Board on June 1, 2023. The budget included approximately $41.4 million for Medi-Cal and OneCare NMT and NEMT transportation expenses.

Based on projected utilization trends over the fiscal year and price changes under the new contract effective April 1, 2024, the budgeted amount is expected to be sufficient to cover the costs of providing NMT and NEMT services through June 30, 2024. Management will include funding for the period on or after July 1, 2024, in future operating budgets.

Rationale for Recommendation

Based on the review of the possible vendors, staff recommends contracting with ModivCare to streamline the transportation process and maintain compliance with NMT and NEMT requirements to ensure members receive safe, reliable transportation to and from covered services.

Concurrence

Troy R. Szabo, Outside General Counsel, Kennaday Leavitt

Attachments

1. Entities Covered by this Recommended Action

/s/ Michael Hunn *07/27/2023*
Authorized Signature **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
American Logistics, LLC	1492 S. Silicon Way Suite A.	St. George	UT	84770
ModivCare Solutions, LLC	6900 Layton Ave. Suite 1200	Denver	CO	80237
Medical Transportation Management, Inc.	16 Hawk Ridge Drive	Lake St. Louis	MO	63367
SafeRide Health	106 Jefferson St. 3rd Fl.	San Antonio	TX	78205
Secure Transportation	12800 Center Court Dr. S Suite 120	Cerritos	CA	90703

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CalOptima Health Board Action Agenda Referral

Action To Be Taken August 3, 2023
Regular Meeting of the CalOptima Health Board of Directors

Report Item

16. Authorize an Amendment to the Contract with Pharmacy Benefit Manager, MedImpact Healthcare Systems, Inc., to extend the Contract

Contact

Zeinab Dabbah, MD, JD, CHIE, Deputy Chief Medical Officer, (657) 900-1481

Recommended Actions

Authorize the Chief Executive Officer (CEO) to execute an amendment to extend the current Pharmacy Benefits Manager (PBM) Services Agreement with MedImpact Healthcare Systems Inc. (MedImpact) for the OneCare and PACE lines of business for two years, effective January 1, 2025 to December 31, 2026.

Background

As CalOptima Health's PBM, MedImpact provides certain administrative services, including maintenance and credentialing of network contracted pharmacies, pharmacy claims administration, prescription drug management and utilization reports, and other services.

At its May 7, 2015, meeting, the CalOptima Health Board of Directors (Board) authorized an agreement with MedImpact to serve as the CalOptima Health PBM effective January 1, 2016. The authorization allowed for a three-year term with two additional one-year extension options. The initial three-year PBM Services Agreement with MedImpact expired December 31, 2018. At its October 4, 2018, meeting, the Board ratified an extension of the MedImpact agreement through December 31, 2019. The agreement was again extended at the August 1, 2019, meeting effective January 1, 2020, through December 31, 2021. At its October 1, 2020, meeting, the Board authorized a revision to the MedImpact PBM Services Agreement to remove the Medi-Cal line of business and extend the end date to December 31, 2024.

Per the terms of the contract, CalOptima Health is required to provide ninety days prior written notice to MedImpact in order to exercise each extension option.

Discussion

A full replacement of the PBM system would take over a year to complete, including the request for proposals process. It would require a dedicated team from several departments within CalOptima Health at a time with multiple competing resource-intensive initiatives. Some of these pharmacy-related initiatives include implementation of the new Medicare Advantage (MA) Value-Based Insurance Design (VBID) Model for OneCare, implementation of a new Chronic Condition Special Needs (C-SNP) plan, and improving Centers for Medicare & Medicaid Services (CMS) star ratings.

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MedImpact has performed well in external regulatory audits. There were no pharmacy-related findings in the recent annual Department of Health Care Services (DHCS) audit, as well as CMS Part D data validation audits. There was one formulary administration finding in the 2021 CMS program audit that has been remediated. Furthermore, MedImpact contributes to the OneCare Part D star rating, which has been at 3.5 or higher for the past six years, including 4.5 stars in 2022.

In addition, CalOptima Health's Audit & Oversight (A&O) Department conducts an annual audit on MedImpact. The purpose of the annual audit is to monitor and ensure that CalOptima Health functions are being performed satisfactorily for OneCare and PACE lines of business. MedImpact is evaluated based upon CalOptima Health requirements, National Committee for Quality Assurance accreditation standards, and Department of Managed Health Care, CMS and DHCS regulatory requirements. The audit is comprised of two components, offsite and desk review. The offsite portion was performed as a desk review, and the onsite portion took place at the MedImpact location. MedImpact performed satisfactorily in the 2021 annual audit and worked cooperatively with A&O to remediate the minor deficiencies identified.

Staff are satisfied with MedImpact's performance to date, and the audit results were favorable. Based on these factors, management recommends that the Board authorize extending the current contract with MedImpact for two years, through December 31, 2026.

Fiscal Impact

The CalOptima Health FY 2023-24 Operating Budget includes funding for pharmacy benefit management fees for the OneCare and PACE lines of business through June 30, 2024. There is no additional fiscal impact in the current fiscal year. Management will include funding for the period of January 1, 2025, through December 31, 2026, in future operating budgets.

Rationale for Recommendation

Extending the MedImpact PBM Services Agreement will ensure there is no disruption of pharmacy services provided for the OneCare and PACE lines of business and will allow for continuity of pharmacy management operations.

Concurrence

Troy R. Szabo, Outside General Counsel, Kennaday Leavitt

Attachments

1. Contracted Entity Covered by this Recommended Board Action

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Board Actions

Board Meeting Dates	Action	Term	Not to Exceed Amount
May 7, 2015	Authorized Agreement	December 31, 2018	N/A
October 4, 2018	Authorized extension	December 31, 2019	N/A
August 1, 2019	Authorized extension	December 31, 2021	N/A
October 1, 2020	Authorized extension	December 31, 2024	N/A

/s/ Michael Hunn *07/27/2023*
Authorized Signature **Date**

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CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
MedImpact Healthcare Systems, Inc.	10181 Scripps Gateway Ct.	San Diego	CA	92131

Board of Directors Meeting
August 3, 2023

Regular Joint Meeting of the Member Advisory Committee and the Provider Advisory Committee

Report to the Board

The Member Advisory Committee (MAC), and the Provider Advisory Committee (PAC) held a regular joint meeting on June 8, 2023 to discuss topics of mutual interest.

The committees reviewed and approved their individual recommendation for their respective slate of candidates. The MAC welcomed new member Keiko Gamez as the OneCare Member/Family Member.

Hieu Nguyen, Director of Population Health and Equity, Orange County Health Care Agency presented on Equity in the OC. He shared the vision, mission and goals of the Orange County Health Care Agency and reviewed the funding the Equity in OC had received to help fund cases of COVID-related inequities and assist in building a foundation for equity work.

Yunkyung Kim, Chief Operating Officer, provided an update on CalOptima Health's membership and noted that it stood at 985,000 members and noted an increase of 7,000 members from the last report. Ms. Kim also gave a redetermination update and answered questions from both the MAC and PAC members.

Zeinab Dabbah, M.D., J.D., M.H., Deputy Chief Medical Officer, provided updates on the resurgence of the Mpox (formerly known as Monkey Pox) virus and noted that 20% of the cases were in California. Dr. Dabbah also noted an increase in congenital syphilis.

The members of the MAC and PAC appreciate the opportunity to update the Board on their current activities.